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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TOJU
Facility ID: 00945

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

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

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

4. TYPE OF ACTION: 7

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

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

6. DATE OF SURVEY **09/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **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 Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 09/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2017
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

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

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00945

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(L1) **245394**

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

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

4. TYPE OF ACTION: **7** (L8)

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

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

6. DATE OF SURVEY **08/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (L17)

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A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 08/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/22/2017 (L20)

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

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

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2017
(L33)

DETERMINATION APPROVAL

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
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

I, ________________________________, _________________________, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated and licensing orders issued to:

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

The Penalty Assessments and licensing orders attached hereto have been corrected as of

Signed: _____________________________, ______________________, Date _____________
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

I, ________________________________, _________________________, of the Health Regulation Division,

(Name)(Please Print) (Title)(Please Print)
Minnesota Department of Health, delivered the Notice of Penalty Assessment dated ,
and issued to:

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

The Notice of Penalty Assessment was handed to _____________________________,
(Name)(Please Print)
______________________, Date _____________
(Title)(Please Print)

Signed: _____________________________, ______________________, Date _____________
(Name)(Please Print) (Title)(Please Print)

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _______ B. WING _______	R-C 08/16/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on August 16 & 17, 2017. The certification tags that were corrected can be found on the CMS2567B. Also there is one tag that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 280} SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	{F 280}		9/6/17

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

Electronically Signed — 09/01/2017

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	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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{F 280}	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 2 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan for 1 of 3 residents (R33) reviewed for dental status. Findings include: R33's was admitted to the facility on 7/15/13. R33's Admission Face Sheet included diagnosis of Alzheimer's disease. On 8/16/17, at 2:58 p.m. R33 was resting in her bed and observed to not have lower teeth. When asked, R33 indicated she did not have lower dentures.	{F 280}	Resident #33 care plan reviewed and revised per resident preference to reflect resident choice of preferred dentist All residents to be given the choice to participate in planning of all cares and treatments based on resident's competency All staff will be re-educated on resident bill of rights specific to resident preferences Random care conference audits to be completed weekly x4 weeks; then as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ______ B. WING ______	R-C **08/16/2017**

