CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TOJU

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	GENCY		Facility ID: 00945
MEDICARE/MEDICAID PROVIDER (L1) 245394 STATE VENDOR OR MEDICAID NO (L2) 914342400		3. NAME AND ADDRESS OF FACILITY (L3) THE ESTATES AT LYNNHURST LLC (L4) 471 LYNNHURST AVENUE WEST (L5) SAINT PAUL, MN		(L6) 55104		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF O' (L9) 03/01/2017	WNERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR' 05 HHA	Y 09 ESRD	<u>02</u> (L7)) 22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other omplaint
6. DATE OF SURVEY 09/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	20/2017 (L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	72 (L18) 72 (L17)	X A. In Complia Program Re Compliance 1. A B. Not in Com	quirements		2. Tecl 3. 24 F 4. 7-Da	hnical Personnel	Following Requirements: 6. Scope of Serv 7. Medical Dire 8. Patient Room 9. Beds/Room (L12)	vices Limit
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 72 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY M 1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):		18 STATE SUR	VEY AGENCY API	PROVAL	Date:
Susanne Reuss,	Unit Supervis		09/20/2017	(L19)			ogram Specialis	
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	(-24)
DETERMINATION OF ELIGIBILE 1. Facility is Eligible to F 2. Facility is not Eligible	articipate		IPLIANCE WITH C	IVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATI					(L30) TARY feet Health/Safety feet Agreement
25. LTC EXTENSION DATE: (L27)	ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involu 04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider 00-Active	· Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (08/22/2017	OF APPROVAL DAT	(L33)	DETERMINA	ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245394

November 1, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

Dear Ms. Pierzina:

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

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

Effective September 6, 2017 the above facility is certified for or recommended for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 1, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

RE: Project Number S5394029 & H5394061

Dear Ms. Pierzina:

On August 22, 2017, as authorized by the CMS Region V Office we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 29, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 22, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 29, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on June 29, 2017 that included an investigation of complaint number H5394061, and a lack of demonstrated compliance at the time of the Post-Certification Revisit (PCR) completed August 17, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On September 20, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 6, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 20, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 6, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy outlined in our letter of August 22, 2017, CMS concurs and has authorized this

The Estates At Lynnhurst LLC November 1, 2017 Page 2

Department to notify you of the following action:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 29, 2017, be rescinded effective September 6, 2017. (42 CFR 488.417 (b))

In our letter of August 22, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 29, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 6, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 1, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

Re: Reinspection Results - Project Number S5394029

Dear Ms. Pierzina:

On September 20, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2017, that included an investigation of complaint number H5394061, with orders received by you on July 18, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TOJU

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PAKI	1 - TO BE COM	PLETED BY	THE STATE	E SURVEY AG	ENCY		Facility ID: 00	945
MEDICARE/MEDICAID PRO (L1) 245394	VIDER NO.		3. NAME AND ADD (L3) THE ESTAT					4. TYPE OF ACTI	ON: <u>7 (</u> L8)	
2.STATE VENDOR OR MEDICA	AID NO.		(L4) 471 LYNNHU	URST AVENUE	WEST			3. Termination	4. CHOW	
(L2) 914342400			(L5) SAINT PAUI	L, MN		(L6)	55104	5. Validation 7. On-Site Visit	6. Comple 9. Other	
5. EFFECTIVE DATE CHANGE	OF OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGOR	RY	<u>02</u> (L7)				
(L9) 03/01/2017			01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey Aft	er Complaint	
6. DATE OF SURVEY	08/17/2017	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	_	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR END	ING DATE:	(L35)
	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31		
11LTC PERIOD OF CERTIFICA	TION		10.THE FACILITY	IS CERTIFIED AS	:					
From (a):			A. In Complian	ce With		And/Or Approv	ed Waivers Of The	Following Requirements	s:	
To (b):			Program Re	•		2. Tech	nical Personnel	_ 6. Scope of	Services Limit	
			Compliance	Based On:		3. 24 H	our RN	7. Medical I	Director	
12 Total Engility Dada	72	(L18)	1. A	acceptable POC		4. 7-Da	y RN (Rural SNF)	8. Patient Ro	oom Size	
12. Total Facility Beds			37			5. Life	Safety Code	9. Beds/Roo	m	
13. Total Certified Beds	72	(L17)	X B. Not in Com	pliance with Progra and/or Applied Wai		* 0.1	B*	(L12)		
14. LTC CERTIFIED BED BREA	KDOWN		requirements	and of Applied Wal	VC15.	* Code: 15. FACILITY M		(112)		
		10 CNIE	ICE	Ш				(L15)		
18 SNF 18/	19 SNF 72	19 SNF	ICF	IID		1861 (e) (1) or 1	1861 (J) (1):	(L13)		
(L37)	L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY I	REMARKS (IF APP	LICABLE S	SHOW LTC CANCELL	LATION DATE):						
17. SURVEYOR SIGNATURE			Date :			18. STATE SURV	YEY AGENCY AP	PROVAL	Date:	
Momodou I	Fatty, HFE	NE II		08/01/2017	(L19)	Kate John	nsTon, Pro	ogram Specia	list 08/2	2/2017 (L20)
	PAR	Г II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR S	INGLE STAT	E AGENCY		, ,
19. DETERMINATION OF ELIC	GIBILITY			IPLIANCE WITH (CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 				
_X 1. Facility is Eligi	ble to Participate		Rigi	1157161.			Soth of the Above :	interest Biselosure Still (1		
2. Facility is not l	Eligible	(L21)								
22. ORIGINAL DATE	22 1.TO	C AGREEM	ENT 2	24. LTC AGREEM	ENT	26. TERMINAT	ION ACTION:		(L30)	
OF PARTICIPATION	BI	EGINNING	DATE	ENDING DAT	ſΈ	VOLUNTARY	00		UNTARY	
12/01/1986						01-Merger, Closur			to Meet Health/Saf	•
(L24)	(L	41)		(L25)		02-Dissatisfaction		nt 06-Fail	to Meet Agreemen	İ
25. LTC EXTENSION DATE:			E SANCTIONS of Admissions:			03-Risk of Involun 04-Other Reason fo		OTHER 07-Prov	<u>R</u> vider Status Chang	e
	A.	Suspension	or Admissions.	(L44)				00-Acti	_	-
(I	L27) B.	Rescind Sus	pension Date:	(2)						
				(L45)						
28. TERMINATION DATE:		29). INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
			01111							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539		32	2. DETERMINATION (OF APPROVAL DA	ATE					
	(L32))	08/22/2017		(L33)	DETERMINA	TION APPRO	VAI.		
	()				\/			7 4 44		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 22, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

RE: Project Number S5394029 & H5394061

Dear Ms. Pierzina:

On July 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 29, 2017 that included an investigation of complaint number H5394061. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 16, 2017, the Minnesota Department of Health and on August 4, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2017. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on June 29, 2017. The deficiencies not corrected is/are as follows:

F0280 -- S/S: D -- 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) -- Right To Participate Planning Care-Revise Cp

In addition, at the time of this revisit, we identified the following deficiencies:

F0411 -- S/S: D -- 483.55(a)(1)(2)(4) -- Routine/emergency Dental Services In SNFs

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective August 27, 2017. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 29, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 29, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 29, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Estates At Lynnhurst LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 29, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results ofthis visit with the President of your facility's Governing Body.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900

> Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Acting Branch Manager by phone at (312)353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

kate.johnston@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered August 22, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

Re: Project # S5474027 & H5474026

Dear Ms. Pierzina:

On August 16, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2017 with orders received by you electronically on July 18, 2017.

State licensing orders issued pursuant to the last survey completed on June 29, 2017 and found corrected at the time of this August 16, 2017 revisit.

State licensing orders issued pursuant to the last survey completed on June 29, 2017, found not corrected at the time of this August 16, 2017 revisit and subject to penalty assessment are as follows:

\$300.00 20570 -- MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision

The details of the violations noted at the time of this revisit completed on August 16, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the

Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to Suzanne Reuss, Unit Supervisor, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900. St. Paul MN, 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on August 16, 2017 additional violations were cited as follows:

21325 -- S/S: -- MN Rule 4658.0725 Subp. 1 -- Providing Routine & Emergency Oral Health Ser

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered August 22, 2017

Ms. Deanna Pierzina, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

Re: Project # S5394029

Dear Ms. Pierzina:

On August 16, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2017 with orders received by you electronically on July 18, 2017.

State licensing orders issued pursuant to the last survey completed on June 29, 2017 and found corrected at the time of this August 16, 2017 revisit.

