

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 21, 2022

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

RE: CCN: 245394

Cycle Start Date: January 25, 2022

Dear Administrator:

On February 8, 2022, we notified you a remedy was imposed. On April 3, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 16, 2022.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 23, 2022 be discontinued as of March 16, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 8, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 23, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

M. Flig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 28, 2022

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

RE: CCN: 245394

Cycle Start Date: January 25, 2022

Dear Administrator:

On February 8, 2022, we informed you of imposed enforcement remedies.

On March 16, 2022, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations

As a result of the revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 23, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2022.

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.

As we notified you in our letter of February 8, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 23, 2022.

The Estates At Lynnhurst LLC March 28, 2022 Page 2

#### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

#### DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota. 56537 Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

#### 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 - Health

The Estates At Lynnhurst LLC March 28, 2022 Page 3

Regulation Division 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 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 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 July 25, 2022 (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.

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. The Estates At Lynnhurst LLC March 28, 2022 Page 4

#### 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/ 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 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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/04/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		152.11.110/1110111101115211	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245394	B. WING		I	R-C 8/ <b>16/2022</b>	
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{E 000}	Initial Comments		{E 00	00}			
	Requirements for L §483.73, deficiencie	nergency Preparedness ong Term Care facilities, CFR es were noted at the time of used Infection Control survey	{F 00	00}			
	conducted to follow a standard abbrevia The facility was fou with the requiremen	6/22, an onsite revisit was up on deficiencies related to ated survey exited 1/25/22. nd NOT to be in compliance ats of 42 CFR Part 483, ments for Long Term Care					
	The following tag w	as recited: F609.					
	as your allegation of Department's acception enrolled in ePOC, y	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567					
{F 609}	on-site revisit of you	d Violations	{F 60	99}		3/16/22	
		onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne	re that all alleged violations glect, exploitation or PER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

**Electronically Signed** 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.

03/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245394	B. WING _			-C <b>16/2022</b>	
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP CO 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		5/10/2022	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 609}	mistreatment, inclusion source and misapp are reported immer hours after the allest that cause the allest serious bodily injurithe events that cause abuse and do not reported including the administrator of officials (including the administrator of officials (included, Parkinson disorder, MDS indictions after the appropriate correct that the appropriate co	ding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ng-term care facilities) in the results of all the administrator or his or her entative and to other officials in that law, including to the State hin 5 working days of the alleged violation is verified live action must be taken.  Note that the results of all the administrator or his or her entative and to other officials in the law, including to the State hin 5 working days of the alleged violation is verified live action must be taken.  Note that the results of all the action must be taken.  The provision of the State of all the facility administrator and labuse, no later than two (2) and does of the allegation of abuse (R 1) reviewed for timely	{F 609	Facility submitted OHFC re 3/8/2022 for R1 and initiated immediately upon Administra aware of the allegation of ab All allegations of abuse and reported to the State Agency no later than 2 hours after ki abuse and neglect. The facil resident interviews to ensure abuse/neglect. The facility c assessments on some resid were not able to answer que abuse/neglect. No abuse/ne identified.	investigation ator becoming buse. neglect will be r immediately, nowledge of lity completed e no ompleted skin lents who estions of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	СОМ	E SURVEY IPLETED
		245394	B. WING			-C <b>16/2022</b>
	NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZI 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	P CODE	
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{F 609}	with activities of da bed mobility, and to R1's care plan revirisk for decreased related to diagnose disorder and Parkii care plan identified directed staff to be signs/symptoms of present, to update and administrator i  The facility SA report identified R1 had not relationship with a facility mental healt facility SA report id the evening of 3/7/regarding the alleg R1 made reference the unnamed staff MHT had not report to the facility leade over 12 hours after On 3/16/22, at 8:42 MHT confirmed should be removed by the sevening. The MHT allegation of sevening. The MHT allegation of sevening above 12 hours after incident. The MHT sexual abuse were immediately to the On 3/16/22, at 8:55	positive and physical abilities as of unspecified mood as onism (Parkinson's). R1's he was a vulnerable adult and aware of statements or abuse and if they were MD, director of nursing (DON), mmediately.  The tated 3/8/22, at 1:50 p.m. ande reference of a sexual female staff member to the the technician (MHT). The entified, at an unknown time on 22, MHT, spoke with R1 ed relationship and revealed at to a sexual relationship with member. The report identified at the alleged sexual abuse arship until the following day, who knowledge of the allegation.  2 a.m. during an an interview, a had been made aware of sexual abuse on 3/7/22, in the stated she reported the all abuse to the float licensed by on 3/8/22, at 12:40 p.m., a she was first notified of the confirmed all allegations of expected to be reported	{F 60	Staff education initiated of Prohibition/Vulnerable Ad to timely reporting of abus Mental Health Tech receiveducation regarding facility Prohibition/Vulnerable Ad boundaries education.  Facility will complete 5 standard Abuse & Reporting Quizz weeks, monthly for 3 more based on audit findings. It completed an audit of all specific to timely reporting weeks, monthly for 3 more based on audit findings. It with QAPI to determine if are needed.  Administrator/Designee is party.	lult Plan specific se and neglect. ved 1:1 verbal ities Abuse lult Plan and aff members sees weekly for 4 oths and PRN Facility will OHFC reports g weekly for 4 oths and PRN Facility will review fany adjustments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER.		IULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		245394	B. WING			R-C 8 <b>/16/2022</b>	
	NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP COI 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		1012022	
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{F 609}	sexual abuse alleg and indicated she administrator imme aware. The LSW v sexual abuse was the required 2 hour On 3/16/22, at 9:10 facility administrate sexual abuse was the 2 hour time fraindicated once the allegation, the report hour later on 3/8/2; hours after staff ha allegation. The administrated once the allegation of the administrated once immediately notified within the 2 of the facility policy to the facility policy to the allegation of the al	ation on 3/8/22, at 12:40 p.m. reported the allegation to the ediately after being made erified R1's allegation of not reported to the SA within time frame.  O a.m. during an interview the or confirmed R1's allegation of not reported to the SA within me. The administrator y had been notified of R1's out was submitted to the SA and 2, at 1:50 p.m, over 12 hours and been made aware of the ministrator confirmed she had for R1's allegation of sexual y, and had expected to be	{F 60	9}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245394	B. WING			R-C <b>03/16/2022</b>	
	PROVIDER OR SUPPLIER			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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 28, 2022

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

Re: Reinspection Results

Event ID: 100012

#### Dear Administrator:

On March 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of state licensing orders found on the survey completed on January 25, 2022. At this time, the state licensing correction orders were found corrected.

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

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/04/2022 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00945	B. WING		R- 03/1	.C <b>6/2022</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
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{2 000}	Initial Comments		{2 000}			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance rines promulgated by rule of artment 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.					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	completed to follow	/22, an onsite revisit was up on licensing orders issued ted 1/25/22. The correction				
		ed in ePOC and therefore a uired at the bottom of the first				

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

**Electronically Signed** 03/29/22

TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		00945	B. WING			-C <b>16/2022</b>
	PROVIDER OR SUPPLIER	TILC 471 LYNN	DRESS, CITY, SIHURST AVE			
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{2 000}	page of the CMS-2!  Although no plan of		{2 000}			

Minnesota Department of Health



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted February 8, 2022

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

RE: CCN: 245394

Cycle Start Date: January 25, 2022

#### Dear Administrator:

On January 25, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On January 25, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 and F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy 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 February 23, 2022.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The Estates At Lynnhurst LLC February 8, 2022 Page 2

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 23, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2022, (42 CFR 488.417 (b)).

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.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 23, 2022. This prohibition is not subject to appeal. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

The Estates At Lynnhurst LLC February 8, 2022 Page 3

- 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.

#### **DEPARTMENT CONTACT**

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

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota. 56537 Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

#### 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 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

The Estates At Lynnhurst LLC February 8, 2022 Page 4

occurred sooner than the latest correction date on the ePoC.

### 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 July 25, 2022 (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.

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 DENIAL OF PAYMENT

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

The Estates At Lynnhurst LLC February 8, 2022 Page 5

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.

#### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

#### 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 The Estates At Lynnhurst LLC February 8, 2022 Page 6

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 02/24/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		245394	B. WING		01	C / <b>25/2022</b>
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		12312022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
	Infection Control su facility by the Minne determine compliar	5/22, COVID-19 Focused irvey was conducted at your esota Department of Health to nce with Emergency lations §483.73(b)(6). The o be IN compliance.				
F 000	signature is not req page of the CMS-2 correction is require acknowledge receip	ot of the electronic documents.	F 00	00		
	survey was conduc was found to be NO requirements of 42	5/22, a standard abbreviated ted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.				
	UNSUBSTANTIATE	394143C (MN00080167),				
		blaint was found to be H5394146C (MN00080259), ted at F880.				
	Focused Infection ( at your facility by th Health to determine	/22, to 1/25/22, a COVID-19 Control survey was conducted e Minnesota Department of e compliance with §483.73 he facility was determined to nce.				
	_	d in an Immediate Jeopardy				
I ABORATOR'	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed 02/17/2022

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.

