DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2023

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

RE: CCN: 245394
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 11, 2023, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 August 11, 2023, (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 November 11, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 05/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/8/23-5/11/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/8/23-5/11/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H53942075C (MN92813) H53942076C (MN92640) H53942078C (MN92599) H53942079C (MN92420) H53942080C (MN92329) H53942081C (MN92168) H53942086C (MN91745) H53942082C (MN91673) H53942083C (MN89690) H53942084C (MN89456) H53942084C (MN89419) H53942186C (MN93293) H53942162C (MN93366)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2023

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

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F 000	Continued From page 1 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 that substantial compliance with the regulations has been attained.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on document review, observations and staff interviews, the facility failed to ensure a medication error rate of less than 5%. Four errors were made with a total of 31 opportunities for error, resulting in a 12.9% error rate. The errors involved one resident (R46), who was not given four medications per physician's order. Findings include: R46's significant change MDS, dated 2/28/23, indicated R46 had moderate cognitive impairment and was not able to clearly communicate her needs and wishes. R46 had difficulty swallowing, weakness, and paralysis on right side due to a	F 759	Immediate Corrective Action: R46 tube was assessed, and found it was patent. R46 Assessed and found no adverse reaction. Facility called and notified MD of medication error and received order to crush medication(s) and administer separately. Facility called POA and notified of medication error regarding R46. Corrective Actions as it applies to others: Administering medications through enteral tube policy was reviewed.	6/20/23

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F 759	Continued From page 2 stroke. R46's Order Summary Report, dated 5/9/23, indicated orders for enteral feed of Jevity 360 cubic centimeters (cc) four times daily, losartan potassium (a hypertension medication used to treat high blood pressure) 25 milligrams (MG) once daily, quetiapine (an antipsychotic medication used to balance certain natural substances in the brain) 25 mg once daily, propranolol (a hypertension medication used to treat high blood pressure) 40 mg twice daily, and Aspirin 325 MG once daily. The order summary report failed to indicate an order to crush medications and slurry (crushed and mixed together with liquid). During observation on 5/10/23 licensed practical nurse (LPN)- A prepared medications for administration. LPN-A crushed all tablet medications together and poured them into a cup. Crushed medications were mixed with 5 cc of water. LPN-A administered 5 cc of water followed by potassium, 5 cc of water followed by valproic acid, 5 cc of water followed with the crushed medications and then 10 cc of water by gravity via feeding tube. During interview on 5/11/23 at 8:48 a.m. director of nursing (DON) stated resident should be administered 10 cc of water before and after feeding via feeding tube. DON reviewed R46's orders and stated it read that 30 cc of water was ordered to be administered before and after feeding. DON stated this is important as it helps keep the feeding tube patent (open, unobstructed, affording free passage). DON stated it is okay for medications to be crushed and slurried together if the resident has an order	F 759	Completed full house audits and determined there are no other residents with enteral tube. Education will be completed with license nurses regarding administering medication through an enteral tube Recurrence will be prevented by: Audits will be completed regarding administering medications separately for residents with enteral tubing unless they have orders for crushing and combine medications. Audits will be completed three times a week for six weeks for all residents that have enteral tube. The results of these audits will be shared with QAPI committee for input on the need to increase, decrease, or discontinue the audits.	

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F 759	Continued From page 3 from the provider. DON reviewed R46's orders and stated resident does not have an order to slurry medications. DON stated this is important due to reactions of certain medications when administered together. During interview on 5/11/23 at 9:09 a.m. LPN-A stated R46 should receive 5-10 cc of water before and after feeds. LPN-A did not review R46's orders and stated "yes, that is what her orders read." LPN-A then reviewed R46's orders and stated she could not find an order to slurry medications. The "Administering Medications through an Enteral Tube" policy dated 3/23/23 indicated "Administer each medication separately and flush between medications unless you have an order from provider that it is ok to administer medication together at the same time", "Meds can be crushed together ONLY if you have a provider order to do so", "administer each medication separately to prevent clumping or interactions between medications. Ensure you are administering all medications out of the medication cup", and "If administering more than one medication, flush with 15 mL lukewarm tap water (or prescribed amount) between medications."	F 759		
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:	F 921		6/20/23

