



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 2, 2025

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

RE: CCN: 245394
Cycle Start Date: April 10, 2025

Dear Administrator:

On May 20, 2025, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



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Electronically delivered

June 2, 2025

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

Re: Reinspection Results
Event ID: F3US12

Dear Administrator:

On May 20, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2025

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

RE: CCN: 245394
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 July 10, 2025 (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 October 10, 2025 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

The Estates At Lynnhurst LLC

April 24, 2025

Page 4

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping".

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: 245394		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	INITIAL COMMENTS On 4/7/25 - 4/10/25, 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. The following complaints were reviewed with no deficiencies cited: H53942449C (MN00102974) H53942450C (MN00103106) H53942542C (MN00104906) H53942451C (MN00104960) H53942525C (MN00110987) H53942452C (MN00109124) H53942453C (MN00108412) H53942492C (MN00101469) 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 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not			F 553			5/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2025

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 553	Continued From page 1 limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident and resident guardian's participation in the development and review of care plans 1 of 1 residents, (R8) reviewed who voiced concerns about care conference participation. Findings include:	F 553	Immediate Corrective Action (what was done for the resident/s identified):¿R8 was offered to attend care conference. How did we identify others: All residents have the chance to be affected by this finding.		

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F 553	Continued From page 2 R8's annual Minimum Data Set (MDS) dated 2/18/25, identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia. R8's MHM BIMS (Brief Interview of Mental Status) Staff Assessment dated 2/18/25, identified five- minute and long past memory recall was "ok" and R8 was able to recall the current season, her own room, staff name and faces and that she was in a nursing home. R8 had modified independence with daily decision making. R8's discharge care plan dated 2/19/25, identified resident and family would be invited to care conferences quarterly or as needed. A review of R8's MDS history identified the following: - 2/18/25 annual MDS and corresponding care conference form 3/25/25, not completed. There was no documentation R8 or her guardian were invited or attended. - 11/22/24 quarterly MDS and corresponding care conference form 11/13/24, there was no documentation R8 or her guardian were invited or attended. - 8/30/24 quarterly MDS and corresponding care conference form dated 8/14/24, there was no documentation R8 was invited or attended, nor if her guardian attended.	F 553	Corrective Action as it applies to others:¿All residents were audited and offered the chance to attend their upcoming care conferences, if refused, documentation added to progress notes. Recurrence will be prevented by (process changes and educations): Social services educate on the importance of offering residents to attend their own care conferences, including care conference policy. Facility to offer every resident the opportunity to attend their care conferences. Audits including how many, how long, and who they will be monitored by: Facility will Audit 5 resident weekly for 4 weeks, to ensure that residents and representatives were offered and attendance noted in care conference form. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Social Services Director to complete audits. Social Services Director/Designee is responsible party.		

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F 553	Continued From page 3 - 6/7/24 quarterly MDS and corresponding care conference form dated 6/27/24, there was no documentation R8 or her guardian were invited or attended. - 3/26/24 significant change MDS lacked a corresponding care conference. - 2/22/24 admission MDS with corresponding care conference 2/26/24, identified the guardian was not involved in the care conference. R8's care conference progress notes identified: - 8/13/24 at 9:32 a.m., the social worker reached out to guardian and caseworker to schedule a care conference. There was no follow up documentation. The note did not identify if R8 was invited. - 6/27/2024 at 14:42 (2:42 p.m.), care conference scheduled for 7/8/24 at 11:00 a.m. The note did not identify if R8 or guardian were invited or attended. - 3/6/24 at 11:31 a.m., care conference held as scheduled. This is the second care conference for R8 upon admission. The note did not identify if the R8 or guardian were invited or attended. - 2/26/2024 at 14:33 (2:33 p.m.), care conference held on this date. In attendance was R8, LPN (licensed practical nurse) coordinator, OT (occupational therapy), and SS (social services). SS attempted to contact guardian to join the care conference but there was not an answer, voicemail was left. . During an interview on 4/7/25 at 6:03 p.m., R8 stated she wanted to know if the facility had care conferences and she was supposed to have a meeting two months ago but it never happened. R8 stated the facility held care conferences but			F 553			

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F 553	Continued From page 4 she has not been invited since she had a legal guardian. R8 stated she would like to be part of the meetings because she did not think they knew about her concerns. R8 stated she wanted her purse with a driver licence, social security card. R8 wanted pictures of her kids and grandkids for her room. She wanted hearing aides, new eyeglasses, dentures and diabetic shoes. R8 stated many of the items she wanted had been left behind in her house after she was taken out of her home. During an interview on 4/10/25 at 10:38 a.m., registered nurse (RN)-A stated she could not find documentation of who attended or was invited to R8's care conferences. During an interview on 4/10/25 at 12:59 p.m., the social services designee (SSD) stated care conferences were held based off the MDS schedule: quarterly/comprehensive, annual, and significant change. The SSD would open the care conference form and invite the interdisciplinary team (IDT) to fill in their respective sections. Guardians and residents were invited to attend with the IDT. The SSD reviewed R8's care conference forms and agreed she could not tell if the resident or guardian had been invited or attended. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated the resident and guardian should be invited to participate in care conferences along with the IDT, and it should be documented who was invited and present/participated. A facility policy for care conferences was requested and not provided. The administrator			F 553			

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

PRINTED: 05/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
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F 553	Continued From page 5	F 553			
F 582 SS=D	emailed a process on 4/10/25, which identified social services meets with resident within 48 hours of admission, and then completes full care conference within first 48 hours, and then every quarter, annually, PRN (as needed) and significant change. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582			5/13/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 582	Continued From page 6 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely provide the required liability and appeal rights notices prior to discharge from Medicare Part A services for 1 of 3 residents (R170) reviewed for beneficiary notices. Findings include: R170's last day of covered Medicare Part A Skilled Services was 1/22/25, as identified on the form CMS-20052 (SNF [skilled nursing facility] Beneficiary Protection Notification Review). R170's Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) was signed by the resident on 1/30/25.			F 582	Immediate Corrective Action (what was done for the resident/s identified):¿R170 was not offered notification of change 48hrs prior to end of coverage, in addition, did not make selection of choice. How did we identify others: All skilled residents have the chance to be affected by this finding. Corrective Action as it applies to others:¿All residents were audited and offered the chance to make an informed decision timely for end of coverage. Recurrence will be prevented by (process		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 582	Continued From page 7 R170's Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-10055) was signed by the resident on 1/30/25, and lacked indication of which option (regarding the appeal process) he had chosen. During interview on 4/10/25 at 3:30 p.m., the administrator stated the expectation was to have the residents sign the CMS-10123 and CMS-10055 at least 2 days before the last day of covered Medicare part A Skilled Services and ensure an option regarding the appeal process was indicated. A facility policy regarding BNP notices dated 2/20/23, indicated: When a Last Covered Day (LCD) is determined by the facility or the resident's insurance provider, and there are benefit days remaining, we must issue a denial to the resident/legal responsible party (POA/Guardian). These denials must be given at minimum two days prior to the LCD. Example: LCD is chosen for the 15th of the month, the denials is due no later than the 13th.	F 582	changes and educations): Business office and Social services were educated on the importance of offering notification of liability timely, in addition to the importance of selecting an option of coverage choice. The facility will review all upcoming coverage changes in facility stand up Monday - Friday. Audits including how many, how long, and who they will be monitored by: Facility will audit 5 skilled residents weekly for 4 weeks to ensure that residents and representatives were offered Notice of Medicare Non Coverage form within the regulatory limit of 48hours prior to discharge or liability change. The result of these audits will be shared with facility QAPI committee for input on needed to increase or decrease or discontinue audits. Social Services Director to complete audits. Business Office Manager/Designee is responsible party.		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583			5/13/25

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F 583	Continued From page 8 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 2 residents (R29) who required staff assistance with personal cares. Findings include: R29's admission Minimum Data Set (MDS) dated 2/12/25, indicated he had intact cognition and was dependent on staff assistance for toileting hygiene and required partial to moderate assistance with personal hygiene cares. The MDS reported he was frequently incontinent of			F 583	Resident affected: R29, Mirror was removed. How did we identify other residents: Full house audits completed to identify mirror placement. What did we do for identified residents? Mirrors were removed from the walls. They all have mirrors in their bathroom. What process was changed? Mirrors will not be hung in residents rooms.		

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F 583	Continued From page 9 urine and bowel. The MDS listed his diagnoses as hemiparesis (one-sided weakness) or hemiplegia (one-sided paralysis), chronic lung disease, and chronic obstructive pulmonary disease (COPD, a chronic restrictive lung and breathing condition). R29's Care Area Assessment (CAA) for functional abilities dated 2/12/25, reported he received limited assistance "with rolling left and right in bed," and "extensive assist with bathing, upper body dressing." The CAA further identified his dependence on staff for toileting hygiene. R29's care plan dated 2/11/25, identified his self-care deficit and categorized him as a "vulnerable adult". The care plan directed staff to provide an assist of 1 with personal hygiene, bathing, and dressing. During observation on 4/7/25 at 2:24 p.m., R29's door was not closed and from the unit hallway reflected through a mirror affixed in the middle of the wall, nursing assistant (NA)-C could be seen standing beside R29's bed on the far end of the shared room. The privacy curtain was not pulled all the way around the bed. The mirror on the wall reflected NA-C removing R29's incontinence brief and his bare genitals were exposed. The mirror reflected NA-C fastening the tabs on the new brief, doffing his gloves, and adjusting the bed to the lowest position. NA-C exited the room and performed hand hygiene at the soiled utility station. During interview on 4/7/25 at 2:27 p.m., NA-C stated staff should first knock then close a resident's door and close the privacy curtain to maintain their dignity and protect their privacy.	F 583	What Education was completed? Maintenance will be educated to not hang mirrors in residents rooms. Audits: Audit 5 residents weekly X 4 weeks to ensure there is no mirror hanging. Recurrence will be prevented by: Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee will be responsible party.		

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F 583	Continued From page 10 NA-C stated R29's door was unable to be closed due to resident preference. When asked if R29's curtain could be closed further to maintain his privacy, NA-C first stood where the surveyor made the observation and looked through the mirror at R29's bed. Next, NA-C and the surveyor entered his room and NA-C demonstrated the privacy curtain could close further. Finally, NA-C and the surveyor returned to the hallway and looked through the mirror at R29 and only his ankles and feet were reflected in the mirror. NA-C confirmed the privacy curtain should have been pulled fully closed to provide privacy. Per interview on 4/8/25 at 9:51 a.m., NA-E expected staff to close the door, pull the curtain and ask a resident's permission before starting cares to protect their privacy and dignity. Per interview on 4/10/25 at 10:22 a.m. with registered nurse (RN)-A, staff were expected to knock before entering a resident's room, ask permission, explain the task being performed, pull the privacy curtain, make sure the blinds are closed if that's appropriate, clean up the supplies, and make sure the resident is safe and comfortable before leaving the room. Per interview on 4/10/25 at 1:03 p.m. with the director of nursing (DON), staff were expected to close the door and pull the privacy curtain to maintain dignity and privacy for residents. A facility policy pertaining to resident rights and privacy was requested but not received.	F 583			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657			5/13/25

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F 657	Continued From page 11 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan with input from the resident to meet a resident's vision needs for 1 of 1 residents reviewed for reassessment of the care plan. Findings include: R21's quarterly Minimum Data Set (MDS) dated 3/4/25, indicated he had moderately impaired	F 657	Resident Affected: R21, Appointment has been made to see optometrist to assess cataract and for new glasses. Care plan was adjusted to include his glasses. Others Affected: Full house audits to identify those who have glasses and in good repair, check if care planned and on NAR guide.		

