

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZKAQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245394		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: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 914342400		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 03/01/2017		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 9/6/2018 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12.Total Facility Beds 72 (L18)		13.Total Certified Beds 72 (L17)		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 Mary Capes, HFE NE II		Date : 09/19/2018 (L19)		18. STATE SURVEY AGENCY APPROVAL Kamala Fiske-Downing, Enforcement Specialist 09/19/2018 (L20)	

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

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT: <u> </u>		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
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 <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 01111 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245394

September 19, 2018

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

Dear Administrator:

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

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

Effective August 31, 2018 the above facility is certified 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,

, Program Specialist

The Estates At Lynnhurst LLC

September 19, 2018

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Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone #: Fax #:

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2018

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

RE: Project Number S5394030

Administrator:

On July 31, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 5, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 30, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on July 12, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 4, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 31, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 12, 2018, as of August 24, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 24, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of July 31, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 30, 2018. (42 CFR 488.417 (b)) be rescinded as of August 24, 2018. (42 CFR 488.417 (b))

The Estates At Lynnhurst Llc

September 19, 2018

Page 2

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZKAQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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17. SURVEYOR SIGNATURE <u>Mary Capes, HFE NE II</u>		Date : 08/27/2018 (L19)		18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Enforcement Specialist</u> 09/10/2018 (L20)	

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2018

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

RE: Project Number S5394030

Dear Mr. Carlson:

On July 12, 2018, 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, 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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 5, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs, is imposing the following remedy, and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective September 30, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 30, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 30, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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 30, 2018. 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.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC 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 latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 30, 2018 (80 days 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 discretionary 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 discretionary 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 January 12, 2019 (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.

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

The Estates At Lynnhurst LLC

July 31, 2018

Page 7

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 09/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2018	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments			E 000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted July 9 through July 12, 2018 during a recertification survey. The facility is in compliance with Appendix Z, Emergency Preparedness Requirements.						
F 000	INITIAL COMMENTS			F 000			
	A standard recertification survey was completed at your facility by the Minnesota Department of Health 7/9-7/12/18, to determine compliance with the requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities.						
	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 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10)(i)(ii)			F 567			8/24/18
	§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a						

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

TITLE

(X6) DATE

Electronically Signed

08/07/2018

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.

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

PRINTED: 09/19/2018
FORM APPROVED
OMB NO. 0938-0391

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F 567	Continued From page 1 resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R8, R19 & R44) who had personal funds deposited with the facility, had access to the personal funds after hours and on weekends.	F 567	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies		

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F 567	Continued From page 2 Findings include: With resident council permission, the Ombudsman attended a resident council meeting with residents and the surveyor on 7/10/18, at 3:00 p.m. The Ombudsman asked the residents about access to their resident trust funds, and their ability to obtain personal funds after hours and on weekends, because she'd recently had concerns reported by facility residents regarding this. During the meeting R44 stated, "We can only get our money from 10:00 a.m. until 2:00 p.m." R19 stated, "We can't get our money on the weekends." R8 stated, "Since the new company came in March, we cannot get our money after hours or on weekends." All three residents expressed they had attempted to obtain funds recently and were told by nursing staff there was no money available. Review of the most recent Minimum Data Set (MDS) assessments for R44, R19 and R8 indicated each resident was cognitively intact. When interviewed on 7/11/18, at 11:49 a.m. the administrator verified there should have been money at the second floor nurses' station for after hours resident use. The administrator stated, "There is a money box at the second floor nurses' station." During the same interview, observation of the "money box" with the administrator revealed there was a key combination metal box at the second floor nurses' desk behind several three ring binders. When the administrator opened the combination metal box it was empty. There was	F 567	and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegations of compliance. R44, R19, R8 have Personal Funds available after hours and on weekends. Residents have the potential to be affected if not given access to personal funds after hours and on weekends Documented education of staff on Resident Trust Policy, involving the individual resident's funds during normal business hours of 8:00 am to 4:30pm, Monday thru Friday. Residents also can access their trust account after hours and on weekends by contacting the charge nurse. Lock box is accessible at the 2nd Floor Nurses station. Residents will be educated at next resident council Weekly Audits of by interviewing cited residents and other residents to determine their satisfaction with ability to access funds after hours. LNHA/designee is responsible for compliance Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results.		

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F 567	Continued From page 3 no money, and no receipts in the locked box. The administrator was not aware if there was any documentation to indicate the last time a resident had obtained any funds after hours from this "money box." Licensed practical nurse (LPN)-B stated on 7/11/18, at 11:49 a.m. "There used to be a system with money available at the nurses' station on second floor for the residents. There hasn't been any money in the money box for many months. Sometime in March or so, the funds were taken away."	F 567			
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576			8/24/18

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F 576	Continued From page 4 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 3 of 3 residents (R8, R19, and R44) at the resident council meeting who verbally confirmed not receiving mail on Saturdays. Findings include: During the resident council meeting on 7/10/18, at 3:00 p.m. R8, R19, & R44 stated mail was not being delivered on Saturdays. Review of the most recent Minimum Data Set	F 576	R8, R19, R44 have mail delivered on Saturday's that USPS delivers mail Residents have the potential to be affected if not given mail delivery on Saturday's that USPS delivers mail Documented education of staff on the facilities mail delivery process. Activities staff or designee will deliver mail to residents on Saturdays, placing mail on resident bed and/or at the nurses station if resident is not available. Residents will be educated at resident council to look in their room for mail or ask nurse. Will post notices on resident unit.		

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F 576	Continued From page 5 (MDS) assessments for R44, R19 and R8 indicated each resident was cognitively intact. When interviewed in the resident council group, R8 stated, "I had my birthday and did not get my birthday cards on Saturday because there was no one to pass the mail." R19 and R44 verified the mail was not being delivered on Saturday because the staff told them the business office needed to go through the mail for bills and they were not here on Saturday so the mail needed to wait until Mondays. When interviewed on 7/11/18 at 12:37 p.m., activities staff (A)-A verified there had been a breakdown with the mail delivery system because the activity person responsible for mail delivery on Saturdays had been out on a medical leave for the past 6 weeks or so and the nursing staff needed to pass the mail in the absence of the activity person. The A-A indicated the nursing staff would be educated immediately to deliver the mail on Saturdays. The A-A verified the facility expectation was for the mail to be delivered on Saturday.	F 576	Weekly Audits by interviewing cited residents and other residents to determine their satisfaction with delivery of mail on Saturday. LNHA/designee is responsible for compliance Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results.		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		8/24/18	

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F 583	Continued From page 6 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 3 of 3 residents (R8, R19, and R44) interviewed who attended a resident council meeting; and for 1 of 3 resident (R24) reviewed who required staff assistance with personal care. Findings include: During the resident council meeting on 7/10/18, at 3:00 p.m. R8, R19 and R44 stated staff did not always provide them privacy during bathing.	F 583	R8, R9, R44 will be provided privacy during cares and bathing with follow up interview to determine satisfaction. Broken vertical blind and privacy film installed on window near 2nd floor bathroom. Curtains repaired and work properly. Residents, staff and the public have the potential to be affected if not provided a privacy during cares and bathing Residents rights related to dignity has been reviewed to include resident privacy.		