State licensing orders issued pursuant to the last survey completed on June 29, 2017, found not corrected at the time of this August 16, 2017 revisit and subject to penalty assessment are as follows:

\$300.00 20570 -- MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision

The details of the violations noted at the time of this revisit completed on August 16, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the

Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to Suzanne Reuss, Unit Supervisor, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900. St. Paul MN, 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on August 16, 2017 additional violations were cited as follows:

21325 -- S/S: -- MN Rule 4658.0725 Subp. 1 -- Providing Routine & Emergency Oral Health Ser

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On ,	
l,	,, received
(Name)(Please Print)	(Title)(Please Print)
the Notice of Penalty Assessment date	, , , , ,
_, _	
The Estates At Lynnhur	
471 Lynnhurst Avenue	West
Saint Paul, MN 55104	
The Penalty Assessments and licensing	g orders attached hereto have been corrected as of
Signed:	. Date
(Name)(Please Print)	,, Title)(Please Print)
DELIVERY OF L	ICENSING PENALTY ASSESSMENT NOTICE
On ,	
	,, of the Health Regulation
Division,	
(Name)(Please Print)	(Title)(Please Print)
Minnesota Department of Health, deli	vered the Notice of Penalty Assessment dated ,
and issued to:	
The Estates At Lynnhur	st I le
471 Lynnhurst Avenue	
Saint Paul, MN 55104	vvest
5ame : 4an, 1711 55 16 1	
The Notice of Penalty Assessment was	
Data	(Name)(Please Print)
, Date (Title)(Please Print)	
()	
Signed:	
(Name)(Please Print)	(Title)(Please Print)

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

PRINTED: 09/19/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(X:	3) DATE SURVEY COMPLETED
		245394	B. WING			R-C 08/16/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
{F 000}	INITIAL COMMEN	ГS	{F 00	00}		
{F 280} SS=D	completed on Augucertification tags the found on the CMS2 that were not found PCR which are local Because you are esignature is not recepage of the CMS-2 submission of the Everification of computer (in the expected goals and amount, frequency)	cification revisit (PCR) was lest 16 & 17, 2017. The last were corrected can be 2567B. Also there is one tag I corrected at the time of onsite lated on the CMS2567. Incolled in ePOC, your luired at the bottom of the first 567 form. Your electronic POC will be used as oliance. Coc will be used as oliance. Coc acceptable electronic POC, an lur facility will be conducted to late attained in accordance with the en attained in accordance with (1)(3),483.21(b)(2) RIGHT TO INNING CARE-REVISE CP contact in the development of his or her person-centered ling but not limited to: Cipate in the planning process, or identify individuals or roles to olanning process, the right to land the right to request son-centered plan of care. Cicipate in establishing the doutcomes of care, the type, and duration of care, and any dot the effectiveness of the	{F 28	30}		9/6/17
ABOBATORY	L / DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.

Electronically Signed

09/01/2017

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
							-C
		245394	B. WING			08/	16/2017
	PROVIDER OR SUPPLIER TATES AT LYNNHURS	THE			STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST		
IIIL LOI	AILS AI LIMMIONS	LEG		,	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		BE	(X5) COMPLETION DATE	
{F 280}	Continued From pa	ge 1	{F 28	30}			
	(iv) The right to receincluded in the plan	eive the services and/or items of care.					
		the care plan, including the gnificant changes to the plan					
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust					
	(i) Facilitate the incl resident representa	usion of the resident and/or tive.					
	(ii) Include an assessive strengths and need	ssment of the resident's s.					
		resident's personal and s in developing goals of care.					
	483.21 (b) Comprehensive	Care Plans					
	(2) A comprehensiv	re care plan must be-					
	(i) Developed within the comprehensive	7 days after completion of assessment.					
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245394	B. WING			R-C / 16/2017
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, 2 471 LYNNHURST AVENUE WES SAINT PAUL, MN 55104	ZIP CODE	710/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 280}	resident. (D) A member of formula (E) To the extent provided the resident and the An explanation must medical record if the and their resident renot practicable for the resident's care pland (F) Other appropriated disciplines as deteror as requested by (iii) Reviewed and ream after each assessments. This REQUIREMENT by: Based on observative review, the facility for the plan for 1 of 3 dental status. Findings include: R33's was admitted R33's Admission Facof Alzheimer's disease on 8/16/17, at 2:58 bed and observed to the resident.	od and nutrition services staff. cacticable, the participation of e resident's representative(s). It is included in a resident's e participation of the resident epresentative is determined the development of the included by the resident's needs the resident. It is staff or professionals in mined by the resident's needs the resident. The vised by the interdisciplinary sessment, including both the diquarterly review Nor is not met as evidenced tion, interview and document ailed to review and revise the residents (R33) reviewed for	F 28	Resident #33 care plan revised per resident pre resident choice of prefer All residents to be given participate in planning or treatments based on rescompetency All staff will be re-educa of rights specific to resident completed weekly x4 we needed	ference to reflect red dentist the choice to f all cares and sident's ted on resident bil dent preferences be audits to be	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY IPLETED
		245394	B. WING _			R-C 16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 280}	for dental problems a full upper denture denture. The goal in denture complication included referral for Review of 7/13/17, conference and quaindicated R33 want Minnesota (U of M) as she only had the On 8/17/17, at 9:16 indicated R33 did nover seen R33 we On 8/17/17, at 9:28 stated R33 had never and they were in the dental appointment On 8/17/17, at 11:1 (DON) stated during three weeks ago, R the U of M dentist a schedule an appoin stated R33 indicate eating with her uppointment On 8/17/17, at 1:50 she wanted to see the was wondering who scheduled. On 8/17/17, at 1:54 nursing (ADON), st consent form had by the scheduled.	plan indicated R33 was at risk and was edentulous. R33 had but did not have a lower endicated R33 would be free of ons and the interventions dental services as needed. interdisciplinary team care arterly review (6/2017) ed to see her University of dentist for bottom dentures, top denture. a.m. nursing assistant (NA)-A ot have dentures, and had earing them. a.m. registered nurse (RN)-A per requested lower dentures e process of scheduling a care conference two to say stated she preferred to see and they were working to attend to the did not have problems	{F 280	DNS or designee will be res QAA will provide redirection when necessary to ensure of and/or continuation of monit based on compliance date of	or change completion coring process	

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

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION		E SURVEY PLETED
		245394	B. WING				-C 16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2017
THE EST	ATES AT LYNNHURS	T LLC			YNNHURST AVENUE WEST IT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 280}	stated she would se	er heard of R33 and R33 ee Apple Tree Dental instead. DN indicated R33 often	{F 28	30}			
F 411 SS=D	have a policy that a plan. The DON con R33's care plan.	p.m. DON stated they did not ddressed updating the care firmed she had not updated ROUTINE/EMERGENCY S IN SNFS	F 4	÷11			9/6/17
	(a) Skilled Nursing	Facilities					
	A facility-						
	resource, in accord	or obtain from an outside ance with §483.70(g) of this nergency dental services to each resident;					
		a Medicare resident an or routine and emergency					
	(a)(4) Must if neces resident;	sary or if requested, assist the					
	(i) In making appoir	ntments; and					
	dental services loca This REQUIREMEN by: Based on observat review, the facility for	transportation to and from the ation; NT is not met as evidenced tion, interview and document ailed to ensure dental services of 3 residents (R33) reviewed		re be	Resident #33 care plan updated to esident's dental preference, reside e seen by on-site dentist at next v 5.17	nt to	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245394	B. WING			-C 16/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	1 33/	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 411	Continued From pa	ge 5	F 41	New admissions/ re-admits will b	e	
		d to the facility on 7/15/13. ace Sheet included diagnosis ase.		assessed for oral/dental preferer appropriate interventions to be in when and as needed	itiated	
	bed and observed t	p.m. R33 was resting in her to not have lower teeth. When ted she did not have lower		All staff will be re-educated of im of resident's oral health and repo changes to appropriate parties was needed	rting all	
	quarterly review (6/ see her U of M den	3/17, IDT care conference and 2017) indicated R33 wanted to tist for bottom dentures, as p denture. DON confirmed she 33's care plan.		Complete facility Oral Dental care audit, complete all dental service follow up appointments schedule Apple Tree Dental's next routine visit	audit, d per	
	indicated R33 was was edentulous. R3 did not have a lowe R33 would be free	plan reviewed on 7/13/17, at risk for dental problems and 33 had a full upper denture but or denture. The goal indicated of denture complications and cluded referral for dental		DNS or designee will be respons QAA will provide redirection or ch when necessary to ensure comp and/or continuation of monitoring based on compliance date of 9.6	ange etion process	
		a.m. nursing assistant (NA)-A ot have dentures, and had earing them.				
	stated R33 had nev	a.m. registered nurse (RN)-A ver requested lower dentures e process of scheduling a				
	(DON) stated during three weeks ago, R	14 a.m. the director of nursing g a care conference two to 133 stated she preferred to see nnesota (U of M) dentist and				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3	3) DATE SURVEY COMPLETED
		245394	B. WING			R-C 08/16/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, ST 471 LYNNHURST AVENUE SAINT PAUL, MN 5510	WEST	00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	
F 411	dentures. DON stat have problems eatin On 8/17/17, at 1:50 she wanted to see the was wondering whe scheduled. On 8/17/17, at 1:54 nursing (ADON), stated she would see the U of M had never stated she would see In addition, the ADO refused to see the CR33's care plan lack resident's refusals to	o schedule an appointment for ed R33 indicated she did not ng with her upper dentures. p.m. when asked, R33 stated the dentist to get dentures and en the appointment was p.m. the assistant director of ated R33's face sheet and een sent to Apple Tree Dental pointment. ADON further stated er heard of R33 and R33 ee Apple Tree Dental instead. ON indicated R33 often dentist. ked information about o keep dental appointments. accility had not scheduled	F 4			

PRINTED: 09/05/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ R-C B. WING 00945 08/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST** THE ESTATES AT LYNNHURST LLC SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation

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.

not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of

the Minnesota Department of Health.