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F 657	Continued From page 12 cognition, did not reject cares, and was usually able to make himself understood and usually able to understand others. The MDS indicated his vision was adequate and he did not wear corrective lenses. The MDS identified diagnoses including aphasia (a condition in which language function is disordered), and cataracts (a progressive disorder of the lens of the eye characterized by a loss of transparency with a white/yellow/brown tinge to the lens). R21's Care Area Assessment (CAA) for visual function dated 6/19/24, was triggered due to his cataracts and indicated he had the potential for impaired visual function related to his diagnosis of bilateral (left and right) age-related cataracts. The CAA indicated the overall objective for care planning this potential problem was to maintain his current level of functioning indicated, "per vision exam 3/28/24: Educated patient regarding ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA [visual acuity]. Resident has adequate vision with use of reading glasses. Care plan to maintain current level of visual acuity." R21's care plan, last revised 3/4/25, identified his potential for impaired vision related to his diagnosis of age-related cataracts and listed a goal to maintain his current vision. The care plan directed staff to set up ophthalmology appointment as needed. Additionally, the care plan identified his self-care deficit related to his hemiplegia and indicated he had glasses "that he wears when he chooses" and was able to put on and take off the glasses himself. The care plan directed staff to assist him clean the eyeglasses and ensure they were in "good repair". The care			F 657	Full house audit to review all optometry dictation from the past year to ensure any follow up orders were followed up on. What process was changed? No Process changed What Education was provided? Begun educating nursing department to notify clinical leader if glasses need repair. HUC and clinical leadership were educated to review optometry dictations and ensure any orders regarding setting up appointments or follow up. Audits: Audit 5 residents weekly X 4 weeks to ensure glasses are in good repair and any optometry orders are followed. Recurrence will be prevented by: Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee will be responsible		

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F 657	Continued From page 13 plan lacked documentation of any use of multiple pairs of non-prescription glasses. Furthermore, the care plan lacked documentation Patient encounter notes dated 9/28/23, 10/3/24, and 3/28/24, indicated R21 was seen by the Doctor of Optometry (OD) for a cataract evaluation. The encounter notes revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an "attempt to improve reduced VA [visual acuity]. Please schedule consultation." A care conference form dated 3/24/25, indicated R21's last eye exam was on 10/3/24 but lacked documentation if he or his representative's input were considered in the care conference or care planning process. R21's EHR was reviewed on 4/8/25 at 2:20 p.m. and lacked documentation that referral to cataract extraction specialist was followed-up on. Furthermore, the EHR lacked documentation his order for consult to optometry for new eyeglasses was followed-up on. During observation on 4/7/25 at 2:33 p.m., R21 showed surveyor a pair of eyeglasses with a missing left temple (long arm on the side of the frame that fit over the ear). Per interview on 4/8/25 at 3:31 p.m. with R21 via interpreter, his cataracts had been ongoing for approximately one year and he believed there was "orange" discoloration to his left eye. He stated he had not seen any provider about the cataract extraction. He also endorsed having difficulty seeing without his eyeglasses and stated he needed a new pair.	F 657			

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F 657	Continued From page 14 During interview on 4/9/25 at 9:15 a.m., OD verified familiarity with R21 and his vision exams. OD explained the decision to make a referral for a cataract extraction was usually driven by either a resident, family, representative or the primary provider. OD stated the decision to move forward with referral was driven by R21. OD confirmed placing the order for the consult in March 2023 and confirmed, "he does have the presence of cataracts" and explained once the referral was made, "it is up to the facility to get that scheduled." Additionally, OD denied being made aware of R21's need for eyeglasses and stated, "at no point have we done a pair of eyeglasses for him or an exam for glasses." OD reviewed R21's progress notes and was unable to find that he presented anytime with a request for eyeglasses. OD stated, "typically, the facility would make us aware of the need for repair or the resident brings them with and makes us aware." Per interview on 4/10/25 at 12:58 p.m. with the director of nursing (DON), staff were expected to follow up on appointment referrals. The DON stated resident's preferences and care planned interventions were discussed and reassessed for appropriateness during care conferences. The DON also stated staff had been purchasing over the counter (OTC) non-prescription eyeglasses because there had been many broken pairs but expected there to be documentation of the use of OTC non-prescription eyeglasses. A facility policy title Care Planning last revised 11/24, indicated each resident would have a person-centered care plan developed by the IDT for the purpose of meeting the resident's			F 657			

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F 657	Continued From page 15 individual needs. The policy directed the IDT to, in conjunction with the resident and the resident representative, develop and implement a comprehenisve individualized care plan with information gathered from the comprehensive assessment. The policy indicated the care plan should be consistent with resident's rights to identify problem areas and their causes to develop interventions that were targeted and meaningful to the resident. The policy also highlighted that the resident had the right and would be encouraged to participate in the development of his or her care plan, and the care plan should be modified and updated as the condition and care needs of the resident changed.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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 document review the facility failed to ensure residents were provided incontinence care in a timely manner for 1 of 1 resident (R9) reviewed for activities of daily living (ADL). Findings include: R9's admission Minimum Data Set (MDS) dated 1/24/25, indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation (A-fib), and pancreatitis. It further indicated R9 was	F 677	Resident affected: R9, Incontinent care was provided to resident. Toilet plan was reviewed in care plan and nar guide. How did we identify others: Full house audits was completed to identify those that require incontinent care. What did we do for others identified: Ensured they have a plan for toileting/incontinence care listed in their care plan and nar guide What process was changed: no change		5/13/25

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F 677	Continued From page 16 dependent on staff for toileting and was frequently incontinent of bowel and bladder. R9's care plan dated 4/8/25, indicated alteration in elimination d/t limited mobility secondary to COPD and alcohol dependence with the following interventions: -Assist of 2 with toileting. -Provide assistance with peri-cares morning (AM), hour of sleep (HS) and as needed (PRN). -Provide incontinent products and assist to change PRN During observation on 4/7/25 at 3:22 p.m., R9 was sitting in his wheelchair by the door to his room, waiting to go in. He asked nursing assistant (NA)-B to change his brief because he had a bowel movement (BM) and NA-B told him to wait until staff was done with R55's (roommate) wound care. R9 asked how long that would be and registered nurse (RN-B) stated 15 minutes. When the surveyor left the room, (following wound care) at 4:25 p.m., R9 was still waiting outside the room and there was an odor of BM. R9 stated he often had to wait from 1-3 hours to have his brief changed because his roommate had a wound and if they change him during wound care "it could be contagious." He further stated he also had to wait for an hour to be changed so both nursing assistants can go on their breaks. At approximately 4:35 p.m. NA-B assisted NA-E to transfer R9 from his wheelchair to the bed and NA-E proceeded to change his brief. He was wet and urine had soaked through his pants so NA-E removed them and got a new pair stating "the weird thing is it didn't go through to your sling (urine)." R9 had also had a BM. NA-E cleaned up the BM, applied new pants, and NA-B assisted NA-E to transfer him from his bed	F 677	What education was completed: Staff educated that residents in shared room can receive cares at the same time. Pull privacy curtain and close door. Train staff to look at the NAR guide to ensure they follow the toileting plan. Audts: Audit 5 residents weekly for 4 weeks to ensure their toileting plan was followed. Recurrence will be prevented by Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee will be responsible party		

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F 677	Continued From page 17 back into his wheelchair. During interview on 4/7/25 at 4:52 p.m. NA-B verified R9 had waited an hour to be changed and stated it was because too many people were in the room and the nurse stated it would only take 15 minutes to complete his roommates wound care. During an interview on 4/10/25 at 12:08 p.m. the nurse manager registered nurse (RN)-C stated an hour was too long for a resident to be sitting in a soiled brief and R9 should've been able to be changed before they started his roommates wound care, stating it takes longer then 15 minutes to complete wound care and change a wound vacuum (vac). During an interview on 04/10/25 at 2:52 p.m., the director of nursing (DON) stated when a resident asked to be changed/toileted, it should be done as soon as possible or within 15-30 minutes (at most) to prevent skin breakdown. If the NA's or nurses are busy the nurse manager can also assist residents to changed/toileted. A facility policy on ADL's dated 3/31/23, indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting d. Dining-eating (meals and snacks) e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. A resident who is unable to carry out			F 677			

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F 677	Continued From page 18 activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident ' s advance directives.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow up on 1 of 1 residents (R55) Urology referral. Finding include: R55's quarterly Minimum Data Set (MDS) dated 3/25/25, indicated intact cognition and diagnoses of paraplegia and neuromuscular disfunction of the bladder. It further indicated R55 required substantial assistance with bed mobility, was dependent on staff for transfers, had a catheter, and was always incontinent of bowel. R55's care plan dated 3/25/25, indicated	F 684	Resident Affected: R55, Appointment was made. How did we identify others: Full house audits completed to identify all appointment orders. What did we do for others identified: Ensure the appointment is scheduled. What process was changed: Initiated an appointment spreadsheet What education was completed: HUC was educated to schedule appointments within		5/13/25

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F 684	Continued From page 19 alteration in elimination related to diagnoses of motor vehicle crash, neurogenic bladder, convulsions, etc. Resident admitted with foley catheter 20 French (F) 30 cubic centimeters (cc) for neurogenic bladder and assist of 1 with toileting. It further indicated the following interventions: -Prefers to notify staff when incontinent to have brief changed -Monitor foley catheter output every shift. -Change foley catheter monthly per order. -Foley catheter care per policy. -Monitor BM's as they occur. -Administer bowel medications as ordered. -Introduce resident to other residents with similar interests. -Monitor target behaviors per protocol. R55's hospital discharge orders dated 1/31/25, indicated: the physician had recommended an appointment with HealthPartners Urology for bladder spasms and urine bypassing Foley catheter. During interview on 4/9/25 at 9:28 a.m., the HUC verified there was an order for a urology appointment, and he hadn't followed through on it, stating he doesn't know why it wasn't scheduled and it should have been. During interview on 4/9/25 8:57 a.m., licensed practical nurse (LPN)-B stated when a resident was admitted/re-admitted to the facility, the Health Unit Coordinator (HUC) entered the discharge orders in PCC (Point Click Care computer system) before the resident arrived at the facility. Once they arrive 2 nurses were required to compare the paperwork the resident brought with them, to the orders the HUC entered	F 684	one week when ordered and to notify the managers and providers if there are any issues with scheduling the appointment. The HUC is educated to the spread sheet. Audits: Audit 5 residents weekly for 4 weeks to ensure any new appointment orders were scheduled. Recurrence will be prevented by Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee will be responsible party		