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F 583	Continued From page 7 Review of the most recent Minimum Data Set (MDS) assessments for R8, R19 and R44 indicated each of the residents had intact cognition. During the resident council meeting, R8 stated, "The aides have dressed me in the hallway, and my privates have been dried in the hallway sometimes. I am blind and I feel very embarrassed." R19 and R44 added, "bathing is not private at the facility." R19 stated, "I have seen other people naked being dried off after the shower sitting in that little area outside the shower room. They [the staff] need better privacy curtains." R44 stated, "The shower room doors do not get closed all the way and sometimes people get dried off in front of a window." During an observation on 7/11/18, at 7:00 a.m. R24 was observed standing naked just outside of the bathing room, in front of a window that did not have the blinds drawn. Nursing assistant (NA)-A was applying an incontinence brief while R24 was standing in front of the window just outside the bathing room. There was a three-story apartment building observed directly across from the window. There were broken vertical shade pieces on the window that were not closed. NA-A verified it was not unusual to towel dry residents in this area outside of the bathing room because the bathing room was so small and hot after baths. R24's cognitive assessment dated 3/7/18, indicated R24 had severe cognitive impairment. On 7/11/18, at 7:10 a.m. the director of nursing (DON) verified staff were expected to provide personal privacy for residents and that it was not a good practice to dry a resident in front of the	F 583	Staff to be educated on resident rights and facility procedure to personal privacy and dignity when cares and showers are being provided. Weekly observation audits of 2 rooms and/or common areas per week to ensure privacy curtains and drapes are operational. Audit staff to ensure they know to provide privacy and honor resident preferences during cares. LNHA/designee is responsible Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results.		

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F 583	Continued From page 8 window naked. On 7/11/18, at 8:00 a.m. the administrator stated the facility standard was for residents to be provided privacy. The facility's policy for privacy with cares was requested. The DON stated there was no written facility policy for provision of resident privacy.	F 583			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625			8/24/18

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F 625	Continued From page 9 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a bed hold was provided for 1 of 2 residents (R17) reviewed who had been hospitalized. The findings include: R17's Quarterly Minimum Data Set (MDS) dated 5/10/18, indicated R17 had diagnoses including dementia, aphasia and diabetes mellitus. In addition, the MDS identified R17 was rarely understood and had been discharged to a hospital on 3/27/18. Review of R17's progress notes revealed on 3/27/18, a staff nurse identified R17's blood glucose reading was high and R17 was transported to the hospital for evaluation and stabilization. The progress notes lacked evidence of the facility providing, or attempting to inform R17 or their responsible representative, of a bed hold during the hospital transfer. During an interview on 7/12/18, at 2:43 p.m. the social services director (SSD) was asked about when bed hold notices were provided. The SSD was unable to provide any documentation regarding a bed hold for R17's hospital transfer 3/27/18. During an interview on 7/12/18, at 3:10 p.m. the health information management (HIM) representative verified he did not see bed hold documentation for the 3/27/18 transfer.	F 625	R17 will be provided the opportunity to hold his bed should he be transferred to hospital again. Residents have the potential to be affected if not given timely notice of bed holds Documented education of staff on the facility bed hold policy. Nurse will provide information to resident and/or representative, about holding bed prior to Hospital stay or on a therapeutic leave greater than 24 hours, a bed hold form will be provided or a narrative note that form was provided to the resident or responsible party. Weekly Audits of Residents who were hospitalized or on a therapeutic leave greater than 24 hours for copy of bed hold. LNHA/designee is responsible for compliance Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results.		

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F 625	Continued From page 10 During an interview on 7/12/18, at 3:15 p.m. R17's responsible representative stated she did not recall receiving a bed hold notice. During an interview on 7/12/18, at 3:23 p.m. the social services director (SSD) confirmed the staff were supposed to "notify family or responsible party" about the bed hold requirements. The facility's Bed-Hold policy for Hospital Transfer and Therapeutic Leave dated 12/2016 indicated: ... "2. A form is provided to acknowledge receipt of the bed hold policies and procedures for return... 5. Documentation in the narrative notes is made to reflect that the resident, resident representative and/or responsible party, received written information informing them of bed-hold and return policies."	F 625			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration, and carrying out physician's orders for one of four residents (R13); and, medication administration via a gastrostomy tube for two of two residents (R13 and R17) observed during Medication Pass. Finding include:	F 658	R13 all the medication orders were reviewed and route of medication for administration to be given by mouth. All residents on G-tube, the medications were reviewed and route of medication to be given by G-tube. All residents g-tube orders are accurate, and all necessary orders are present.		8/24/18

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F 658	Continued From page 11 During Medication Administration Observation on 7/12/18 at 10:03 a.m., Registered Nurse (RN)-D set up R13's medication including : senna S one tablet, multivitamin, one tablet, sodium Chloride 1mg tab, one tablet, acetaminophen 325 mg, 2 tablets, valporic acid poured 15 ml in a graduated medication cup, Polyethylene Glycol Powder 1 capful, poured into a 4 ounce glass, lamotrigine 100 mg, one tablet, potassium chloride 10 meq tab, gave one, levetiracetam 1000 mg tab. RN -D crushed all pills together and put into a cup and added approximately 3 ounces of water. RN-D entered R 13's room and informed R13 that he was going to administer her medications. He stated that she had a g-tube (gastric) and that is how she got her medications. RN-D drew up the valporic acid into a 60 milliliter (ml) syringe and drew up about 10 mls of water. He pushed the medications into the g-tube, drew up the crushed pill mixture into the syringe and pushed into the g tube. RN -D flushed the g-tube with water. He indicated it was about 60 mls. When interviewed, RN-D verified he did not check placement, did not attempt to administer the medications with gravity, and did not flush between medications. After completion of the medication administration, RN-D indicated that R13 had an order to cocktail the meds, so that was why he mixed them all together. Interview with the Director of Nursing (DON) on 7/12/18 at 10:30 a.m., he verified procedures for medications through a gastric tube: placement should be checked, water flush between medications and administration by gravity should be attempted. The DON indicated R13's medications were to be given by mouth, per current physician orders.	F 658	Education provided to the nurses upon hire, annually, and as needed about medication administration via prescribed route per policy and procedure; to also include appropriate physician order needed, crushing of meds, mixing medication, checking placement, flushing of tube, and straight gravity administration. Policy was reviewed and remains current. Medication Administration Observation Audit will be completed weekly x 4 and as needed. Observation audit to ensure general guidelines for administering medication were followed. Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results. DON/designee is responsible for compliance.		