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 8/16/17 and 8/17/17, surveyors of the MN Department of Health completed an on-site licensing revisit to follow up on licensing orders issued as a result of a licensing survey completed on 6/29/17. All licensing orders were found in compliance with state regulations.

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/01/17 **Electronically Signed**

STATE FORM TOJU12 If continuation sheet 1 of 6

TITLE

(X6) DATE

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R-	
		00945			08/1	6/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S HURST AVE	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	THC	UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Continued From page 1		{2 000}			
	This facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.					
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		{2 570}			9/6/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility f	on, interview and document ailed to review and revise the residents (R33) reviewed for		Completed upon compliance date 9.6.17	of	
	Findings include:					
		I to the facility on 7/15/13. ace Sheet included diagnosis ase.				
	bed and observed t	p.m. R33 was resting in her o not have lower teeth. When ed she did not have lower				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00945	B. WING		R- 08 / 1	-C 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
THE EST	TATES AT LYNNHURS	IIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 570}	dentures. R33's current care for dental problems a full upper denture denture. The goal in denture complication included referral for Review of 7/13/17, conference and quaindicated R33 want Minnesota (U of M) as she only had the On 8/17/17, at 9:16 indicated R33 did nover seen R33 we On 8/17/17, at 9:28 stated R33 had never and they were in the dental appointment On 8/17/17, at 11:1 (DON) stated during three weeks ago, R the U of M dentist a schedule an appoint stated R33 indicate eating with her upper On 8/17/17, at 1:50 she wanted to see for the dental to see for	plan indicated R33 was at risk and was edentulous. R33 had but did not have a lower endicated R33 would be free of one and the interventions dental services as needed. interdisciplinary team care exterly review (6/2017) ed to see her University of dentist for bottom dentures, top denture. a.m. nursing assistant (NA)-A ot have dentures, and had earing them. a.m. registered nurse (RN)-A rer requested lower dentures e process of scheduling a care conference two to 33 stated she preferred to see and they were working to a timent for dentures. The DON d she did not have problems	{2 570}	DEPIGIENCY		
	nursing (ADON), st	p.m. the assistant director of ated R33's face sheet and een sent to Apple Tree Dental				

Minnesota Department of Health

STATE FORM 6899 TOJU12 If continuation sheet 3 of 6

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R-C	
00945		B. WING		08/16/2017		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X5) COMPLETE DATE	
{2 570}	Continued From page 3		{2 570}			
	the U of M had nev stated she would se In addition, the ADO refused to see the o					
	have a policy that a	p.m. DON stated they did not ddressed updating the care firmed she had not updated				
21325	21325 MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser		21325			9/6/17
	home must provide resource, routine de needs of each resid include dental exan fillings and crowns, oral surgery, bridge orthodontic procedu that are provided fo	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, s and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party cies.				
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview and document ailed to ensure dental services of 3 residents (R33) reviewed		Completed upon compliance date 9.6.17	of	
	Findings include:					
		I to the facility on 7/15/13. ace Sheet included diagnosis ase.				

Minnesota Department of Health

STATE FORM 6899 TOJU12 If continuation sheet 4 of 6 Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		00045	B. WING		R-C		
		00945			08/16/2017		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE EST	TATES AT LYNNHURS	THC	HURST AVE UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21325	Continued From pa	ge 4	21325				
	bed and observed t	p.m. R33 was resting in her o not have lower teeth. When ed she did not have lower					
	quarterly review (6/ see her U of M den	8/17, IDT care conference and 2017) indicated R33 wanted to tist for bottom dentures, as p denture. DON confirmed she 33's care plan.					
	indicated R33 was was edentulous. R3 did not have a lowe R33 would be free	plan reviewed on 7/13/17, at risk for dental problems and 33 had a full upper denture but r denture. The goal indicated of denture complications and cluded referral for dental					
		a.m. nursing assistant (NA)-A ot have dentures, and had aring them.					
	stated R33 had nev	a.m. registered nurse (RN)-A ver requested lower dentures e process of scheduling a					
	(DON) stated during three weeks ago, R the University of Mi they were working to dentures. DON state	4 a.m. the director of nursing g a care conference two to 33 stated she preferred to see nnesota (U of M) dentist and o schedule an appointment for ed R33 indicated she did not ng with her upper dentures.					
	she wanted to see	p.m. when asked, R33 stated the dentist to get dentures and en the appointment was					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AIND FLAIN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:					
		00945	B. WING		R-C 08/16/2017			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
THE EST	I THE ESTATES AT LYNNHIIRSTILC			NHURST AVENUE WEST AUL, MN 55104				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21325	Continued From page 5		21325					
	nursing (ADON), st consent form had be to schedule an apport the U of M had new stated she would see In addition, the ADO refused to see the CR33's care plan lace resident's refusals to As of 8/17/17, the fix R33's dental appoint SUGGESTED MET. The director of nursed develop and implement to ensure appropriate residents who present Monitoring systems ongoing compliance quality committee.	ked information about to keep dental appointments. acility had not scheduled						

6899

Minnesota Department of Health STATE FORM

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TOJU

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	Γ I - TO BE COMPLETED BY THE ST	ATE SURVEY AGENCY	Facility ID: 00945		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245394 2.STATE VENDOR OR MEDICAID NO. (L2) 914342400	3. NAME AND ADDRESS OF FACILITY (L3) THE ESTATES AT LYNNHURST (L4) 471 LYNNHURST AVENUE WEST (L5) SAINT PAUL, MN		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 03/01/2017	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESR	<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 06/29/2017 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF 04 SNF 08 OPT/SP 12 RHG		FISCAL YEAR ENDING DATE: (L35) 12/31		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 72 (L18) 13.Total Certified Beds 72 (L17)	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 72 (L37) (L38) (L39)	F ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICATION OF	Date :	18. STATE SURVEY AGENCY AP Joanne Simon, Certifica			
PART II - TO 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	L OFFICE OR SINGLE STATE AGENCY 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:			
12/01/1986 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERN.	NG DATE (L25) ATIVE SANCTIONS usion of Admissions:	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change		
(L27) B. Rescino	(L44) Suspension Date: (L45)		00-Active		
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 01111 (L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 08/22/2017 (L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 18, 2017

Mr. Daniel Strittmater, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

RE: Project Number S5394029

Dear Mr. Strittmater:

On June 29, 2017, a standard 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. In addition, at the time of the June 29, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5394061.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 8, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 29, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

The Estates At Lynnhurst LLC July 18, 2017 Page 6

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

PRINTED: 09/07/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		245394	B. WING		06/29/2017	
	PROVIDER OR SUPPLIER	T LLC	4	STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENT	TS .	F 000			
		cation survey and complaint onducted on June 26, 27, 28,				
	complaint H539406	urvey, an investigation of the state of the				
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are four signature is not required of first page of the CMS-2567 of submission of the POC will cition of compliance.				
F 241 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 241		7/28/17	
	resident in a manner promotes maintena her quality of life reindividuality. The far promote the rights of This REQUIREMENT by: Based on observatoreview, the facility for (R39) currently resident maintenance.	NT is not met as evidenced ion, interview and document ailed to treat 1 of 32 residents ding on the second floor with		Resident #39 is provided with dignity during meals as outlined in individual plan.	care	
APODATORY		d floor dining room when staff DER/SUPPLIER REPRESENTATIVE'S SIGN	JATLIDE	All residents will continue to be provid	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