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG	CON	COMPLETED	
		245394	B. WING		1	C / <b>25/2022</b>
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP COD 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	(IJ) at F880 when the properly implement transmission-based floor secured unit, fithe facility failed to induring a COVID out spread of COVID-1 and the immediacy.  The survey resulted (IJ) at F886 when the outbreak COVID-19 Centers for Medical (CMS) guidelines distributed which began on 1/8 and the immediacy.  The facility's plan of as your allegation of Department's acceptant of the form.	ge 1 the facility failed to failed to appropriate isolation and I precautions on the second or R11 and R14. In addition, implement proper use of PPE threak to prevent further 9. The IJ began on 1/21/22, was removed on 1/25/22.  If in an Immediate Jeopardy the facility failed to complete 9 testing of all staff per and Medicaid Services uring a COVID-19 outbreak 1/22. The IJ began on 1/8/22, was removed on 1/25/22.  If correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567	FO	00		
	onsite revisit of you validate substantial	r facility may be conducted to compliance with the en attained in accordance with d Violations	F 6	09		2/22/22
	neglect, exploitation must: §483.12(c)(1) Ensu	onse to allegations of abuse, in, or mistreatment, the facility re that all alleged violations glect, exploitation or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(3) DATE SURVEY COMPLETED	
		245394	B. WING			C <b>25/2022</b>
	NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT LYNNHURST LLC			STREET ADDRESS, CITY, STATE, ZIP C 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	mistreatment, inclusource and misappare reported immed hours after the alleg that cause the alleg serious bodily injury the events that cause and do not rethe administrator of officials (including the administrator of officials (included panerous after the administrator of officials (included panerous after the allegation of the administrator of officials (included panerous after the allegation of officials (included panerous bodies) included included panerous after the allegation of officials (including the administrator of officials (i	ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other the facility and to other to the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established for the results of all the administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified live action must be taken.  Note that the results of all the administrator are sevidenced and document review, the neediately report to the State he administrator an allegation of later than 2 hours after llegation of abuse, for 1 of 3	F 60	OHFC report was filed on 1 12:37am for R1. Education Abuse Prohibition/Vulnerabl which includes timely report immediately provided to CN involved verbally.  Other residents were intervi time of the OHFC being filed abuse, neglect or exploitation Facility policy and procedure Prohibition/ Vulnerable adult current. Staff education has been ini	on facility e adult plan, ing, was A and Nurse ewed at the d and no on was noted. e, Abuse t plan remains	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED C	
		245394	B. WING		I	25/2022
	PROVIDER OR SUPPLIER	TLLC		STREET ADDRESS, CITY, STATE, ZIP CO 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	and lacked docume R1 and R2.  Review of the Facil Analysis report date NA- F witnessed R between her legs dwas visiting R1 in hithe report indicated timely reporting of Review of the Nurs #345730, submitted resident to resident NA-F had reported (DON) during an in a.m. R2 had inappresat on her bed in his proceeded to ask F had become upset the allegation of se 1/12/22, at 3:00 a.m on 1/12/22, at 12:3 minutes later after staff had failed to reuntil later in the day during a interview with the control of abuse at a 1/12/22, during an verified NA-F had rabuse to the nurse occurred. The DON abuse had not been hours of the allegations of the allegations.	es were reviewed for 1/12/22, ention of the incident between lity Incident Review and ed 1/12/22, identified at 3 a.m. 2 inappropriately touching R1 during the night shift while R2 her room. After further review distaff had been educated on incidents.  Ling Home Incident Report distance to the SA, identified a distance at altercation occurred when to the director of nursing terview on 1/12/22, at 11:45 repriately touched R1 while she er room. NA-F stated she R2 to leave R1's room and R1 with her. The report identified xual abuse occurred on m. and was reported to the SA 7 p.m. over 9 hours and 37 the incident had occurred and eport the allegation of abuse y on 1/12/22, at 11:45 a.m.	F 609	remains on-going regarding and procedure as it relates to Prohibition and Vulnerable Aspecific to timely reporting.  The facility will complete aud OHFC reports weekly for 4 wonthly for 3 months, then Faudit findings. Results will be facility QAPI committee for in need to increase, decrease, discontinue audits.  Administrator/Designee will be responsible party.  Date of Completion: 2/22/202	o Abuse dult Plan lits of all weeks, then PRN based on e shared with nput on the or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C	
		245394	B. WING _		01	/25/2022	
	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 609	it to her. The DON education on repore ducation on timely On 1/20/22, at 10:3 confirmed she had of abuse on 1/12/2 morning. The admit was on duty at the reported the allegal immediately, howe submit a report to the of the incident. The allegation of abuse of the AS within 2 hou and it should have indicated NA-F and timely reporting. The expectation would	indicated NA-F was provided ting and RN-C was given a reporting to the SA.  30 a.m. the administrator been notified of the allegation 2, at 9 or 10 a.m. in the inistrator indicated NA-F who time of the incident had tion to the charge nurse ever, the charge nurse did not the AS when NA-F informed. The administrator confirmed buse had not been reported to urs of the incident occurring been. The administrator did RN-C were both educated on the administrator stated her be for staff to report all e within two hours to the state	F 60	9			
	identified once disc (Minnesota Depart Notify MDH immedincident,. Suspecte Office of Health Falater than 2 hrs afte abuse, suspicion of misappropriation of reported to OHFC incident resulted in nurse must immedincidents while the The policy further in	tled, Abuse able Adult Plan revised 8/21, covered, report to the MDH ment of Health) as follows: liately after discovery of ad abuse was to be reported to acility Complaints (OHFC) no aer forming the suspicion of f neglect, exploitation, or f resident property must be no later than 2 hours if the serious bodily injury. The iately assess the situation and t from possible subsequent matter was being investigated. dentified when a vulnerable s suspected it should have					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG	COM	COMPLETED	
		245394	B. WING _		I	/25/2022
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	been reported immediate supervisions	ediately to the following: for and the administrator. In & Control	F 60			2/22/22
SS=L	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program.  The facility must es and control program a minimum, the foll §483.80(a)(1) A system of communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national signal system of survivial procedures for the but are not limited to (i) A system of survivial procedures for the but are not limited to (ii) A system of survivial procedures for the but are not limited to (ii) A system of survivial procedures for the but are not limited to (ii) When and to who will be a signal and to who will be a signal and the procedure of the persons in the facilial (iii) When and to who will be a signal and the provided and the procedure of the persons in the facilial (iii) When and to who will be a signal and the provided and the provi	control tablish and maintain an a and control program a a safe, sanitary and ament and to help prevent the ansmission of communicable cions.  In prevention and control tablish an infection prevention on (IPCP) that must include, at owing elements:  Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment og to §483.70(e) and following standards;  en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			C <b>25/2022</b>	
	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104	ESS, CITY, STATE, ZIP CODE RST AVENUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	(iii) Standard and to to be followed to prove followed to prove followed to prove fiv) When and how resident; including (A) The type and depending upon the involved, and (B) A requirement to least restrictive posticized in the contact with reside contact with reside contact will transmit (vi) The hand hygies by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection.  §483.80(f) Annual of the facility will consider for and update to the facility will consider for an and transmit the second floor see (R11 and R14) who in addition, the facility of the facility of addition, the facility of addition, the facility of the facility of the facility of the second floor see (R11 and R14) who in addition, the facility of th	ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct ints or their food, if direct interest to be followed direct resident contact.  Stem for recording incidents a facility's IPCP and the aken by the facility.	F 88	All residents have the pote affected by the facility failin appropriate isolation and transmission-based precau COVID-19 positive residen	ng to implement utions for uts.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245394	B. WING			l '	C <b>01/25/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	01/2	LOTEGEE	
					1 LYNNHURST AVENUE WEST			
THE EST	ATES AT LYNNHURS	ST LLC			AINT PAUL, MN 55104			
	OLINA A DV OT	ATEMENT OF REFIGIENCIES		0,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 7	F 8	380				
	·	e Control and Prevention			affected by the facility failing to imp	lement		
		vent and/or minimize further			proper use of personal protective	ioiiioiii		
		19. Further, the facility failed to			equipment (PPE) per CDC to preve	ent		
		ve cleaning of bathrooms			and/or minimize further spread of			
		use during a COVID-19			COVID-19.			
		cient practice resulted in an			All residents have the potential to b	е		
	immediate jeopard	y (IJ) which had the potential to			affected be affected by the facility f	ailing		
		nts, staff, family, and visitors in			to provide appropriate cleaning of			
	the facility.				bathrooms between resident use d	uring		
					COVID-19 outbreak.			
		pardy began on 1/20/22, when						
		on control practices to			Immediate corrective action:			
		residents and proper use of			COVID-19 positive residents were	h d		
		e equipment (PPE) were not duce the spread of COVID-19			immediately placed in transmission precautions and room changes we			
		administrator, associate			completed to ensure COVID-19 po			
		director of nursing (DON),			residents were not sharing a room			
		operations (RDO), regional			bathroom with COVID-19 negative	01		
		RNC) were notified of the			residents.			
		y at 5:10 p.m. on 1/21/22.						
					Staff working were immediately edu	ucated		
		pardy was removed on			on proper use of PPE and compete	ency		
		m. when the facility			was completed to ensure staff are			
		ventions to ensure residents			wearing appropriate PPE along with			
		educated on proper isolation			resident wearing appropriate PPE	and		
		oper use of PPE. However,			being redirected.			
		mained at the lower pattern			Action as it applies to others.			
		level F, which indicated no otential for more than minimal			Action as it applies to others: The facilities policy Coronavirus			
		immediate jeopardy.			(COVID-19) has been reviewed an	Ч		
	Findings include:	minicalate jeoparay.			remains current. The policy has spe			
	ago inolado.				related to proper isolation of COVII			
	Review of R11, R	14, R6, R24, R22, R17, R18,			positive residents, redirecting of res			
		23, R18 and R4's COVID-19 lab			to their room who are COVID-19 po			
	results revealed th				and all residents are wearing appro	priate		
					surgical masks, and appropriate PF			
		ratories test resulted dated			usage including donning/doffing an	d N95		
		R11 was positive for COVID			use.			
	19.				Staff education has been initiated a	ınd		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
			A. DOILDI	VO		c	
		245394	B. WING _		I	25/2022	
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP COD			
TUE EQT	ATEC AT I VAINILIED	21173		471 LYNNHURST AVENUE WEST			
INE EST	ATES AT LYNNHUR	SILLO		SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	R14's Simple Laborated 19. R6's Simple Laborated 1/12/22, indicated R24's Simple Laborated R24's Simple R24	ratories test resulted dated R14 was positive for COVID ratories test resulted dated R6 was positive for COVID 19. oratories test resulted dated R24 was positive for COVID	F 8	remains on-going regarding C (COVID-19) policy regarding a PPE usage including donning/ fit testing, proper isolation of C positive residents, redirecting to their rooms who are COVID positive, encourage residents surgical masks and practice p	ppropriate doffing, N95 OVID-19 of residents -19 to wear		
	R22's Simple Lab 1/19/22, indicated 19. R17's Simple Lab 1/19/22, indicated 19. R19's Simple Lab 1/19/22, indicated 19.	surgical mask hygiene. Staff 19/22, indicated R22 was positive for COVID start of their not provide di educated. Staff 19/22, indicated R17 was positive for COVID staff and/or are facility will be 19's Simple Laboratories test resulted dated 19/22, indicated R19 was positive for COVID and/or verbal completed.		hygiene. Staff will be educated start of their next scheduled start of provide direct care until the educated. Staff who are on leastaff and/or are not frequently facility will be mailed an educated and/or verbal education via ph	prior to the hift and will by are live, on-call in the tion packet		
	1/19/22, indicated 19. R21's Simple Lab. 1/19/22, indicated 19. R13's Simple Lab. 1/12/22, indicated 19. R23's Simple Lab. 1/19/22, indicated 19. R18's Simple Lab. 1/12/22, indicated 19. R4's Simple Lab. 1/15/22, indicated 19. CDC guidance, In Control Recomme Personnel During	oratories test resulted dated R20 was positive for COVID oratories test resulted dated R21 was positive for COVID oratories test resulted dated R13 was positive for COVID oratories test resulted dated R23 was positive for COVID oratories test resulted dated R28 was positive for COVID oratories test resulted dated R18 was positive for COVID oratories test resulted dated R4 was positive for COVID oratories test resulted dated R4 was positive for COVID oratories test resulted dated R4 was positive for COVID 19.		Recurrence will be prevented Audits of 5 staff will be conduct shifts four times a week for on then twice weekly for one week compliance is met to ensure fare appropriately wearing PPE with precautions/isolation resident non-precaution/isolated resident specific to donning and doffing including appropriate use of N removing PPE appropriately we room.  Audit of all rooms will be conducted shifts four times a week for on then twice weekly for one week compliance is met to ensure C positive residents are not room COVID-19 negative residents. includes the use of shared bat	ted on all e week, k once acility staff including dents and nts. This is of PPE 95 and ithin the  ucted on all e week, k once OVID-19 ning with This		

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	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIF 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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F 880	SARS-CoV-2 infect healthcare professis spread and protect severe infections, healthcare infections, healthcare infections, healthcare infections, healthcare person of a resident with sample sare person of a resident with sample sare used in the sample sample.	ractices and remain vigilant for tion among residents and ionals in order to prevent residents and HCP from nospitalizations, and death,  fection prevention and control en caring for a patient with rmed SARS-CoV-2 infection, ring guidelines:  Inptoms of COVID-19 (even agnostic testing) and ents who have met the criteria rased Precautions (quarantine) intact with someone with tion.  NOT be cohorted with patients RS-CoV-2 infection unless they are SARS-CoV-2 infection eally, a resident with suspected tion should be moved to a might with a private bathroom while	F 88	The correction will be mor Director of Nursing/ Infect Preventionist/ Designee			
	several residents o out in the dining roo	on the secured unit were seated om area with two staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3)			
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104				
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F 880	unit. R11, who had on 1/19/22, was se room area sitting a over his face and v COVID-19 negative without a facemask watch TV. The two area were not obse mask on his face or room.  - at 10:54 a.m., R1 COVID-19 on 1/19 which indicated R1 precautions (used	tested positive for COVID-19 eated at the end of the dining alone wearing a surgical mask was sleeping. R15 who was e entered the dining room area k on and sat down in a chair to activity staff that were in the erved directing R15 to place a per redirecting R11 back to his  7 who had tested positive for //22, had a sign on his door 7 was in droplet isolation for diseases or pathogens 9 that can spread in tiny	F 88	0			
	droplets caused by Nursing assistant ( N95 mask on, with face shield covering disposable gown, of while licensed practive hallway closed opened R17's door gloves. NA-E stood surgical mask, disp	v coughing or sneezing).  (NA)-E was observed to have a a surgical mask over it and a g his face. NA-E donned a gloves and entered R17's room ctical nurse (LPN)-F who was in the door behind him. NA-E r, had removed his gown and d in the door way, removed his posed of it in in the room, is while exiting the room into the					
	gown out of a plass down to the nurses removed her eye p LPN-F proceeded nose and mouth, a her N95 mask, pla and walked down twho had tested po	N-F obtained a disposable tic bin in the hallway, walked a station, obtained a N95 mask, protection and surgical mask. It to donn her N95 mask over her pplied a surgical mask over ced her eye protection back on the hallway to R14's room. R14 sitive for COVID-19 on 1/15/22, on her doorway which					