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F 921	Continued From page 4 Based on observation, interview, and document review, the facility failed to identify and repair fix damaged hot water heat shielding which was broken away from the wall in 1 of 18 resident rooms on the 2nd floor. Findings include: During initial observations of resident rooms on 5/8/23, at 3:33 p.m. in room 213 the current resident was laying in bed. In observing the room the bed was placed in the north east corner against the wall and under the window. The room's hot water heat pipe ran under the exterior windows (approximately 7 feet), then angled against the east wall (for approximately 6 feet). The hi/lo bed (a hi-low hospital bed is a fully adjustable bed with an enhanced head, foot, and height adjustability) had been placed so that the length and head of the bed was over the heating base board coverings were under the length and head board of the bed. Having the bed in this location, whenever the facility staff placed the bed in low position, it crushed the metal coverings caused sharp edges, pulling the unit and large sections of drywall from the wall. During environmental tour with facility management on 5/10/23, at 1:36 p.m. the regional maintenance director (RMD), facility administrator (ADM) and housekeeping director (HD) reviewed of the heating unit's damage in room 213. RMD checked the "TELS" system (a reporting system used by the facility staff to alert maintenance of needed repairs) was reviewed and found no work orders had been placed for repair. Both RMD and ADM both stated it was the responsibility of floor staff to report such repair needs. RMD further stated the facility did not	F 921	Immediate Corrective Action: The damage to hot water heat shielding in room 213 was repaired on 5/11/2023. Corrective Actions as it applies to others: House wide facility audit to ensure hot water heating shields are appropriately functioning and affixed to the wall completed. Staff education on reporting maintenance repairs through TELs system to be initiated. Recurrence will be prevented by: Audits of 4 resident rooms to be completed weekly x 4 weeks, monthly x 3 months, then PRN based on audit findings to ensure hot water heating shields are functioning and affixed to the wall will be completed. The results of these audits will be shared with QAPI committee for input on the need to increase, decrease, or discontinue the audits.	

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F 921	Continued From page 5 have a policy on the reporting of facility repairs, while the "TELS" program was their procedure. In an interview on 5/11/23, at 8:24 a.m. laundry staff person (Laundry)-A stated she had not noticed the damage while she just deliveries laundry. In an interview on 5/11/23, at 8:25 a.m. nursing assistant (NA)-A also stated the damage had not been noted, nor how long the base board damage was present. In a follow up interview on 5/11/23, at 9:15 a.m. ADM stated the RMD had no record of when the facility did their last total room review. ADM stated maintenance do facility rounding inspections, however not every room is checked.	F 921		

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245394	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**5/10/2023**

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THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	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 and staff interviews, the facility failed to install Fire Extinguisher per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.12, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.1. This deficient finding could have an isolated impact the residents within the facility. Findings include: On May 10, 2023, at 10:30 AM, it was revealed by observation that the water-type fire extinguisher for the indoor smoking lounge was not properly mounted. An interview with Facility Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 10, 2023. 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
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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 building was constructed at two different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the one addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 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 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

Electronically delivered

May 26, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: PTMT11

Dear Administrator:

The above facility was surveyed on May 8, 2023, through May 11, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 05/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 5/8/23-5/11/23, 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		

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the licensing survey, the following complaints were reviewed with no orders issued. H53942075C (MN92813) H53942076C (MN92640) H53942078C (MN92599) H53942079C (MN92420) H53942080C (MN92329) H53942081C (MN92168) H53942086C (MN91745) H53942082C (MN91673) H53942083C (MN89690) H53942084C (MN89456) H53942084C (MN89419) H53942186C (MN93293) H53942162C (MN93366) 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/regulatio	2 000		

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2 000	Continued From page 2 n/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 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is:	21545		6/20/23

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21545	Continued From page 3 (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review, observations and staff interviews, the facility failed to ensure a medication error rate of less than 5%. Four errors were made with a total of 31 opportunities for error, resulting in a 12.9% error rate. The errors involved one resident (R46), who was not given four medications per physician's order. Findings include:	21545	Corrected.	