07/31/2017

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		E SURVEY PLETED
		245394	B. WING		06/	29/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	, ,	
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F 241	6/26/17, at 6:20 p.n room, residents we waiting for staff to stable with other respaper placemats or resident's place. Roplacemat on the tale edge of the table. In the placemat out frostraightened it on the need someone to for NA-A's words to Rodining room. In an interview on a sked if R39 needed and added that R39. Review of R39's cast functioning last reveneded extensive as In the Minimum Da 3/9/17, staff assess understood. The Minimum Da 3/9/17, staff assess understood. The Minimum problems, names and faces, and nursing home howers as having severely fluctuations in level. In an interview on 6 director of nursing staff education about residents.	meal dining observation on in. in the second floor dining re observed to sit at tables serve supper. R39 sat at a idents. Staff previously set in the tables in front of each 39 reached for the paper ole and pulled it toward the sursing assistant (NA)-A pulled om under R39's hands, he table and said to R39, "You eed you, you're a feeder." 39 were heard across the 6/28/17, at 2:25 p.m. when ed help to eat, NA-A said "yes,"	F 24	with dignity during meal services All staff will be re-educated on re of rights, specific to dignity. Audits of resident dignity during services to be completed weekly weeks; then as needed. DNS or designee will be respons party. QAA will provide redirection or of when necessary to ensure comp and/or continuation of monitoring based on compliance date of Au 2017.	dining x4 sible hange bletion g process	

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY PLETED
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	OVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 280 SS=D F 4(i) in brown (i) early (i) early (i) early (ii) early (ii) early (iii) brown (iii) early (iii) early (iiii) brown (iiiiii) early (iiiiii) early (iiiiiii) early (iiiiiiiii) early (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	a "feeder" the DON use that term about provide education to perm "feeder" to desponent. The facility provided State Bill of Rights, or a policy about dineading on page 15 are for residents in environment that mesident's dignity and its or her individualities or her individu	about staff calling a resident said staff are not trained to residents, and that she would be staff about not using the scribe a resident needing help of the Combined Federal and dated 12/4/15, upon request gnity. Under the Dignity of the facility must promote a manner and in an aintains or enhances each of respect in full recognition of ity." (3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP articipate in the development of his or her person-centered ng but not limited to: cipate in the planning process, or identify individuals or roles to lanning process, the right to not the right to request son-centered plan of care. cipate in establishing the outcomes of care, the type, and duration of care, and any do to the effectiveness of the	F 24	41		7/28/17