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F 880	indicated R14 was precautions. R14 surgical mask on h disposable gown a her room. LPN-F pand entered R14's - at 11:13 a.m., R1 surgical mask belo hallway past NA-E adjust her mask up proceeded to walk in the hallway. NA-her room. LPN-F eye protection and nurses station, pla station counter and NA-E removed their eye protection R14 walked by LP below her nose, LF mask up due to R14 walked by LP below her nose, LF mask up due to R14 complied while watowards her room.  - at 11:29 a.m., R1 dining room and separticipate in activity were present. No separticipate in activity were present.	in droplet isolation came out of her room with a her face while LPN-F donned a nd directed R14 her back to broceeded to glove her hands	F8	880		

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	PROVIDER OR SUPPLIER	T LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  471 LYNNHURST AVENUE WEST  SAINT PAUL, MN 55104				
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F 880	COVID-19 on 1/19/doorway which indication preserved as a same N95 COVID-19 positive - at 12:04 p.m., R9 COVID-19 wheeled medication cart and dispensed pain medication and he discation and he discation and he at 12:04 p.m., R9 COVID-19 wheeled medication cart and dispensed pain medication and he discation and he	22, had a sign present on their cated R6 and R22 were in ecautions.  N-A exited R6's and R22's her gown and gloves and her surgical mask over her eye protection in place. LPN-A om down the hallway, removed and was not observed to hask. LPN-A walked over to awaring the same N95 mask, negative for COVID-19 in his wheel chair and of water. LPN-A handed R7 a R7 proceeded to pull down his ewater. LPN-A continued to mask while she was working residents.  N-A continued to stand by her iewing the computer, when R8 or COVID-19 approached her with her. LPN-A continued to	F 8	880			
	and R10's room wh while continuing to	N-A delivered meals to R9's to was negative for COVID-19, wear the same N95 mask.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  IG		C (X3) DATE SURVEY		
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F 880	cart, walked down to and R27's room with were known to be recontinued to wear to at 12:16 p.m., NA-mask and donned at mask. NA-E proceed gown, gloves, while eye protection on, at mask over her N95 disposable gown at tested positive for the who was negative for the wear to make the room with the R12 were in drople entered the room with R12 and the DON I tray to R11. NA-E resanitized his hands sanitized his hands	the hallway and entered R26's the medications in hand, who negative for COVID-19. LPN-A he same N95 mask.  E had a face shield on, N95 a surgical mask over his N95 eded to donn a disposable registered nurse (RN)-A had a N95 mask on and surgical mask and began to donn a nd gloves. R11, who had COVID-19 on 1/19/22, and R12 for COVID-19 had a sign orway which indicated R11 and t isolation precautions. NA-E with a food tray, delivered it to nanded NA-E another room emoved his gown, gloves, removed surgical mask, and exited the room and he same N95 mask on and	F 88				
	COVID-19 on 1/15/positive for COVID-present on their do and R24 were in dr RN-A entered R14' tray, delivered it an another room tray a donned a surgical r mask, a disposable R17's room who ha COVID-19 on 1/19/negative for COVID NA-E delivered the	4 who had tested positive for 1/22, and R24 who had tested 1-19 on 1/15/22, had a sign orway which indicated R14 oplet isolation precautions. Is and R24's room with a room of the DON handed RN-A and she delivered it. NA-E mask over the same N95 agown, gloves and entered and tested positive for 1/22, and R2's room who was 1/24 on the DON on tray for R2. NA-E set the					

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F 880	room tray on R2's bedoor.  - at 12:26 p.m. NA-wearing the same hallway to the bathly and washed his hall mask over his N95 gown, gloves and wassist other staff to COVID-19 resident.  - at 2:05 p.m., contivas in the hallway COVID-19 testing five aring a disposal protection and a NSR11 who had tested 1/19/22, wheeled hallway. CAS-A per COVID-19 test on hallway. CAS-A per COVID-19 test on hallway. CAS-A per COVID-19 test on hallway. CAS-A did not remove no other residence a COVID CAS-A did not removed her paperwork, used a applied a new pair R11's room, asked complete a COVID CAS-A did not removed her paperwork, used a applied a new pair R11's room, asked complete a COVID CAS-A did not remove the positivattempting the test negative. CAS-A in for the facility two tistaff.  - at 2:52 p.m., CAS-A in for the facility two tistaff.	E exited R17's and R2's room N95 mask, walked down the room next to the nurse station nds. NA-E donned a surgical mask, donned a disposable valked down the hallway to deliver more room trays to s.  racted agency staff (CAS)-A with a supply cart, completing or residents. CAS-A was ble gown, gloves, eye 95 mask over a surgical mask. It is positive for COVID-19 on imself out of his room into the formed a nasal swab R11 while in the hallway. There lents or staff in the vicinity.  It gloves, filled out the wipe to sanitize her hands and of gloves. CAS-A entered R11's roommate R12 to 19 test and R12 refused. Ove her gown and N95 after 19 testing on R11, who was the for COVID-19, prior to on R12 who was COVID-19 dicated she completed testing mes a week for residents and S-A was observed while	F 88				
		ole gown, gloves, a N95 mask urgical mask and had eve					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 880	room however, did up and R11 complied - at 8:10 a.m. R11 eseveral other resided directed R11 to go room.  - at 8:12 a.m. R11's positioned below himouth, and DON at however did not att his room. RN-A broodrink, while other regroom area. RN-A did back to his room.  - at 8:18 a.m. R15 of COVID-19 without a independently out of entire length of the staff who did not regon or return to his room area where the his room. R15 refusin a chair in the dinic coffee while R11 was Regional nurse conwear a mask and Regional nurse conwear a mask and Regional nurse conwear a mask in my  - at 8:24 a.m. R15 of room area while driged from R11 as breakfast independent - at 8:25 a.m. R15 of dining room, walked	ask him to readjust his mask ed.  entered the dining room where ents were seated and DON to the other side of the dining as mask was again noted to be so nose and noted only over his sked R11 to readjust his mask empt to redirect him back to ught R11 a cup of coffee to esidents remained in the dining donot attempt to redirect R11  who was negative for a facemask on, walked of his room and down the hallway passing by several direct him to put a facemask oom. R15 entered the dining he DON asked R15 to eat in sed and proceeded to sit down and room area and drank as eating his breakfast. Isultant (RNC) asked R15 to eat in set and the complete saying "I never life".	F8	80			

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	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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F 880	R15 to go back to he R11 continued to e room area.  - at 8:43 a.m., R15 independently to the down in a chair, whe dining room area whis chin. RNC asked he refused.  - at 8:48 a.m. RNC up, he complied and dining room area is and R15 was not on by nursing staff or lused it earlier.  On 1/20/22, at 1:57 were expected to when entering a CO stated staff were exiting the room inclinated staff were hands and place a having contact with LPN-F indicated sher N95 mask and wearing her N95 mshe only wore a sure stated staff were and wearing her N95 mshe only wore a sure stated staff were she not sure stated staff were hands and place a having contact with LPN-F indicated she not sure stated staff were she not sure stated staff were sharing contact with LPN-F indicated she not sure stated staff were sharing her N95 mask and wearing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure stated staff were sharing her N95 mshe only wore a sure staff were sharing staff were shar	with no facemask on walked e dining room area and sat alle R11 continued to be in the with his mask positioned belowed R15 to put a mask on and asked R11 to adjust his mask ad she wheeled him out of the back to his room.  The property of	F 88	,			
	On 1/20/22, at 2:11 staff entered a CO were expected to wand a N95 mask. L	p.m. LPN-A indicated when VID-19 positive room, they vear a gown, goggles, gloves PN-A confirmed her usual to the same N95 mask on					

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F 880	during the shift and removed the N95 r R22's positive CON sometimes she wo N95 mask for extra had not been traine with every COVID-not changing it the transmitting COVID indicated she had mask either.  On 1/21/22, at 9:14 positive for COVID his activities of dail using the bathroom positive for COVID move R12, howeve R12 was independent with A independent with A independently. NA-was for staff to clear each resident user residents. NA-A independents. NA-A independent with a independe	I confirmed she had not mask she wore in R6's and /ID-19 room. LPN-A indicated re a surgical mask over her a protection. LPN-A stated she led to change her N95 mask 19 resident and indicated by possibility existed of 0-19 to other residents. LPN-A not been fit tested for her N95 a.m. NA-A verified R11 was -19 and was independent with y living (ADL's) which included a. NA-A indicated R12 was not -19 and the facility had tried to ler he refused. NA- A stated lent with ADL's and used the dently. NA-A indicated R15 was DL's and used the bathroom a stated the usual practice an a shared bathroom after for COVID-19 positive licated he had cleaned R11, athroom earlier that morning and verified R11 had used the t. NA-A confirmed he had not le to being busy on the floor. the risk and benefits which	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION  G	COV	E SURVEY  MPLETED  C
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F 880	gown or an N95 ma After a few minutes wearing his eye prodiscarded a bag of room and sanitized wearing the same R5's who was CON the him and then in NA-D walked down room, who were Coroom to check on the room. NA-D was urgical mask after positive room.  -at 10:57 a.m., NA surgical mask which area and a hairnet to donn a disposab room, who tested positive room.  -at 10:57 a.m., NA surgical mask which area and a hairnet to donn a disposab room, who tested positive room. NA-C beg R20 walked out of his bed. NA-C rem hands and immediate noom. NA-C was not a N95 mask and him mask after exiting a gown, glow mask over her surged Administrator-B prowho had tested positive room. Administrator-B work and her surgical mask after surgical mask after surgical mask and her s	ask when entering R4's room. It is NA-D exited R4's room of tection and surgical mask, it garbage in the soiled utility it his hands. NA-D while surgical mask, walked into Individual mask, walked Individua	F 880			

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F 880	bathroom down the and surgical mask, Administrator-B apply and stated she sho surgical mask over into a COVID-19 portated at 2:55 p.m, however, h	hall, removed her N95 mask and sanitized her hands. Olied a clean surgical mask uld have been wearing her her N95 mask when going ositive room.  Ospice registered nurse ask and sanitized her hands. The for COVID-19 on 1/12/22. The apply a face shield and sat arses desk. At 3:13 p.m., ask obe seated behind the nurses ame N95 mask. HRN-A stated ough the Hospice agency to ask over her N95 mask and dent's room to only remove and to keep the N95 mask on.  Osa.m., R14 who tested positive (15/22, was observed exiting aring a surgical mask covering osing her nose. R14 walked ast registered nurse (RN)-Ad not redirected R14 to adjust to her room. R14 continued to vay, entered the dining room over the cover of the dining room over the cover of the dining room and the cover of the dining room	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	I \ /	TE SURVEY MPLETED
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F 880	-at 8:06 a.m., R14 her mask remaining covering her mouth dining room past R redirect her back to adjust her mask. R middle of the dining residents seated ar dining room and be to the other resident at 8:12 a.m., R14 shallway with her surher nose. R14 walk to R14 to adjust he and was not asked room.  -at-9:36 a.m., R14 surgical mask in the hallway past RN her mask and she is observed to redirect continued to walk for the dining room are continued to be posexposing her nose R14 and talked to her mask.  - at-9:51 a.m., R14 dining room area wher chin seated new walked over to the LPN-A approached	returned into the hallway with g below her nose and only area. R14 walked to the N-B who was not observed to her room or remind her to 14 sat down in a chair in the room area with multiple ound her. RN-A entered the gan to handout surgical mask ts in the dining room.  Stood up, walked down the regical mask positioned below ed past the DON who asked mask. R14 did not comply or redirected back to her  exited her room wearing a esame position, walked down N-B who asked her to adjust refused. RN-B was not to R14 back to her room. R14 urther down the hallway into a and sat down. R14's mask sitioned below her chin and mouth. LPN A approached her however was not observed to her room or to re-position continued to be seated in the ith her mask positioned below to R15. R14 stood up, smoking room area, when R14 however was not to R14 back to her room or ask	F 88			