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F 684	Continued From page 20 in PCC. If there were any questions or clarifications, the nurses were responsible for calling the provider to clarify. During interview 4/9/25 9:17 a.m., the director of nursing (DON) stated when a resident was admitted/re-admitted to the facility, they would receive an email with the admitting residents discharge orders and the HUC would enter it into PCC. Once the resident arrived, they should have a paper copy of the orders/discharge summary and the admitting nurse would print off the order and make a copy (so they aren't writing on the original order). Then the admitting nurse would start confirming the orders and a 2nd nurse would compare the orders the HUC entered to the orders the resident brought with them. If there are were any discrepancies or clarifications, it was the nurses responsibility to call the provider to clarify. The DON also verified R55 had an order for a referral to urology and was unable to find the date of his last urology appointment or one scheduled in the future.	F 684			
F 685 SS=D	A facility policy regarding coordination of care was requested but not received. Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to	F 685			5/13/25

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F 685	Continued From page 21 and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow-up on consults for vision-related appointments for 1 of 3 residents (R21) and failed to provide assistive devices to maintain hearing for 1 of 3 residents (R29) reviewed for communication. Findings include: R21 Glasses and Cataracts Consults R21's quarterly Minimum Data Set (MDS) dated 3/4/25, indicated he had moderately impaired cognition, did not reject cares, and was usually able to make himself understood and usually able to understand others. The MDS indicated his vision was adequate and he did not wear corrective lenses. The MDS identified diagnoses including aphasia (a condition in which language function is disordered), one-side weakness or one-sided paralysis (hemiparesis or hemiplegia, respectively), anxiety, and cataracts (a progressive disorder of the lens of the eye characterized by a loss of transparency with a white/yellow/brown tinge to the lens). R21's Care Area Assessment (CAA) for visual function dated 6/19/24, was triggered due to his cataracts and indicated he had the potential for impaired visual function related to his diagnosis of bilateral (left and right) age-related cataracts. The CAA indicated the overall objective for care planning this potential problem was to maintain			F 685	Resident Affected: R21, Appointment has been made to see optometrist to assess cataract and for new glasses. : R29, Ensured pocket talker is on the care plan and NAR guide, hang a sign in his room with his permission. Others Affected: Full house audits to identify those who have glasses and in good repair, check if care planned and on NAR guide. Full house audit to review all optometry dictation from the past year to ensure any follow up orders were followed up on. Full house audits completed to identify others that use communication device. Ensure those communication devices are in the care plan and NAR guide. What process was changed? No Process changed What Education was provided? Begun educating nursing department to notify clinical leader if glasses need repair. HUC and clinical leadership were educated to review optometry dictations and ensure any orders regarding setting up appointments or follow up. Therapy was educated to utilize therapy forms to communicate to clinical leadership on communication devices		

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F 685	Continued From page 22 his current level of functioning indicated, "per vision exam 3/28/24: Educated patient regarding ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA [visual acuity]. Resident has adequate vision with use of reading glasses. Care plan to maintain current level of visual acuity." Furthermore, the CAA revealed health information management (HIM) was notified. R21's order summary report dated 2/28/25, included the following orders: - "consult optometry for new glasses," dated 12/14/24. - "may see audiologist, dentist, podiatrist, optometrist, psychology" as needed (PRN), 1/2/24. - "OK for ancillary orders: may see eye care physician if requested by resident or family," dated 12/3/19. A review of R21's electronic health record (EHR) on 4/8/25 at 2:20 p.m., revealed an Ovitsky Vision Care of Minnesota PC order dated 3/1/23 for "refer for cataract extraction evaluation with cataract specialist." The order indicated the resident requested the consult to prevent vision decrease and the specialist could be determined by his attending medical doctor (MD) or nurse practitioner (NP). R21's care plan, last revised 3/4/25, identified his potential for impaired vision related to his diagnosis of age-related cataracts and listed a goal to maintain his current vision. The care plan			F 685	they are recommending for residents. Clinical leadership was educated in regard to their responsibilities to add new devices to the care plan and NAR guide. Begun education of the nursing department on how to use communication devices. Audits: Audit 5 residents weekly X 4 weeks to ensure glasses are in good repair and any optometry orders are followed. Audit all residents with communication devices weekly x 4 weeks to ensure they are being utilized. Recurrence will be prevented by: Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee is responsible party		

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F 685	Continued From page 23 directed staff to set up ophthalmology appointment as needed. Additionally, the care plan identified his self-care deficit related to his hemiplegia and indicated he had glasses "that he wears when he chooses" and was able to put on and take off the glasses himself. The care plan directed staff to assist him clean the eyeglasses and ensure they were in "good repair". A patient encounter note dated 9/28/23, indicated R21 was seen by the Doctor of Optometry (OD) for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an "attempt to improve reduced VA [visual acuity]. Please schedule consultation." A patient encounter note dated 10/3/24, indicated R21 was seen by OD for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an "attempt to improve reduced VA [visual acuity]. Please schedule consultation." A patient encounter note dated 3/28/24, indicated R21 was seen by OD for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed, and he elected to proceed with the consultation in an "attempt to improve reduced VA [visual acuity]. Please schedule consultation." A nursing progress note dated 3/1/23 indicated R21 was seen by OD and received new orders for "cataract extraction evaluation with cataract specialist. Resident requests consult secondary to reported vision decrease."	F 685			

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F 685	Continued From page 24 A provider progress note dated 11/22/23 indicated under the "chief complaint/nature of presenting problem" header that R21 "took a lens out of his pocket in order to request a new pair of eyeglasses." The provider 's progress note indicated under the "plan" header, "make eye doctor appt [appointment] for new eyeglasses," for the diagnosis impaired vision. A nursing progress note dated 9/28/23 indicated he was seen by OD but lacked documentation on cataract extraction consult. R21's EHR was reviewed on 4/8/25 at 2:20 p.m. and lacked documentation that referral to cataract extraction specialist was followed-up on. Furthermore, the EHR lacked documentation his order for consult to optometry for new eyeglasses was followed-up on. During observation on 4/7/25 at 2:33 p.m., R21 showed surveyor a pair of eyeglasses with a missing left temple (long arm on the side of the frame that fit over the ear). Per interview on 4/8/25 at 3:31 p.m. with R21 via interpreter, his cataracts had been ongoing for approximately one year and he believed there was "orange" discoloration to his left eye. He stated he had not seen any provider about the cataract extraction. He also endorsed having difficulty seeing without his eyeglasses and stated he needed a new pair. During interview on 4/9/25 at 9:15 a.m., OD verified familiarity with R21 and his vision exams. OD explained the decision to make a referral for a cataract extraction was usually driven by either a resident, family, representative or the primary			F 685			

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F 685	Continued From page 25 provider. OD stated the decision to move forward with referral was driven by R21. OD confirmed placing the order for the consult in March 2023 and confirmed, "he does have the presence of cataracts" and explained once the referral was made, "it is up to the facility to get that scheduled." OD stated cataracts do change a person's vision but once a cataract is removed, the vision "is significantly clearer for a person." OD stated any change in vision from cataracts "is only temporary." OD explained the symptoms of having a cataract or cataracts could include blurred vision, difficulty reading, loss of ability to "perform a specific activity they were doing", glare from lights or difficulty with overhead lighting, or trouble with nighttime driving. OD denied being made aware of R21's need for eyeglasses and stated, "at no point have we done a pair of eyeglasses for him or an exam for glasses." OD reviewed R21's progress notes and was unable to find that he presented anytime with a request for eyeglasses. OD stated, "typically, the facility would make us aware of the need for repair or the resident brings them with and makes us aware." Per interview on 4/9/25 at 11:00 a.m. with HIM, if an additional referral is made from the vision team for cataract extraction, the vision team would write up the referral and the facility would send that out to the respective clinic. HIM reviewed R21's chart and the vision encounter note dated 10/3/24 and stated, "there it is, the consult for the cataract eval. The referral should have been noted and sent out." HIM reviewed the Ovitsky Vision Care of Minnesota PC order dated 3/1/23 and stated the order should have gone to the HIM and then it should have been faxed over and acted upon. HIM stated the facility used an	F 685			

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F 685	Continued From page 26 electronic fax and had the capability of seeing if faxes were successfully submitted and if there were not, they should have been re-attempted. HIM stated if there was a reason the referral was not followed up on, there should have been documentation in the progress notes. Per interview on 4/10/25 at 10:06 a.m., licensed practical nurse (LPN)-A stated consults and referrals were entered in the orders and then communicated to HIM. LPN-A stated they received confirmation the consult or referral was followed up on by seeing the resident was scheduled for an appointment. LPN-A stated if HIM was out, "its sort of all of us" to ensure the consults or referrals were followed up on. During follow-up interview on 4/10/25 at 10:28 p.m., HIM stated if the vision team decided to work with a consult for eyeglasses, they would work with the resident and the facility to complete the consult. HIM reviewed R21's EHR and confirmed the consult to optometry for new eyeglasses dated 12/14/24 and stated, "I did see that order, it didn't come to me right away. IT should have been communicated better, and I should have gotten it and forwarded that on to the vision team." HIM explained the normal process would be that the consult be communicated to HIM and then emailed or faxed to the vision team. HIM stated the vision team would confirm receiving the consult by letting the facility know the resident was on the schedule for their next visit at the facility. Per interview on 4/10/25 at 12:58 p.m. with the director of nursing (DON), the health unit coordinator (HUC) was expected to facilitate referrals and consults and "should be calling over	F 685			

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F 685	Continued From page 27 to get the appointment" and the appointment should be entered in PointClickCare (PCC). The DON also stated appointments were discussed during daily interdisciplinary (IDT) standup meetings "so we can make any other arrangements" necessary to accommodate the resident. The DON indicated the in-house providers sent the facility a list of residents they would see on their visit days and the list was posted on the nurse's station. The DON stated the facility had been purchasing R21 over-the-counter non-prescription glasses because there had been many broken pairs but expected there to be documentation of this use of non-prescription eyeglasses. The DON stated the facility was awaiting insurance approval for his cataract extraction but was unable to provide documentation of the referral being followed-up on in a timely manner. R29 Assistive Hearing Devices R29's admission Minimum Data Set (MDS) dated 2/12/25, indicated he had intact cognition, had moderate difficulty hearing and utilized a hearing aid or other hearing appliance. The MDS reported he was dependent on staff for toileting hygiene and required partial-to-moderate staff assistance for personal hygiene cares. The MDS identified diagnoses including hemiparesis (one-side weakness) or hemiplegia (one-sided paralysis), asthma (a condition where the airways narrow), and chronic obstructive pulmonary disease (COPD, a chronic restrictive lung and breathing condition) and depression. R29's Care Area Assessment (CAA) for communication dated 2/12/25, identified his hearing problem and indicated he "has moderate			F 685			