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 658	Continued From page 12 Review of R13's Order summary report for July 2018, indicated all medications observed were ordered to be given by mouth. The DON verified giving medications by the wrong route was a medication error. The DON indicated R13 medications were given via the gastric tube until R13 returned from the hospital on 7/4/18, and the medications were ordered orally upon R13's return. Review of the facility's "Medication Administration-Preparation and General Guideline" policy dated 5/12 indicated: A. Preparation 4) FIVE RIGHTS- Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration. Licensed practical nurse (LPN)-E failed to follow standards of practice by combining, crushing and administering R17's medication all at once via a gastric tube. During Medication Administration Observation on 7/11/18 at 8:58 a.m., Licensed Practical Nurse (LPN) -E set up R17's medication including : lisinopril 40 mg, amlodipine 10 mg, Clopidogrel 75 mg, hydralazine 25 mg , iron supplement, and pantoprazole 20 ml, LPN-E crushed all pills together and put into a cup LPN-E indicated the pills are given together as "R17 has a physician order for that and the liquid medications are given separately and individually. LPN-E explained to R17 what was going to be done. LPN-E checked gastric tube placement, and completed the	F 658			

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F 658	Continued From page 13 medication administration correctly Review of R17's physician orders for July 2018, lacked an order for medications to be all crushed, and mixed together before administration. Interview with the director of nursing (DON) on 7/12/18 at 10:30, he verified R17 did not have an order to "cocktail" medication. Review of the facility's policy "Medication Administration -Preparation and General Guidelines. General Guidelines for Administering Medication Via Enteral Tube" dated 12/17 indicated: E. 2) Crushed medications are not mixed together. The powder from each medication is mixed with 15-30 ml (milliliters) water before administration.	F 658			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the failed to provide timely incontinence care for 1 of 3 residents (R27) who was dependent upon staff for incontinence care. Findings include: R27 was continuously observed on 7/11/18, from 6:50 a.m. until 10:00 a.m. and there was no offer of a check and change for incontinence care. At	F 677	Resident R27 has been reassessed for ADL care and care plan and nursing assistant sheets reviewed and revised specific to incontinence care. Resident will be offered timely care per care plan. New admissions/readmits will continue to be reassessed for incontinence care and ADL's and preferences and appropriate interventions will be initiated. For all other		8/24/18

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F 677	Continued From page 14 6:50 a.m. R27 was lying in bed positioned on her back with the head of the bed elevated twenty degrees. At 8:42 a.m. nursing assistant (NA)-A brought in the breakfast tray and set it on the counter and left the room to retrieve a bedside tray table to set the breakfast tray on. At 8:50 a.m. registered nurse (RN)-B elevated the head of the bed to thirty degrees in order to feed R27. At 9:12 a.m. R27 finished eating and RN-B adjusted the bed to have the head of the bed elevated twenty degrees. There was no offer for an incontinence check. At 10:03 a.m. surveyor asked licensed practical nurse (LPN)-A responsible for R27's care if there were any treatments for R27 that needed to be completed. LPN-A went to the nursing desk to check. At 10:05 a.m. LPN-A returned to the room with NA-A to check R27 for incontinence and discovered R27 was incontinent of a large amount of urine in the incontinence brief. Observation continued on 7/11/18, and at 10:14 a.m. R27 was turned to the left side to remove the incontinence brief and visualize the buttocks and posterior thighs. There were multiple red creases/craters and wrinkling of the skin to the buttocks and posterior thigh areas on R27. When interviewed on 7/11/18, at 10:30 a.m., NA-A verified not knowing what time the night shift completed a check and change for incontinence care. Furthermore, NA-A verified R27 did not have any incontinence check and change since coming on the day shift at 7:00 a.m. R27's Resident Face Sheet, indicated diagnoses included Type 1 Diabetes, right below knee amputation (BKA) and profound intellectual disabilities.	F 677	residents this may affect they will continue to be assessed quarterly/annually with significant change in condition and as needed with individual care plans being updated accordingly. Nursing staff to be educated on ADL and incontinence care procedures; to include care assessments, evaluation and follow up. Weekly observation audits of 5 residents care plan and interventions to ensure that care is being provided timely as according to plan of care. Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results. DON/designee is responsible for compliance		

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F 677	Continued From page 15 Document review of the facility form dated 5/24/18, titled; Brief Interview for Mental Status (BIMS) revealed R27's cognition was moderately impaired. The plan of care last revised 9/20/17, read "The resident has bladder incontinence r/t (related to) immobility and self-care deficit." The Care Area Assessment dated 9/9/17 directed urinary incontinence and moisture related skin damage and total dependence on staff for toilet use/brief changes. "She is at risk for alterations in skin integrity, rashes, and urinary tract infections." The document titled Braden scale for predicting pressure sore risk dated 5/22/18 read, "Resident is at risk for pressure ulcers and tissue breakdown r/t diabetes, intellectual disabilities and incontinence. Nurses to monitor blood glucose and inspect skin weekly. Staff are to anticipate needs and provide brief changes and repositioning every two hours." The undated document referred to as the aide assignment sheet indicated R27 was incontinent and to check and change Q2H and PRN (whenever necessary.) A policy for check and change incontinence care was requested but according to the director of nursing on 7/12/18, at 10:00 a.m. the facility do not have a policy and the expectation is to follow the assessment as indicated by the Braden assessment dated 5/22/18, which directed staff to provide incontinence brief changes every two hours.	F 677			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686			8/24/18