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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F 880	-at 10:01 a.m., FCOVID-19 on 1/1 light was noted to flushing and R11 bathroom in his wR11's doorway, stR11 if he needed no and RN- B insibathroom call light himself into the bathroom call light clean or disinfect done using it.  -at 10:33 a.m., Rand the toilet was observed to be wrown, gloves and R11's room, aske bathroom and R1 his head up and chared bathroom gown, gloves in the while exiting the rhallway, removed and sanitized his cleaning or disinfer R11 used it.  - at 10:44 a.m., Rroom to use the broom, verified R1 the toilet was hear staff or housekee cleaning or disinfer R15 had used On 1/20/22, at 9:20 on 1/20/2	R11's (who tested positive for 9/22), shared bathroom call be on. The toilet was heard was observed coming out of his rheelchair. RN- B walked up to good in the hallway and asked anything. R11 shook his head tructed R11 to turn off his at. R11 proceeded to wheel athroom and shut off the athroom and shut off the athroom after R11 was  11's bathroom call light was on heard to be flushing. NA-A was earing eye protection, donning a a N95 mask. NA-A entered d R11 if he had used the 1 responded to NA-A by shaking down indicating he had used the NA-A proceeded to remove his ne room and sanitized his hands oom. NA-A walked out into the his N95 mask, threw it away hands. NA- A was not observed ecting the shared bathroom after 15 was observed going into his pathroom. OTA-A entered R15's 5 was using the bathroom and rd to be flushing. No nursing ping staff were observed ecting the bathroom before or	F	380			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245394	B. WING _		01	/25/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		i	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	room as he was or NA-D indicated he N95 before enterin do so since he had with R4.  On 1/20/22, at 11:0 positive for COVID to wear full PPE wigown, gloves and eshe only wore heredoing direct cares a positive with COVII not have a N95 materied R19's room 1/20/22 at 12:00 p. R13 was positive for when entering a powere expected to wand a surgical mask Administrator-B incif she pulled her suthen she needed to confirmed she had surgical mask when verified she was we incorrectly.  1/20/22 at 1:54 p.m resident was positive expected to place a encourage the resinual number of the place of th	ally emptying his commode. should have worn a gown and g R4's room however did not a not completed direct cares  26 a.m. NA-C verified R19 was an and her usual practice was nich included: a N95 mask, eye protection. NA-C indicated N95 mask and gloves when with a resident known to be D-19. NA-C confirmed she did ask and gloves on before she	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING	COV	TE SURVEY MPLETED
		245394	B. WING		I	C / <b>25/2022</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	should have remove sanitized their hand staff received eductext messages from 1/20/22 at 2:07 p.m positive for COVID resident tested posexpected to place at them to their room been wearing a gobefore entering a Coshould have remove hands before exiting staff were expected the hallway, sanitized clean surgical mass have encouraged a with COVID-19 to reshould have been rooms if they are acconfirmed she had room when she can R4 On 1/20/22, at 8:33 who was only wear protection came outpositive for COVID carrying a meal tracent. R4's door had identified R4 was in NA-C verified she can coviding direct can COVID-19. NA-C states and stafe and sta	red their gown and gloves and ds. NA-E indicated nursing cation weekly on COVID-19 by in the administration.  1 RN-A confirmed R14 was -19 and indicated when a sitive for COVID-19 staff were a sign on the door and isolate. RN-A stated staff should have wn, gloves and a N95 mask COVID-19 room and staff yed the gown and sanitized in the gown and sanitized in the their hands and place a lik on. RN-A stated staff should all residents that are positive remain in their rooms and staff redirecting them back to their oming out of their rooms. RN-A not redirected R14 back to her me out into the hallway.  B a.m. nursing assistant (NA)-Cring a surgical mask and eye at of R4's (who had tested -19 on 1/15/22) room while y and put in on the serving It a sign on his door which in droplet isolation precautions. did not wear PPE when picking and only wore PPE while res to residents who had verified she was not wearing a land gloves while picking up	FE	380		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	1, ,	TE SURVEY MPLETED	
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F 880	who wore a surgic R11's (who had te 1/19/22) room car cart, then walked noted to not have door had a sign prindicated R11 was precautions.  R17 On 1/21/22, at 7:5 the shared bathro tested positive for filled a basin with negative) was seat the door and a cu NA-A proceeded to R17, while he sat NA-A was done co R17, NA-A went to the basin water in faucet, rinsed the filled the basin with proceeded to assi his morning cares returned to the sh basin, turned on the emptied the water while NA-A was si was COVID-19 not the adjoining room to use the bathroom into R1 disinfecting the bathroom.	page 25  27 a.m. facility scheduler (FS)-A cal mask and eye goggles left ested positive for COVID-19 on trying a meal tray to serving down the hallway. FS-A was a gown or gloves on. R11's resent on his door which in droplet isolation  27 a.m. NA-A was observed in om of R2, R25, and R17 (who COVID-19 on 1/19/22) and water. R2 (who was COVID-19 ated on the edge of his bed by train divided the two residents. To provide morning cares for on the edge of his bed. After completing morning cares for on the shared bathroom, emptied to the toilet, turned on the water basin, emptied it again and the soap and water. NA-A lest R17 to complete the rest of at R17 to complete the rest of at R17 to complete the he faucets, rinsed the basin and the into the toilet. At 8:15 a.m. till in the bathroom, R25 (who egative) opened the door from and informed NA-A he needed on. NA-A left the shared 7's room without cleaning or athroom before R25 used the	F8	380			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED C
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	with NA-C stated safter she picked up NA-C indicated she surgical mask for sPPE when providing who had COVID-19 worn N95 masks, oup trays from COV morning.  On 1/20/22, at 11:5 assisted R4 by emand was not able to gown prior to enter usual practice was gown, gloves, N95 entering any COVI and to dispose of broom.  On 1/21/22, at 8:2 not use the bathroom indephad used the bathroom prior times R17 would be out to smoke. NA-redirect residents to	he had sanitized her hands breakfast trays that morning. It wore eye protection and a cource control, and wore other ag cares in rooms of residents P. NA-C indicated she had not gowns or gloves when picking ID positive residents that  66 a.m. NA-D indicated he had ptying his commode earlier or remember if he had applied a ing R4's room. NA-D stated his to apply full PPE, including mask and eye protection when D-19 positive residents' rooms his N95 when he exited the  4 a.m. NA-A indicated R17 did om, however R2 and R25 used bendently. NA-A confirmed R25 oom right after he had emptied to R25 using it. NA-A stated at eave his room at times to go A indicated it was difficult to their rooms who were D-19 and to remind them to	F 88	30		
	(DON) indicated in currently had COV responsible for the while IP-A was out the last time the fac	B p.m. director of nursing fection preventionist (IP)-A ID-19 and DON was infection prevention program of the facility. The DON stated cility had completed fit testing a last year, and confirmed not				

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STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	CON	TE SURVEY MPLETED
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NAME OF PROVIDER OF		T LLC		471	LYNNHURST AVENUE WEST		
				SA	INT PAUL, MN 55104		
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
verified sh (gown, glowhen enter to be positive wearing at when leave was imported to other resisolated their N95 resident's to save the expected of it after indicated mask more COVID-19 confirmed supplies, mode for On 1/21/2 confirmed R12 and I R11 was part R15 were R11, R12 bathroom	ad been fine expect oves, eye ering a retitive with (N95 masking the rotant to presidents vis. The Dostoremove mask beforemove leaving a staff were than or positive and was in PPE suppositive for negative and R15 share ositive for the bath and the bath at the bath and the bath and the bath and the bath and R15 share ositive for the bath and R15 share	it tested at that time. DON ed staff to wear full PPE protection) for any reason sident's room who was known COVID-19, which included sk and to remove the N95 room. The DON indicated this revent the spread of COVID-19 The DON stated the facility who were COVID-19 positive ON verified staff were allowed mask over their N95 mask, if om one resident COVID-19 sident's room who had ON indicated the staff were the surgical mask covering fore entering a different to was positive for COVID-19 OON stated staff were their N95 mask and dispose COVID-19 room. The DON allowed to wear their N95 noce if going from one room and to another. DON ty had no concerns with PPE not in contingency or crisis colies.  O a.m. registered nurse (RN)-A R12 shared a room, and R11, and a bathroom. RN-A verified or COVID-19, and R12 and for COVID-19. RN-A stated independently used the atted the facility had not arroom after each resident use.	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245394	B. WING _		01	C / <b>25/2022</b>	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	RN-A stated it had routine due to a not and the facility had stated the facility had stated the facility has known to be Croom who was post refused to mov tried to isolate resimuch as possible at their masks. RN-Acompliant with isolate went out to public a expected staff to a his room whenever indicated she expesshared bathrooms used it, or staff use positive residents. isolate the resident to prevent COVID-residents to negati identify she had provided to the resident of the resident of the resident to prevent to NID-residents to negati identify she had provided to the resident of the resident to the resident to prevent to NID-residents to negati identify she had provided to the resident of the resident to th	been difficult to change R15's sted increase in his behaviors I not changed his room. RN-A ad offered to move R2, who COVID-19 negative, from R17's sitive with COVID-19, however e. RN-A indicated the facility dents who were positive as and reminded them to wear a confirmed R11 was not atting to his room, and he freely areas. RN-A stated she ttempt to redirect R11 back to r he was out of his room. RN-A acted staff to disinfect the after a COVID-19 resident ed it after caring for COVID-19 RN-A stated it was important to ts who were COVID-19 positive 19 transmission from positive ve residents. RN-A did not ovided any education, or risk to staying in his room.	F 88	0			
	non-compliant to is indicated when a C their room she attered their room and eduindicated it was on time due to their be LPN-C stated residnegative were allow however they were LPN-C confirmed C negative residents	colate in their rooms. LPN-C COVID-19 positive resident left empted to redirect them back to acated them, however, she ly effective for short periods of chaviors and refusal to comply. Idents who were COVID-19 wed out of their rooms, a encouraged to wear masks. COVID-19 positive and were out of their rooms at the icated it was difficult to keep					