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT (COM-		E SURVEY MPLETED			
		245394	B. WING		06/	/29/2017
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP COD 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	<u> </u>	
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F 280	(v) The right to see right to sign after si of care. (c)(3) The facility sl right to participate is shall support the replanning process in (i) Facilitate the incresident representation (ii) Include an assess trengths and need (iii) Incorporate the cultural preference 483.21 (b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending procession (B) A registered nu resident.	the care plan, including the ignificant changes to the plan hall inform the resident of the in his or her treatment and esident in this right. The nust clusion of the resident and/or ative. Issment of the resident's dis. resident's personal and s in developing goals of care. Care Plans We care plan must be- in 7 days after completion of assessment. interdisciplinary team, that limited to	F 2	30		
	483.21 (b) Comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending p (B) A registered nuresident. (C) A nurse aide wiresident.	e Care Plans ve care plan must be- n 7 days after completion of assessment. interdisciplinary team, that limited to ohysician. rse with responsibility for the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMI	SURVEY PLETED		
		245394	B. WING		06/2	29/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 6 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 280	the resident and the An explanation must medical record if the and their resident in not practicable for resident's care pla. (F) Other appropriate disciplines as deteor as requested by (iii) Reviewed and team after each as comprehensive an assessments. This REQUIREME by: Based on observative review, the facility care plan for 1 of 3 dental status. Findings include: R58 was observed have upper and low interviewed about explained having of them because ther worry about now. The current care parea initiated 5/12/chewing difficulty eresident has 3 rem Has upper and low resident has 3 rem Has upper and low and the supper and low resident has 3 rem Has upper and low and the supper and low resident has 3 rem Has upper and low remarks re	racticable, the participation of e resident's representative(s). st be included in a resident's ne participation of the resident representative is determined the development of the n. ate staff or professionals in rmined by the resident's needs the resident. revised by the interdisciplinary is sessment, including both the	F 2	Resident #58 has been as care/dental preferences to residents individual ADL Ca updated and reflective of the refusals. Risk and benefit education resident and POA r/t refusated and reflective of the resident and POA r/t refusated dentures. New admissions/ re-admits to be assessed for oral/ depreferences and appropriate are initiated. All residents will continue to quarterly, annually, with a sechange in condition, and as individual care plans being accordingly. All staff will be re-educated of rights, specific to resider refusal of care procedures.	ensure are Plan is neir needs and completed with als to wear s will continue ntal te interventions to be assessed significant s needed with updated on resident bill nt preferences,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
		245394	B. WING	·····	06/	29/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	dated 11/17/16, reacleaning and exam. We applied fluoride can eat as normal. denture adhesive, vouse it. We asked an hour a day, and sores next visit. [R5 longer than one hou comfortable". On 6/29/17, at 8:27 acknowledged haviand did not like weaconditions that were indicated that facilit decision. On 6/29/17, at 9:21 (RD) confirmed that revised regarding the conditions of the conditions that were indicated that facilit decision. On 6/29/17, at 9:41 verified R58 had not indicated R58 was dentures for a long was evident when Finot in place. On 6/29/17, at 9:50 (DON) confirmed R information about the dentures.	on Rapids progress notes d, " [R58] had [R58], we adjusted [R58] dentures. and a filling was done. He Please provide [R58] with we discussed with [R58] how [R58] to wear the dentures for we will follow up on denture 58] can wear the dentures ar a day, if [R58] is a.m. R58 again ng upper and lower dentures aring them because of medical e more troubling. R58 y staff were aware of the a.m. the registered dietician the R58's care plan was not the refusal to wear dentures. a.m. nursing assistant (NA)-C at been wearing dentures and observed not wearing time. NA-C acknowledged it R58 ate that the dentures were a.m. the director of nursing 58's care plan lacked the resident's refusal to wear dentures.	F 280	also be educated on the oral care assessment/evaluation and follow procedures. Oral/dental care audits to be comweekly x4 weeks; then as needed DNS or designee will be responsil party. QAA will provide redirection or chawhen necessary to ensure compleand/or continuation of monitoring based on compliance date of Aug 2017.	r up pleted l. ble ange etion process	
F 311 SS=D	483.24(a)(1) TREA IMPROVE/MAINTA	TMENT/SERVICES TO IN ADLS	F 311			7/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245394	B. WING		06/2	29/2017	
	PROVIDER OR SUPPLIER	ST LLC		STREET ADDRESS, CITY, STATE, ZIP C 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 311	treatment and serve or her ability to car living, including the of this section. This REQUIREME by: Based on observareview, the facility hygiene care for 1 for activities of dail upon staff for assist Findings include: On 6/26/17 at 7:24 have several gray/s greater in length, on At that time, R2 staindependently shaw because he did not resident further state an electric shaver thim whenever it was aid sometimes the days apart, and that more often than even on 6/27/17, at 9:24 in bed. He still had facial hairs on his to the control of the control of the still had facial hairs on his to the control of the control of the still had facial hairs on his to the control of the control of the still had facial hairs on his to the control of the control of the still had facial hairs on his to the control of the co	given the appropriate rices to maintain or improve his ry out the activities of daily use specified in paragraph (b) NT is not met as evidenced ation, interview and document failed to provide personal of 3 residents (R2) reviewed y living who were dependent extance with personal cares. p.m., R2 was observed to white facial hairs 1 inch or in his upper lip and chin area. Atted he was unable to we with a regular razor blade to want to cut himself. The ited the facility did not provide for use. R2 stated staff shaved as convenient for them, but at would occur greater than 10 at he would prefer to be shaved	F3	Resident # 2 has been shar assessed for hygiene prefer ensure the residents individing ADL/grooming care plan is a resident preferences. New admissions/re-admits where the assessed for hygiene presidents will continue to with care conferences and a individual care plans being a conferences are completed annually, and significant chat All staff will be re-educated of rights, specific to resident dignity, and refusal of care party. Audits of resident dignity religiene and grooming incluits to be completed weekly x4 where the complete w	rences to ual accurate per will continue to eferences and e initiated. be assessed as needed with updated. Care quarterly, ange. on resident bill t preferences, orocedures. ated to ding shaving, weeks; then as ponsible or change completion toring process		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06/	29/2017
	PROVIDER OR SUPPLIER	TLLC		4	STREET ADDRESS, CITY, STATE, ZIP CODE 171 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	over his upper lip a On 6/28/17, from 1 R2 was observed s remained unshaver During an observat R2 appeared freshl it, R2 confirmed sta stated he really app R2's admission and diagnoses which in movements. R2's annual minimu 4/12/17, identified F independent after s needs including act brushing teeth, sha washing/drying face and showers). Review of R2's We revealed R2 had be other documented s clean shaven 6/28/ documentation to ir (shaving) between R2's care plan was 1/22/17 included: "F dressing. Receives reminders with hygi often refuse to shav 3/8/17 indicated R2 set up grooming su	bus long gray/white facial hairs and chin area. 1:49 a.m. through 12:24 p.m., itting in a chair for lunch. He in. ion at 1:45 p.m. on 6/28/17, y shaved. When asked about affed had shaved him. R2 preciated that. I clinical records noted R2 had cluded abnormal involuntary the data set (MDS) dated R2 as cognitively intact and set up with personal hygiene civities such as: combing hair, ving, applying makeup, and hands (excludes baths beekly Skin Inspection sheet seen shaved on 6/18/17, with no shaving since until he was 17. There was no indicate R2 had refused care	F3	311			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
	245394	B. WING _		06/	29/2017
PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
A Nursing Assistant dated 6/27/17, indicassistance to shave assistance to provide During an interview indicated that R2 has 10:45 a.m. after the executive director (During an interview 2:24 p.m. the ED co	t (NA) Assignment Sheet cated R2 required staff e as needed, and to staff de supervision with grooming. on 6/28/17, at 2:12 p.m. NA-B ad been shaved that day at e resident had asked the ED) to be shaven. with the ED on 6/28/17, at onfirmed that staff shaved R2	F 3	11		
director of nursing (independent with cares because independently. The whether R2 went w did say R2 could have the resident's p. A policy and proced requested, but not p. 483.90(i)(5) SAFE/FUNCTIONAE ENVIRON (i) Other Environment of the facility must presanitary, and comforesidents, staff and	(DON) said R2 was ares and refused assistance the liked doing things. DON said she could not say ithout a shave for 10 days, but ave an electrical shaver if it preference. dure related to shaving was provided. AL/SANITARY/COMFORTABL ental Conditions ovide a safe, functional, ortable environment for the public.	F 46	55		7/28/17
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa A Nursing Assistant dated 6/27/17, indic assistance to shave assistance to provious During an interview indicated that R2 ha 10:45 a.m. after the executive director (During an interview 2:24 p.m. the ED coafter the resident hat morning. During an interview director of nursing independent with cares because independently. The whether R2 went with cares because independently. The whether R2 went with cares decause independently. The whether R2 went with cares director of nursing independent with cares direct	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 A Nursing Assistant (NA) Assignment Sheet dated 6/27/17, indicated R2 required staff assistance to shave as needed, and to staff assistance to provide supervision with grooming. During an interview on 6/28/17, at 2:12 p.m. NA-B indicated that R2 had been shaved that day at 10:45 a.m. after the resident had asked the executive director (ED) to be shaven. During an interview with the ED on 6/28/17, at 2:24 p.m. the ED confirmed that staff shaved R2 after the resident had requested to be shaved that morning. During an interview on 6/29/17, at 9:59 a.m. the director of nursing (DON) said R2 was independent with cares and refused assistance with cares because he liked doing things independently. The DON said she could not say whether R2 went without a shave for 10 days, but did say R2 could have an electrical shaver if it was the resident's preference. A policy and procedure related to shaving was requested, but not provided. 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	PROVIDER OR SUPPLIER A PROVIDER OR SUPPLIER ATES AT LYNNHURST LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 A Nursing Assistant (NA) Assignment Sheet dated 6/27/17, indicated R2 required staff assistance to shave as needed, and to staff assistance to provide supervision with grooming. During an interview on 6/28/17, at 2:12 p.m. NA-B indicated that R2 had been shaved that day at 10:45 a.m. after the resident had asked the executive director (ED) to be shaven. During an interview with the ED on 6/28/17, at 2:24 p.m. the ED confirmed that staff shaved R2 after the resident had requested to be shaved that morning. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 8 A Nursing Assistant (NA) Assignment Sheet dated 6/27/17, indicated R2 required staff assistance to shave as needed, and to staff assistance to provide supervision with grooming. During an interview on 6/28/17, at 2:12 p.m. NA-B indicated that R2 had been shaved that day at 10:45 a.m. after the resident had asked the executive director (ED) to be shaven. During an interview with the ED on 6/28/17, at 2:12 p.m. the director of nursing (DON) said R2 was independently. The DON said she could not say whether R2 went without a shave for 10 days, but did say R2 could have an electrical shaver if it was the resident's preference. A policy and procedure related to shaving was requested, but not provided. 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	A BUILDING COMPONENT CONTROLL ON THE PROVIDER OR SUPPLIER ATES AT LYNNHURST LLC SUMMARY STATEMENT OF DEFICIENCIES (FLAN DEFICIENCY) (FLAN DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 A Nursing Assistant (INA) Assignment Sheet dated 6/27/17, indicated R2 required staff assistance to shave as needed, and to staff assistance to shave as needed, and lo staff assistance to provide supervision with grooming. During an interview on 6/28/17, at 2:12 p.m. NA-B indicated that R2 had been shaved that day at 10:45 a.m. after the resident had asked the executive director (ED) to be shaved that morning. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245394	B. WING		06/2	29/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	applicable Federal, regulations, regard and smoking safety non-smoking reside This REQUIREMEI by: Based on observareview, the facility fincluding walls, floor maintained in good R40, R80, R33, R1 and failed to ensure maintained in a cle. This had the potent staff and visitors. Findings include: On 6/27/17, at 9:39 bathroom, soiled as hanging on the bath and a basin were not he bottowas noted as curler into the room. On 6/26/17, at 6:48 bedroom was obse bubbled paint near thon 6/27/17, at 10:2 was noted to have rough paint near thon 6/27/17, at 10:2	State, and local laws and ing smoking, smoking areas, or that also take into account ents. NT is not met as evidenced tion, interview and document ailed to ensure resident rooms ors and fixtures, were repair for 8 of 60 residents (4, R51, R15, R60 and R74); excommon areas were an and functional manner. Tital to impact all 60 residents, oted on the floor. Ta.m. in R40's shared the wraps were observed on the floor. Ta.m. in R80's room, the office of the closet door do up, and protruding sharply appear to the window. Ta.m. the wall in R33's reved to have large areas of the window.	F 465	Resident #40, 80,33,14,51,15,60, all have a clean and well repaired environment. All common areas habeen cleaned and maintained in a functional manner. The common are throughout the facility have been assessed and repairs begun. All residents have the potential to be effected if not provided a sanitary as afe environment. All staff will be re-educated on ensuclean and well-maintenance environ Audits of facility cleanliness and maintenance function to be comple weekly x4 weeks; then as needed. Administrator or designee will be responsible party. QAA will provided redirection or chawhen necessary to ensure complet and/or continuation of monitoring p based on compliance date of Augus 2017.	reas e and arment. eted ange ion rocess	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245394	B. WING			06/2	29/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE 471 LYNNHURST AVENUE WE SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 465	panel wall piece ne it, and was sticking On 6/27/17, at 9:49 observed in the wa pipe was located in R60's room, paint wall behind the doo On 6/27/17, at 12:1 was observed to ha colored areas on it. During a tour on 6/2 10:30 a.m., the obsverified during a tou director, corporate director. In addition frayed carpet were on both the first and floor dining room, be were noted through the baseboard heat crumbs, and garbay These findings were director, housekeep consultant during on the tour. At 9:20 a.r facility wanted to rea non-carpet option purchased any replifor evidence of any no additional inform. The facility's policy,	p.m. in R15's room, a wood ar the television had a hole in out of the wall. a.m. a large hole was all under the sink where the R60's shared bathroom. In was noted as chipping off the r. 7 p.m. R74's bathroom door twe paint peeling, and rust	F 4	.65			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED		
		245394	B. WING		06	/29/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	procedure, dated 1 policy did not inclu- up or removing ext bathroom.	1/1/2000, was reviewed. The de directions related to tidying traneous items in the routine maintenance were	F 4	65		