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F 685	Continued From page 28 difficulty hearing when not in quiet setting." The CAA reported a referral was sent to nursing and social services because hospital notes reported he used a "pocket talker" and questioned if this could be beneficial to him. The CAA directed staff to his care plan. Per progress note dated 3/12/25, "admin order a pocket talker for resident as that is what he was using in the hospital. The pocket talker came in today and SS: [sic, social services] gave to the resident. Resident response was what a pleasure it is to hear again." R29's care plan dated 2/11/25 noted his alteration in communication and included goals to "have adequate communication" and have his needs "anticipated and met by staff." The care plan directed staff to use a "pocket talker" to aid in communication. During observation on 4/07/25 1:41 p.m., R29 was sitting in his bed. There was a black box with a small, round microphone on the one end and headphones connected to the other end sitting on top of the nightstand next to his bed. During observation on 4/7/25 at 2:24 p.m., nursing assistant (NA-C) changed R29's soiled incontinence brief. R29 stated, "I am hard of hearing," and NA-C continued changing the brief without offering him the use of the assistive hearing device on the bedside table. During observation on 4/10/25 at 9:16 a.m., NA-C and NA-D delivered R29's breakfast meal tray to his room. R29 was lying in bed with his eyes closed and appeared to be asleep. NA-C and NA-D attempted to wake him up by calling his	F 685			

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F 685	Continued From page 29 name out at the same time, but he did not wake up. They repeated his name again together, but louder and his eyes opened wide. When asked what the black box on the nightstand next to his bed was, NA-D picked it up, the black speaker box in one hand and the headphones in the other and stated, "he listens to music out of it." NA-C and NA-D both stated they had assisted him listen to music with the device before. Per interview on 4/10/25 at 10:16 a.m., licensed practical nurse (LPN)-A expected staff to utilize "pocket talkers" if a resident was hard of hearing. LPN-A was unsure if there was any in-service or training for staff on how to use them, but stated R29 was the only resident using a "pocket talker" at that time and indicated he knew how to use the device appropriately. Per interview on 4/10/25 at 1:03 p.m. with the director of nursing (DON), staff were expected to use assistive hearing devices, such as a "pocket talker" with residents who had communication deficits. Policies pertaining to communication devices and vision treatment and/or appointments were requested but not received.	F 685			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687			5/13/25

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F 687	Continued From page 30 medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained or 1 of 1 resident (R8) reviewed for foot care. Findings include: R8's annual Minimum Data Set (MDS) dated 2/18/25, identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia. R8's MHM BIMS Staff Assessment (staff assessment of cognition) dated 2/18/25, identified memory recall was ok after five minutes and R8 seemed to recall long past. R8 was able to recall the current season, location of own room, staff name and faces and that they were in a nursing home. R8 required modified independence regarding tasks of daily life. R8's care plan dated 2/19/24, identified she had a self care deficit related to neuropathy and type two diabetes mellitus. R8 preferred to complete ADLs (activities of daily living) independently, would accept assistance PRN (as needed). R8's care plan lacked information about diabetic shoes	F 687	Resident Affected: R8, appointment was made for diabetic shoes. How did we identify other residents? Full house audit to identify others with orders for diabetic shoes. What did we do for others identified? There was not anybody with orders Education: Clinical leaders to be educated that if an order cannot be followed we need to notify provider. Audits: Audit weekly x 4 weeks to check for diabetic orders and to see if they are followed. Recurrence will be prevented by: Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee is responsible party		

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F 687	Continued From page 31 or podiatry preferences. During an interview on 4/7/25 at 5:58 p.m., R8 stated she was promised diabetic shoes but no one at the facility followed up. R8's in-house podiatry visit note dated 7/8/24, identified a diabetic foot exam was completed and R8 was encouraged to wear appropriate shoe gear that would not impinge or rub on feet. R8 should continue ongoing at-risk foot care to prevent infection and ulceration. Follow up in nine to 12 weeks. R8's medical record was reviewed from 7/8/24 until 4/7/25, and no further podiatry appointments were scheduled. R8's regulatory provider visit dated 9/11/24, identified R8 requested diabetic shoes as she felt her current Crocs (clog style foam footwear) were not supportive and would like a shoe with more support. R8's painful bilateral LE (lower extremity) edema had not improved. A referral to podiatry was requested due to need for diabetic shoes. R8's doctor's order dated 3/10/25, identified to see podiatry for diabetic shoes. R8 had not been seen by podiatry to obtain diabetic shoes for six months since the initial order from 9/11/24. During an observation and interview on 4/10/25 at 10:37 a.m., R8 was in bed with her feet uncovered. Toenails were long and feet had dry skin with some edema. R8 stated her feet hurt and she could not wear her Croc shoes. During an interview on 4/10/25 at 10:47 a.m., registered nurse (RN)-A stated in-house podiatry			F 687			

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F 687	Continued From page 32 visited residents at the facility monthly and was not sure why R8 had not been seen after the initial orders on 9/11/24. The health information manager (HIM) typically scheduled appointments. During an interview on 4/10/25 at 10:58 a.m., the HIM stated he thought R8 refused a podiatry visit, however, did not have any documentation. The HIM stated he could schedule podiatry appointments with the in-house provider or at an outside clinic for residents. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated typically podiatry referrals could be scheduled within a month of the provider orders. The DON stated R8's previous guardian was supposed to follow up on the podiatry referral, however, a new guardian was assigned and no follow up was processed. A facility policy for referrals was requested and not provided. The administrator emailed a process on 4/10/25, which identified when referrals were received from providers, they are given to the HUC (health unit coordinator)/HIM (health information manager) to follow up and schedule appointments and rides. If escorts were needed, they were provided by the facility. Resident would be made aware when the appointment was confirmed and the day before.	F 687			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			5/13/25

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F 689	Continued From page 33 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall prevention interventions were implemented consistently according to the comprehensive care plan for 1 of 1 residents (47) reviewed for falls. Findings include: R47's quarterly Minimum Data Set (MDS) dated 3/12/25, indicated he was sometimes able to make himself understood and was able to understand others with clear comprehension. The MDS reported he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition. R21's Care Area Assessment for falls dated 6/28/24, was triggered due to his fall history and indicated the care plan was ongoing as he was "observed for changes in his mobility". A quarterly fall review evaluation dated 9/20/24, indicated the interventions in place included "mat placed on floor by bed, bed in lowest position." R21's care plan last reviewed 3/12/25, identified he was at risk for falls related to his right hemiparesis. The care plan indicated he "puts himself on the floor mat" and the goal was to			F 689	Resident affected: R47, Fall mat was put back into place. How did we identify other residents: Full house audits completed to identify residents with fall interventions. What did we do for others identified? Ensure fall interventions in place. What Process was changed? No change What education was completed: Nursing staff educated to follow resident interventions when caring for them. Have an ADL sheet with them and double check and make sure interventions are in place before leaving the room. Audits: Audit 5 residents weekly x 4 weeks to check if fall interventions are being followed by staff. Recurrence will be prevented by: Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee is responsible party		

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F 689	Continued From page 34 keep him safe and free from falls. The care plan directed staff to "place mattress next to bed". During a continuous observation on 4/9/25 at 8:11 a.m., licensed practical nurse (LPN)-B entered R47's room and told him, "I'm going to turn your tube feeding off and flush you." LPN-B moved the mattress that was on the floor next to his bed up and to the side and proceeded to disconnect the tube feed tubing from him and flush his drain before clamping his drain. LPN-B discarded the empty tube feed bottle and tubing in the bathroom garbage can, performed hand hygiene and lowered his bed to the lowest position before exiting his room at 8:20 a.m. LPN-B did not replace the mattress next to his bed before exiting the room. At 8:22 a.m., nursing assistant (NA)-F entered the room carrying a meal tray into the room. NA-F exited the room at 8:23 a.m. and the mattress was not in place next his bed. At 8:28 a.m., social services (SS)-A walked into the room and asked, "are you all done?" before walking out of the room at 8:29 a.m. with meal trays. The fall mattress was not in place next to his bed. At 8:30 a.m., NA-F walked into his room and walked back out of the room at 8:32 a.m. The fall mattress was not in place next to 47's bed. At 8:39 a.m., LPN-B and surveyor entered the room together and LPN-B confirmed the fall mattress was not in place and should have been down. LPN-B stated the mattress should be down "unless someone was in here with him" assisting with his meal. LPN-B explained he used to fall out	F 689			

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F 689	Continued From page 35 of bed when he first admitted to the facility, so the mattress was utilized "for his protection." LPN-B put the mattress down on the floor next to his bed and ensured the call light and bed remote were within his reach before exiting the room. Per interview on 4/9/25 at 8:56 a.m., NA-F stated fall interventions included ensuring residents have their call lights within reach and educating them on the call light, asking a resident if they feel okay before a transfer, and making sure resident-specific interventions are in place. NA-F stated some residents have recommendations, like fall mats, that staff are expected to put into place for safety. NA-F stated staff are given weekly education by the nurse managers and fall interventions can be located on the care sheets. Per interview on 4/10/25 at 12:39 p.m. with the director of nursing (DON), staff were expected to replace R47's fall mattress when they were finished working with him to prevent fall injuries and it should be in place when he was in bed. Upon subsequent interview on 4/10/25 at 3:41 p.m., the DON confirmed the interdisciplinary team (IDT) had reviewed and reassessed the fall interventions for R47 and stated the IDT discovered despite being positioned in the middle of the bed, he would "somehow move himself right over to the edge of the bed." The DON cited this discovery was the reason the fall mattress intervention was still considered appropriate and stated, "that is why we kept the intervention in place." Per facility policy titled Fall Prevention and Management last revised 2/24, facility staff would identify interventions related to a resident's			F 689			

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F 689	Continued From page 36	F 689			
F 758 SS=D	specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. The policy directed staff to implement interventions, monitor and document a resident's response to interventions intended to reduce falling or the risks of falling. Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758			5/13/25

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F 758	Continued From page 37 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an antipsychotic medication had an appropriate indication for use for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include: R6's annual Minimum Data Set (MDS) dated 3/15/25, identified no behaviors or rejection of care. Medications taken included antipsychotic, antidepressant and anticonvulsant. Diagnoses included dementia, depression and anxiety. R6 had intact cognition. R6's Order Summary Report dated 4/10/25, identified the following antipsychotic medications currently in use: 1. Quetiapine fumarate 25 milligrams (mg) by mouth two times a day for dx (diagnosis)			F 758	Resident affected: R6, was given an appropriate indication for use. How did we identified others: Full house audit completed to ensure all antipsychotic has an appropriate indication for use. Process Change? Add area to morning meeting to ensure appropriate indication for use of antipsychotics. What education was completed: Clinical leadership educated on addressing pharmacy consults timely and to the change in the morning meeting. Audits: Audit 5 residents weekly in 4 weeks to ensure the antipsychotic has appropriate indication for use.		