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F 880	population.  On 1/21/22, at 10:2 the DON confirmed outbreak and had 1 tested positive for 0 the facility was atterpositive residents a changes. The DON out of R17's room verfused to move out COVID-19. The DOW who shared bathrook known to have COV move. The DON in staff sanitize the shift. The DON concovides and staff attempted sure they were not have COVID-19. The R14 were not comprooms and were our residents who did not confirmed most of the non-compliant.  On 1/21/22, at 11:3 facility had a contract conducted the facility DON indicated she wear proper PPE we gown, gloves and Noresidents for COVID expected staff to dowith positive COVID having exposure to	ge 29  6 a.m. in a follow-up interview, the facility was in a COVID 3 residents who had currently COVID-19. The DON indicated mpting to cohort COVID and had made some room stated R2 refused to move who had COVID-19, and R12 to f R11's room who had DN indicated those residents oms with residents who were I/ID-19 had been offered to dicated their plan was to have ared bathrooms used by and negative residents twice a firmed residents who had to being isolated to their rooms to redirect them, to make around residents who did not ne DON confirmed R11 and oliant with isolating to their tin common areas with not have COVID-19, and their residents were  5 a.m. the DON confirmed the ct with an outside vendor who they COVID-19 testing. The expected the vendor staff to which included eye protection, 195 mask when swabbing D-19. The DON stated she on new PPE after working D-19 residents and after them. The DON verified neducated on proper infection	F8	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245394	B. WING			1	25/2022	
	PROVIDER OR SUPPLIER TATES AT LYNNHURS	TLLC	STREET ADDRESS, CITY, STATE, ZIP CODE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104					
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F 880	control measures be and was not sure if The DON indicated staff was to be properly and to be fit to of COVID-19 to oth. The facility form title 8/20/21, identified 6 identified 22 staff we to 8/6/21, and 47 staff testing.  On 1/24/22, at 12:3 (IP)-A confirmed the had provided was the facility had complete confirmed she was last completed N95 2021. IP-A stated fi important to assure protect the staff meatransmitting COVID should have been coften if the person I	y the facility regarding testing CAS-A had been fit tested. her expectation for vender perly educated on the use of ested to prevent further spread er residents and staff.  The Fit Testing Record updated by staff members. The form were fit tested between 6/18/21, waff members had not received as permission of the facility he only documentation the ed for fit testing. IP-A trained to fit test staff and had a mask fit testing in June of testing of N95 masks was a they sealed correctly and to ember from contracting or 1-19. IP-A indicated fit testing completed annually or more had weight loss, facial surgery heir facial structure for all staff	F8	880				
	1/25/22, at 1:00 p.n through observation review the facility of whom were COVID negative. The facil to the resident who	n on 1/21/22, was removed on n. when it could be verified n, interview and document chorted residents together 1-19 positive and COVID-19 ity explained risk and benefits m were non-complaint and care plan. The facility sible for testing had						

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F 880	competencies com during testing and cOVID-19. Staff ed remains on-going f which included dor of COVID-19 positive, encouragi hand hygiene for rehigh touch areas. Start of their next s direct care until eduthat were on leave, in the facility were verbal education with the facility were verbal education with the facility per (COVID-19) revises had initiated steps respiratory pathogowith clinical feature and to adhere to appractices. The strain policy would remain Department of Heaprepare for and resof Coronavirus Dischanged. Monarch facilities would con residents as indicated and at the approprioutbreak Protocol: rooms with private initiate droplet and cohort residents idesymptoms/COVID-19.	pleted for proper PPE usage training for antigen testing for ducation was initiated and or appropriate PPE usage uning/doffing, proper isolation we residents, redirection of forms who are COVID-19 and surgical mask use and esidents and disinfection of Staff were educated prior to the hift and would not provide ucation was completed. Staff on-call and/or not frequently mailed an education packet or ould be completed on the ts had been conducted on the ts had been conducted on the second at risk for COVID-19 appropriate infection control tegies indicated within this in fluid as CDC and alth recommendations to spond to the community spread ease -2019 (COVID-19) healthcare management tinue to provide care for our ted within their plan of care ate level of care. Under Facility to place residents in private bathroom (if possible) and contact precautions and	F 88	30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 880	protection, per isola would be applied ar before exiting the re Department of Hea guidance. Resident COVID-19 would be recommended PPE or higher level resp and utilize PPE acc Department of Hea The facility docume undated, identified year, barring any m structure (weight ga document instructe different type of res would need to be redocument identified	loves, gown, mask, eye ation precautions guidelines) and removed when entering or esident rooms, per CDC and the donning and doffing with known or suspected	F 88	0		
	Equipment-Conting Respirators (COVIE identified during commask use included used respirators. TI "just in time" fit test COVID-19 Testing-CFR(s): 483.80 (h) (S483.80 (h) COVID must test residents individuals providing and volunteers, for for all residents and	Residents & Staff	F 88	6		2/22/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245394	B. WING			1	C <b>25/2022</b>
	PROVIDER OR SUPPLIER	111		ST 47	TREET ADDRESS, CITY, STATE, ZIP CODE 71 LYNNHURST AVENUE WEST AINT PAUL, MN 55104	1 01/2	25/2022
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F 886	and volunteers, the §483.80 (h)((1) Coparameters set for but not limited to: (i) Testing frequency (ii) The identification this paragraph diage COVID-19 in the factors in the paragraph with consistent with CO suspected exposur (iv) The criteria for asymptomatic individual paragraph, such as COVID-19 in a cout (v) The response to (vi) Other factors is help identify and put transmission of CO §483.80 (h)((2) Co is consistent with conducting COVID §483.80 (h)((3) For (i) Document that the results of each state (ii) Document in the was offered, computo the resident's teleach test.	e LTC facility must:  Induct testing based on the bythe Secretary, including by;  In of any individual specified in gnosed with acility;  In of any individual specified in a symptoms byID-19 or with known or reto COVID-19;  Conducting testing of byiduals specified in this is the positivity rate of anty;  In effort est results; and pecified by the Secretary that revent the byID-19.  Induct testing in a manner that current standards of practice for 19 tests;  In each instance of testing:  In each instance of testing:	F	386			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER	T LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  471 LYNNHURST AVENUE WEST  SAINT PAUL, MN 55104			
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F 886	for COVID-19, take transmission of CO §483.80 (h)((5) Have residents and staff, services under arrarefuse testing or an §483.80 (h)((6) Whemergencies due to contact state and local health de efforts, such as obtening test resident to contact state and local health de efforts, such as obtening test resident facility failed to contesting of all staff a Control (CDC) guida result the facility 1/08/22. This practice popardy (IJ) situation likelihood of serious had the potential to family and visitors in the facility failed to COVID-19 outbread administrator and the p.m. on 1/24/22. The removed on 1/25/2 facility implemented staff were tested for the p.m. on the contact tested for the staff were tested for the p.m. on 1/24/22. The staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.m. on 1/25/2 facility implemented staff were tested for the p.	VID-19, or who tests positive actions to prevent the DVID-19.  Ive procedures for addressing including individuals providing angement and volunteers, who is unable to be tested.  Item necessary, such as in testing supply shortages, partments to assist in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing taining testing supplies or ults.  In item necessary, such as in testing testi	F 88	The facility immediately impletesting protocol per CDC guidaccordance with the facilities Testing Policy which was reviremains current. The policy house to staff testing during an outbincludes documentation and testing.  The facility has initiated outbrof all residents and staff on 1/CDC guidance and in accordate facilities COVID-19 Testing Policy The facility conducted an anatesting, to include tracking, and updated facility procedure to compliance with CDC guidance Facility LNHA, Associate Adm DON, and Infection Prevention	lance and in COVID-19 ewed and as specifics reak which racking of eak testing 24/2022 per ance with the olicy.  Lysis of staff and has ensure ce.  Ininistrator, nist have		
	however, noncomp	liance remained at the lower severity level F, which		been educated on facility staf procedure and the facilities C	f testing		

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F 886	indicated no actual than minimal harm jeopardy.  Findings Include:  The CDC: Interim In Control Recommen Personnel During th (COVID-19) Pande facilities to develop for testing residents SARS-CoV-2. The any new COVID-19 nursing home-onse triggered an outbreak investigati isolation of new cast further viral transmisingle new case of staff or residents, to immediately.  On 1/20/22, at 2:53 (DON) indicated the tested two times a various due to the Con 1/20/22, at 5:09 e-mail, which identificating was initiated.  On 1/24/22, at 9:20 preventionist confinand three staff were Review of the facility.	harm with potential for more that was not immediate  Infection Prevention and adations for Healthcare the Coronavirus Disease 2019 mic, directed healthcare and implement a testing plan is and healthcare professionals CDC guidance recommended infection in any staff or any at COVID-19 resident infection ask investigation. In an ion, rapid identification and is see was critical in stopping ission. Upon identification of a COVID-19 infection in any esting should begin  p.m. director of nursing a facility staff were being week, on Monday and the ir outbreak status.  p.m. Administrator sent an fied the facility outbreak in 1/10/2022.	F 886	Testing Policy including immonutbreak testing to begin upon identification of a single new COVID-19 and tracking.  Staff education initiated on the protocol per CDC guidance accordance with the facilities. Testing Policy. This has been remains on-going. Staff who on-call and/or are not frequent facility were mailed education verbal education via phone of the self-COVID-19 testing if the fine necessary due to staff shortate.  Audits of testing will be compared to the PRN based on audit fine Results will be shared with factor input on the new increase, decrease, or discordad in the self-covide party.	esting and in COVID-19 in initiated and are on leave, ntly in the n and/or completed. To perform facility deems ages oleted weekly a 3 months, dings. acility QAPI eed to intinue audits.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP COE 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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F 886	Review of facility for Outbreak Testing, frevealed the follow -1/10/22, identified tested1/13/22, identified tested1/17/22, identified tested. No further testing in On 1/24/22, at 12:3 facility was current status, and began regardless of their and every Monday indicated residents tested with a comb tests and provided tested to the admirindicated she had in administrator to hastest prior to their necovided to the indicated to the indicated she had in administrator to hastest prior to their necovided tested to the admiringuity of the indicated she had in administrator to hastest prior to their necovided tested to the admiristrator to hastest prior to their necovided the assumed it was the track of the testing. On 1/24/22, at 2:22 process to assure for COVID-19 begatext messages to a when the testing were considered.	from 1/10/22, to 1/17/22, ing: 26 of 53 staff members were 16 of 53 staff members were 17 of 53 staff members were 18 p.m. IP-A indicated the ly in COVID-19 outbreak testing all staff and residents, vaccination status on 1/10/22, and Thursday. The IP and staff were currently being ination of antigen and PCR the list of the staff she had histrator and DON. IP-A instructed the DON and ve staff complete an antigen ext shift if they missed the PCR IP-A stated she expected the tor to keep track of which staff COVID-19 tests, and administrator who had kept of p.m. DON stated the facility all employees had been tested an with the facility sending out all employees informing them	F 88	36			
	informing the facilit	relied on the employees by if they had testing completed DON confirmed IP-A kept track					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
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F 886	of the staff tested a DON indicated the put a better process were tested. DON administrator kept a On 1/24/22, at 2:28 with associate adm the administrator in process they had in keeping track of whas ociate administration at the process they had in keeping track of whas ociate administration at the staff who completed keep the list when they were unable to complete the tested she assume who had antigen terregular testing's continuity and provide documentation the outbreak testing. Accountered testing has a staff per CDC record On 1/24/22, at 2:39 interview IP-A confit tracking COVID-19 outbreak and was responsible to assume that they were unable to the countered testing has a staff per CDC record On 1/24/22, at 2:39 interview IP-A confit tracking COVID-19 outbreak and was responsible to assume that they were unable to the countered testing has a staff per CDC record on 1/24/22, at 2:39 interview IP-A confit tracking COVID-19 outbreak and was responsible to assume the countered testing the countered testing has a staff per countered testing the countered testing	nd sent the information to her. facility has been attempting to a sin place to assure all staff stated the associate a checklist too.  p.m. during a joint interview inistrator and administrator, dicated the facility tracking place was not accurate in ich staff had been tested. The testing and the testing. She did not hey completed testing and to determine which staff still had ting. Associate administrator di IP-A kept track of the staff sting done between their mpleted on Mondays and strator confirmed the testing ded were the only facility had during their dministrator confirmed dinot been completed on all mmendations.  p.m. during a follow up remed she had not been testing of staff during the	F8	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRAND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING				TE SURVEY MPLETED  C			
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP COD 471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104			
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F 886	On 1/24/22, at 3:16 indicated he got technowever, was not to the however, was not to the facility (DIC)-A corbeen conducting C staff per CDC recorbeen conducting system in had been tested durindicated there had place to compare rested positive for confirmed she was been tested since to 1/8/22. The DON is complete outbreak control the spread outbreak.  The facility lacked resident contact traprocess for testing outbreak.  On 1/24/22, at 5:53 the facility outbreak licensed practical r COVID-19 positive.  The facility policy tirevised 10/5/21, identicated traprocess for testing outbreak.	S p.m. nursing assistant (NA)-B sted in the facility last week, ested the week before.  It p.m. director of infection of infection of infermed the facility had not OVID-19 outbreak testing of mmendations. DIC-A verified have a system in place to be tested.  It p.m. during a follow-up of infermed the facility did not have not place to determine all staff uring the outbreak. The DON of been no contact tracing in the esidents and staff who had covidents are how many staff had the outbreak was identified on indicated it was important to covidents in the covidents of staff to of covidents and estaff and acing or any evidence of a staff and residents during an of 1/8/22, when haves (LPN)-E was found	F 88	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 886	investigation. In an identification and is critical in stopping policy identified all regardless of vacci for SARS-CoV-2 wexperiencing an outhe facility would coand staff every 3 to passed since the laidentified upon ider case in the facility, the case was ident residents and staff residents and staff retested, and the retested, and the retested, and the retested per coview the facility in COVID-19 for all council control of testing of unvaccion of testing of testi	outbreak investigation rapid solation of new cases was further viral transmission. The health care workers, nation status, would be tested hen working in a facility tbreak. The policy identified onduct testing of all residents of a days, until 14 days had ast positive case. The policy ntification of a new COVID-19 they would document the date ified, the date the other were tested, the dates the who tested negative were		36			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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F 886	the start of their nex leave, on-call and/o were mailed an edu education would be Lastly, staff compet COVID-19 antigen	ge 40 At shift. Staff that were on our not frequently in the facility in it is cation packet or verbal completed on the phone. The rency testing was initiated for self testing if the facility ends cessary due to staff shortages.	F8	386		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 8, 2022