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F 686	Continued From page 16 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and implement interventions to promote the healing of current pressure ulcers, and prevent new pressure ulcers from developing for 2 of 2 residents (R27 and R32) reviewed for pressure ulcers. This resulted in actual harm for R27 who was not repositioned per protocol and developed a new pressure ulcer. Findings include: R27 was not repositioned on 7/11/18, for three hours and twenty-four minutes (3 hrs 24 min). When repositioned, it was observed R27 had acquired a new Stage 2 open area (Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow opening). The ulcer was recorded as measuring 1.7 centimeter (cm) length by 0.5 cm width to the right of the coccyx.	F 686	R27 has now been offered check/change and repositioned per current care plan and assessment. R27 Weekly wound and skin evaluation have now been completed per policy. Resident and MD/NP have been made aware of resident's open area including current condition. R32 weekly wound and skin evaluation have now been completed per policy. R27 and R32 wounds have been treated per current physician order, care plan and assessments. New admissions/readmits will continue to be assessed for pressure ulcer or risk and appropriate interventions will be initiated. For all other residents this may affect they will continue to be assessed quarterly/annually with significant change in condition and as needed with individual care plans being updated accordingly. Skin assessment and Wound		

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F 686	Continued From page 17 Review of R27's progress notes indicated the resident had previously had an open area identified 6/28/18. A progress note documented by licensed practical nurse (LPN)-C, dated 6/28/18 at 10:34 a.m. included: "NA [nursing assistant] reported res [resident] has an open area between buttocks' crease measuring 2.0 x 0.5 cm. Area cleaned and a dry dressing applied. Left message for NP (nurse practitioner) waiting on call back." When interviewed on 7/12/18, at 2:30 p.m. LPN-C verified there had been an open area to R27's buttock crease at the end of June. LPN-C verified that area was not the same as the new open area discovered 7/11/18, at 10:14 a.m. to the right of R27's coccyx. LPN-C stated registered nurse (RN)-K had observed the open area to R27's buttock crease on 6/28/18. LPN-C stated RN-K could confirm the open area in June was in the crease of the buttock and not on the coccyx. RN-K was interviewed by phone on 7/12/18, at 2:35 p.m.. RN-K verified R27 had an open area to the buttock crease on 6/28/18. Document review of the form titled, Reporting Reminders, dated 6/28/18 included: "open area on buttock crease 2.0 x 0.5 cm (centimeter)." Furthermore the report sheet indicated LPN-C was the day shift nurse and RN-C was the relieving evening shift nurse. RN-C was interviewed by phone on 7/13/18, at 2:42 p.m. RN-C could not recall receiving information in report regarding the open area to the buttock crease for R27 on 6/28/18. RN-C could verify the physician had not returned a	F 686	Management Policy has been reviewed and is current. Education was provided to all nursing staffs per policy to include repositioning, toileting, care plan and assessment, weekly wound and skin inspection evaluation and management of new and ongoing wounds. In addition to all other nursing staffs, Nursing Management team will be reeducated on comprehensively assessing for pressure ulcer risk and implementing appropriate interventions to prevent and/or heal pressure ulcers and other wounds. Education will be provided to nursing assistants regarding reporting of skin issues they observe during their routine daily cares of resident□s and following interventions within the plan of care to prevent and/or heal pressure ulcers and other wounds. Audit to occur weekly for residents to ensure wounds/pressure ulcers have been monitored and managed per policy to include repositioning, toileting, care plan, assessment, weekly wound and skin evaluation and documentation. Additionally, skin inspection will be completed weekly by licensed nurse on all residents with documentation of any skin impairment noted per policy. DON/ designee will be responsible party to ensure weekly skin and wound monitoring, management, interventions and documentation has been completed per policy and plan of care. The results of the audits will be reviewed		

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F 686	Continued From page 18 phone call regarding the area, and stated information pertaining to an open area on the buttock crease for R28 was not passed on to the night shift through report. Continuous observations were made of R27 on 7/11/18, from 6:50 a.m. until 10:14 a.m. and R27 was not offered any position change or assistance with any other care. At 6:50 a.m. R27 was lying in bed positioned on her back with the head of the bed elevated twenty degrees. At 8:42 a.m. NA-A brought R27 a breakfast tray. At 8:50 a.m. RN-B elevated the head of R27's bed to approximately thirty degrees in order to feed R27. At 9:12 a.m. RN-B adjusted the bed to lower the head of the bed to about twenty degrees. R27 was not offered any position change or other cares during the observation. At 10:03 a.m. the surveyor asked LPN-A, who was responsible for R27's care, if there were any treatments for R27 that needed to be completed. LPN-A went to the nursing desk to check. At 10:05 a.m. LPN-A returned to the room with NA-A to perform care. At 10:14 a.m., R27 was turned to the left side to remove an incontinence brief and to visualize the buttocks and posterior thighs. There were multiple red creases and wrinkling of the skin to the buttocks and posterior thigh areas observed. Furthermore, there was an open area to the right of the coccyx measuring approximately 1.7 cm in length by 0.5 cm size in width. When interviewed on 7/11/18, at 10:20 a.m. LPN-A confirmed not having been aware of any current open areas. LPN-A also stated the new open area looked like a Stage 2 pressure area to the right of the coccyx. There were no open areas visualized to the crease of the buttocks at that time.	F 686	by the QAPI committee monthly and scope and frequency of the audit will be adjusted based on the result.		

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F 686	Continued From page 19 When interviewed on 7/11/18, at 10:30 a.m. NA-A stated she was not aware of when the night shift staff had last completed repositioning for R27. NA-A stated R27 had not had any repositioning since NA-A had come on duty at 7:00 a.m. NA-A also acknowledged not being aware of any open areas to R27's buttocks or coccyx. Furthermore, NA-A verified R27 required assistance with position changes "every two hours" according to the nursing assistant assignment sheet. R27's Resident Face Sheet, indicated her diagnoses included: Type 1 Diabetes and profound intellectual disabilities. A facility form titled, Brief Interview for Mental Status (BIMS) revealed R27 had moderately impaired cognition. A Skin Assessment, Skin Risk and Braden dated 5/22/18, indicated R27 was at moderate risk to develop pressure ulcers: "Resident is at risk for pressure ulcers and tissue breakdown r/t (related to) diabetes, intellectual disabilities, and incontinence. Nurses to monitor blood glucose and inspect skin weekly. Staff are to anticipate needs and provide brief changes and repositioning q2h (every 2 hours)." R27's record lacked any evidence of weekly skin checks and lacked any bath or body audits. When interviewed on 7/12/18, at 1:52 p.m. the director of nursing (DON) verified there was no follow up to the 6/28/18, documented progress note indicating R27 had an open area to the "crease" of the buttocks. The DON stated, "The staff should have charted whether the area healed or resolved." Furthermore, the DON verified the nursing staff should have attempted	F 686			