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

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{F 280}	Continued From page 3 R33's current care plan indicated R33 was at risk for dental problems and was edentulous. R33 had a full upper denture but did not have a lower denture. The goal indicated R33 would be free of denture complications and the interventions included referral for dental services as needed. Review of 7/13/17, interdisciplinary team care conference and quarterly review (6/2017) indicated R33 wanted to see her University of Minnesota (U of M) dentist for bottom dentures, as she only had the top denture. On 8/17/17, at 9:16 a.m. nursing assistant (NA)-A indicated R33 did not have dentures, and had never seen R33 wearing them. On 8/17/17, at 9:28 a.m. registered nurse (RN)-A stated R33 had never requested lower dentures and they were in the process of scheduling a dental appointment. On 8/17/17, at 11:14 a.m. the director of nursing (DON) stated during a care conference two to three weeks ago, R33 stated she preferred to see the U of M dentist and they were working to schedule an appointment for dentures. The DON stated R33 indicated she did not have problems eating with her upper dentures. On 8/17/17, at 1:50 p.m. when asked, R33 stated she wanted to see the dentist to get dentures and was wondering when the appointment was scheduled. On 8/17/17, at 1:54 p.m. the assistant director of nursing (ADON), stated R33's face sheet and consent form had been sent to Apple Tree Dental to schedule an appointment. ADON further stated	{F 280}	DNS or designee will be responsible QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 9.6.17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 4 the U of M had never heard of R33 and R33 stated she would see Apple Tree Dental instead. In addition, the ADON indicated R33 often refused to see the dentist. On 8/17/17, at 2:54 p.m. DON stated they did not have a policy that addressed updating the care plan. The DON confirmed she had not updated R33's care plan.	{F 280}		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 3 residents (R33) reviewed for dental status.	F 411	Resident #33 care plan updated to reflect resident's dental preference, resident to be seen by on-site dentist at next visit of 9.5.17	9/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 411	Continued From page 5 Findings include: R33's was admitted to the facility on 7/15/13. R33's Admission Face Sheet included diagnosis of Alzheimer's disease. On 8/16/17, at 2:58 p.m. R33 was resting in her bed and observed to not have lower teeth. When asked, R33 indicated she did not have lower dentures. A review of the 7/13/17, IDT care conference and quarterly review (6/2017) indicated R33 wanted to see her U of M dentist for bottom dentures, as she only had the top denture. DON confirmed she had not updated R33's care plan. R33's current care plan reviewed on 7/13/17, indicated R33 was at risk for dental problems and was edentulous. R33 had a full upper denture but did not have a lower denture. The goal indicated R33 would be free of denture complications and the interventions included referral for dental services as needed. On 8/17/17, at 9:16 a.m. nursing assistant (NA)-A indicated R33 did not have dentures, and had never seen R33 wearing them. On 8/17/17, at 9:28 a.m. registered nurse (RN)-A stated R33 had never requested lower dentures and they were in the process of scheduling a dental appointment. On 8/17/17, at 11:14 a.m. the director of nursing (DON) stated during a care conference two to three weeks ago, R33 stated she preferred to see the University of Minnesota (U of M) dentist and	F 411	New admissions/ re-admits will be assessed for oral/dental preferences and appropriate interventions to be initiated when and as needed All staff will be re-educated of importance of resident's oral health and reporting all changes to appropriate parties when and as needed Complete facility Oral Dental care plan audit, complete all dental service audit, follow up appointments scheduled per Apple Tree Dental's next routine facility visit DNS or designee will be responsible QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 9.6.17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 411	Continued From page 6 they were working to schedule an appointment for dentures. DON stated R33 indicated she did not have problems eating with her upper dentures. On 8/17/17, at 1:50 p.m. when asked, R33 stated she wanted to see the dentist to get dentures and was wondering when the appointment was scheduled. On 8/17/17, at 1:54 p.m. the assistant director of nursing (ADON), stated R33's face sheet and consent form had been sent to Apple Tree Dental to schedule an appointment. ADON further stated the U of M had never heard of R33 and R33 stated she would see Apple Tree Dental instead. In addition, the ADON indicated R33 often refused to see the dentist. R33's care plan lacked information about resident's refusals to keep dental appointments. As of 8/17/17, the facility had not scheduled R33's dental appointment.	F 411		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: ______ B. WING ______	R-C 08/16/2017

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

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{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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 000}	Continued From page 1 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.	{2 000}		
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan for 1 of 3 residents (R33) reviewed for dental status. Findings include: R33's was admitted to the facility on 7/15/13. R33's Admission Face Sheet included diagnosis of Alzheimer's disease. On 8/16/17, at 2:58 p.m. R33 was resting in her bed and observed to not have lower teeth. When asked, R33 indicated she did not have lower	{2 570}	Completed upon compliance date of 9.6.17	9/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 570}	Continued From page 2	{2 570}		

dentures.

R33's current care plan indicated R33 was at risk for dental problems and was edentulous. R33 had a full upper denture but did not have a lower denture. The goal indicated R33 would be free of denture complications and the interventions included referral for dental services as needed.

Review of 7/13/17, interdisciplinary team care conference and quarterly review (6/2017) indicated R33 wanted to see her University of Minnesota (U of M) dentist for bottom dentures, as she only had the top denture.

On 8/17/17, at 9:16 a.m. nursing assistant (NA)-A indicated R33 did not have dentures, and had never seen R33 wearing them.

On 8/17/17, at 9:28 a.m. registered nurse (RN)-A stated R33 had never requested lower dentures and they were in the process of scheduling a dental appointment.

On 8/17/17, at 11:14 a.m. the director of nursing (DON) stated during a care conference two to three weeks ago, R33 stated she preferred to see the U of M dentist and they were working to schedule an appointment for dentures. The DON stated R33 indicated she did not have problems eating with her upper dentures.

On 8/17/17, at 1:50 p.m. when asked, R33 stated she wanted to see the dentist to get dentures and was wondering when the appointment was scheduled.