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

Re: State Nursing Home Licensing Orders

Event ID: 100011

#### Dear Administrator:

The above facility was surveyed on January 19, 2022 through January 25, 2022 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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

The Estates At Lynnhurst LLC February 8, 2022 Page 2

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:

LeAnn Huseth, RN, Unit Supervisor Fergus Falls District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota. 56537

Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

Minnesota Department of Health

AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00945		B. WING		01/2	5/2022	
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		SAINT PA	UL, MN 551		ON	()(5)
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2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag alle number indicated below. In a several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your fa Minnesota Departm	rs: /22, a complaint survey was acility by surveyors from the nent of Health (MDH). Your ot in compliance with the MN				
	The following comp	laints were found to be				

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

02/17/22 **Electronically Signed** 

STATE FORM 6899 100011 If continuation sheet 1 of 29

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	Minnesota Departness the State Licensing Federal software. The assigned to Minness Nursing Homes. The appears in the far-I Tag." The state stallisted in the "Summer column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time Period for Conyounty for the Minnesota Department of State lices the Minnesota Department of Headyou electronically, is necessary for State lices the word "Contavailable for text. Yelectronic State lices the Minnesota Department of Headyou electronic State lices the Minnesota Department of the M	Correction of ag numbers sota state state state eff column eff col	Orders using have been atutes/rules for tag number intitled "ID Prefix to foompliance is ent of Deficiencies" omply" portion of an also includes on of the state is Rule is not met surveyor's findings correction and in the electronic is consistent with lealth ailable at licensing tached Minnesotateing submitted to plan of correction (Rules, please in the box in indicate in the late your orders will ally submitting to				

Minnesota Department of Health

STATE FORM 6899 100011 If continuation sheet 2 of 29

Minnesota Department of Health

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		and therefore a signature is bottom of the first page of				
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21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			2/22/22
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the development of the procedures of resid the prevention and F. the development of the procedures of resid the prevention and F. the development of the procedures of resid the procedures of residual the procedures of the proc	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of act infection control, such as eptics, gloves, and				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DIAN OF CORRECTION . DENTIFICATION NUMBER:		, ,	LE CONSTRUCTION 3:	(X3) DATE COMF	SURVEY PLETED	
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21390	Continued From pa	nge 3	21390			
	current standards o	of practice in infection contr	ol.			
	by:	ent is not met as evidence				
	by: Based on observation, interview and document review, the facility failed to implement appropriate isolation and transmission based precautions on the second floor secured unit for 2 of 2 residents (R11 and R14) who were positive for COVID-19. In addition, the facility failed to implement proper use of personal protective equipment (PPE) per Centers for Disease Control and Prevention (CDC) CDC to prevent and/or minimize further spread of COVID-19. Further, the facility failed to provide appropriative cleaning of bathrooms between resident use during a COVID-19 outbreak. This deficient practice resulted in an immediate jeopardy (IJ) which had the potential to affect all 51 residents, staff, family, and visitors in the facility.		iate on nts 9. per er I to	Corrected.		
	appropriate infection isolate/quarantine in personal protective implemented to recein the facility. The administrator (AA), regional director of nurse consultant (F	pardy began on 1/20/22, when control practices to residents and proper use of equipment (PPE) were not duce the spread of COVID-administrator, associate director of nursing (DON), operations (RDO), regional RNC) were notified of the yeat 5:10 p.m. on 1/21/22.	t 19			
	1/25/22, at 1:00 p.n implemented interv and all staff were e precautions and pro noncompliance rem	pardy was removed on n. when the facility rentions to ensure residents ducated on proper isolation oper use of PPE. However nained at the lower pattern level F, which indicated no				

Minnesota Department of Health

STATE FORM 6899 100011 If continuation sheet 4 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		00945	B. WING		01/2	25/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	Continued From pa	ige 4	21390			
	actual harm with po	otential for more than minimal mmediate jeopardy.				
		4, R6, R24, R22, R17, R18, 3, R18 and R4's COVID-19 lab e following:				
	1/19/22, indicated F 19.	ratories test resulted dated R11 was positive for COVID				
		ratories test resulted dated R14 was positive for COVID				
	R6's Simple Labora 1/12/22, indicated F R24's Simple Labo	atories test resulted dated R6 was positive for COVID 19. ratories test resulted dated R24 was positive for COVID				
	R22's Simple Labo	ratories test resulted dated R22 was positive for COVID				
	R17's Simple Labo	ratories test resulted dated R17 was positive for COVID				
	R19's Simple Labo	ratories test resulted dated R19 was positive for COVID				
	R20's Simple Labo 1/19/22, indicated F 19.	ratories test resulted dated R20 was positive for COVID				
	1/19/22, indicated F 19.	ratories test resulted dated R21 was positive for COVID				
	1/12/22, indicated F 19.	ratories test resulted dated R13 was positive for COVID				
		ratories test resulted dated R23 was positive for COVID				

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AND DUAN OF CORRECTION INDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			2
		00945	B. WING			25/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	STIIC	NHURST AVE AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21390	Continued From pa	age 5	21390			
21390	R18's Simple Labora 1/12/22, indicated in 19. R4's Simple Labora 1/15/22, indicated in 1	ratories test resulted dated R18 was positive for COVID atories test resulted dated R4 was positive for COVID 19.  Perim Infection Prevention and adations for Healthcare the Coronavirus Disease 2019 amic, identified the facility must ractices and remain vigilant for tion among residents and ionals in order to prevent residents and HCP from mospitalizations, and death,  Fection prevention and control and caring for a patient with remed SARS-CoV-2 infection, and guidelines:  Approximately and the prevention and control and caring for a patient with remed SARS-CoV-2 infection, and the prevention and control and caring for a patient with remed SARS-CoV-2 infection, and the preventions of COVID-19 (even agnostic testing) and the preventions (quarantine) that with someone with tion.  BOT be cohorted with patients RS-CoV-2 infection unless they				
	are confirmed to hat through testing. Ide SARS-CoV-2 infect single-person room test results are pen-	ave SARS-CoV-2 infection eally, a resident with suspected tion should be moved to a with a private bathroom while				
		tion should adhere to Standard				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00945	B. WING		01/2	5 25/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	equivalent or highe gloves, and eye proshield that covers the shield that covers the coveral residents of out in the dining roomembers completing unit. R11, who had on 1/19/22, was seroom area sitting all over his face and we cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.  - at 10:54 a.m., R1: cover his face or room.	the a approved N95 or r-level respirator, gown, otection (i.e., goggles or a face the front and sides of the face).  4 a.m. during an observation, in the secured unit were seated on area with two staffing activities on the secured tested positive for COVID-19 ated at the end of the dining one wearing a surgical mask was sleeping. R15 who was a entered the dining room area on and sat down in a chair to activity staff that were in the enved directing R15 to place a redirecting R11 back to his  7 who had tested positive for (22, had a sign on his door of was in droplet isolation for diseases or pathogens of that can spread in tiny coughing or sneezing).  NA)-E was observed to have a a surgical mask over it and a g his face. NA-E donned a loves and entered R17's room tical nurse (LPN)-F who was in the door behind him. NA-E, had removed his gown and in the door way, removed his losed of it in in the room, while exiting the room into the	21390			
		ic bin in the hallway, walked				

Minnesota Department of Health

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	IT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDV/EV/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
					C	
		00945	B. WING		01/2	5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
			HURST AVE			
THE EST	TATES AT LYNNHURS	TIIC	UL, MN 551			
040.15	CUMMADY CTA					()(5)
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
21390	Continued From pa	ge 7	21390			
	down to the nurses	station, obtained a N95 mask,				
		otection and surgical mask.				
		o donn her N95 mask over her				
		oplied a surgical mask over				
	her N95 mask, plac	ed her eye protection back on				
		ne hallway to R14's room. R14				
		itive for COVID-19 on 1/15/22,				
		on her doorway which				
	indicated R14 was i					
	•	ame out of her room with a				
		er face while LPN-F donned a nd directed R14 her back to				
		oceeded to glove her hands				
	and entered R14's					
	and ontolog IVI+31					
	- at 11:13 a.m., R14	exited her room wearing her				
		w her nose, walked down the				
		and NA-E directed R14 to				
	adjust her mask up	. R14 complied and				
		by several residents and staff				
		E did not re-direct R14 back to				
		kited R14's room wearing her				
		N95 mask, walked up to the				
		ed paper towels on nursing				
		gloved her hands. LPN-F				
		their N95 masks, cleaned				
		and donned new N95 masks. I-F wearing a surgical mask				
		N-F directed her to adjust her				
		4 pulling it down, R14				
		king down the hallway back				
	towards her room.	g arms are named, back				
		remained sleeping in the				
		veral residents continued to				
		ies while two staff members				
		taff were observed to redirect				
		m even though he was COVID				
	19 positive.					