F5394025

PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245394 B. WING 06/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST** THE ESTATES AT LYNNHURST LLC SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY 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 COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 28, 2017. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/28/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			06/	28/2017
	PROVIDER OR SUPPLIER TATES AT LYNNHURS	T LLC		471 LY	T ADDRESS, CITY, STATE, ZIP CODE YNNHURST AVENUE WEST F PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficited. 2. The actual, or proceeding and the control of the correct the deficited. 3. The name and/or responsible for correct a reoccurred are constructed at 2 distribution of the constructed at 2 distribution of the construction and the 1 addition of the construction and the 1 addition of the construction and t	tate.mn.us and n@state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done lency. oposed, completion date. If title of the person rection and monitoring to ence of the deficiency. ter Lynnhurst is a 2-story ial basement. The building was ferent times. The original ructed in 1962 and was for Type II(222) construction. In was constructed to the determined to be of Type in Because the original building meet the construction type is buildings, the facility was	KO	00	DEFICIENCY)		
	throughout. The far with smoke detectionen to the corrido automatic fire depart	omatic sprinkler protected cility has a fire alarm system on in the corridors and spaces rs that is monitored for artment notification. The facility 2 beds and had a census of 62 ey.					
	The requirement a	t 42 CFR. Subpart 483.70(a) is					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245394	B. WING,		06/	28/2017
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	equipped with a late use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security need only one locking deeach door and provapid removal of oclocks; keying of all all times; or other sto the staff at all times, or other sto the staff at all times. SPECIAL NEEDS I Where special lock safety needs of the Clinical or Security being met. In additional electrical locks that upon loss of power protected by a supersystem and the lock complete smoke deconstantly monitors within the locked special stage.	means of egress shall not be ch or a lock that requires the from the egress side unless lowing special locking OR SECURITY THREAT ing arrangements for the eds of the patient are used, evice shall be permitted on visions shall be made for the ecupants by: remote control of locks or keys carried by staff at such reliable means available nes. 2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 LOCKING ARRANGEMENTS ing arrangements for the expatient are used, all of the Locking requirements are son, the locks must be a fail safely so as to release to the device; the building is ervised automatic sprinkler ked space is protected by a setection system (or is ead at an attended location cace); and both the sprinkler ems are arranged to unlock the on. 2.2.5.2, TIA 12-4 S LOCKING	K 0 K 2			7/28/17
		elayed-egress locking systems				

PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A: BUILDING 01 - MAIN BUILDING 01 245394 B: WING 06/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST** THE ESTATES AT LYNNHURST LLC SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 222 Continued From page 3 K 222 installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING **ARRANGEMENTS** Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4. 19.2.2.2.4 **ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS** Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: The exit door to the outside of the facility Based on observation and interview, the facility has been repaired. has failed to provide a proper exit to the outside. Audits of facility maintenance to be This deficient practice could affect the safe and completed weekly x4 weeks; then as rapid evacuation of all residents, visitors, and needed. staff in the event of an emergency that may Maintenance Director or designee will be require quick evacuation in accordance with section 7.1. 19.2.1 responsible party. QAA will provide redirection or change when necessary to ensure completion Findings include: On facility tour between 09:00 AM and 12:30 PM and/or continuation of monitoring process on 06/28/2017, it was observed that the 1st floor based on compliance date of August 8. stairwell exit door to the outside was difficult to 2017 open and took several attempts to open the door. This deficient practice was verified by the facility staff (DC), at the time of discovery.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′		CONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY PLETED
		245394	B. WING			06/2	28/2017
	PROVIDER OR SUPPLIER	T LLC		47	REET ADDRESS, CITY, STATE, ZIP CODE 1 LYNNHURST AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 321 SS=C	Hazardous Areas - 2012 EXISTING Hazardous areas a having 1-hour fire r fire rated doors) or system in accordar approved automatic option is used, the other spaces by sm doors in accordance self-closing or auto have nonrated or fit that do not exceed the door. Describe the floor a hazardous areas th 19.3.2.1 Area Separation N/a a. Boiler and Fuel-f b. Laundries (large c. Repair, Maintena d. Soiled Linen Roc e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322 This STANDARD i Based on observa facility did not prophazardous areas. 1	are protected by a fire barrier resistance rating (with 3/4-hour an automatic fire extinguishing nee with 8.7.1. When the crime extinguishing system areas shall be separated from noke resisting partitions and rewith 8.4. Doors shall be smatic-closing and permitted to reld-applied protective plates 48 inches from the bottom of read zone locations of nat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms Than 100 square feet) Fired Heater Rooms Than 100 square feet) Fired Heater Rooms Than 100 square feet) Fired Rooms Fired Roo	K3	321	Penetrations in the wall have bee repaired. Audits of facility maintenance to be completed weekly x4 weeks; then needed. Maintenance Director or designee the responsible party.	e as	7/28/17

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G 01 - MAIN BUILDING 01	1, /	SURVEY PLETED	
		245394	B. WING		06/2	28/2017
	PROVIDER OR SUPPLIER	ST LLC		STREET ADDRESS, CITY, STATE, ZIP COI 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 321	1230 on June 28, 2 following: The Oxygen Stora the wall from a cor The Soiled Linen Fin the walls from w	etween the hours of 0900 and 2017, observation revealed the	K 32	QAA will provide redirection of when necessary to ensure continuation of monitor based on compliance date of 2017.	mpletion ring process	
At the time of discovery. K 712 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fir signal and simulation of emergency fire conditions. Fire drills are held at unexpectimes under varying conditions, at least q on each shift. The staff is familiar with properties aware that drills are part of establismoutine. Responsibility for planning and conducting drills is assigned only to compersons who are qualified to exercise least Where drills are conducted between 9:00 6:00 AM, a coded announcement may be instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidence Base on review of records and staff interwas determined that the facility failed to call a fire drill, for two shifts in accordance with 101 LSC (12) Section 19.7.1.2. This deficition of the could affect how staff react in the		ne transmission of a fire alarm on of emergency fire lls are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established willity for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. 8.7.1.7, 19.7.1.4 through its not met as evidenced by: records and staff interview, it at the facility failed to conducte shifts in accordance with NFPA ion 19.7.1.2. This deficient	K 712	Fire Drills are being held at times and under varying condoffire drills will be completed months; then as needed. Maintenance Director or des responsible party.	ditions. Audits monthly x3	7/28/17

PRINTED: 08/03/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245394 B. WING 06/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **471 LYNNHURST AVENUE WEST** THE ESTATES AT LYNNHURST LLC SAINT PAUL, MN 55104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 712 | Continued From page 6 K 712 QAA will provide redirection or change the safety of all 72 residents. when necessary to ensure completion and/or continuation of monitoring process Findings include: based on compliance date of August 8, On facility tour between 0900 and 1230 on 2017. 06/28/2017, a review of the availableFire drill reports in 2016 and 2017 revealed that the facility failed to conduct a fire drill for the third shift 2200-0600 during the 4th quarter of 2016 and the third shift 2200-0600 in the first quarter of 2017 in accordance with Section 19.7.1.4. This deficient practice was confirmed by staff (DC).



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 18, 2017

Mr. Daniel Strittmater, Administrator The Estates At Lynnhurst LLC 471 Lynnhurst Avenue West Saint Paul, MN 55104

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5394029

Dear Mr. Strittmater:

The above facility was surveyed on June 26, 2017 through June 29, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5394061. 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 <u>only a suggestion</u> 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

The Estates At Lynnhurst LLC July 18, 2017 Page 2

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 Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

PRINTED: 09/07/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00945 06/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **471 LYNNHURST AVENUE WEST** THE ESTATES AT LYNNHURST LLC SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these

Minnesota Department of Health

INITIAL COMMENTS:

29, and 30, 2017.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

At the time of the survey, an investigation of complaint H5394061 was completed and was

found to be substantiated at 1805.

orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

A standard State licensing survey and complaint investigation was conducted on June 26, 27, 28,

07/31/17 **Electronically Signed**

STATE FORM TOJU11 If continuation sheet 1 of 15

TITLE

(X6) DATE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00945	B. WING		06/2	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC 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	Continued From page 1		2 000			
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.sobul.htm The Stat delineated on the a Department of Hea you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, th	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	of this Department' provider and the fol issued. Please ind correction that you	3, 29, and 30, 2017, surveyors is staff, visited the above lowing correction orders are licate in your electronic plan of have reviewed these orders, is when they will be completed.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for				
	column entitled "ID statute/rule out of commany Statement and replaces the "To correction order. The findings which are in after the statement."	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings				

Minnesota Department of Health

STATE FORM 6899 TOJU11 If continuation sheet 2 of 15

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:	·		
		00945	B. WING		06/2	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	IHURST AVE .UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000 2 570	are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECUPLAN OF CORRECUMINNESOTA STAT	Method of Correction and rection. RD THE HEADING OF THE	2 000			7/28/17
2370	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirements of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required	2 370	Completed by compliance date of 8, 2017.	August	7/20/17
	and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requiremby: Based on observative review, the facility for care plan for 1 of 3 dental status.	practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required subpart 3, item B. ent is not met as evidenced ion, interview and document ailed to review and revise the			August	