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F 686	Continued From page 20 to contact the physician again when the physician did not respond to the call made on 6/28/18, at 10:34 a.m. The DON verified the facility did not have a good system for documentation and follow through with skin checks, but stated the facility was in the process of implementing weekly skin checks on all residents. Furthermore, the DON verified R27 had a "new" open area that was assessed as a "Stage 2 pressure area to the right of the coccyx." Document review of the nurse practitioner (NP) notes verified the last medical provider visit had been made on 6/19/18, and there were no new physician orders or NP notes to indicate whether the physician was informed of the 6/28/18 initial skin breakdown to R27's buttock crease. Facility policies for Wound Documentation, Off-loading, Positioning, Care Planning, Weekly skin checks, and Notificaiton of the Physician were requested, but none were provided. When interviewed on 7/12/18, at 1:52 p.m. the DON verified there were no specific policies, but stated the facility expectation was staff would provide care "per care plan and assessment, in accordance with Federal and State regulations." R27's care plan dated 7/11/18, indicated R27 had "Risk for skin breakdown related to impaired mobility. Open area to coccyx. Date initiated: 7/11/18." A Care Area Assessment (CAA) dated 9/20/17, triggered pressure ulcer and included: "CAA triggered related to resident's need for extensive assistance with bed mobility, incontinence of bowel and bladder, being at risk for alterations in skin integrity, suspected deep tissue injury, and a	F 686			

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F 686	Continued From page 21 stage 1 pressure area. Pressure areas were noted on admission. She is at risk for further alterations in skin integrity, rashes, and infection. No referral needed at this time." When interviewed on 7/12/18, at 2:50 p.m. the DON verified the facility expectation would be to evaluate the wounds weekly ensuring the physician was well informed and to follow the interventions for repositioning. The DON confirmed R27 should have been repositioned at least every two hours. R32's skin was not assessed per facility policy, and R32 developed a pressure ulcer. On 7/10/18, at 9:43 a.m., R32 was observed to be seated in a wheelchair. R32 stated she had a wound from the wheelchair rubbing the side of her left leg. R32 also stated staff had removed the left side piece from the wheelchair to prevent it from rubbing again. F32's face sheet undated, identified diagnoses that included multiple sclerosis. R32's Minimum Data Set (MDS) assessment dated 6/5/18, indicated R32 required extensive two person assistance with bed mobility, dressing, and toileting, and extensive one person assistance with locomotion on and off the unit with two person total assistance with transfers. The MDS further indicated R32 had an unstageable pressure ulcer. R32's care plan indicated potential for impaired skin integrity, and identified risk factors for pressure ulcers including: extensive assist with bed mobility, incontinence of bowel and bladder, dependence on staff for changing and pericare,	F 686			

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F 686	Continued From page 22 Braden score of 13, and an unstageable pressure ulcer to left outer thigh. The care plan goal was for the pressure ulcer to heal without complication. Care plan interventions included: extra protein for wound healing, wound vac placed 6/25, and to change treatment per MD orders. R32's orders included house supplement in the evening for wound healing, provide house supplement QD for wound healing. During an interview on 7/12/18, at 9:40 a.m. LPN-D stated R32 had no feeling on the left side, which was where the wheelchair was rubbing on the resident's left leg. LPN-D stated that's why R32 had not known there was a wound. LPN-D further stated skin assessments should be done weekly for R32 with her bath. During an interview on 7/12/18, at 11:59 a.m. the director of nursing (DON) verified skin inspections should be completed weekly, but verified they were not being completed. The DON said an order was entered, so they would now be done. The May treatment administration record (TAR) indicated weekly skin evaluations were to be completed. The TAR skin evaluations were checked as having been completed 5/5/18, 5/12/18 and 5/19/18. Review of a skin assessment dated 4/7/18, indicated R32's skin was intact. A skin assessment dated 5/24/18, indicated a wound had been identified 5/21/18. Although the May TAR had been checked to indicate assessments had been completed, no skin evaluations were documented for 5/5, 5/12 or 5/19/18. The skin assessment documentation for 5/24/18 indicated	F 686			

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
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F 686	Continued From page 23 R32 had a wound measuring 5 cm length, 3.5 cm width, which was unstageable with 25% granulation, 0% slough, 75% eschar (an unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed). Wound documentation for 5/31, 6/6, 6/14, 6/21, 6/28 and 7/5/18, indicated R32's wound continued to be unstageable. The facility wound process checklist dated 9/2011 indicated: "start weekly wound documentation form (pressure only)." In addition, the facility's weekly charting/wound ulcer documentation protocol dated 9/2011 included: "Once charted on weekly Wound/Skin Data Sheet, nurse's notes should reflect the progress of the wound and any changes in plan of care... Always measure length, width, and depth and document it in that order... Describe the wound bed appearance. If the wound base has a mixture of these, use the percentage of its extent (i.e., the wound base is 75% granulation tissue with 25% slough tissue."	F 686			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695			8/24/18

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F 695	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oxygen according to physician orders for 1 of 1 resident (R17) receiving oxygen therapy. Findings include: R17 was observed on 7/11/18, at 12:03 p.m. sleeping in bed and not receiving oxygen. Registered nurse (RN)-B was in the room and when asked about oxygen, RN-B indicated R17 should receive oxygen administration while sleeping and applied the oxygen via nasal cannula. R17's physician orders dated 7/1/2018 - 7/31/2018 revealed an order dated 12/16/17, for oxygen 2 liters via nasal cannula while sleeping every shift for obstructive sleep apnea. Review of R17's Treatment Administration Record (TAR) for July 2018 revealed facility staff initialed on the administration sheets that R17 had received 2 liters of oxygen while sleeping every shift except 7/2/18, 7/4/18, and 7/8/18. During an interview on 7/11/18, at 1:24 p.m. the director of nursing indicated his expectation was that R17 has oxygen on while sleeping. Oxygen administration policy dated 9/11 indicated: "1. Licensed nursing staff verifies that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration."	F 695	R17 order for Oxygen has been clarified with MD and care plan has been updated. Resident has been provided oxygen per orders with observation of self-removal. Risk and benefits have been reviewed with pertinent parties. All other residents on oxygen, orders have been reviewed and care plan updated per policy. All new admits/readmits will have appropriate oxygen orders, assessment and care plan initiated. Education provide to all the nursing staffs about oxygen administration including Licensed Nursing staff verifying that there is a physician's order for oxygen administration and nursing assistants' role for residents with oxygen per policy. Oxygen Administration observation audit will be completed weekly x 4 to ensure residents have been provided oxygen per physician order and new admit/ readmit have appropriate physician orders. Results of these audits will be reviewed at the facility QA meeting for further recommendation. DON/designee is responsible for compliance.		
F 759	Free of Medication Error Rts 5 Prcnt or More	F 759		8/24/18	