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS		` ′	E CONSTRUCTION		SURVEY PLETED		
							С
		00945		B. WING		01/2	25/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	T LLC		HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	Continued From paratitistic and proceeded to donnentering R6 and R2 R6 who had tested 1/12/22, and R22 w COVID-19 on 1/19/doorway which indidroplet isolation preserved to wear from the surgical mask aremoved her N95 mask with her entered the bathrocher surgical mask aremoved her N95 mask with her entered the bathrocher surgical mask aremoved her N95 mask with her entered the bathrocher surgical mask aremoved her N95 mask with her entered the bathrocher surgical mask aremoved her N95 mask with her entered a glass of water and mask and drank the wear the same N95 COVID-19 positive  - at 12:00 p.m., LPI medication cart rev who was negative from the same N95 COVID-19 wheeled medication cart and dispensed pain me medication and he water. LPN-A continuask.	N-A was obsurgical mask eye protectia gown, gloward positive for who had tested 22, had a signated R6 and ecautions.  N-A exited R6 and ecautions.  N-A exited R6 and ecautions.  N-A exited R6 and every protection down the and was not mask. LPN-A was wearing the every proceeded water. LPN R7 pr	donned over the on on. LPN-A ves prior to the medications. COVID-19 on ed positive for gn present on their d R22 were in  6's and R22's and gloves and mask over her on in place. LPN-A hallway, removed observed to walked over to exame N95 mask, COVID-19 chair and N-A handed R7 a ed to pull down his I-A continued to exhaus working a pain pill. LPN-A continued to egative for com up to LPN-A's a pain pill. LPN-A nded R9 the endently with	21390			

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Minnesota Department of Health

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00945	B. WING		l l	C <b>25/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	NHURST AVE			
	OLIMANA DV. OTA		AUL, MN 5510			0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ge 9	21390			
	and R10's room wh	N-A delivered meals to R9's o was negative for COVID-19 wear the same N95 mask.	,			
	cart, walked down t and R27's room wit were known to be n	N-A set up medications at her he hallway and entered R26's h medications in hand, who regative for COVID-19. LPN-A he same N95 mask.				
	mask and donned a mask. NA-E proceed gown, gloves, while eye protection on, a mask over her N95 disposable gown are tested positive for the who was negative for present on their door R12 were in dropled entered the room we R12 and the DON in tray to R11. NA-E resanitized his hands sanitized his hands	E had a face shield on, N95 a surgical mask over his N95 eded to donn a disposable registered nurse (RN)-A had a N95 mask on and surgical mask and began to donn a nd gloves. R11, who had COVID-19 on 1/19/22, and R12 or COVID-19 had a sign proway which indicated R11 and isolation precautions. NA-E with a food tray, delivered it to nanded NA-E another room emoved his gown, gloves, removed surgical mask, and exited the room and the same N95 mask on and				
	COVID-19 on 1/15/ positive for COVID- present on their doc and R24 were in dre RN-A entered R14's tray, delivered it and another room tray a donned a surgical re	4 who had tested positive for 22, and R24 who had tested 19 on 1/15/22, had a sign prway which indicated R14 oplet isolation precautions. It is and R24's room with a room the DON handed RN-A and she delivered it. NA-E mask over the same N95 gown, gloves and entered				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00945	B. WING	<del></del>	1	5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	HURST AVE UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	COVID-19 on 1/19/negative for COVID NA-E delivered the handed another roor room tray on R2's k door.  - at 12:26 p.m. NA-wearing the same hallway to the bathly and washed his hall mask over his N95 gown, gloves and wassist other staff to COVID-19 resident.  - at 2:05 p.m., contiwas in the hallway to COVID-19 testing for wearing a disposal protection and a NSR11 who had tested 1/19/22, wheeled hallway. CAS-A per COVID-19 test on for were no other residence.	ad tested positive for 1/22, and R2's room who was 20-19 while carrying a room tray. The tray to R17 and the DON om tray for R2. NA-E set the ped side table and closed the one of the side table and table and table and table and table and table and table a	21390			
	R11's room, asked complete a COVID CAS-A did not remo completing COVID known to be positiv attempting the test negative. CAS-A in	of gloves. CAS-A entered R11's roommate R12 to -19 test and R12 refused. ove her gown and N95 after -19 testing on R11, who was re for COVID-19, prior to on R12 who was COVID-19 dicated she completed testing times a week for residents and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00945	B. WING		l l	C <b>25/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	-	
THE EST	TATES AT LYNNHURS	TIIC	NHURST AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 11	21390			
	wearing a disposable over her surgical supportection, to enter wearing the same FR11. CAS-A attemprefused who was not seem to be supported by the same of the same	S-A was observed while ble gown, gloves, a N95 mask argical mask and had eye R16's room, CAS-A was PPE she wore while testing bated to swab R16, and she egative for COVID-19.				
	CAS-A stated she had been fit tested years ago for proper N95 mask use, however had not been recently. CAS-A said she had entered the facility with the surgical mask and just placed her N95 mask over it. CAS-A confirmed she mistakenly tested R11, who was known to be COVID-19 positive, and stated she should have changed her PPE after testing R11. CAS-A verified she continued to test other residents while wearing the same gown, surgical mask and N95 mask. CAS-A indicated she had not received any training on infection control practices and was not fit tested for her N95 mask. CAS-A verified other residents were at risk of transmitting the virus to non COVID-19 patients when proper infection control measures were not followed.					
	COVID-19 on 1/19/ negative for COVID observed. After the flushed, R11 was o	a.m., R11 tested positive for 22, R12 and R15's were 19-19 shared bathroom was toilet was heard being bserved to be pulling up his m around his thighs.				
	in his wheelchair, D back to his room ar R11 by placing a m away. R11 pulled hi his chin and wheele	exited his room independently ON attempted to redirect R11 and he refused. DON assisted ask on his face and walked as surgical mask down belowed passed LPN-A and RN-B room area and they did not				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.2.2.1.1	o. oo.u.20o		A. BUILDING:				
		00945	B. WING		I	2 <b>5/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EST	ATES AT LYNNHURS	TIIC	IHURST AVE .UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
21390	himself further dow passing RN-A who room however, did up and R11 complied - at 8:10 a.m. R11 eseveral other resided directed R11 to go room.  - at 8:12 a.m. R11's positioned below himouth, and DON as however did not atthe his room. RN-A broodrink, while other regroom area. RN-A did back to his room.  - at 8:18 a.m. R15 of COVID-19 without a independently out centire length of the staff who did not recon or return to his room area where the his room. R15 refusin a chair in the dinicoffee while R11 was Regional nurse conwear a mask and Rwore a mask in my - at 8:24 a.m. R15 of room area while dri	o his room. R11 wheeled in the hallway and while did not redirect him back to his ask him to readjust his mask ed.  entered the dining room where ents were seated and DON to the other side of the dining as mask was again noted to be so nose and noted only over his sked R11 to readjust his mask empt to redirect him back to high R11 a cup of coffee to esidents remained in the dining id not attempt to redirect R11.  Who was negative for a facemask on, walked of his room and down the hallway passing by several direct him to put a facemask oom. R15 entered the dining he DON asked R15 to eat in sed and proceeded to sit down ing room area and drank has eating his breakfast.  Issultant (RNC) asked R15 to extinate the dining normal of the dini	21390				
	- at 8:25 a.m. R15 s	stood up from his chair in the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00945	B. WING		I	C <b>25/2022</b>
	PROVIDER OR SUPPLIER	TIIC 471 LYN	DDRESS, CITY, S	NUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	dining room, walked hallway to the nurse R15 to go back to h R11 continued to earoom area.  - at 8:43 a.m., R15 independently to the down in a chair, wh dining room area whis chin. RNC asked he refused.  - at 8:48 a.m. RNC up, he complied and dining room area be at 9:28 a.m. the stand R15 was not of by nursing staff or hused it earlier.  On 1/20/22, at 1:57 were expected to when entering a C0 stated staff were exeiting the room indicated staff were exiting the room indicated staff were hands and place a having contact with LPN-F indicated sher N95 mask and wearing her N95 m she only wore a sum mask to provide exemple of the control of the cont	d independently down the es station where RN-A asked his room and R15 complied. at independently in the dining with no facemask on walked e dining room area and sat ile R11 continued to be in the ith his mask positioned below d R15 to put a mask on and asked R11 to adjust his mask d she wheeled him out of the				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00945	B. WING		I	C <b>25/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE ES	TATES AT LYNNHURS	TIIC	IHURST AVE AUL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21390	practice was to kee during the shift and removed the N95 n R22's positive COV sometimes she wo N95 mask for extra had not been traine with every COVID-not changing it the transmitting COVID indicated she had remask either.  On 1/21/22, at 9:14 positive for COVID his activities of dail using the bathroom positive for COVID move R12, howeve R12 was independent with A indepe	ep the same N95 mask on a confirmed she had not mask she wore in R6's and VID-19 room. LPN-A indicated are a surgical mask over her a protection. LPN-A stated she ad to change her N95 mask 19 resident and indicated by possibility existed of D-19 to other residents. LPN-A not been fit tested for her N95 a.m. NA-A verified R11 was a-19 and was independent with y living (ADL's) which included a. NA-A indicated R12 was not and the facility had tried to be the refused. NA- A stated ent with ADL's and used the dently. NA-A indicated R15 was DL's and used the bathroom A stated the usual practice an a shared bathroom after for COVID-19 positive licated he had cleaned R11, athroom earlier that morning and verified R11 had used the st. NA-A confirmed he had not	21390				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00945	B. WING		I .	2 <b>5/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
THE ES	TATES AT LYNNHURS	STIIC	NHURST AVE AUL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21390	wearing his eye prodiscarded a bag of room and sanitized wearing the same is R5's who was COV the him and then in NA-D walked down room, who were CO room to check on the room. NA-D was urgical mask after positive room.  -at 10:57 a.m., NA surgical mask which area and a hairnet to donn a disposab room, who tested positive room, who tested positive room.  -at 10:57 a.m., NA surgical mask which area and a hairnet to donn a disposab room, who tested positive room. NA-C began R20 walked out of his bed. NA-C remented and immedia room. NA-C was not a N95 mask and hamask after exiting in a N95 mask and hamask after exiting in a number of the removed and delivered a metal proceeded to remove and delivered a metal proceeded to remove and her surgical mask, a	otection and surgical mask, garbage in the soiled utility I his hands. NA- D while surgical mask, walked into I/ID-19 negative to check on mediately exited the room. In the hallway to R28 and R29's DVID-19 negative, entered the hem and immediately exited as not observed to change his er exiting R4's COVID-19  -C wore eye protection, and the covered her nose and mouth on her head. NA-C proceeded also gown and entered R19's positive for COVID-19 on an making R19's bed when the bathroom and sat down on oved her gown, washed her ately walked out of R19's ot observed to wear gloves or and not removed her surgical					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00945	B. WING		1	25/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT LYNNHURS	TIIC	IHURST AVE JUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21390	surgical mask over into a COVID-19 por into a COVID-19 por -at at 2:55 p.m, how (HRN)-A walked our protection, a N95 m R6 had tested posith HRN-A proceeded down behind the number HRN-A continued to desk wearing the sishe was taught throughly a surgical mask as the surgical mask and RN-B who had her mouth and expedown the hallway p and RN-B who had her mask or return walk down the hallwarea where other Copresent and sat downarea where other Coprese	buld have been wearing her her N95 mask when going ositive room.  Dispice registered nurse at of R6's room wearing eye hask and sanitized her hands. The for COVID-19 on 1/12/22 to apply a face shield and sat surses desk. At 3:13 p.m., to be seated behind the nurses ame N95 mask. HRN-A stated ough the Hospice agency to ask over her N95 mask and ident's room to only remove and to keep the N95 mask on.  B. a.m., R14 who tested positive aring a surgical mask covering osing her nose. R14 walked ast registered nurse (RN)-Ad not redirected R14 to adjust to her room. R14 continued to way, entered the dining room covid negative residents were with a chair.  B. stood up, walked down the who instructed her to adjust did not comply. RN-A was not at R14 back to her room and walk independently down the ring her mouth.  Teturned into the hallway with g below her nose and only	21390			
		n area. R14 walked to the N-B who was not observed to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00945	B. WING		I	C <b>25/2022</b>
	ROVIDER OR SUPPLIER	TIIC 471 LYNN	DRESS, CITY, SIHURST AVE			
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	adjust her mask. Rimiddle of the dining residents seated and dining room and be to the other resident at 8:12 a.m., R14 shallway with her sur her nose. R14 walk to R14 to adjust her and was not asked room.  -at-9:36 a.m., R14 surgical mask in the hallway past RN her mask and she robserved to redirect continued to walk futhe dining room are continued to be post exposing her nose at R14 and talked to he to redirect R14 back her mask.  - at-9:51 a.m., R14 dining room area wher chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area wher chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area wher chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area where chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area where chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area where chin seated next walked over to the surgical mask.  - at-9:51 a.m., R14 dining room area where chin seated next walked over to the surgical mask.	her room or remind her to 14 sat down in a chair in the 17 room area with multiple ound her. RN-A entered the 18 gan to handout surgical mask to 18 to her down the 19 gical mask positioned below 19 ded past the DON who asked 19 mask. R14 did not comply or redirected back to her 19 was not to R14 back to her room. R14 urther down the hallway into 19 and sat down. R14's mask sitioned below her chin and mouth. LPN A approached we however was not observed to her room or to re-position continued to be seated in the 18 to R15. R14 stood up, 18 smoking room area, when 18 R14 however was not to 18 R14 back to her room or ask	21390			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00945	B. WING		I	C <b>25/2022</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
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R11 if he needed ar no and RN- B instrubathroom call light. himself into the bath bathroom call light. clean or disinfect the done using it.  -at 10:33 a.m., R11' and the toilet was he observed to be wear gown, gloves and a R11's room, asked bathroom and R11 his head up and down shared bathroom. No gown, gloves in the while exiting the room hallway, removed his and sanitized his had cleaning or disinfect R11 used it.  - at 10:44 a.m., R15 room to use the bathroom, verified R15 with the toilet was heard staff or housekeeping cleaning or disinfect after R15 had used  On 1/20/22, at 9:25 not worn a gown or room as he was onl NA-D indicated he says before entering	od in the hallway and asked hything. R11 shook his head acted R11 to turn off his R11 proceeded to wheel proom and shut off the RN -B was not observed to be bathroom after R11 was  s bathroom call light was on eard to be flushing. NA-A was ring eye protection, donning a N95 mask. NA-A entered R11 if he had used the responded to NA-A by shaking who indicating he had used the IA-A proceeded to remove his room and sanitized his hands om. NA-A walked out into the is N95 mask, threw it away ands. NA- A was not observed ting the shared bathroom after to was observed going into his hroom. OTA-A entered R15's was using the bathroom and to be flushing. No nursing a staff were observed ting the bathroom before or	21390				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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21390	Continued From pa	ge 19	21390				
	positive for COVID- to wear full PPE wh gown, gloves and e she only wore her N doing direct cares v positive with COVID not have a N95 ma entered R19's room						
	1/20/22 at 12:00 p.m., administrator-B confirmed R13 was positive for COVID-19-19 and indicated when entering a positive COVID-19 room staff were expected to wear a gown, gloves, eyewear and a surgical mask covering the N95 mask. Administrator-B indicated her usual practice was if she pulled her surgical mask down three times then she needed to change it. Administrator-B confirmed she had worn her N95 mask over her surgical mask when she entered R13's room and verified she was wearing her N95 mask incorrectly.						
	resident was positive expected to place a encourage the residence in the residence of the r	a NA-E indicated when a ve for COVID-19 staff were a sign on the door and were to dent to remain in their room. Idents did not always listen to to come out of their rooms OVID-19. NA-E stated staff wearing a gown, a N95 mask, eves before entering a id before exiting the room they ed their gown and gloves and its. NA-E indicated nursing ation weekly on COVID-19 by in the administration.					
		i RN-A confirmed R14 was -19 and indicated when a					