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00945		B. WING		06/2	9/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TLLC		HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN YMUST BE PRECEDED SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 570	R58 was observed have upper and low interviewed about the explained having determined them because there worry about now. The current care plarea initiated 5/12/chewing difficulty eresident has 3 remained that a supper and low wears consistently. Complaints of difficulty complaints of difficulty eresident has 3 remained to difficulty eresident has 3 remained that upper and low wears consistently. Complaints of difficulty complaints of difficulty eresident has 3 remained that a supper and low wears consistently. Complaints of difficulty complaints of difficulty and exam we applied fluoride can eat as normal. denture adhesive, to use it. We asked an hour a day, and sores next visit. [R5] longer than one hor comfortable". On 6/29/17, at 8:27 acknowledged haviand did not like wear conditions that were indicated that facility decision. On 6/29/17, at 9:21 (RD) confirmed that revised regarding the conditions that were indicated that facility decision.	on 6/26/17 at 6:4 ver missing teeth, he missing teeth, he missing teeth, entures, but not lite were other med an for R58 includ 17 including: "Pot lated to partial ed aining teeth to the er dentures, denied Has a regular disulty chewing". on Rapids progred, " [R58] had a filling was Please provide [R58] and a filling was Please provide [R58] to wear the we will follow up [R58] to wear the we will follow up [R58] can wear the four a day, if [R58] if a.m. R58 again and upper and low aring them because more troubling. The staff were award a.m. the register it R58's care plan he refusal to wear the refusal to the refus	When R58 king to wear lical things to ed a problem ential for entulous, e lower front. es problems, et with no es notes [R58] with no [R58] how e dentures for on denture dentures is e of medical R58 e of the ed dietician was not r dentures.	2 570			
	verified R58 had no						

Minnesota Department of Health

STATE FORM FORM TOJU11 If continuation sheet 4 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00945	B. WING		06/2	9/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 4	2 570			
	dentures for a long	observed not wearing time. NA-C acknowledged it R58 ate that the dentures were				
	(DON) confirmed F	a.m. the director of nursing 158's care plan lacked ne resident's refusal to wear				
	The director of nursidevelop and impler related to care plan designee, could prostaff related to the trevisions. The qual	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			7/28/17
	comprehensive reshome must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to:	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the as, and groom; d ambulate;				

Minnesota Department of Health

STATE FORM 6899 TOJU11 If continuation sheet 5 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00945	B. WING		06/2	9/2017
	PROVIDER OR SUPPLIER	TILC 471 LYNN	DRESS, CITY, SIHURST AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	(5) use speecl	ge 5 n, language, or other ication systems; and	2 915			
	by: Based on observation review, the facility for hygiene care for 1 of for activities of daily	on, interview and document ailed to provide personal of 3 residents (R2) reviewed vilving who were dependent tance with personal cares.		Completed by compliance date of 8, 2017.	August	
	have several gray/v greater in length, or At that time, R2 sta independently shav because he did not resident further sta an electric shaver f him whenever it wa said sometimes tha	p.m., R2 was observed to white facial hairs 1 inch or in his upper lip and chin area. Ited he was unable to e with a regular razor blade want to cut himself. The sted the facility did not provide or use. R2 stated staff shaved is convenient for them, but it would occur greater than 10 the would prefer to be shaved ery 10 days.				
	in bed. He still had facial hairs on his under the control of the	a.m. R2 was observed lying numerous long gray/white pper lip and chin area. p.m. R2 was observed sitting oking area. He remained a.m. R2 was observed lying ce had still not been shaven				

Minnesota Department of Health

STATE FORM FORM TOJU11 If continuation sheet 6 of 15

00945 B. WING 06/29/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			00945	B. WING		06/2	9/2017
	NAME OF P	F PROVIDER OR SUPPLIER					
THE ESTATES AT LYNNHURST LLC 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	THE EST	STATES AT LYNNHURS	I I I G				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	((EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
2 915 and he had numerous long gray/white facial hairs over his upper lip and chin area. On 6/28/17, from 11:49 a.m. through 12:24 p.m., R2 was observed sitting in a chair for lunch. He remained unshaven. During an observation at 1:45 p.m. on 6/28/17, R2 appeared freshly shaved. When asked about it, R2 confirmed staffed had shaved him. R2 stated he really appreciated that. R2's admission and clinical records noted R2 had diagnoses which included abnormal involuntary movements. R2's annual minimum data set (MDS) dated 4/12/17, identified R2 as cognitively intact and independent after set up with personal hygiene needs including activities such as: combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers). Review of R2's Weekly Skin Inspection sheet revealed R2 had been shaved on 6/18/17, with no other documented shaving since until he was clean shaven 6/28/17. There was no documentation to indicate R2 had refused care (shaving) between 6/18-6/28/17. R2's care plan was reviewed. A problem dated 1/22/17 included: "Requires assistance with dressing. Receives occasional supervision and reminders with hygiene, grooming. Resident will often refuse to shave" A care plan topic dated 3/8/17 indicated R2 required staff assistance to set up grooming supplies and to assist him with completing his grooming needs as needed.	2 915	and he had numero over his upper lip at On 6/28/17, from 11 R2 was observed s remained unshaver During an observati R2 appeared freshlit, R2 confirmed stated he really appeared he revealed he really appeared he revealed R2 had be other documented sclean shaven 6/28/documentation to in (shaving) between the refuse to shave a refuse to shave 3/8/17 indicated R2 set up grooming su	ous long gray/white facial hairs and chin area. 1:49 a.m. through 12:24 p.m., itting in a chair for lunch. He in. ion at 1:45 p.m. on 6/28/17, y shaved. When asked about affed had shaved him. R2 preciated that. I clinical records noted R2 had cluded abnormal involuntary am data set (MDS) dated R2 as cognitively intact and et up with personal hygiene ivities such as: combing hair, ving, applying makeup, and hands (excludes baths eekly Skin Inspection sheet een shaved on 6/18/17, with no shaving since until he was 17. There was no adicate R2 had refused care 6/18-6/28/17. reviewed. A problem dated Requires assistance with occasional supervision and iene, grooming. Resident will we" A care plan topic dated required staff assistance to pplies and to assist him with	2 915			

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00945	B. WING		06/	29/2017
	PROVIDER OR SUPPLIER	TILC 471 LYNN	DRESS, CITY, S HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 915	A Nursing Assistant dated 6/27/17, indicassistance to shave assistance to provide During an interview indicated that R2 had 10:45 a.m. after the executive director (During an interview 2:24 p.m. the ED coafter the resident had that morning. During an interview director of nursing (independent with cawith cares because independently. The whether R2 went with cares because independently. The whether R2 went with cares decays independently. The whether R2 went with cares because independently. The whether R2 went with cares decays independently independently independent with cares decays independently. The whether R2 went with cares decays independently	a (NA) Assignment Sheet cated R2 required staff as needed, and to staff de supervision with grooming. on 6/28/17, at 2:12 p.m. NA-B ad been shaved that day at resident had asked the ED) to be shaven. with the ED on 6/28/17, at onfirmed that staff shaved R2 ad requested to be shaved on 6/29/17, at 9:59 a.m. the EDON) said R2 was ares and refused assistance he liked doing things. DON said she could not say ithout a shave for 10 days, but are an electrical shaver if it oreference. SHOD OF CORRECTION: Sing (DON) or designee, could nent policies and procedures gresident shaving buld provide assistance based eference. The DON or ovide training for all nursing e policies and procedures. ment and assurance erform random audits to	2 915			