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F 759 SS=D	Continued From page 25 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were passed without an error rate greater than 5 percent (%) by failing to ensure accurate route of medication administration for 1 of 4 residents (R13) observed for medication administration. There were 28 opportunities for medication administration with nine errors. This resulted in an error rate of 32.14%. Findings: During Medication Administration Observation on 7/12/18, at 10:03 a.m., registered nurse (RN)-D set up R13's medication including : Senna S, one tablet, multivitamin, one tablet, sodium chloride 1mg tab, one tablet, acetaminophen 325 mg, 2 tablets, valporic acid poured 15 ml in a graduated medication cup, Polyethylene Glycol Powder 1 capful, poured into a 4 ounce glass, lamotrigine 100 mg, one tablet, potassium chloride 10 meq tab, gave one, levetiracetam 1000mg tab. RN -D crushed all pills together, put into a cup, and added approximately 3 ounces of water. RN-D entered R13's room and informed R13 that he was going to administer medications. RN-D stated that R13 had a g-tube (gastric) and that was how R13's medications were administered. RN-D drew up the valporic acid into a 60 milliliter (ml) syringe and drew up	F 759	R13 all the medication orders were reviewed and route of medication for administration to be given by mouth. R13 has been provided medication via prescribed route without medication error. On 7/12/18 RN-D was educated by DON about medication administration via prescribed route per policy and procedure. On 7/12/18 DON observed RN-D administering medication via prescribed route per policy and procedure. All residents' medications were reviewed and has been given without medication error. Education provided to the nurses about medication administration via prescribed route per policy and procedure; to include 5 right of medication administration per policy. Policy was reviewed and remains current. Medication Administration Observation Audit will be completed weekly x 4 and as needed. Observation audit to ensure general guidelines for administering medication were followed. Pharmacy Consultant will assist facility with medication administration observation.		

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F 759	Continued From page 26 about 10 mls of water. He pushed the medications into the g-tube, drew up the crushed pill mixture into the syringe and pushed into the g-tube. RN-D flushed the g-tube with water and indicated it was about 60 mls. When interviewed, RN-D verified he did not check placement, did not attempt to administer the medications with gravity, and did not flush between medications. After completion of the medication administration, RN-D indicated that R13 had an order to cocktail the meds, so that was why he mixed them all together. Interview with the Director of Nursing (DON) on 7/12/18 at 10:30 a.m., he verified the procedure for medications through a gastric tube: placement should be checked, water flush between medications and administration by gravity should be attempted. The DON then indicated R13's medications were to be given by mouth. Review of R13's Order summary report for July 2018, indicated all medications observed were ordered to be given by mouth. The DON verified giving medications by the wrong route was a medication error. Review of the facility's "Medication Administration-Preparation and General Guideline" policy dated 5/12 indicated: A. Preparation 4) FIVE RIGHTS- Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration.	F 759	Results of these audits will be reviewed at the facility QA meeting and scope and frequency will be based on results. DON/designee is responsible for compliance.		
F 761	Label/Store Drugs and Biologicals	F 761			8/24/18

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F 761 SS=D	Continued From page 27 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 medication carts was free of expired resident medications for 1 of 1 residents (R28) who received Latanoprost eye drops. Findings include: During medication storage review on 7/9/18, at 4:44 p.m. two open bottles of Latanoprost eye	F 761	R28 has been provided Latanoprost eye drop that is not expired. Expired medications have been removed for the med cart/ dispensing area. All other medications being stored for administration has been audited and is properly stored and not expired. Policy and procedures for medication		

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F 761	Continued From page 28 drops were in a plastic bag labeled for R28. One bottle of eye drops were received on 2/18/18, and no date when opened label was observed. The second bottle was received on 4/18/18 and had a date of 4/26 on the bottom of the bottle. Interview with Registered nurse (RN)-E at that time he did not know how long the medication was good for after opening. Review of R28's medication administration record for July 2018 and June 2018 indicated R28 received the medication every evening. Review of R28's medical record, included diagnoses of age related nuclear cataracts, psychosis and high blood pressure. On 7/12/18, at 11:20 a.m. the director of nursing (DON) stated he did not know where a list of medications which needed to be dated when opened or when the medications expired were located. On 7/12/18, at 11:30 a.m. licensed practical nurse (LPN)-B identified where the list was kept in the medication room, and verified R28's medications were expired and removed them from the medication cart. Review of undated form titled "Medication to date when opened" indicated Latanoprost or Xalatan eye drops were to be stored in the refrigerator until open, then kept at room temperature, and expired 6 weeks after open.	F 761	storage reviewed and remains current. All licensed nurses have been educated on proper medication storage procedure to include checking expiration dates. Pharmacy Technician will assist facility with auditing med carts and removing expired medications. Med cart and med room audit to be completed weekly x 4 to ensure meds are properly store, labeled and not expired. Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results. DON/designee is responsible for compliance		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining	F 791		8/24/18	

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F 791	Continued From page 29 routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) 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 locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred	F 791			

