Electronically delivered

June 25, 2021

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

RE: CCN: 245394
Cycle Start Date: May 27, 2021

Dear Administrator:

On June 14, 2021, we informed you that we may impose enforcement remedies.

On June 11, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J).

REMOVAL OF IMMEDIATE JEOPARDY

On June 9, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and 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 § 488.417(a), effective July 10, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 10, 2021.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Estates At Lynnhurst LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 11, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C District Office
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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 27, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/10/21 and 6/11/21, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5394120C (MN73573). The following complaint was found to be UNSUBSTANTIATED: H5394121C (MN71369). The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to ensure safety measures were put into place to prevent R1 from elopement from the facility. The Administrator and Director of Nursing were informed of the immediate jeopardy on 6/10/21 at 12:30 p.m. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/11/21.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		6/28/21

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

Electronically Signed | 06/28/2021

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the safety interventions for elopement were implemented for 1 of 3 residents (R1) reviewed for elopement. This failure resulted in an immediate jeopardy (IJ) when R1 followed an outside provider from the secured unit down an elevator and eloped out the front door. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance. The IJ began on 6/4/21, at 5:45 p.m. when R1 left the facility after following an outside provider from the secured unit down the elevator and out the front door of the building. The administrator and director of nursing (DON) were notified of the IJ on 6/10/21, at 12:30 p.m. The facility implemented immediate corrective action on 6/9/21, prior to the start of the survey and was issued as past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) dated 5/24/21, included cognitively intact with a diagnosis of traumatic subdural hemorrhage (bleeding between the brain and its covering) and was independent with activities of daily living (ADLs). R1's elopement risk evaluation with an effective date of 5/17/21, identified, R1 voiced intentions	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 for elopement and appeared to be at risk for elopement and was placed on the secured unit. R1's care plan dated 6/7/21, identified, "Resident is at risk for elopement due to cognitive impairment and discontentment with placement." R1's goal was, "Resident will not leave the building alone." Interventions included, "Staff will be aware of residents whereabouts in the building, door alarms will be answered promptly, in the event of a hospitalization facility will send a disclaimer card along with paperwork to inform hospital of elopement risk and decision maker status, elopement assessment completed per facility protocol, follow facility elopement protocol, notify administrator and police department for missing person as indicated, and notify family and responsible parties." R1's incident review and analysis dated 6/5/21, at 9:27 a.m. included, "Resident was last seen around 1700 [5:00 p.m.] using the phone at the nurses' station, then went missing since. Writer noticed resident was not in the area around 1745 [5:45 p.m.] and called an all staff search throughout the building, but the resident was nowhere to be found. Per staff report, resident went in his wheelchair in front of an outside provider in the elevator downstairs around 1730. Social service designee was notified by floor staff around 6:00 p.m. the resident had left the building via the elevator when an outside provider left the building." Further included, "Staff searched thoroughly and could not locate resident. Writer called 911 and reported around 1800 [6:00 p.m.]. The officer arrived and got information from the writer, which included information of what the resident looked like and a facesheet. The guardian, administrator, DON, medical director,	F 689		

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F 689	Continued From page 3	F 689		

and social service notified. A missing persons report was filed with the police." Additionally included, "Resident had expressed his past desire to discharge from the facility. Resident has a history of homelessness and so resident does have street smarts in regard to safety in the community."

R1's progress note dated 6/4/21, at 6:49 p.m. included, R1 was last seen around 5:00 p.m. around the nurses' station using the phone and then went missing.

When interviewed on 6/10/21, at 11:02 a.m. nursing assistant (NA)-A stated, she had seen R1 go out the door with a lady and had reported this to the nurse. NA-A had found out later that R1 was missing.

When interviewed on 6/10/21, at 11:40 a.m. licensed practical nurse (LPN)-A stated, " I saw the resident in his wheelchair follow a lady out the door but I didn't know either of them. I just thought they were visiting."

The elopement guideline dated 11/2017, included, "The facility will identify such environmental hazards such as entrances, stairwells or exits that pose a foreseeable danger to residents who wander or have an exit seeking behavior." Further included, "The facility will implement interventions to minimize these risks and hazards as appropriate."

The past noncompliance immediate jeopardy began on 6/4/21. The immediate jeopardy was removed, and the deficient practice corrected by 6/9/21, after the facility implemented a systemic plan that included the following actions:

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F 689	Continued From page 4 On 6/4/21, at 6:00 p.m. the nurse on duty called 911 and reported R1 missing. On 6/4/21 an audit of residents at risk for elopement was completed and care plans updated accordingly by the DON. A Visitors For Secure Unit All Staff Education sign in sheet identified, on 6/4/21 through 6/9/21 all facility staff, outside providers, and hospice agencies were educated on the elopement guideline dated 11/2017. All staff were educated on all guests, visitors, hospice agencies, etc. will be escorted up to second floor and will always be escorted back down to first floor by a staff member. All staff were educated on at no point will a guest go up to the secured unit by themselves to ensure that residents that aren't supposed to leave the secured unit, do not leave the secured unit. A report entitled The Estates at Lynnhurst, Ad hoc, dated 6/7/21, identified the administrator, DON, registered nurse manager, social service director (SSD), social service worker, assistant director of nursing (ADON), and the health information/admissions director performed an adhoc Quality Assessment and Performance Improvement (QAPI) meeting to discuss root cause analysis and the plan of correction. During observation of the doors and inside the elevator on 6/10/21, at 10:20 a.m. signs were posted stating, "VISITORS, GUESTS AND PROVIDERS PLEASE READ: Effective 6/4/21 all guests, visitors and providers must be escorted on and off second floor. Please ask a staff member to bring you upstairs, and when you are	F 689		

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F 689	Continued From page 5 ready to leave please ask a staff member to bring you back down. This is for the safety of all of our residents." LPN-B, LPN-C, NA-A, NA-B, HSKP-A, and ADON were interviewed on 6/10/21, between 10:00 a.m. and 11:08 a.m. and stated they had received education on the elopement guideline, not allowing visitors or any outside providers in the elevator to the secured unit without a staff escort, and the elopement binders. In addition, elopement binders were available to determine which residents are at risk for elopement in which they could reference.	F 689		

Electronically delivered
June 25, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: QNBC11

Dear Administrator:

The above facility was surveyed on June 10, 2021 through June 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/10/21 and 6/11/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5394120C (MN73573), however NO licensing orders were issued. The following complaint was found to be UNSUBSTATIATED: H5394121C (MN71369). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	2 000		