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F 758	Continued From page 38 depression. 2. Quetiapine fumarate 50 mg by mouth at bedtime related to anxiety disorder. R6's Pharmacist's Recommendation to Prescriber form dated 2/3/25, recommended the prescriber address the diagnosis for quetiapine fumarate and update order to an approved CMS indication, or consider a GDR (gradual dosage reduction) or taper plan. R6's prescriber visit note dated 3/15/25, had not addressed the diagnosis for quetiapine fumarate. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated after a pharmacist reviewed records monthly, recommendations were typically emailed to the DON within one to two days, then the DON would distribute the forms to the nurse managers who in turn would route them to the prescribers. During an interview on 4/10/25 at 3:20 p.m., the consultant pharmacist (CP) stated she issued the above recommendation in February 2025 and March 2025 because she had not received a response. The CP stated the diagnosis for quetiapine fumarate needed to be addressed to ensure the resident was only on an antipsychotic that was deemed necessary. During a interview on 4/10/25 at 3:21 p.m., R6's prescriber, psychiatrist-A stated he did not have any facility pharmacist recommendation forms regarding R6 at his office to review. When he would visit the facility any pharmacist recommendations were placed in a folder for him to to review and fill out.	F 758	Recurrence will be prevented by Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee is responsible party		

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F 758	Continued From page 39 A facility policy for antipsychotics was requested and not provided. The administrator emailed a process on 4/10/25, which identified with new admissions with guardian we get consent and of own person, get consent to administer the medications. Then they are review by the psychiatrist monthly, as well as pharmacy review monthly and offer recommendations to psychiatrist for GDR and are attempted at least twice a year based upon behaviors.	F 758			
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801			5/13/25

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F 801	Continued From page 40 supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a	F 801			

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F 801	Continued From page 41 course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to employ either a full-time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since 3/26/24, which had the potential to affect all 65 residents who resided in the facility. During interview on 4/9/25 at 11:30 a.m., the registered dietitian (RD) stated she worked full time, overseeing 5 buildings but only worked 8 hours a week at this facility. During interview on 4/9/25 at 11:45 a.m., the Culinary Director (CD) stated he had been working for the facility for almost a year and had been asked about starting training for his Certified Dietary Manager's certificate (CDM) but he wanted to "wait a little bit" and wasn't ready to start the training yet. During interview on 4/10/25 at 12:44 p.m. the administrator stated he expected the Culinary Director to either have their CDM upon hire or	F 801	Immediate corrective action: CD enrolled in CDM class. Facility will utilize Dietitian/qualified culinary personnel to meet regulation requirements. How did we identify others: N/A Corrective Action as it applies to others: Audits including how many, how long, and who they will be monitored by: The facility will audit dietitian/qualified culinary personnel timecards weekly for 4 weeks, then monthly for 2 months, then PRN to ensure appropriate coverage to the facility. QAPI Committee will review audit results. Administrator/Designee is responsible party.		

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F 801	Continued From page 42	F 801			
F 812 SS=E	within the first 3 months. He further verified the CD's date of hire was 3/26/24 and he'd been working at the facility for almost over a year. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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 ensure dietary staff was wearing beard guards when preparing food This had the potential to affect all 65 residents who reside at the facility and consume food from the kitchen. During observation on 10/7/25 at 11:49 a.m. the Culinary Director (CD) was in the kitchen cutting up fruit. He had a beard but was not wearing a beard guard/restraint.	F 812			5/13/25
			Immediate corrective action: Educate culinary staff on proper head and beard wear when prepping meals and the importance of sanitary		
			How did we identify others: All members working in the kitchen		
			Corrective Action as it applies to others: n/a		

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F 812	Continued From page 43 During interview on 4/9/25 at 10:41 a.m., the CD verified he was not wearing a beard guard/restraint while prepping food stating it was hard to determine if the facility wanted staff to wear them or not. The CD further stated the facility did not have any beard guards for staff to wear, but he could get some if needed. During interview on 4/10/25 at 12:44 p.m., the administrator stated dietary staff (who had beards) were expected to be wearing beard guards/restraints when preparing food and this was important for infection control purposes. A policy regarding infection control in the kitchen was requested but not received.	F 812	Audits including how many, how long, and who they will be monitored by: Audit 5 staff each week for four weeks, then monthly for 2 months, then PRN depending on audit results specific to staff proper use of head and beard wear. QAPI Committee will review results. Culinary Director/Designee is responsible party.		
F 880 SS=D	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	F 880			5/13/25

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F 880	Continued From page 44 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 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.	F 880			

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F 880	Continued From page 45 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 ensure proper personal protective equipment (PPE) was utilized for 1 of 2 residents (R14) reviewed for enhanced barrier precautions (EBP). Findings include: R14's quarterly Minimum Data Set (MDS) dated 3/19/25, identified no behaviors or rejection of care. Dependent on staff for eating, hygiene, toileting hygiene, bathing and dressing. Diagnoses included dementia, seizure disorder, and contractures of right and left hand. R14's care plan dated 4/7/25 identified resident is currently on EBP R/T (related to) wound on coccyx. Resident will remain free from infection. Staff to follow EBP. R14's wound care progress note dated 4/3/25, identified resident was seen for new area of sacrum MASD (moisture associated skin damage). The wound measured 2.9 centimeters (cm) long, 2.2 cm wide, 0.1 cm deep with scant serosanguinous exudate (wound drainage with serous fluid and blood). During an observation and interview on 4/07/25 at 11:59 a.m., R14's name sign next to her room			F 880	Resident Affected: R14, EBP sign was posted, PPE was near the door and in the care plan. Resident has no adverse effects related to staff not wearing PPE. How did you identify others: Full house audit completed to identify those who should be on EBP Precautions. What did we do for others identified? Ensure they have a sign on the door, the PPE bin close by, and in the care plan Education: Began education with all staff regarding EBP including how to apply PPE and when to apply it. Audits: Audit 5 residents weekly x 4 weeks to check if staff are wearing PPE for EBP . Recurrence will be prevented by Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits. DON/Designee is responsible party		

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F 880	Continued From page 46 door identified EBP following the name. Trained medication assistant (TMA)-A was asked if the resident was currently on EBP. TMA-A was not able to answer and was shown the name sign with the initials EBP following the name. TMA-A was still not able to answer the question. TMA-A was shown the poster on the door identifying EBP was in place and TMA-A was not able to reply if R14 was on EBP. There was no PPE bin directly outside the room, however, there was one on the other side of the hallway. During an observation on 4/7/25 at 12:46 p.m., nursing assistant (NA)-A was in R14's room, no PPE on. TMA-A entered R14's room and gave R14 her oral medications, no PPE on. TMA-A then brought in the full body lift to assist NA-A to transfer R14 out of bed. NA-A and TMA-A leaned against the bed with scrubs touching the bedding, connected R14 to the sling for the full body lift which. Both staff had direct contact with R14 and her bedding during the transfer process from bed to wheelchair. After R14 was positioned in her wheelchair, the director of nursing (DON) entered at 12:52 p.m., and asked the staff where their EBP PPE was. Staff did not answer the question and continued to provide cares without PPE on. NA-A tucked in a blanket over R14's lap, picked up her feet and positioned them in the wc footrests and applied foam booties to both feet. NA-A stated she was not aware R14 was on EBP. During an interview on 4/10/25 at 10:52 a.m., registered nurse (RN)-A stated the presence of wounds would be a criteria for staff to follow EBP during cares. During an interview on 04/10/25 02:52 PM the DON stated R14 was seen on wound rounds			F 880			

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F 880	Continued From page 47 today. All staff were educated on EBP and she expected staff to always follow EBP for infection control. The facility policy dated 4/1/24 titled EBP, identified the use of gown and gloves during high contact resident care activities was required for residents known to be colonized or infected with a MDRO (multidrug-resistant organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).	F 880			
F 921 SS=D	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 a personal refrigerator was monitored and kept sanitary in a resident's (R47) shared room. Findings include: R47's quarterly Minimum Data Set (MDS) dated 3/12/25, indicated he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition.	F 921	Resident affected: R47, cleaned refrigerator and temperature was checked. Order was entered for night nurse to check temperature daily. How did we identify others: Full house audits to identify if any other residents have a refrigerator. What did we do for others identified: There are no others. What Process was changed: Night nurse will check temperature daily and nurse manager will check refrigerator weekly and clean it if needed.		5/13/25

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F 921	Continued From page 48 Per observation on 4/7/25 at 12:50 p.m., of R47's room, there was a black mini refrigerator on a nightstand on his side of the privacy curtain. There was a Record of Refrigerator Temperatures sign posted on the door of the mini refrigerator dated "July 2024" and there were temperatures documented for the dates of 7/1/24 - 7/23/24. The other entries were blank. There was a second Record of Refrigerator Temperatures taped underneath that was dated "August 2024", and it was completely void of documentation. The contents inside the mini refrigerator included six small plastic water bottles, a small can of "Shasta Cola", two dark green-to-brown avocados, five unlabeled and undated resealable plastic sandwich bags with unidentified food items inside, two lumps of rolled up aluminum foil, an unlabeled and undated blue plastic cup with a white liquid inside, a silver-colored mug with a black handle and top, a clear plastic bottle with a dark teal top and handle, three unlabeled and undated plastic containers with unidentified items inside, a tied up grocery bag, an labeled glass jar of "Smuckers" brand jam, and two unlabeled "Chobani" brand yogurt beverages. There was a second mini refrigerator in the room located behind the first one. It was empty and unplugged. Per interview on 4/7/25 at 4:00 p.m., family member (FM)-B was unsure who the refrigerator in R47's room belonged to. FM-B believed it was his roommate's food inside the refrigerated and stated, "that is very unsanitary, so who cleans that? It is so dirty there." Per interview on 4/9/25 at 7:40 a.m. with licensed practical nurse (LPN)-B, the nursing staff were	F 921	What education was completed? Educated nurses/floor staff on new process for monitoring resident refrigerators. Audits: Audits all resident that have a personal fridge weekly x 4 weeks to ensure refrigerator is being cleaned and monitored. Recurrence will be prevented by Sharing Audit results with the facility QAPI committee for input on need to increase, decrease, or discontinue the audits DON/Designee is responsible party		

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F 921	Continued From page 49 responsible for checking the temperature of the mini refrigerator in R47's room every night and documenting them on the record of temperature log. LPN-B stated when the logs were completed, they were turned into management who kept them. On 4/9/25 at 11:48 a.m., the administrator was asked to provide personal refrigerator temperature logs for the floor R47 resided on dated 6/24 - 3/25. During interview at 1:17 p.m., the administrator provided logs for 2025 and responded, "we got rid of the ones from the prvious [sic] year". The temperature logs dated 6/24 - 12/24 were requested but not received. The Record of Refrigerator Temperatures dated 1/25 - 3/25 were reviewed and included completed documentation. During observation and interview on 4/10/25 at 12:39 p.m., the director of nursing (DON) and surveyor were in R47's room. There was only one mini black refrigerator in the room and the Record of Temperatures was dated April 2025 and included documentation of temperatures from 4/1/25 - 4/8/25. The refrigerator's contents included four small disposable plastic water bottles, one "Chobani" brand yogurt beverage, one glass jar of "Smuckers" brand jam, a silver-colored mug with a black handle and top, and a clear plastic bottle with a dark teal top and handle. The DON stated staff were expected to check the temperature every night and document it on the log sheet. Additionally, staff were expected to clean the resident refrigerators out and update the log sheet each month. The DON and surveyor reviewed the photographs of the Record of Refrigerator Temperatures dated 7/24 and 8/24 from surveyor's observation on 4/7/25	F 921			

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F 921	Continued From page 50 as well as the photographs of the contents of the refrigerator from the observation. The DON confirmed the deficient practice and stated staff should have cleaned the refrigerator out prior to 4/7/25 and should have updated the temperature log before 4/7/25. Per an undated facility policy titled Resident's Personal Refrigerator, to assure infection control practices, including refrigerator function, was maintained, cleaning would be done for prevention of food-borne illness. The purpose of the policy was to assure personal refrigerators in resident room's are functioning at the correct temperature and are clean and do not contain expired products that could cause food-borne illness. The policy directed staff to check the temperature of the refrigerator in the room weekly and record the results in the temperature log in the room. Additionally, the policy guided staff to check the temperature, condition of food/beverage, and spoilage on a weekly basis and remove expired perishable food items after notifying the resident. The policy indicated the refrigerator would be cleaned monthly and as needed and would be defrosted as needed.	F 921			

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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 04/09/2025. At the time of this survey, THE ESTATES AT LYNNHURST 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		05/02/2025

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 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. THE ESTATES AT LYNNHURST is a 2-story building with a partial basement. The facility 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.	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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K 000	Continued From page 2 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 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility maintain fire extinguisher documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.1.2.2, 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5. This deficient finding could have a widespread impact on the residents within the facility.			K 355			5/13/25
					All portable fire extinguishers have been checked and the log completed. Maintenance Director to receive education regarding fire extinguisher inspections and maintenance. Audit of 3 portable fire extinguishers will be checked weekly for 4 weeks, then monthly for 2 months, then PRN based on audit results.		