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STATE FORM 6899 TOJU11 If continuation sheet 8 of 15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00945	B. WING		06/2	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	IHURST AVE JUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 8	2 915			
	(21) days.					
21426	6 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			7/28/17
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.				
	by: Based on documen facility did not comp screening for 1 of 5 and did not comple	ent is not met as evidenced at review and interview, the plete tuberculosis symptom is residents (R68) reviewed, the a tuberculin skin test (TST) as (C-A) reviewed for and control.		Completed by compliance date of 8, 2017.	August	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
A71 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104 (A4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL NN 55104 (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION) SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE OATE (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION) SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE OATE (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION) SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE OATE (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION) (A5)			00945	B. WING		06/2	9/2017
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID FROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY PULL PRED) PREFIX TAG FROUDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) PREFIX TAG PROPORTIATE COMPLETE (DATE) 21426 Continued From page 9 21426 The Facility'S Tuberculosis (TB) Risk Assessment Worksheet dated 6/3/17, described the facility being a medium risk facility for TB. Review of the Baseline TB Screening Tool for Residents form for R86 revealed the resident had recleved two TSTs one completed on 4/21/16 and the other 4/28/16, however a TB symptom screen had not been completed. Review of the Baseline TB Screening Tool for Healthcare Workers for Cook (C)-A revealed C-A had a TST administered on that date however, the TST had not been read/interpreted and no second-step was documented. C-A's personnel file indicated an employment start date of 3/23/17. When interviewed on 6/29/17, at 3:15 p.m. the director of nursing confirmed she could not locate symptom screening documentation for R68, and could not locate any further TST documentation for C-A.	NAME OF I	PROVIDER OR SUPPLIER					
PRÉFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 21426 Continued From page 9 The Facility's Tuberculosis (TB) Risk Assessment Worksheet dated 6/3/17, described the facility being a medium risk facility for TB. Review of the Baseline TB Screening Tool for Residents form for R68 revealed the resident had recieved two TSTs one completed on 4/21/16 and the other 4/28/16, however a TB symptom screen had not been completed. Review of the Baseline TB Screening Tool for Healthcare Workers for Cook (C)-A revealed C-A had a TB symptom screen completed on 3/21/17, and a TST administered on that date however, the TST had not been read/interpreted and no second-step was documented. C-A's personnel file indicated an employment start date of 3/23/17. When interviewed on 6/29/17, at 3:15 p.m. the director of nursing confirmed she could not locate symptom screening documentation for R68, and could not locate any further TST documentation for R68, and could not locate of the facility's Tuberculosis Screening-Health Care Worker policy indicated: "1. All paid and unpaid Health care workers, after passing pre-employment physical and upon conditional job offer, will receive baseline TB screening. The screening will include a written assessment of TB Risk factors, any current TB symptoms, and a 2-step tuberculin skin test" SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee	THE EST	TATES AT LYNNHURS	1116:				
The Facility's Tuberculosis (TB) Risk Assessment Worksheet dated 6/3/17, described the facility being a medium risk facility for TB. Review of the Baseline TB Screening Tool for Residents form for R68 revealed the resident had recieved two TSTs one completed on 4/21/16 and the other 4/28/16, however a TB symptom screen had not been completed. Review of the Baseline TB Screening Tool for Healthcare Workers for Cook (C)-A revealed C-A had a TB symptom screen completed on 3/21/17, and a TST administered on that date however, the TST had not been read/interpreted and no second-step was documented. C-A's personnel file indicated an employment start date of 3/23/17. When interviewed on 6/29/17, at 3:15 p.m. the director of nursing confirmed she could not locate symptom screening documentation for R68, and could not locate any further TST documentation for C-A. Page 1 of the facility's Tuberculosis Screening-Health Care Worker policy indicated: "1. All paid and unpaid Health care workers, after passing pre-employment physical and upon conditional job offer, will receive baseline TB screening. The screening will include a written assessment of TB Risk factors, any current TB symptoms, and a 2-step tuberculin skin test" SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
ensure the policy is being followed.	21426	The Facility's Tuber Worksheet dated 6/being a medium risk. Review of the Base Residents form for recieved two TSTs of the other 4/28/16, had not been comp. Review of the Base Healthcare Workers had a TB symptom and a TST administ the TST had not be second-step was do file indicated an em 3/23/17. When interviewed of director of nursing of symptom screening could not locate any for C-A. Page 1 of the facility Screening-Health Of "1. All paid and unp passing pre-employ conditional job offer screening. The scrassessment of TB is symptoms, and a 2-SUGGESTED MET director of nursing of review/revise policies Tuberculosis screen	roulosis (TB) Risk Assessment /3/17, described the facility k facility for TB. line TB Screening Tool for R68 revealed the resident had one completed on 4/21/16 and lowever a TB symptom screen leted. line TB Screening Tool for so for Cook (C)-A revealed C-A screen completed on 3/21/17, tered on that date however, en read/interpreted and no occumented. C-A's personnel ployment start date of on 6/29/17, at 3:15 p.m. the confirmed she could not locate and documentation for R68, and and further TST documentation y's Tuberculosis care Worker policy indicated: aid Health care workers, after ment physical and upon r, will receive baseline TB eening will include a written Risk factors, any current TB estep tuberculin skin test" THOD OF CORRECTION: The or designee, could es on resident and employee ning and perform audits to	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00945	B. WING		06/2	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 10	21426			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			7/28/17
	Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms including walls, floors and fixtures, were maintained in good repair for 8 of 60 residents (R40, R80, R33, R14, R51, R15, R60 and R74); and failed to ensure common areas were maintained in a clean and functional manner. This had the potential to impact all 60 residents, staff and visitors.			Completed by compliance date of 8, 2017.	August	
	Findings include:					
	bathroom, soiled ac	a.m. in R40's shared se wraps were observed broom hand rails. Paper towels oted on the floor.				
	veneer on the botto	7 a.m. in R80's room, the m corner of the closet door d up, and protruding sharply				
	On 6/26/17, at 6:48	p.m. the wall in R33's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
00945		B. WING		06/2	29/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	NHURST AVE NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 11	21695			
	bedroom was obse bubbled paint near	rved to have large areas of the window.				
		8 a.m. R14's bedroom wall large areas of bubbled and e window.				
	On 6/27/17, at 10:24 a.m. a graduated basin and toilet hat were observed on the floor in R51's shared bathroom. A stale urine odor was noted in R51's room.					
	On 6/27/17, at 1:54 p.m. in R15's room, a wood panel wall piece near the television had a hole in it, and was sticking out of the wall.					
	On 6/27/17, at 9:49 a.m. a large hole was observed in the wall under the sink where the pipe was located in R60's shared bathroom. In R60's room, paint was noted as chipping off the wall behind the door.					
	On 6/27/17, at 12:17 p.m. R74's bathroom door was observed to have paint peeling, and rust colored areas on it.					
	10:30 a.m., the obsverified during a toudirector, corporate director. In addition frayed carpet were on both the first and floor dining room, bwere noted through the baseboard heat crumbs, and garbay These findings were	28/17, between 9:20 a.m. and servations noted above were ar with the housekeeping consultant, and activity, large areas of soiled and noted on the walls of hallways disecond floors. In the second tent metal baseboard heaters tout the room. Several areas of ters had sticky substances, ge stuck in or on the heaters. e verified by the activity bing director, and corporate				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
00945		B. WING		06/2	/29/2017	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	ATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695	facility wanted to rea non-carpet option purchased any repl for evidence of any no additional inform. The facility's policy, Inc. Jobs To Be Doprocedure, dated 1, policy did not include up or removing extra bathroom. Policies related to requested, but not purchased, but not purchased staff regard clean, functional and DON or designee, of maintenance and his periodic audits of a ensure a safe, clea environment is maintenance.	m., the administrator stated the place the carpeted walls with a, however had not yet accement. A request was made invoices for current project, nation was provided. Healthcare Services Group, ne: Bathroom Cleaning /1/2000, was reviewed. The de directions related to tidying raneous items in the	21695			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			7/28/17
	Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.					

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
		00945	B. WING		06/2	9/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
21805	Continued From pa	ge 13	21805				
	by: Based on observati review, the facility for (R39) currently resi dignity in the secon called the resident a	on, interview and document ailed to treat 1 of 32 residents ding on the second floor with d floor dining room when staff a "feeder."		Completed by compliance date of 8, 2017.	August		
	Findings include:						
	During an evening meal dining observation on 6/26/17, at 6:20 p.m. in the second floor dining room, residents were observed to sit at tables waiting for staff to serve supper. R39 sat at a table with other residents. Staff previously set paper placemats on the tables in front of each resident's place. R39 reached for the paper placemat on the table and pulled it toward the edge of the table. Nursing assistant (NA)-A pulled the placemat out from under R39's hands, straightened it on the table and said to R39, "You need someone to feed you, you're a feeder." NA-A's words to R39 were heard across the dining room.						
	asked if R39 needed and added that R39 Review of R39's can functioning last revineeded extensive at In the Minimum Data 3/9/17, staff assess understood. The Minemory problems, names and faces, a nursing home hower	id help to eat, NA-A said "yes," of help to eat, NA-A said "yes," of was "a feeder." The plan related to physical sed 3/8/17, indicated R39 assistance of one staff to eat. It is a Set assessment dated sed R39 to be rarely DS also indicated R39 had but was able to recall staff and could remember being in a ever, R39 was also identified impaired decision making with					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00945		B. WING		06/29/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 14	21805			
	fluctuations in levels	s of consciousness.				
	director of nursing (staff education about say "let me assist you to eat. When asked a "feeder" the DON use that term about provide education to term "feeder" to desto eat.	/29/17, at 2:30 p.m. the DON) said when she provided ut dining, she directed staff to ou" to a resident needing help about staff calling a resident said staff are not trained to residents, and that she would o staff about not using the scribe a resident needing help				
	The facility provided the Combined Federal and State Bill of Rights, dated 12/4/15, upon request for a policy about dignity. Under the Dignity heading on page 15, "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."					
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of dignified resident treatment. The DON or designee, could coordinate training to include expectations regarding dignity during dining, and could conduct periodic audits of the resident dining experience.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

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