On 8/17/17, at 1:54 p.m. the assistant director of nursing (ADON), stated R33's face sheet and consent form had been sent to Apple Tree Dental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: ______ B. WING ______	R-C 08/16/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 570}	Continued From page 3 to schedule an appointment. ADON further stated the U of M had never heard of R33 and R33 stated she would see Apple Tree Dental instead. In addition, the ADON indicated R33 often refused to see the dentist. On 8/17/17, at 2:54 p.m. DON stated they did not have a policy that addressed updating the care plan. The DON confirmed she had not updated R33's care plan.	{2 570}		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 3 residents (R33) reviewed for dental status. Findings include: R33's was admitted to the facility on 7/15/13. R33's Admission Face Sheet included diagnosis of Alzheimer's disease.	21325	Completed upon compliance date of 9.6.17	9/6/17

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21325	Continued From page 4	21325		

On 8/16/17, at 2:58 p.m. R33 was resting in her bed and observed to not have lower teeth. When asked, R33 indicated she did not have lower dentures.

A review of the 7/13/17, IDT care conference and quarterly review (6/2017) indicated R33 wanted to see her U of M dentist for bottom dentures, as she only had the top denture. DON confirmed she had not updated R33's care plan.

R33's current care plan reviewed on 7/13/17, indicated R33 was at risk for dental problems and was edentulous. R33 had a full upper denture but did not have a lower denture. The goal indicated R33 would be free of denture complications and the interventions included referral for dental services as needed.

On 8/17/17, at 9:16 a.m. nursing assistant (NA)-A indicated R33 did not have dentures, and had never seen R33 wearing them.

On 8/17/17, at 9:28 a.m. registered nurse (RN)-A stated R33 had never requested lower dentures and they were in the process of scheduling a dental appointment.

On 8/17/17, at 11:14 a.m. the director of nursing (DON) stated during a care conference two to three weeks ago, R33 stated she preferred to see the University of Minnesota (U of M) dentist and they were working to schedule an appointment for dentures. DON stated R33 indicated she did not have problems eating with her upper dentures.

On 8/17/17, at 1:50 p.m. when asked, R33 stated she wanted to see the dentist to get dentures and was wondering when the appointment was scheduled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21325	Continued From page 5	21325		

On 8/17/17, at 1:54 p.m. the assistant director of nursing (ADON), stated R33's face sheet and consent form had been sent to Apple Tree Dental to schedule an appointment. ADON further stated the U of M had never heard of R33 and R33 stated she would see Apple Tree Dental instead. In addition, the ADON indicated R33 often refused to see the dentist.

R33's care plan lacked information about resident's refusals to keep dental appointments. As of 8/17/17, the facility had not scheduled R33's dental appointment.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop and implement policies and procedures to ensure appropriate dental care is sought for residents who present with dental problems. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TOJU
Facility ID: 00945

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial　2. Recertification
3. Termination　4. CHOW
5. Validation　6. Complaint
7. On-Site Visit　9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **06/29/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **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 Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE　Date :
Michelle Torrance, Health Laboratory Surveyor　08/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL　Date:
Joanne Simon, Certification Specialist　08/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/22/2017** (L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> Electronic Plan of Correction - **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

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ______ B. WING ______	06/29/2017

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F 000	INITIAL COMMENTS A standard recertification survey and complaint investigation was conducted on June 26, 27, 28, 29 and 30, 2017. At the time of the survey, an investigation of complaint H5394061 was completed and was found to be substantiated. A deficiency was cited at F241. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to treat 1 of 32 residents (R39) currently residing on the second floor with dignity in the second floor dining room when staff	F 241	Resident #39 is provided with dignity during meals as outlined in individual care plan. All residents will continue to be provided	7/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 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.