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F 791	Continued From page 30 medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure necessary dental care was provided for 1 of 1 resident (R58) reviewed for dental care. Findings include: During an interview with R58 on 7/12/18, at 2:00 p.m. R58 stated, "I have missing teeth in the bottom lower jaw and it bothers me. I would like to see the dentist but no one tells me about it." R58 stated he had asked the nurse to see the dentist. R58 was observed to have missing and broken teeth at this time. R58's face sheet dated 7/12/2018 indicated a diagnosis of heart failure and hypertension. The annual minimum data set (MDS) dated 6/11/18 indicated moderate cognitive impairment, R58 needed assist for daily hygiene and assessment of oral and dental status indicated broken teeth. The Care Area Assessment dated 6/11/18 indicated, "Resident triggers for dental care related to having broken teeth. Resident is seen by on-site dental yearly and was last seen in October of 2017. He will be seen again at their next visit. Resident requires assistance with oral cares. Plan to continue to assist with oral cares and arrange dental appointments as requested by resident." The current care plan dated 7/12/2017 indicated R58 had an alteration in dental care due to broken teeth, and the facility should assist with setting up dental visits as needed.	F 791	R58 has been assessed for oral care/dental preferences to ensure residents individual ADL Care Plan is updated and reflective of their needs. R58 has an appointment setup to be seen by Apple Tree Dental on Aug 8th, 2018 at 1140am. All residents were reviewed for appropriate dental services. New admissions/ re-admits will continue to be assessed for oral/ dental preferences and appropriate interventions are initiated with services offered and provided. 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 and services being offered and provided. Audit to be performed to determined when all residents were last seen by dentist and dental referral were made. Oral/dental care audits to be completed weekly x4 weeks. Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results. DON/designee is responsible for compliance.		

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F 791	Continued From page 31 The medical record included an Oral/ Dental assessment dated 10/5/17 completed by a dental hygienist indicating 'missing teeth and root tips, routine dental care to be provided by the in house dental service.' There were no follow-up dental services in the record. On 7/12/18, at 2:24 p.m. the health records staff verified there were no follow up dental appointments scheduled at this time for R58, he stated the onsite dental provider would get a list of residents needing to be seen at the time of their visits. He did not know of direction from nursing for R58 to be seen and stated he would make the list for the dentist of residents to be seen. He verified that the contracted dentist had provided dental services in the facility on 11/21/17, 12/11/17, 1/17/18, 3/28/18 and 5/7/18. On 7/12/18, at 2:53 p.m. the director of nursing stated he had completed an oral screening for R58 last week, and was aware that he needed to see a dentist and will be placed on the list. He stated that he was working on the facility's dental services to make sure the resident's with the greatest need are seen at the time of the dental visits.	F 791			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804			8/24/18

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F 804	Continued From page 32 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meals at a proper, palatable temperature and taste for 6 residents (R34, R209, R29, R23, R2, R49) reiveid at dining and had the potential to impact all 58 residents in the facility. Findings include: On 7/9/18, at 5:45 p.m. steam table was observed in the first floor dining room. When asked culinary services cook (CSC) to check the temperature of the cold turkey wraps, the thermometer read 60 degrees. CSC stated the temperature should be 34 degrees. CSC got another thermometer to re-check the temperature. The temperature again read 60 degrees and the dietary services director (DSD) was notified. On 7/9/18, at 5:59 p.m. DSD verified the cold turkey wraps temperature should be 34 degrees. DSD stated the temperature was 34 degrees in the kitchen and it must have warmed because the tray was sitting on the steam table. DSD stated the turkey wraps should not have been served and should be held on a separate food cart. DSD left to retrieve a separate cart with fresh ice in a tray underneath. CSC re-checked those turkey wraps and the temperature now read 50 degrees. The director of nursing (DON) and administrator indicated they would do something about the turkey wraps.	F 804	R34, R209, R29, R23, R2, R49 will be provided with meals with a proper temperature, palatable and taste. Facility has reviewed food distribution procedures. Facility has evaluated functionality and operation of steam table, ovens and refrigerators. Service contractor has been contacted to review the operation and thermal regulation of food production equipment. Facility holds monthly food council. Staff education provided to kitchen employees and nursing staff in regards to Dietary Services Policies and Procedures that includes Food temperatures. Residents will be educated at resident food council regarding there satisfaction with food temps. Mealtime audits, weekly x4, including resident interviews for satisfaction. Audits to evaluate meal temperature and storage temperatures per recommended guidelines. Completed by Dietary Manager and or Designee. Results of these audits will be reviewed at the facility QA meeting and scope and frequency will based on results. LNHA/designee is responsible for		

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F 804	Continued From page 33 On 7/9/18, at 6:27 p.m. the administrator indicated the turkey wraps were brought back to the kitchen to cool off and staff was serving soup instead. On 7/9/18, at 1:55 p.m. R34 indicated food is either cold or too hot. On 7/9/18, at 5:39 p.m. R209 indicated food is cold and does not like it. On 7/9/18, at 7:15 p.m. R29 indicated sometimes the food is not hot. Tonight's supper was horrible, tater tots and soup. No turkey wrap with no alternative offered. On 7/10/18, at 9:03 a.m. R23 indicated this was the worse menu; it stated a turkey wrap and received tomato based vegetable soup and tater tots. No alternative was offered for the turkey wrap and R23 stated, "How can they get away with this?" None of the dietary staff explained anything to the residents about the turkey wraps. On 7/10/18, at 9:39 a.m. R2 complained that for last night's supper he received tater tots, which he cannot have due to the potassium level and soup with tomatoes and vegetables, which he did not like. When he complained to the DSD, he asked for and received a "turkey" sandwich, which usually does not happen. On 7/10/18, at 10:55 a.m. R49 indicated food was always lukewarm and there was no microwave to heat up the food. On 7/11/18 at 11:24 a.m. DSD prepared a test tray, which was placed on the lunch tray cart.	F 804	compliance		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2018
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From page 34 On 7/11/18 at 11:54 a.m., DSD check temperatures of the food. Mashed potatoes were 140 degrees, Jello was 45 degrees, juice was 44 degrees, milk was 55 degrees, meat was 138 degrees and broccoli was 120 degrees. DSD stated temperatures drop from readings taken in the kitchen when they are on the cart. When asked about the warm milk temperature DSD indicated the milk was taken from the freezer and put on individual trays. The hot food plate was placed on first but the heat warms up the milk. Milk was observed to be served. Culinary department policy dated 12/2016 indicated: Purpose: To prevent infection by correct handling, preparation, purchase, storage of foods and by proper cleaning procedures... B. To inhibit growth of bacteria in food by maintaining temperatures that are higher or lower than those that permit bacterial growth. C. To kill pathogens (disease-producing bacteria) by thorough cooking... 1. Food Preparation... e... Food held between 40 degrees F. and 150 degrees F. provide optimum conditions for the growth of bacteria."	F 804			
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary and orderly environment for 9 of 9 residents (R11, R27, R31,	F 921	R27 (115), R31 (211), R55 (212), R159 (213), R54 (214), R45 (218) to addressed all issues identified: peeling paint,		8/31/18