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K 355	Continued From page 3 Findings include: On 04/09/2025 between 10:30 AM and 1:30PM, it was revealed by a review of available documentation, that no documentation was presented to demonstrate that at least the last 12 monthly inspections have been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	QAPI committee will review audits Maintenance Director/Designee is responsible party		
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		5/13/25	

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K 741	Continued From page 4 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2025 between 10:30 AM and 1:30PM, it was revealed by a review of available documentation that the smoking policy was generic in content, not providing facility specific, identified and approved locations for staff, residents, visitors to smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	The smoking policy has been revised to be facility specific to identify approved locations for staff, residents, and visitors to smoke. Staff educated on facility specific smoking policy Audits of observation of smoking areas will be completed weekly for 4 weeks, then monthly for 2 months, then PRN depending on audit results. QAPI committee will review audit results. Maintenance Director/Designee is responsible party.		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced	K 926			5/13/25

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K 926	Continued From page 5 by: Based on review of available documentation and staff interview, the facility failed to provide correct documentation and policy associated to medical gas education and staff training per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5, 11.5.1, 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2025 between 10:30 AM and 1:30PM, it was revealed by a review of available documentation that the policy documentation presented for review was as associated to assisted living facilities, not skilled nursing facilities. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	The identified policy has been removed. Facility will audit the life safety binder to ensure policy is not in the book, weekly for 4 weeks, then monthly x 2 weeks, then PRN depending on audit results. QAPI committee will review audits to determine frequency. Maintenance Director/Designee is responsible party.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: F3US11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 10, 2025 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/7/25 - 4/10/25, a licensing 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 have reviewed these orders and		2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53942449C (MN00102974) H53942450C (MN00103106) H53942542C (MN00104906) H53942451C (MN00104960) H53942525C (MN00110987) H53942452C (MN00109124) H53942453C (MN00108412) H53942492C (MN00101469). NO citations were issued. 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 surveyors 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 555	Corrected.		5/13/25

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2 555	Continued From page 3 facility failed to ensure resident and resident guardian's participation in the development and review of care plans 1 of 1 residents, (R8) reviewed who voiced concerns about care conference participation. Findings include: R8's annual Minimum Data Set (MDS) dated 2/18/25, identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia. R8's MHM BIMS (Brief Interview of Mental Status) Staff Assessment dated 2/18/25, identified five- minute and long past memory recall was "ok" and R8 was able to recall the current season, her own room, staff name and faces and that she was in a nursing home. R8 had modified independence with daily decision making. R8's discharge care plan dated 2/19/25, identified resident and family would be invited to care conferences quarterly or as needed. A review of R8's MDS history identified the following: - 2/18/25 annual MDS and corresponding care conference form 3/25/25, not completed. There was no documentation R8 or her guardian were invited or attended. - 11/22/24 quarterly MDS and corresponding care conference form 11/13/24, there was no	2 555			

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2 555	Continued From page 4 documentation R8 or her guardian were invited or attended. - 8/30/24 quarterly MDS and corresponding care conference form dated 8/14/24, there was no documentation R8 was invited or attended, nor if her guardian attended. - 6/7/24 quarterly MDS and corresponding care conference form dated 6/27/24, there was no documentation R8 or her guardian were invited or attended. - 3/26/24 significant change MDS lacked a corresponding care conference. - 2/22/24 admission MDS with corresponding care conference 2/26/24, identified the guardian was not involved in the care conference. R8's care conference progress notes identified: - 8/13/24 at 9:32 a.m., the social worker reached out to guardian and caseworker to schedule a care conference. There was no follow up documentation. The note did not identify if R8 was invited. - 6/27/2024 at 14:42 (2:42 p.m.), care conference scheduled for 7/8/24 at 11:00 a.m. The note did not identify if R8 or guardian were invited or attended. - 3/6/24 at 11:31 a.m., care conference held as scheduled. This is the second care conference for R8 upon admission. The note did not identify if the R8 or guardian were invited or attended. - 2/26/2024 at 14:33 (2:33 p.m.), care conference held on this date. In attendance was R8, LPN (licensed practical nurse) coordinator, OT (occupational therapy), and SS (social services). SS attempted to contact guardian to join the care conference but there was not an answer, voicemail was left. .	2 555			

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2 555	Continued From page 5 During an interview on 4/7/25 at 6:03 p.m., R8 stated she wanted to know if the facility had care conferences and she was supposed to have a meeting two months ago but it never happened. R8 stated the facility held care conferences but she has not been invited since she had a legal guardian. R8 stated she would like to be part of the meetings because she did not think they knew about her concerns. R8 stated she wanted her purse with a driver licence, social security card. R8 wanted pictures of her kids and grandkids for her room. She wanted hearing aides, new eyeglasses, dentures and diabetic shoes. R8 stated many of the items she wanted had been left behind in her house after she was taken out of her home. During an interview on 4/10/25 at 10:38 a.m., registered nurse (RN)-A stated she could not find documentation of who attended or was invited to R8's care conferences. During an interview on 4/10/25 at 12:59 p.m., the social services designee (SSD) stated care conferences were held based off the MDS schedule: quarterly/comprehensive, annual, and significant change. The SSD would open the care conference form and invite the interdisciplinary team (IDT) to fill in their respective sections. Guardians and residents were invited to attend with the IDT. The SSD reviewed R8's care conference forms and agreed she could not tell if the resident or guardian had been invited or attended. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated the resident and guardian should be invited to participate in care conferences along with the IDT, and it should be documented who was invited and	2 555			

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2 555	Continued From page 6 present/participated. A facility policy for care conferences was requested and not provided. The administrator emailed a process on 4/10/25, which identified social services meets with resident within 48 hours of admission, and then completes full care conference within first 48 hours, and then every quarter, annually, PRN (as needed) and significant change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), social services or designee could review and revise policies and procedures related to inviting and documenting the invitation and participation of residents/families/guardians in care planning and care conferences. The director of nursing or designee could develop a system to educate staff and audit compliance to ensure collaboration in the development individual care plans, and could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	2 570			5/13/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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2 570	Continued From page 7 and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan with input from the resident to meet a resident's vision needs for 1 of 1 residents reviewed for reassessment of the care plan. Findings include: R21's quarterly Minimum Data Set (MDS) dated 3/4/25, indicated he had moderately impaired cognition, did not reject cares, and was usually able to make himself understood and usually able to understand others. The MDS indicated his vision was adequate and he did not wear corrective lenses. The MDS identified diagnoses including aphasia (a condition in which language function is disordered), and cataracts (a progressive disorder of the lens of the eye characterized by a loss of transparency with a white/yellow/brown tinge to the lens). R21's Care Area Assessment (CAA) for visual function dated 6/19/24, was triggered due to his cataracts and indicated he had the potential for impaired visual function related to his diagnosis of bilateral (left and right) age-related cataracts. The CAA indicated the overall objective for care planning this potential problem was to maintain his current level of functioning indicated, "per vision exam 3/28/24: Educated patient regarding	2 570	corrected.		

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2 570	Continued From page 8 ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA [visual acuity]. Resident has adequate vision with use of reading glasses. Care plan to maintain current level of visual acuity." R21's care plan, last revised 3/4/25, identified his potential for impaired vision related to his diagnosis of age-related cataracts and listed a goal to maintain his current vision. The care plan directed staff to set up ophthalmology appointment as needed. Additionally, the care plan identified his self-care deficit related to his hemiplegia and indicated he had glasses "that he wears when he chooses" and was able to put on and take off the glasses himself. The care plan directed staff to assist him clean the eyeglasses and ensure they were in "good repair". The care plan lacked documentation of any use of multiple pairs of non-prescription glasses. Furthermore, the care plan lacked documentation Patient encounter notes dated 9/28/23, 10/3/24, and 3/28/24, indicated R21 was seen by the Doctor of Optometry (OD) for a cataract evaluation. The encounter notes revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an "attempt to improve reduced VA [visual acuity]. Please schedule consultation." A care conference form dated 3/24/25, indicated R21's last eye exam was on 10/3/24 but lacked documentation if he or his representative's input were considered in the care conference or care planning process. R21's EHR was reviewed on 4/8/25 at 2:20 p.m. and lacked documentation that referral to cataract	2 570			

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2 570	Continued From page 9 extraction specialist was followed-up on. Furthermore, the EHR lacked documentation his order for consult to optometry for new eyeglasses was followed-up on. During observation on 4/7/25 at 2:33 p.m., R21 showed surveyor a pair of eyeglasses with a missing left temple (long arm on the side of the frame that fit over the ear). Per interview on 4/8/25 at 3:31 p.m. with R21 via interpreter, his cataracts had been ongoing for approximately one year and he believed there was "orange" discoloration to his left eye. He stated he had not seen any provider about the cataract extraction. He also endorsed having difficulty seeing without his eyeglasses and stated he needed a new pair. During interview on 4/9/25 at 9:15 a.m., OD verified familiarity with R21 and his vision exams. OD explained the decision to make a referral for a cataract extraction was usually driven by either a resident, family, representative or the primary provider. OD stated the decision to move forward with referral was driven by R21. OD confirmed placing the order for the consult in March 2023 and confirmed, "he does have the presence of cataracts" and explained once the referral was made, "it is up to the facility to get that scheduled." Additionally, OD denied being made aware of R21's need for eyeglasses and stated, "at no point have we done a pair of eyeglasses for him or an exam for glasses." OD reviewed R21's progress notes and was unable to find that he presented anytime with a request for eyeglasses. OD stated, "typically, the facility would make us aware of the need for repair or the resident brings them with and makes us aware."	2 570			