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F 241	Continued From page 1 called the resident a "feeder." 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. In an interview on 6/28/17, at 2:25 p.m. when asked if R39 needed help to eat, NA-A said "yes," and added that R39 was "a feeder." Review of R39's care plan related to physical functioning last revised 3/8/17, indicated R39 needed extensive assistance of one staff to eat. In the Minimum Data Set assessment dated 3/9/17, staff assessed R39 to be rarely understood. The MDS also indicated R39 had memory problems, but was able to recall staff names and faces, and could remember being in a nursing home however, R39 was also identified as having severely impaired decision making with fluctuations in levels of consciousness. In an interview on 6/29/17, at 2:30 p.m. the director of nursing (DON) said when she provided staff education about dining, she directed staff to say "let me assist you" to a resident needing help	F 241	with dignity during meal services. All staff will be re-educated on resident bill of rights, specific to dignity. Audits of resident dignity during dining services to be completed weekly x4 weeks; then as needed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	

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F 241	Continued From page 2 to eat. When asked about staff calling a resident a "feeder" the DON said staff are not trained to use that term about residents, and that she would provide education to staff about not using the term "feeder" to describe a resident needing help to eat. 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."	F 241		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		7/28/17

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F 280	Continued From page 3 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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	245394	A. BUILDING ______ B. WING ______	06/29/2017

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F 280	Continued From page 4 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan for 1 of 3 residents (R58) reviewed for dental status. Findings include: R58 was observed on 6/26/17 at 6:49 p.m. to have upper and lower missing teeth. When interviewed about the missing teeth, R58 explained having dentures, but not liking to wear them because there were other medical things to worry about now. The current care plan for R58 included a problem area initiated 5/12/17 including: "Potential for chewing difficulty elated to partial edentulous, resident has 3 remaining teeth to the lower front. Has upper and lower dentures, denies problems, wears consistently. Has a regular diet with no	F 280	Resident #58 has been assessed for oral care/dental preferences to ensure residents individual ADL Care Plan is updated and reflective of their needs and refusals. Risk and benefit education completed with resident and POA r/t refusals to wear dentures. New admissions/ re-admits will continue to be assessed for oral/ dental preferences and appropriate interventions are initiated. All residents will continue to be assessed quarterly, annually, with a significant change in condition, and as needed with individual care plans being updated accordingly. All staff will be re-educated on resident bill of rights, specific to resident preferences, refusal of care procedures. All staff will	

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F 280	Continued From page 5 complaints of difficulty chewing". The Apple Tree Coon Rapids progress notes dated 11/17/16, read, " ... [R58] had [R58] cleaning and exam, we adjusted [R58] dentures. We applied fluoride and a filling was done. He can eat as normal. Please provide [R58] with denture adhesive, we discussed with [R58] how to use it. We asked [R58] to wear the dentures for an hour a day, and we will follow up on denture sores next visit. [R58] can wear the dentures longer than one hour a day, if [R58] is comfortable". On 6/29/17, at 8:27 a.m. R58 again acknowledged having upper and lower dentures and did not like wearing them because of medical conditions that were more troubling. R58 indicated that facility staff were aware of the decision. On 6/29/17, at 9:21 a.m. the registered dietician (RD) confirmed that R58's care plan was not revised regarding the refusal to wear dentures. On 6/29/17, at 9:41 a.m. nursing assistant (NA)-C verified R58 had not been wearing dentures and indicated R58 was observed not wearing dentures for a long time. NA-C acknowledged it was evident when R58 ate that the dentures were not in place. On 6/29/17, at 9:50 a.m. the director of nursing (DON) confirmed R58's care plan lacked information about the resident's refusal to wear dentures.	F 280	also be educated on the oral care assessment/evaluation and follow up procedures. Oral/dental care audits to be completed weekly x4 weeks; then as needed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		7/28/17