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F 921	Continued From page 35 R45, R50, R54, R55, R159 & R160) whose rooms were reviewed. Findings include: During an observation on 7/9/18, at 5:00 p.m. in R159 and R160's bedroom, there were multiple areas on the wall where the paint had peeled away. Some of the areas were greater than a 9-inch plate size. In addition, the built in cupboards had two missing drawers, and the privacy curtain was torn at the top in the netting area, and hooks were missing. The bathroom door was also noted not to close due to wood expansion. At the time of the observation, R159 and R160 stated they were "new to the facility" and had been surprised by the condition of the room. Both residents expressed frustration with the warped door not closing properly, and confirmed the privacy curtain was in need of repair. R159 stated, "I came from a nice home that I took care of myself. When I got here I thought, this room sure needs work done." During an observation on 7/9/18, at 5:30 p.m. R27, R50 and R55's rooms were observed to have broken cupboards with door fronts missing. The residents all verified the door fronts had been missing for a very long time, and stated the facility was aware but apparently there were no parts to repair them at this time. During an observation on 7/9/18, at 6:00 p.m. the air conditioner wall units in the bedrooms for R11, R31, R45, and R54 were observed to have open gaps to the outside of the building of approximately 5 inches wide by 18 inches tall, and there were no screen protectors to prevent	F 921	cupboard drawers, privacy curtains, a/c install, toilet base grout, and doors sticking. First Floor hallway gouges have been repaired and flooring stripped and waxed. Environmental Audit will be done to identify other resident rooms/common areas with similar issues, for safe functional comfortable environment. Identified issues will be corrected. Maintenance Director educated on necessary repairs to be completed. Staff to be educated on system to report issues as needing repair. Housekeeping staff to be educated on privacy curtain application and maintenance and bathroom cleaning procedure. Weekly audits of identified rooms and 1st floor hallway for the necessary repairs completed and maintained. LNHA/designee is responsible Results of these audits will be reviewed at the facility QA meeting and scope and frequency will be based on results.		

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F 921	Continued From page 36 bugs and gnats from swarming about and observed coming into the bedroom. There were multiple dead bugs in the broken heat registers on the floorboard below the wall air conditioning unit. Furthermore, the residents complained their bathroom door "sticks" and does not close when they go into the bathroom. R31's family member was present during the observation and stated, "facility staff were informed of the door not closing but no action has been taken." In addition, R31's family stated the privacy curtain was torn at the top and did not come all the way around the bed in order to prevent people walking by in the hallway from seeing the resident in the first bed. R45 verified the privacy curtain had been torn for a "very long time." During an observation on 7/9/18 at 7:00 p.m., the bedroom walls for R11, R27, R50, R54, and R55 were observed to be gouged and have areas where the paint was scraped away from the walls. According to the residents these areas had been like that for "many months if not years." During an observation on 7/9/18, at 7:10 p.m. there was a strong foul odor in the shared bathroom of R31 & R45, and the toilet base grout was observed to be black and brown in areas with the floor separating from the grout area. During a follow up environmental rounds tour on 7/10/18 at 11:00 a.m., with the environmental services director (ED), the ED verified all of the surveyors findings. The ED stated the facility needed a system to finish painting rooms, to go around and check the privacy curtains, and to ensure grout replacement around toilet bases was evaluated. The ED verified there was not a facility policy on these issues but stated as staff	F 921			

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F 921	Continued From page 37 notice the issues, they should document them in the computer system. The ED said "everyone" has access to the computer system and verified the facility did not have a routine maintenance system in place to monitor for concerns, so relied on the housekeepers and nursing staff to report issues. The ED stated, "Staff just need to get the information into the computer system so I can take care of the problem." When interviewed on 7/11/18, at 10:00 a.m. the ED verified being new to the facility and was in the process of "catching up" with the multiple projects needing repair at the facility. The ED verified the facility process was to address the needed repairs in the computer system. The issue is "getting all the staff to use the system to alert maintenance timely." During an observation and interview with the administrator on 7/12/18 at 1:00 p.m., the first floor hallway was observed to have substantial gouges to the flooring. The administrator confirmed the finding and stated a resident with an electric wheel chair had caused the gouges to the flooring due to a faulty wheel and brake dragging. A black rubber like substance was visible where the floor was gouged. The administrator verified the surface was uneven from the gouges.	F 921			

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FS 394026

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000			

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

TITLE

(X6) DATE

Electronically Signed

08/07/2018

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 St Paul, MN 55101-5145, or By email to: 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. The Estates at 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.	K 000			

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K 000	Continued From page 2 The facility has a capacity of 72 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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 or 19.3.5.9. 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, 19.3.5.9 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 REQUIREMENT is not met as evidenced	K 321			7/20/18

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K 321	Continued From page 3 by: The facility failed to comply with Life Safety Code (19.3.2.1, 19.3.5.9) This deficient practice could affect the safety of all (18) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/12/18, observations and staff interview revealed the following: Found the utility room 117 has opening around electric wiring at ceiling tile. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 321	All deficient areas noted by the state fire marshal during annual inspection repaired so they meet current life safety code requirement. LNHA/designee is responsible		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.1, 9.7.5, 15.5.2 (NFPA 25))	K 354	Out of Service Plan-updated to LSC 2012 code		7/13/18

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K 354	Continued From page 4 This deficient practice could affect the safety of all (61) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/12/2018, observation and documentation reviewed revealed the following: Facility does not have a current out of service policy for fire sprinkler system to be up-dated to LSC 2012 code. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354			
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363			8/24/18

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K 363	Continued From page 5 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.3) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/12/2018, observations and staff interview revealed the following: Found resident room doors were not closing tight. Room 101,103,109. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363			
K 521 SS=C	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521	All deficient areas noted by the state fire marshal during annual inspection repaired so they meet current life safety code requirement. Audit of all fire doors completed LNHA/designee is responsible		7/17/18

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K 711	Continued From page 7 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3) This deficient practice could affect the safety of all (61) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/12/2018, observation and documentation reviewed revealed the following: The Facility does not have a current written Fire safety plan up-dated to LSC 2012 code. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 711	Evacuation Plan updated to LSC 2012 code		