DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 13, 2021

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

RE: CCN: 245394
Cycle Start Date: August 3, 2021

Dear Administrator:

On September 10, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
August 18, 2021

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

RE: CCN: 245394
Cycle Start Date: August 3, 2021

Dear Administrator:

On August 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 3, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 3, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 08/03/2021

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 8/3/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5394129 (MN75244), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	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 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 observation, interview, and document	F 689	The Estates at Lynnhurst POC for 8/3/21	8/16/21

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

Electronically Signed | 08/27/2021

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

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F 689	Continued From page 1 review, the facility failed to ensure smoking assessments were completed and/or updated for 3 of 3 residents (R1, R2, R3) reviewed for active smokers when the doorbell was not in working order for residents to gain re-entry to the building after exit doors were locked at 10:00 p.m. R1's Face Sheet printed 8/3/21, indicated R1's diagnosis included type 2 diabetes and chronic pain. R1's quarterly Minimum Data Set (MDS) dated 6/23/21, indicated R1 was cognitively intact, and lacked R1's current tobacco use. R1's care plan dated 3/31/21, indicated R1 was currently smoking at the facility, and was independent with smoking per smoking evaluation. R1's smoking evaluation dated 3/19/21, lacked indication R1 was a current smoker. R1's progress note dated 6/17/21, at 5:57 a.m. indicated R1 was outside smoking. R1's progress note dated 7/3/21, at 11:47 p.m. indicated R1 was outside smoking. R1's progress note dated 7/28/21, at 2:11 a.m. indicated R1 was outside smoking. On 8/3/21, at 10:22 a.m. R1 was interviewed and stated the front door was locked at approximately 10:00 p.m. and staff needed to unlock the door to allow residents in and out. R1 stated he had been "locked out" for 30 to 40 minutes at a time waiting to be let inside the facility by staff, who were sitting at the nursing station. R1 stated he felt	F 689	Visit Cited on: F689: Free of Accidents Hazards/Supervision Immediate Corrective Action: • Full house audit of smoking assessments was conducted, and updated smoking assessments were created for all smokers, including R1, R2, and R3 noted in this report. • Care plans for R1, R2, and R3 were reviewed and updated to reflect smoking habits and safety precautions necessary. • Residents R1, R2, and R3 were educated on the implementation of a new smoking schedule for over the NOC shift hours starting at 10:00pm. Corrective Action as it applies to others: • Facility has implemented a new smoking schedule for during the NOC shift hours starting at 10:00pm. Residents will now only be allowed to smoke outside at scheduled times to increase safety, and to ensure that residents are let in and out promptly. This will ensure that staff are present and available to let residents in and out and will eliminate the potential for accidents and lack of supervision while outside smoking at night. • All staff were educated on the newly instated scheduled smoking during the NOC shift beginning on 8/3/21. • All residents were educated on the newly instated smoking schedule • A new Doorbell was purchased and installed on 8/16/2021. • As part of this POC, maintenance will begin doing monthly doorbell checks to ensure that it is functioning properly. This is out of an abundance of caution,	

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F 689	Continued From page 2 there were not enough staff in the building at night. R1 stated strangers had approached him on multiple occasions asking for cigarettes while he was locked out of the facility, and one time the police were called as the individual appeared to be "high" which concerned R1. On 8/3/21, at 11:22 a.m. the director of nursing (DON) was interviewed and stated smoking assessments should be done quarterly, annually, and with a change in condition. The DON verified R1 had not been assessed as a smoker. The DON stated "everything" was wrong with the assessment, as R1 did smoke. The DON stated smoking assessments needed to be completed accurately. R2's Face Sheet printed 8/3/21, indicated R2's diagnosis included hemiplegia (paralysis of one side) affecting right dominant side, epilepsy, and diffuse traumatic brain injury. R2's quarterly MDS dated 7/14/21, indicated R2 was cognitively intact, and lacked indication of R2's current tobacco use. R2's care plan dated 8/13/18, indicated R2 was safe to smoke without assistance. R2's smoking evaluation dated 12/22/20, indicated R2 was an independent smoker. On 8/3/21, at 9:30 a.m. R2 stated the front door was usually locked before or around 10:00 p.m. but residents could choose to stay up and go outside to smoke. R2 stated staff needed to unlock the door to allow residents in and out. R2 stated staff do not come quickly and in the past, he has had to call the nurses station from his	F 689	because the newly instated scheduled smoking times should diminish the likelihood of requiring the doorbell for re-entry. Recurrence will be prevented by: • In summary of the above-mentioned actions, the facility has implemented the new smoking schedule during the NOC shift hours. Residents will be able to smoke at 12:30-1am and 3:30am-4am throughout the night. At these established times, staff will be available to supervise, and ensure everyone gets in and out in a timely fashion. This will eliminate the problem of residents being outside waiting to return in. All the staff and residents who smoke have been educated on this change and have begun this new practice. The facility has purchased a new doorbell and it was installed on 8/16/2021 date. Corrections will be monitored by: DON/Social Services Director/Administrator Duration of Audit Audit all new admits + 5 random charts Were smoking assessments up to date? Was care plan updated/congruent with assessment? Any additional concerns? Week 1 Week 2 Week 3 Week 4 Week 6 Week 8 Week 10 Week 12	

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F 689	Continued From page 3	F 689	Date of Compliance: 08/16/2021	

cellphone to be let back into the building. R2 estimated on average he waited about 15 minutes to be let in, and would see staff walking around the nurse's station, but they would not come to the door. R2 stated he had been approached by strangers who asked for cigarettes.