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F 311	Continued From page 6 (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 1 of 3 residents (R2) reviewed for activities of daily living who were dependent upon staff for assistance with personal cares. Findings include: On 6/26/17 at 7:24 p.m., R2 was observed to have several gray/white facial hairs 1 inch or greater in length, on his upper lip and chin area. At that time, R2 stated he was unable to independently shave with a regular razor blade because he did not want to cut himself. The resident further stated the facility did not provide an electric shaver for use. R2 stated staff shaved him whenever it was convenient for them, but said sometimes that would occur greater than 10 days apart, and that he would prefer to be shaved more often than every 10 days. On 6/27/17, at 9:24 a.m. R2 was observed lying in bed. He still had numerous long gray/white facial hairs on his upper lip and chin area. On 6/27/17, at 1:24 p.m. R2 was observed sitting in a chair in the smoking area. He remained unshaven. On 6/28/17, at 7:24 a.m. R2 was observed lying in bed again. His face had still not been shaven	F 311	Resident # 2 has been shaven and assessed for hygiene preferences to ensure the residents individual ADL/grooming care plan is accurate per resident preferences. New admissions/re-admits will continue to be assessed for hygiene preferences and appropriate interventions are initiated. All residents will continue to be assessed with care conferences and as needed with individual care plans being updated. Care conferences are completed quarterly, annually, and significant change. All staff will be re-educated on resident bill of rights, specific to resident preferences, dignity, and refusal of care procedures. Audits of resident dignity related to hygiene and grooming including shaving, to be completed weekly x4 weeks; then as needed. DNS or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	

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F 311	Continued From page 7	F 311		

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.

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F 311	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.	F 311		
F 465 SS=F	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. (5) Establish policies, in accordance with	F 465		7/28/17

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F 465	Continued From page 9 applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This 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. Findings include: On 6/27/17, at 9:39 a.m. in R40's shared bathroom, soiled ace wraps were observed hanging on the bathroom hand rails. Paper towels and a basin were noted on the floor. On 6/27/17, at 10:37 a.m. in R80's room, the veneer on the bottom corner of the closet door was noted as curled up, and protruding sharply into the room. On 6/26/17, at 6:48 p.m. the wall in R33's bedroom was observed to have large areas of bubbled paint near the window. On 6/27/17, at 10:28 a.m. R14's bedroom wall was noted to have large areas of bubbled and rough paint near the 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	F 465	Resident #40, 80,33,14,51,15,60, and 74 all have a clean and well repaired environment. All common areas have been cleaned and maintained in a functional manner. The common areas throughout the facility have been assessed and repairs begun. All residents have the potential to be effected if not provided a sanitary and safe environment. All staff will be re-educated on ensuring a clean and well-maintenance environment. Audits of facility cleanliness and maintenance function to be completed weekly x4 weeks; then as needed. Administrator or designee will be responsible party. QAA will provided redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	

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F 465	Continued From page 10	F 465		

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.

During a tour on 6/28/17, between 9:20 a.m. and 10:30 a.m., the observations noted above were verified during a tour with the housekeeping director, corporate consultant, and activity director. In addition, large areas of soiled and frayed carpet were noted on the walls of hallways on both the first and second floors. In the second floor dining room, bent metal baseboard heaters were noted throughout the room. Several areas of the baseboard heaters had sticky substances, crumbs, and garbage stuck in or on the heaters. These findings were verified by the activity director, housekeeping director, and corporate consultant during ongoing discussion throughout the tour. At 9:20 a.m., the administrator stated the facility wanted to replace the carpeted walls with a non-carpet option, however had not yet purchased any replacement. A request was made for evidence of any invoices for current project, no additional information was provided.

The facility's policy, Healthcare Services Group, Inc. Jobs To Be Done: Bathroom Cleaning

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F 465	Continued From page 11 procedure, dated 1/1/2000, was reviewed. The policy did not include directions related to tidying up or removing extraneous items in the bathroom. Policies related to routine maintenance were requested, but not provided.	F 465		

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

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FORM APPROVED
OMB NO. 0938-0391