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2 570	Continued From page 10 Per interview on 4/10/25 at 12:58 p.m. with the director of nursing (DON), staff were expected to follow up on appointment referrals. The DON stated resident's preferences and care planned interventions were discussed and reassessed for appropriateness during care conferences. The DON also stated staff had been purchasing over the counter (OTC) non-prescription eyeglasses because there had been many broken pairs but expected there to be documentation of the use of OTC non-prescription eyeglasses. A facility policy title Care Planning last revised 11/24, indicated each resident would have a person-centered care plan developed by the IDT for the purpose of meeting the resident's individual needs. The policy directed the IDT to, in conjunction with the resident and the resident representative, develop and implement a comprehensive individualized care plan with information gathered from the comprehensive assessment. The policy indicated the care plan should be consistent with resident's rights to identify problem areas and their causes to develop interventions that were targeted and meaningful to the resident. The policy also highlighted that the resident had the right and would be encouraged to participate in the development of his or her care plan, and the care plan should be modified and updated as the condition and care needs of the resident changed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision and reassessment of the care plan as needed to meet the needs of each individual resident and include input from the resident	2 570			

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2 570	Continued From page 11 and/or resident's representative. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised and reassessed with input from the residenet and/or resident's representative as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall prevention interventions were implemented consistently according to the comprehensive care plan for 1 of 1 residents (47) reviewed for falls. Findings include: R47's quarterly Minimum Data Set (MDS) dated	2 830	corrected.		5/13/25

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2 830	Continued From page 12 3/12/25, indicated he was sometimes able to make himself understood and was able to understand others with clear comprehension. The MDS reported he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition. R21's Care Area Assessment for falls dated 6/28/24, was triggered due to his fall history and indicated the care plan was ongoing as he was "observed for changes in his mobility". A quarterly fall review evaluation dated 9/20/24, indicated the interventions in place included "mat placed on floor by bed, bed in lowest position." R21's care plan last reviewed 3/12/25, identified he was at risk for falls related to his right hemiparesis. The care plan indicated he "puts himself on the floor mat" and the goal was to keep him safe and free from falls. The care plan directed staff to "place mattress next to bed". During a continuous observation on 4/9/25 at 8:11 a.m., licensed practical nurse (LPN)-B entered R47's room and told him, "I'm going to turn your tube feeding off and flush you." LPN-B moved the mattress that was on the floor next to his bed up and to the side and proceeded to disconnect the tube feed tubing from him and flush his drain before clamping his drain. LPN-B discarded the empty tube feed bottle and tubing in the bathroom garbage can, performed hand hygiene and lowered his bed to the lowest position before exiting his room at 8:20 a.m. LPN-B did not	2 830			

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2 830	Continued From page 13 replace the mattress next to his bed before exiting the room. At 8:22 a.m., nursing assistant (NA)-F entered the room carrying a meal tray into the room. NA-F exited the room at 8:23 a.m. and the mattress was not in place next his bed. At 8:28 a.m., social services (SS)-A walked into the room and asked, "are you all done?" before walking out of the room at 8:29 a.m. with meal trays. The fall mattress was not in place next to his bed. At 8:30 a.m., NA-F walked into his room and walked back out of the room at 8:32 a.m. The fall mattress was not in place next to 47's bed. At 8:39 a.m., LPN-B and surveyor entered the room together and LPN-B confirmed the fall mattress was not in place and should have been down. LPN-B stated the mattress should be down "unless someone was in here with him" assisting with his meal. LPN-B explained he used to fall out of bed when he first admitted to the facility, so the mattress was utilized "for his protection." LPN-B put the mattress down on the floor next to his bed and ensured the call light and bed remote were within his reach before exiting the room. Per interview on 4/9/25 at 8:56 a.m., NA-F stated fall interventions included ensuring residents have their call lights within reach and educating them on the call light, asking a resident if they feel okay before a transfer, and making sure resident-specific interventions are in place. NA-F stated some residents have recommendations, like fall mats, that staff are expected to put into place for safety. NA-F stated staff are given weekly education by the nurse managers and fall	2 830			

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2 830	Continued From page 14 interventions can be located on the care sheets. Per interview on 4/10/25 at 12:39 p.m. with the director of nursing (DON), staff were expected to replace R47's fall mattress when they were finished working with him to prevent fall injuries and it should be in place when he was in bed. Upon subsequent interview on 4/10/25 at 3:41 p.m., the DON confirmed the interdisciplinary team (IDT) had reviewed and reassessed the fall interventions for R47 and stated the IDT discovered despite being positioned in the middle of the bed, he would "somehow move himself right over to the edge of the bed." The DON cited this discovery was the reason the fall mattress intervention was still considered appropriate and stated, "that is why we kept the intervention in place." Per facility policy titled Fall Prevention and Management last revised 2/24, facility staff would identify interventions related to a resident's specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. The policy directed staff to implement interventions, monitor and document a resident's response to interventions intended to reduce falling or the risks of falling. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to ensure appropriate implementation of care planned interventions are in place for fall prevention. The director of nursing or designee could conduct random audits to ensure care planned fall prevention interventions are in place for residents at risk for falls. The	2 830			

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2 830	Continued From page 15 DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830			
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.]	2 840			5/13/25

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2 840	Continued From page 16 Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were provided incontinence care in a timely manner for 1 of 1 resident (R9) reviewed for activities of daily living (ADL). Findings include: R9's admission Minimum Data Set (MDS) dated 1/24/25, indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation (A-fib), and pancreatitis. It further indicated R9 was dependent on staff for toileting and was frequently incontinent of bowel and bladder. R9's care plan dated 4/8/25, indicated alteration in elimination d/t limited mobility secondary to COPD and alcohol dependence with the following interventions: -Assist of 2 with toileting. -Provide assistance with peri-cares morning (AM), hour of sleep (HS) and as needed (PRN).	2 840	corrected.		

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2 840	Continued From page 17 -Provide incontinent products and assist to change PRN During observation on 4/7/25 at 3:22 p.m., R9 was sitting in his wheelchair by the door to his room, waiting to go in. He asked nursing assistant (NA)-B to change his brief because he had a bowel movement (BM) and NA-B told him to wait until staff was done with R55's (roommate) wound care. R9 asked how long that would be and registered nurse (RN-B) stated 15 minutes. When the surveyor left the room, (following wound care) at 4:25 p.m., R9 was still waiting outside the room and there was an odor of BM. R9 stated he often had to wait from 1-3 hours to have his brief changed because his roommate had a wound and if they change him during wound care "it could be contagious." He further stated he also had to wait for an hour to be changed so both nursing assistants can go on their breaks. At approximately 4:35 p.m. NA-B assisted NA-E to transfer R9 from his wheelchair to the bed and NA-E proceeded to change his brief. He was wet and urine had soaked through his pants so NA-E removed them and got a new pair stating "the weird thing is it didn't go through to your sling (urine)." R9 had also had a BM. NA-E cleaned up the BM, applied new pants, and NA-B assisted NA-E to transfer him from his bed back into his wheelchair. During interview on 4/7/25 at 4:52 p.m. NA-B verified R9 had waited an hour to be changed and stated it was because too many people were in the room and the nurse stated it would only take 15 minutes to complete his roommates wound care. During an interview on 4/10/25 at 12:08 p.m. the nurse manager registered nurse (RN)-C stated	2 840			

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2 840	Continued From page 18 an hour was too long for a resident to be sitting in a soiled brief and R9 should've been able to be changed before they started his roommates wound care, stating it takes longer then 15 minutes to complete wound care and change a wound vacuum (vac). During an interview on 04/10/25 at 2:52 p.m., the director of nursing (DON) stated when a resident asked to be changed/toileted, it should be done as soon as possible or within 15-30 minutes (at most) to prevent skin breakdown. If the NA's or nurses are busy the nurse manager can also assist residents to changed/toileted. A facility policy on ADL's dated 3/31/23, indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting d. Dining-eating (meals and snacks) e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident ' s advance directives. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could	2 840			

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2 840	Continued From page 19 develop and implement policies and procedures to ensure that residents who require assistance with toileting receive timely servies: educate staff as appropriate, then develop monitoring systems or audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840			
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained or 1 of 1 resident (R8) reviewed for foot care. Findings include: R8's annual Minimum Data Set (MDS) dated 2/18/25, identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia.	2 860	corrected.	5/13/25	

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2 860	Continued From page 20 R8's MHM BIMS Staff Assessment (staff assessment of cognition) dated 2/18/25, identified memory recall was ok after five minutes and R8 seemed to recall long past. R8 was able to recall the current season, location of own room, staff name and faces and that they were in a nursing home. R8 required modified independence regarding tasks of daily life. R8's care plan dated 2/19/24, identified she had a self care deficit related to neuropathy and type two diabetes mellitus. R8 preferred to complete ADLs (activities of daily living) independently, would accept assistance PRN (as needed). R8's care plan lacked information about diabetic shoes or podiatry preferences. During an interview on 4/7/25 at 5:58 p.m., R8 stated she was promised diabetic shoes but no one at the facility followed up. R8's in-house podiatry visit note dated 7/8/24, identified a diabetic foot exam was completed and R8 was encouraged to wear appropriate shoe gear that would not impinge or rub on feet. R8 should continue ongoing at-risk foot care to prevent infection and ulceration. Follow up in nine to 12 weeks. R8's medical record was reviewed from 7/8/24 until 4/7/25, and no further podiatry appointments were scheduled. R8's regulatory provider visit dated 9/11/24, identified R8 requested diabetic shoes as she felt her current Crocs (clog style foam footwear) were not supportive and would like a shoe with more support. R8's painful bilateral LE (lower extremity) edema had not improved. A referral to podiatry was requested due to need for diabetic shoes.	2 860			

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2 860	Continued From page 21 R8's doctor's order dated 3/10/25, identified to see podiatry for diabetic shoes. R8 had not been seen by podiatry to obtain diabetic shoes for six months since the initial order from 9/11/24. During an observation and interview on 4/10/25 at 10:37 a.m., R8 was in bed with her feet uncovered. Toenails were long and feet had dry skin with some edema. R8 stated her feet hurt and she could not wear her Croc shoes. During an interview on 4/10/25 at 10:47 a.m., registered nurse (RN)-A stated in-house podiatry visited residents at the facility monthly and was not sure why R8 had not been seen after the initial orders on 9/11/24. The health information manager (HIM) typically scheduled appointments. During an interview on 4/10/25 at 10:58 a.m., the HIM stated he thought R8 refused a podiatry visit, however, did not have any documentation. The HIM stated he could schedule podiatry appointments with the in-house provider or at an outside clinic for residents. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated typically podiatry referrals could be scheduled within a month of the provider orders. The DON stated R8's previous guardian was supposed to follow up on the podiatry referral, however, a new guardian was assigned and no follow up was processed. A facility policy for referrals was requested and not provided. The administrator emailed a process on 4/10/25, which identified when referrals were received from providers, they are given to the HUC (health unit coordinator)/HIM (health information manager) to follow up and	2 860			

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2 860	Continued From page 22 schedule appointments and rides. If escorts were needed, they were provided by the facility. Resident would be made aware when the appointment was confirmed and the day before. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents requiring assistance with foot care or referral for diabetic foot care and educate staff to cares. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk of complications associated from lack of appropriate foot care. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860			
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course.	2 980			5/13/25

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2 980	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to employ either a full-time registered dietician (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since 3/26/24, which had the potential to affect all 65 residents who resided in the facility. During interview on 4/9/25 at 11:30 a.m., the registered dietician (RD) stated she worked full time, overseeing 5 buildings but only worked 8 hours a week at this facility. During interview on 4/9/25 at 11:45 a.m., the Culinary Director (CD) stated he had been working for the facility for almost a year and had been asked about starting training for his Certified Dietary Manager's certificate (CDM) but he wanted to "wait a little bit" and wasn't ready to start the training yet. During interview on 4/10/25 at 12:44 p.m. the administrator stated he expected the Culinary Director to either have their CDM upon hire or within the first 3 months. He further verified the CD's date of hire was 3/26/24 and he'd been working at the facility for almost over a year. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The administrator or designee could educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance.	2 980	Corrected.		