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21545	Continued From page 4 R46's significant change MDS, dated 2/28/23, indicated R46 had moderate cognitive impairment and was not able to clearly communicate her needs and wishes. R46 had difficulty swallowing, weakness, and paralysis on right side due to a stroke. R46's Order Summary Report, dated 5/9/23, indicated orders for enteral feed of jevity 360 cubic centimeters (cc) four times daily, losartan potassium (a hypertension medication used to treat high blood pressure) 25 milligrams (MG) once daily, quetiapine (an antipsychotic medication used to balance certain natural substances in the brain) 25 mg once daily, propranolol (a hypertension medication used to treat high blood pressure) 40 mg twice daily, and Aspirin 325 MG once daily. The order summary report failed to indicate an order to crush medications and slurry (crushed and mixed together with liquid). During observation on 5/10/23 licensed practical nurse (LPN)- A prepared medications for administration. LPN-A crushed all tablet medications together and poured them into a cup. Crushed medications were mixed with 5 cc of water. LPN-A administered 5 cc of water followed by potassium, 5 cc of water followed by valproic acid, 5 cc of water followed with the crushed medications and then 10 cc of water by gravity via feeding tube. During interview on 5/11/23 at 8:48 a.m. director of nursing (DON) stated resident should be administered 10 cc of water before and after feeding via feeding tube. DON reviewed R46's orders and stated it read that 30 cc of water was ordered to be administered before and after	21545		

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21545	Continued From page 5 feeding. DON stated this is important as it helps keep the feeding tube patent (open, unobstructed, affording free passage). DON stated it is okay for medications to be crushed and slurried together if the resident has an order from the provider. DON reviewed R46's orders and stated resident does not have an order to slurry medications. DON stated this is important due to reactions of certain medications when administered together. During interview on 5/11/23 at 9:09 a.m. LPN-A stated R46 should receive 5-10 cc of water before and after feeds. LPN-A did not review R46's orders and stated "yes, that is what her orders read." LPN-A then reviewed R46's orders and stated she could not find an order to slurry medications. The "Administering Medications through an Enteral Tube" policy dated 3/23/23 indicated "Administer each medication separately and flush between medications unless you have an order from provider that it is ok to administer medication together at the same time", "Meds can be crushed together ONLY if you have a provider order to do so", "administer each medication separately to prevent clumping or interactions between medications. Ensure you are administering all medications out of the medication cup", and "If administering more than one medication, flush with 15 mL lukewarm tap water (or prescribed amount) between medications." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee, could review the facility's policy and procedures for medications given per gastric tube, to ensure	21545		

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21545	Continued From page 6 medication is given as ordered. The DON and /or designee could train staff and conduct audits to ensure complince. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and repair fix damaged hot water heat shielding which was broken away from the wall in 1 of 18 resident rooms on the 2nd floor. Findings include: During initial observations of resident rooms on 5/8/23, at 3:33 p.m. in room 213 the current resident was laying in bed. In observing the room the bed was placed in the north east corner against the wall and under the window. The room's hot water heat pipe ran under the exterior windows (approximately 7 feet), then angled against the east wall (for approximately 6 feet). The hi/lo bed (a hi-low hospital bed is a fully adjustable bed with an enhanced head, foot, and	21685	Corrected.	6/20/23

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21685	Continued From page 7 height adjustability) had been placed so that the length and head of the bed was over the heating base board coverings were under the length and head board of the bed. Having the bed in this location, whenever the facility staff placed the bed in low position, it crushed the metal coverings caused sharp edges, pulling the unit and large sections of drywall from the wall. During environmental tour with facility management on 5/10/23, at 1:36 p.m. the regional maintenance director (RMD), facility administrator (ADM) and housekeeping director (HD) reviewed of the heating unit's damage in room 213. RMD checked the "TELS" system (a reporting system used by the facility staff to alert maintenance of needed repairs) was reviewed and found no work orders had been placed for repair. Both RMD and ADM both stated it was the responsibility of floor staff to report such repair needs. RMD further stated the facility did not have a policy on the reporting of facility repairs, while the "TELS" program was their procedure. In an interview on 5/11/23, at 8:24 a.m. laundry staff person (Laundry)-A stated she had not noticed the damage while she just deliveries laundry. In an interview on 5/11/23, at 8:25 a.m. nursing assistant (NA)-A also stated the damage had not been noted, nor how long the base board damage was present. In a follow up interview on 5/11/23, at 9:15 a.m. ADM stated the RMD had no record of when the facility did their last total room review. ADM stated maintenance do facility rounding inspections, however not every room is checked.	21685		

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21685	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate staff regarding the importance of a clean and safe environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure the areas are keep clean, good repair are being maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 29, 2023

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

RE: CCN: 245394
Cycle Start Date: May 11, 2023

Dear Administrator:

On June 21, 2023, the Minnesota Department of Health, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Electronically delivered

June 29, 2023

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

Re: Reinspection Results
Event ID: PTMT12

Dear Administrator:

On June 21, 2023, 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 May 11, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us