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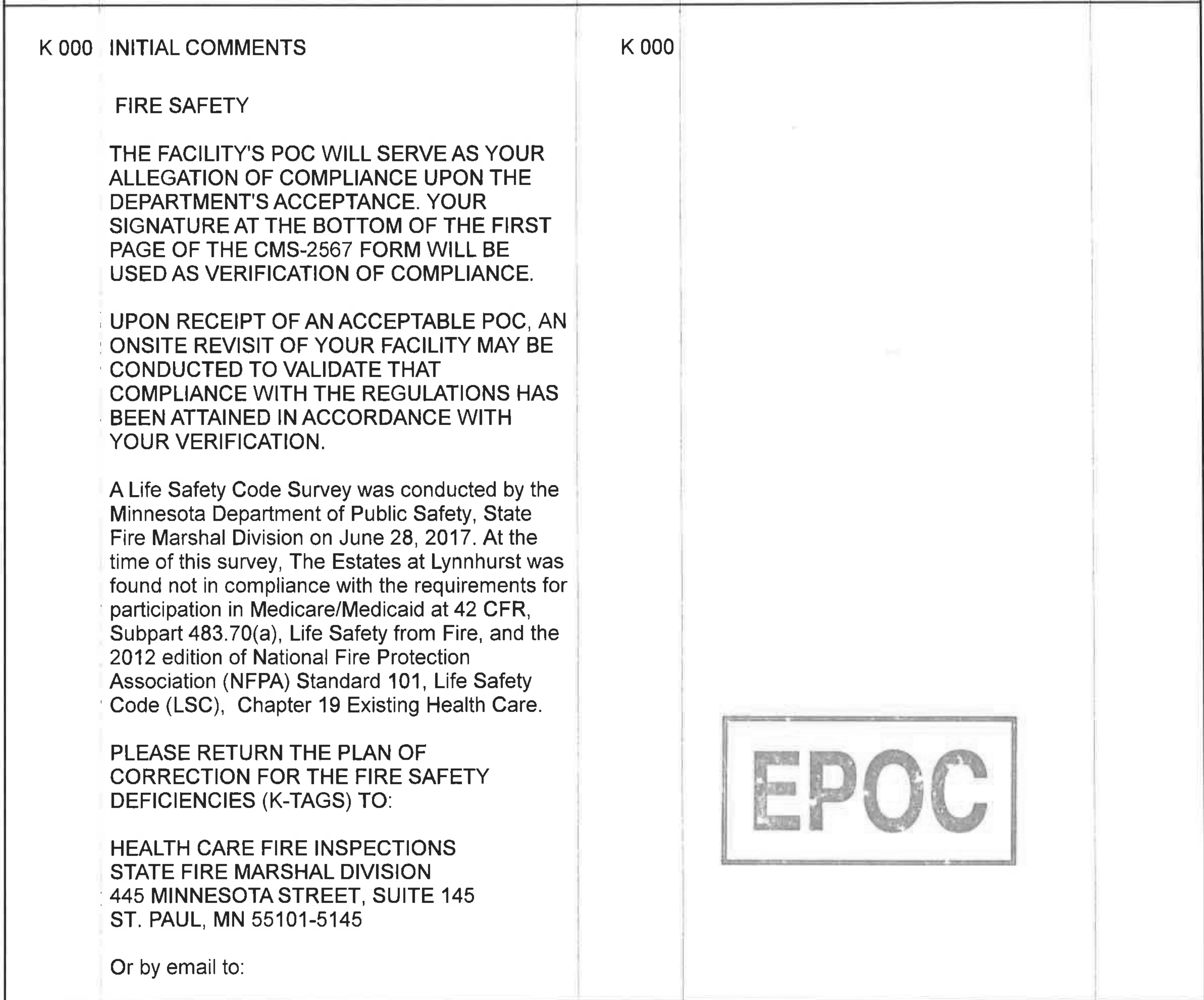

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K 000	INITIAL COMMENTS	K 000		

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:

EPOC

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.

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K 000	Continued From page 1	K 000		

Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Golden Living Center Lynnhurst is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is automatic sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 62 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 **NOT MET** as evidenced by:	K 000		
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems	K 222		7/28/17

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K 222	Continued From page 3 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: Based on observation and interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all residents, visitors, and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 09:00 AM and 12:30 PM on 06/28/2017, it was observed that the 1st floor stairwell exit door to the outside was difficult to open and took several attempts to open the door. This deficient practice was verified by the facility staff (DC), at the time of discovery.	K 222	The exit door to the outside of the facility has been repaired. Audits of facility maintenance to be completed weekly x4 weeks; then as needed. Maintenance Director or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**06/28/2017**

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

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K 321 SS=C	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly separate and protect hazardous areas. 19.3.2.1. This deficient practice could affect all residents within the smoke compartment. Findings include:	K 321	Penetrations in the wall have been repaired. Audits of facility maintenance to be completed weekly x4 weeks; then as needed. Maintenance Director or designee will be the responsible party.	7/28/17