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2 980	Continued From page 24	2 980			
	TIME PERIOD FOR CORRECTION: Twenty (21) days.				
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper personal protective equipment (PPE) was utilized for 1 of 2 residents (R14) reviewed for enhanced barrier precautions (EBP). Findings include: R14's quarterly Minimum Data Set (MDS) dated 3/19/25, identified no behaviors or rejection of care. Dependent on staff for eating, hygiene, toileting hygiene, bathing and dressing. Diagnoses included dementia, seizure disorder, and contractures of right and left hand. R14's care plan dated 4/7/25 identified resident is currently on EBP R/T (related to) wound on coccyx. Resident will remain free from infection. Staff to follow EBP. R14's wound care progress note dated 4/3/25, identified resident was seen for new area of sacrum MASD (moisture associated skin damage). The wound measured 2.9 centimeters	21375	Corrected.		5/13/25

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21375	Continued From page 25 (cm) long, 2.2 cm wide, 0.1 cm deep with scant serosanguinous exudate (wound drainage with serous fluid and blood). During an observation and interview on 4/07/25 at 11:59 a.m., R14's name sign next to her room door identified EBP following the name. Trained medication assistant (TMA)-A was asked if the resident was currently on EBP. TMA-A was not able to answer and was shown the name sign with the initials EBP following the name. TMA-A was still not able to answer the question. TMA-A was shown the poster on the door identifying EBP was in place and TMA-A was not able to reply if R14 was on EBP. There was no PPE bin directly outside the room, however, there was one on the other side of the hallway. During an observation on 4/7/25 at 12:46 p.m., nursing assistant (NA)-A was in R14's room, no PPE on. TMA-A entered R14's room and gave R14 her oral medications, no PPE on. TMA-A then brought in the full body lift to assist NA-A to transfer R14 out of bed. NA-A and TMA-A leaned against the bed with scrubs touching the bedding, connected R14 to the sling for the full body lift which. Both staff had direct contact with R14 and her bedding during the transfer process from bed to wheelchair. After R14 was positioned in her wheelchair, the director of nursing (DON) entered at 12:52 p.m., and asked the staff where their EBP PPE was. Staff did not answer the question and continued to provide cares without PPE on. NA-A tucked in a blanket over R14's lap, picked up her feet and positioned them in the wc footrests and applied foam booties to both feet. NA-A stated she was not aware R14 was on EBP. During an interview on 4/10/25 at 10:52 a.m., registered nurse (RN)-A stated the presence of	21375			

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21375	Continued From page 26 wounds would be a criteria for staff to follow EBP during cares. During an interview on 04/10/25 02:52 PM the DON stated R14 was seen on wound rounds today. All staff were educated on EBP and she expected staff to always follow EBP for infection control. The facility policy dated 4/1/24 titled EBP, identified the use of gown and gloves during high contact resident care activities was required for residents known to be colonized or infected with a MDRO (multidrug-resistant organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375			
21665	MN Rule 4658.1400 Physical Environment	21665			5/13/25

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21665	Continued From page 27 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a personal refrigerator was monitored and kept sanitary in a resident's (R47) shared room. Findings include: R47's quarterly Minimum Data Set (MDS) dated 3/12/25, indicated he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition. Per observation on 4/7/25 at 12:50 p.m., of R47's room, there was a black mini refrigerator on a nightstand on his side of the privacy curtain. There was a Record of Refrigerator Temperatures sign posted on the door of the mini refrigerator dated "July 2024" and there were temperatures documented for the dates of 7/1/24 - 7/23/24. The other entries were blank. There was a second Record of Refrigerator Temperatures taped underneath that was dated "August 2024", and it was completely void of documentation. The contents inside the mini refrigerator included six small plastic water bottles, a small can of "Shasta Cola", two dark green-to-brown avocados, five unlabeled and	21665	corrected.		

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21665	Continued From page 28 undated resealable plastic sandwich bags with unidentified food items inside, two lumps of rolled up aluminum foil, an unlabeled and undated blue plastic cup with a white liquid inside, a silver-colored mug with a black handle and top, a clear plastic bottle with a dark teal top and handle, three unlabeled and undated plastic containers with unidentified items inside, a tied up grocery bag, an labeled glass jar of "Smuckers" brand jam, and two unlabeled "Chobani" brand yogurt beverages. There was a second mini refrigerator in the room located behind the first one. It was empty and unplugged. Per interview on 4/7/25 at 4:00 p.m., family member (FM)-B was unsure who the refrigerator in R47's room belonged to. FM-B believed it was his roommate's food inside the refrigerated and stated, "that is very unsanitary, so who cleans that? It is so dirty there." Per interview on 4/9/25 at 7:40 a.m. with licensed practical nurse (LPN)-B, the nursing staff were responsible for checking the temperature of the mini refrigerator in R47's room every night and documenting them on the record of temperature log. LPN-B stated when the logs were completed, they were turned into management who kept them. On 4/9/25 at 11:48 a.m., the administrator was asked to provide personal refrigerator temperature logs for the floor R47 resided on dated 6/24 - 3/25. During interview at 1:17 p.m., the administrator provided logs for 2025 and responded, "we got rid of the ones from the prvious [sic] year". The temperature logs dated 6/24 - 12/24 were requested but not received. The Record of Refrigerator Temperatures dated 1/25 - 3/25 were reviewed and included	21665			

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21665	Continued From page 29 completed documentation. During observation and interview on 4/10/25 at 12:39 p.m., the director of nursing (DON) and surveyor were in R47's room. There was only one mini black refrigerator in the room and the Record of Temperatures was dated April 2025 and included documentation of temperatures from 4/1/25 - 4/8/25. The refrigerator's contents included four small disposable plastic water bottles, one "Chobani" brand yogurt beverage, one glass jar of "Smuckers" brand jam, a silver-colored mug with a black handle and top, and a clear plastic bottle with a dark teal top and handle. The DON stated staff were expected to check the temperature every night and document it on the log sheet. Additionally, staff were expected to clean the resident refrigerators out and update the log sheet each month. The DON and surveyor reviewed the photographs of the Record of Refrigerator Temperatures dated 7/24 and 8/24 from surveyor's observation on 4/7/25 as well as the photographs of the contents of the refrigerator from the observation. The DON confirmed the deficient practice and stated staff should have cleaned the refrigerator out prior to 4/7/25 and should have updated the temperature log before 4/7/25. Per an undated facility policy titled Resident's Personal Refrigerator, to assure infection control practices, including refrigerator function, was maintained, cleaning would be done for prevention of food-borne illness. The purpose of the policy was to assure personal refrigerators in resident room's are functioning at the correct temperature and are clean and do not contain expired products that could cause food-borne illness. The policy directed staff to check the temperature of the refrigerator in the room weekly	21665			

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21665	Continued From page 30 and record the results in the temperature log in the room. Additionally, the policy guided staff to check the temperature, condition of food/beverage, and spoilage on a weekly basis and remove expired perishable food items after notifying the resident. The policy indicated the refrigerator would be cleaned monthly and as needed and would be defrosted as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with nursing, housekeeping, and culinary staff to conduct periodic audits of resident's personal personal refrigerators to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665			
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.	21855			5/13/25

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21855	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 2 residents (R29) who required staff assistance with personal cares. Findings include: R29's admission Minimum Data Set (MDS) dated 2/12/25, indicated he had intact cognition and was dependent on staff assistance for toileting hygiene and required partial to moderate assistance with personal hygiene cares. The MDS reported he was frequently incontinent of urine and bowel. The MDS listed his diagnoses as hemiparesis (one-sided weakness) or hemiplegia (one-sided paralysis), chronic lung disease, and chronic obstructive pulmonary disease (COPD, a chronic restrictive lung and breathing condition). R29's Care Area Assessment (CAA) for functional abilities dated 2/12/25, reported he received limited assistance "with rolling left and right in bed," and "extensive assist with bathing, upper body dressing." The CAA further identified his dependence on staff for toileting hygiene. R29's care plan dated 2/11/25, identified his self-care deficit and categorized him as a "vulnerable adult". The care plan directed staff to provide an assist of 1 with personal hygiene, bathing, and dressing. During observation on 4/7/25 at 2:24 p.m., R29's door was not closed and from the unit hallway	21855	corrected.		

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21855	Continued From page 32 reflected through a mirror affixed in the middle of the wall, nursing assistant (NA)-C could be seen standing beside R29's bed on the far end of the shared room. The privacy curtain was not pulled all the way around the bed. The mirror on the wall reflected NA-C removing R29's incontinence brief and his bare genitals were exposed. The mirror reflected NA-C fastening the tabs on the new brief, doffing his gloves, and adjusting the bed to the lowest position. NA-C exited the room and performed hand hygiene at the soiled utility station. During interview on 4/7/25 at 2:27 p.m., NA-C stated staff should first knock then close a resident's door and close the privacy curtain to maintain their dignity and protect their privacy. NA-C stated R29's door was unable to be closed due to resident preference. When asked if R29's curtain could be closed further to maintain his privacy, NA-C first stood where the surveyor made the observation and looked through the mirror at R29's bed. Next, NA-C and the surveyor entered his room and NA-C demonstrated the privacy curtain could close further. Finally, NA-C and the surveyor returned to the hallway and looked through the mirror at R29 and only his ankles and feet were reflected in the mirror. NA-C confirmed the privacy curtain should have been pulled fully closed to provide privacy. Per interview on 4/8/25 at 9:51 a.m., NA-E expected staff to close the door, pull the curtain and ask a resident's permission before starting cares to protect their privacy and dignity. Per interview on 4/10/25 at 10:22 a.m. with registered nurse (RN)-A, staff were expected to knock before entering a resident's room, ask permission, explain the task being performed, pull	21855			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21855	Continued From page 33 the privacy curtain, make sure the blinds are closed if that's appropriate, clean up the supplies, and make sure the resident is safe and comfortable before leaving the room. Per interview on 4/10/25 at 1:03 p.m. with the director of nursing (DON), staff were expected to close the door and pull the privacy curtain to maintain dignity and privacy for residents. A facility policy pertaining to resident rights and privacy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on privacy and/or dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts are offered and assisted to appropriately cover their exposed skin and to ensure personal hygiene is maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21855			