On 8/3/21, at 11:27 a.m. the director of nursing verified R2's most recent smoking assessment was 12/22/20, and stated, "It should be done more frequently than that, quarterly, annually, and PRN [as needed]."

R3's Face Sheet printed 8/3/21, indicated R3's diagnosis included Parkinson's disease, dementia without behavioral disturbance, and mild cognitive impairment.

R3's quarterly MDS dated 6/2/21, indicated R3 was cognitively intact and lacked indication of R1's tobacco use.

R3's care plan dated 3/31/20, indicated R3 was independent with smoking per smoking evaluation.

R3's smoking assessment dated 6/3/21, indicated R2 was a current smoker, and two had prior instances of smoking in the building and had been educated on smoking policies and risks/benefits. Then assessment indicated the facility would continue to assess for R3's smoking.

On 8/3/21, at 9:54 a.m. R3 was outside lighting a cigarette. R3 stated the facility doors were locked at 10:00 p.m. and he had to go find staff to let him. R3 stated sometimes it took staff "a long

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F 689	Continued From page 4	F 689		

time" to answer the door when outside smoking. R3 stated he had been told by staff "we're gonna leave you out there" in the past. R3 stated he had been approached by a stranger who asked him for a cigarette in the past while waiting to be let in. R3 stated the doorbell "doesn't always work" and was replaced about a week ago. R3 stated the doorbell "works sometimes and other times it doesn't."

When interviewed on 8/3/21, at 12:15 p.m. nursing assistant (NA)-B stated she worked on the second floor but had come down to the first floor for various tasks in the past and had seen "one or two residents standing outside to come in," and she had let them back in when first floor staff were not present.

When interviewed on 8/3/21, at 12:40 p.m. RN-A stated smoking assessments were completed upon admission, annually, and as needed with changes in condition or "safety issues."

The facility policy Resident Smoking Policy dated 11/18, directed residents who choose to smoke will be evaluated upon admission, significant change in condition/cognition, or exhibits inability to follow safe smoking practices or quarterly.

The facility policy The Estates at Lynnhurst Resident Smoking Policy dated 7 /10/19, directed when a resident has a change in their ability to smoke safely and/or requires more assistance than the facility provides, reassessment will occur.

On 8/3/21, the following observations of doorbell functionality were made:
-9:10 a.m. the doorbell was tested and was

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F 689	Continued From page 5	F 689		

functioning.
-9:20 a.m. the doorbell was tested and was functioning.
-10:08 a.m. the doorbell was tested and was not functioning.
-10:22 a.m. the doorbell was tested and was not functioning.
-10:37 a.m. the doorbell was tested by social services director (SSD)-A who verified the doorbell was not functioning.
-10:50 a.m. the doorbell was tested by the regional director (RD) and was functioning.
-11:14 a.m. the doorbell was tested by maintenance director (MD)-A who verified the doorbell and was not functioning and stated he was "not sure" of the problem. MD-A stated RD had just gone to purchase a new doorbell and he hoped to "get it figured out" today.

When interviewed on 8/2/31, at 12:18 p.m. NA-A stated the front door of the facility locked by 10:00 p.m. and staff have to let residents in and out of the facility. NA-A stated R1 frequently went out to smoke in the evening and overnight. NA-A stated it was "hard" to get to the door when only one person was on the floor, and, "It is not easy to meet the demands of those who are going out" due to attending to the other residents. NA-A further stated she believed only one doorbell was working, but the doorbell could not be heard in the laundry room or some resident rooms.

When interviewed on 8/3/21, at 9:15 a.m. MD-A stated he believed the front doorbell was working and it was just replaced last week. MD-A stated he was aware of functional issues with the doorbell and had received a resident complaint via the nurse about one month ago regarding the doorbell not working. MD-A stated at that time,

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F 689	Continued From page 6 the battery in the doorbell was replaced. MD-A stated he was informed again on 7/30/21, the doorbell "was not working again." MD-A replaced both the doorbell and the chime. MD-A stated there was no system in place previously to check the functionality of the doorbells and, "From now on it will be a monthly check." On 8/3/21, at 11:43 a.m. the administrator verified the facility doors automatically locked at approximately 10:00 p.m. for safety, and a code was needed to exit and enter. The administrator stated the doorbell was working "inconsistently."	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2021

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

Re: Event ID: M10I11

Dear Administrator:

The above facility survey was completed on August 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00945	A. BUILDING: _____ B. WING _____	C 08/03/2021

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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 8/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN 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: H5394129C (MN75244) however, no licensing orders were issued. 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, it is required that the facility acknowledge receipt of the electronic documents.	2 000		