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	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**06/28/2017**

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K 321	Continued From page 5 On a facility tour between the hours of 0900 and 1230 on June 28, 2017, observation revealed the following: The Oxygen Storage Room had a penetration in the wall from a conduit. The Soiled Linen Room had several penetrations in the walls from wires and around a pipe. This deficient practice was verified by staff (DC) at the time of discovery.	K 321	QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	
K 712 SS=D	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used 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 evidenced by: Base on review of records and staff interview, it was determined that the facility failed to conducte a fire drill, for two shifts in accordance with NFPA 101 LSC (12) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect	K 712	Fire Drills are being held at unexpected times and under varying conditions. Audits of fire drills will be completed monthly x3 months; then as needed. Maintenance Director or designee will be responsible party.	7/28/17

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K 712	Continued From page 6 the safety of all 72 residents. Findings include: On facility tour between 0900 and 1230 on 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).	K 712	QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of August 8, 2017.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: ______ B. WING ______	06/29/2017

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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 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:
A standard State licensing survey and complaint investigation was conducted on June 26, 27, 28, 29, and 30, 2017.

At the time of the survey, an investigation of complaint H5394061 was completed and was found to be substantiated at 1805.

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2 000	Continued From page 1 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 attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates 26, 27, 28, 29, and 30, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings	2 000		

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2 000	Continued From page 2 are the Suggested Method of Correction and 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.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan for 1 of 3 residents (R58) reviewed for dental status. Findings include:	2 570	Completed by compliance date of August 8, 2017.	7/28/17

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2 570	Continued From page 3	2 570		

R58 was observed on 6/26/17 at 6:49 p.m. to have upper and lower missing teeth. When interviewed about the missing teeth, R58 explained having dentures, but not liking to wear them because there were other medical things to worry about now.

The current care plan for R58 included a problem area initiated 5/12/17 including: "Potential for chewing difficulty elated to partial edentulous, resident has 3 remaining teeth to the lower front. Has upper and lower dentures, denies problems, wears consistently. Has a regular diet with no complaints of difficulty chewing".

The Apple Tree Coon Rapids progress notes dated 11/17/16, read, " ... [R58] had [R58] cleaning and exam, we adjusted [R58] dentures. We applied fluoride and a filling was done. He can eat as normal. Please provide [R58] with denture adhesive, we discussed with [R58] how to use it. We asked [R58] to wear the dentures for an hour a day, and we will follow up on denture sores next visit. [R58] can wear the dentures longer than one hour a day, if [R58] is comfortable".

On 6/29/17, at 8:27 a.m. R58 again acknowledged having upper and lower dentures and did not like wearing them because of medical conditions that were more troubling. R58 indicated that facility staff were aware of the decision.

On 6/29/17, at 9:21 a.m. the registered dietician (RD) confirmed that R58's care plan was not revised regarding the refusal to wear dentures.

On 6/29/17, at 9:41 a.m. nursing assistant (NA)-C verified R58 had not been wearing dentures and

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2 570	Continued From page 4 indicated R58 was observed not wearing dentures for a long time. NA-C acknowledged it was evident when R58 ate that the dentures were not in place. On 6/29/17, at 9:50 a.m. the director of nursing (DON) confirmed R58's care plan lacked information about the resident's refusal to wear dentures. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and	2 915		7/28/17

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2 915	Continued From page 5 (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 1 of 3 residents (R2) reviewed for activities of daily living who were dependent upon staff for assistance with personal cares. Findings include: On 6/26/17 at 7:24 p.m., R2 was observed to have several gray/white facial hairs 1 inch or greater in length, on his upper lip and chin area. At that time, R2 stated he was unable to independently shave with a regular razor blade because he did not want to cut himself. The resident further stated the facility did not provide an electric shaver for use. R2 stated staff shaved him whenever it was convenient for them, but said sometimes that would occur greater than 10 days apart, and that he would prefer to be shaved more often than every 10 days. On 6/27/17, at 9:24 a.m. R2 was observed lying in bed. He still had numerous long gray/white facial hairs on his upper lip and chin area. On 6/27/17, at 1:24 p.m. R2 was observed sitting in a chair in the smoking area. He remained unshaven. On 6/28/17, at 7:24 a.m. R2 was observed lying in bed again. His face had still not been shaven	2 915	Completed by compliance date of August 8, 2017.	

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2 915	Continued From page 6	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.

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2 915	Continued From page 7 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to assessing resident shaving preferences, and could provide assistance based on the resident's preference. The DON or designee, could provide training for all nursing staff related to these policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 915		

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	00945	A. BUILDING: ______ B. WING ______	06/29/2017

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2 915	Continued From page 8 (21) days.	2 915		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not complete tuberculosis symptom screening for 1 of 5 residents (R68) reviewed, and did not complete a tuberculin skin test (TST) for 1 of 5 employees (C-A) reviewed for tuberculosis prevention and control. Findings include:	21426	Completed by compliance date of August 8, 2017.	7/28/17

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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 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 Tuberculosis screening and perform audits to ensure the policy is being followed.

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21426	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance 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. Findings include: On 6/27/17, at 9:39 a.m. in R40's shared bathroom, soiled ace wraps were observed hanging on the bathroom hand rails. Paper towels and a basin were noted on the floor. On 6/27/17, at 10:37 a.m. in R80's room, the veneer on the bottom corner of the closet door was noted as curled up, and protruding sharply into the room. On 6/26/17, at 6:48 p.m. the wall in R33's	21695	Completed by compliance date of August 8, 2017.	7/28/17

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21695	Continued From page 11 bedroom was observed to have large areas of bubbled paint near the window. On 6/27/17, at 10:28 a.m. R14's bedroom wall was noted to have large areas of bubbled and rough paint near the 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. During a tour on 6/28/17, between 9:20 a.m. and 10:30 a.m., the observations noted above were verified during a tour with the housekeeping director, corporate consultant, and activity director. In addition, large areas of soiled and frayed carpet were noted on the walls of hallways on both the first and second floors. In the second floor dining room, bent metal baseboard heaters were noted throughout the room. Several areas of the baseboard heaters had sticky substances, crumbs, and garbage stuck in or on the heaters. These findings were verified by the activity director, housekeeping director, and corporate consultant during ongoing discussion throughout	21695		

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21695	Continued From page 12 the tour. At 9:20 a.m., the administrator stated the facility wanted to replace the carpeted walls with a non-carpet option, however had not yet purchased any replacement. A request was made for evidence of any invoices for current project, no additional information was provided. The facility's policy, Healthcare Services Group, Inc. Jobs To Be Done: Bathroom Cleaning procedure, dated 1/1/2000, was reviewed. The policy did not include directions related to tidying up or removing extraneous items in the bathroom. Policies related to routine maintenance were requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights 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.	21805		7/28/17

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21805	Continued From page 13	21805		

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to treat 1 of 32 residents (R39) currently residing on the second floor with dignity in the second floor dining room when staff called the resident a "feeder."

Completed by compliance date of August 8, 2017.

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.

In an interview on 6/28/17, at 2:25 p.m. when asked if R39 needed help to eat, NA-A said "yes," and added that R39 was "a feeder."

Review of R39's care plan related to physical functioning last revised 3/8/17, indicated R39 needed extensive assistance of one staff to eat. In the Minimum Data Set assessment dated 3/9/17, staff assessed R39 to be rarely understood. The MDS also indicated R39 had memory problems, but was able to recall staff names and faces, and could remember being in a nursing home however, R39 was also identified as having severely impaired decision making with

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21805	Continued From page 14	21805		

fluctuations in levels of consciousness.

In an interview on 6/29/17, at 2:30 p.m. the director of nursing (DON) said when she provided staff education about dining, she directed staff to say "let me assist you" to a resident needing help to eat. When asked about staff calling a resident a "feeder" the DON said staff are not trained to use that term about residents, and that she would provide education to staff about not using the term "feeder" to describe a resident needing help to eat.

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 FOR CORRECTION: Twenty-one (21) days.