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		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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resident to expected them to the been weather before en should had hands be staff were the hallward clean surthave end with COV should had rooms if to confirmed room who was protection positive for carrying a cart. R4's identified NA-C verup the maproviding COVID-1 N95 mas meal tray	to place a heir room. aring a government of the expected ay, sanitizing and a literature of the expected ay and the expected at the expected and the expected at the expected and the expected at the expected	itive for COVID-19 state a sign on the door and RN-A stated staff shown, gloves and a N95 cOVID-19 room and stated the gown and saniting the room. RN-A indicated to remove their N95 to their hands and place to remove their nooms are directing them back for their hands and place to redirecting them back forming out of their room not redirected R14 barne out into the hallway and put in on the sering a surgical mask are to f R4's (who had test 19 on 1/15/22) room was a sign on his door who droplet isolation precedid not wear PPE when a sign on his door who droplet isolation precedid not wear PPE when and only wore PPE when and gloves while picking a meal tray to sering a meal	isolate old have mask aff tized cated mask in e a f should ositive and staff to their ns. RN-A ock to her vi.  Int (NA)-C nd eye sted while ving ich autions. In picking le ad earing a ing up  In (FS)-A es left 0-19 on	21390				

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			SURVEY
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21390	Continued From pa	ge 21	21390			
	door had a sign present on his door which indicated R11 was in droplet isolation precautions.					
	the shared bathroot tested positive for C filled a basin with w negative) was seated the door and a curta NA-A proceeded to R17, while he sat on NA-A was done cor R17, NA-A went to the basin water into faucet, rinsed the billed the basin with proceeded to assist his morning cares. Treturned to the shall basin, turned on the emptied the water in while NA-A was still was COVID-19 negathe adjoining room to use the bathroom bathroom into R17's disinfecting the bath bathroom.  1/20/22, at 11:10 a. with NA-C stated shall bathroom.  1/20/22, at 11:10 a. with NA-C indicated she surgical mask for so PPE when providing who had COVID-19 worn N95 masks, g	a.m. NA-A was observed in m of R2, R25, and R17 (who COVID-19 on 1/19/22) and ater. R2 (who was COVID-19 ed on the edge of his bed by ain divided the two residents. provide morning cares for in the edge of his bed. After inpleting morning cares for the shared bathroom, emptied in the toilet, turned on the water asin, emptied it again and soap and water. NA-A again and soap and water. At 8:15 a.m. in the bathroom, R25 (who ative) opened the door from and informed NA-A he needed as room without cleaning or aroom before R25 used the m. during a follow up interview he had sanitized her hands breakfast trays that morning. wore eye protection and a purce control, and wore other g cares in rooms of residents by NA-C indicated she had not owns or gloves when picking D positive residents that				

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· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00945	B. WING		l l	C <b>25/2022</b>
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21390	Continued From pa	ge 22	21390			
	morning.					
	assisted R4 by empand was not able to gown prior to enteriusual practice was gown, gloves, N95 entering any COVID and to dispose of hiroom.  On 1/21/22, at 8:24 not use the bathroom indephad used the bathroothe bathroom prior times R17 would lead to smoke. NA-A redirect residents to	6 a.m. NA-D indicated he had obying his commode earlier or remember if he had applied ing R4's room. NA-D stated he to apply full PPE, including mask and eye protection when D-19 positive residents' rooms is N95 when he exited the sendently. NA-A confirmed R2 own, however R2 and R25 use bendently. NA-A confirmed R2 own right after he had emptied in R25 using it. NA-A stated a lave his room at times to go a indicated it was difficult to be their rooms who were D-19 and to remind them to	a is in S			
	(DON) indicated info	p.m. director of nursing fection preventionist (IP)-A D-19 and DON was infection prevention program				
	while IP-A was out of the last time the fact for N95 masks was	of the facility. The DON state cility had completed fit testing last year, and confirmed not				
	verified she expecte (gown, gloves, eye	t tested at that time. DON ed staff to wear full PPE protection) for any reason				
	to be positive with 0 wearing a N95 mas	sident's room who was knowr COVID-19, which included sk and to remove the N95 oom. The DON indicated this				
	was important to pr	revent the spread of COVID-1 The DON stated the facility	9			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	L COM		E SURVEY PLETED			
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	00945	B. WING		I	C <b>25/2022</b>			
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THE ESTATES AT LYNNHURST	SAINT PA	AUL, MN 551	04					
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for 14 days. The DO to wear a surgical methey were going from room to another resist COVID-19. The DOI expected to remove their N95 mask beforesident's room who to save time. The DOI expected to remove of it after leaving a Condicated staff were mask more than one COVID-19 positive resident and was not mode for PPE supplemental to the facility supplies, and was not mode for PPE supplemental to the facility supplies, and R15 shared R11 was positive for R15 were negative for R15 were negative for R15 were negative for R11, R12 and R15 in bathroom. RN-A stated ithe bathresides and the facility had restated the facility had restated the facility had restated the facility had was known to be CO room who was posit R2 refused to move tried to isolate reside	ho were COVID-19 positive on verified staff were allowed task over their N95 mask, if mone resident COVID-19 ident's room who had nindicated the staff were the surgical mask covering ore entering a different of was positive for COVID-19 on stated staff were their N95 mask and dispose COVID-19 room. The DON allowed to wear their N95 ce if going from one froom and to another. DON by had no concerns with PPE ot in contingency or crisis	21390						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00945	B. WING		01/2	5/2022
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21390	Continued From pa	ge 24	21390			
		ting to his room, and he freely				
		reas. RN-A stated she				
		tempt to redirect R11 back to				
		he was out of his room. RN-A				
	•	cted staff to disinfect the				
		after a COVID-19 resident				
		d it after caring for COVID-19				
		RN-A stated it was important to s who were COVID-19 positive				
		9 transmission from positive				
		e residents. RN-A did not				
		vided any education, or risk				
		to staying in his room.				
	vo porionto rolatoa i	is staying in the reem.				
	On 1/21/22, at 10:03 a.m. LPN-C confirmed					
		positive residents were				
	non-compliant to is	plate in their rooms. LPN-C				
		OVID-19 positive resident left				
		mpted to redirect them back to				
		cated them, however, she				
		y effective for short periods of				
		haviors and refusal to comply.				
		ents who were COVID-19				
	O	red out of their rooms, encouraged to wear masks.				
	,	OVID-19 positive and				
		were out of their rooms at the				
	0	cated it was difficult to keep				
		e to the facility's challenged				
	population.	, 3 -				
	-					
		6 a.m. in a follow-up interview,				
		the facility was in a COVID				
		3 residents who had currently				
		COVID-19. The DON indicated				
		mpting to cohort COVID				
		nd had made some room				
	changes. The DON stated R2 refused to move					

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refused to move out of R11's room who had

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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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who shared bathro known to have CO' move. The DON in staff sanitize the sh COVID-19 positive shift. The DON cor COVID-19 were not and staff attempted sure they were not have COVID-19. TR14 were not comprooms and were our residents who did roonfirmed most of non-compliant.  On 1/21/22, at 11:3 facility had a contract conducted the facil DON indicated she wear proper PPE with gown, gloves and for residents for COVI expected staff to do with positive COVII having exposure to CAS-A had not be control measures be and was not sure if The DON indicated staff was to be proper to COVID-19 to other the facility form title 8/20/21, identified 6 identified 22 staff was to be staff was to be proper to covie the control of the pool of the control of the pool of the	ON indicated those residents oms with residents who were VID-19 had been offered to dicated their plan was to have hared bathrooms used by and negative residents twice a affirmed residents who had being isolated to their rooms do to redirect them, to make around residents who did not he DON confirmed R11 and pliant with isolating to their at in common areas with not have COVID-19, and their residents were  85 a.m. the DON confirmed the fact with an outside vendor who with included eye protection, N95 mask when swabbing D-19. The DON stated she conn new PPE after working D-19 residents and after on them. The DON verified en educated on proper infection by the facility regarding testing of CAS-A had been fit tested. If her expectation for vender perly educated on the use of ested to prevent further spread her residents and staff.  Ided Fit Testing Record updated for staff members. The form were fit tested between 6/18/21, taff members had not received	21390			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY		
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21390	Continued From pa	ge 26	21390				
	(IP)-A confirmed the had provided was the facility had complet confirmed she was last completed N95 2021. IP-A stated frimportant to assure protect the staff metransmitting COVID should have been confirmed if the person hor any changes in the who required a N95 10 confirmed the confirmed that the person hor any changes in the last confirmed that the person had been confirmed to the person had						
	1/25/22, at 1:00 p.n through observation review the facility of whom were COVID negative. The facilit to the resident whom added this to their demployees respons competencies computing testing and the COVID-19. Staff edremains on-going for which included don of COVID-19 positive residents to their ropositive, encouraging hand hygiene for rehigh touch areas. Start of their next shadirect care until eduthat were on leave, in the facility were residents to their next shadirect care until eduthat were on leave, in the facility were residents.	n on 1/21/22, was removed on a when it could be verified an interview and document chorted residents together 19 positive and COVID-19 ty explained risk and benefits an were non-complaint and care plan. The facility sible for testing had colleted for proper PPE usage raining for antigen testing for ucation was initiated and or appropriate PPE usage raining/doffing, proper isolation are residents, redirection of coms who are COVID-19 and surgical mask use and sidents and disinfection of taff were educated prior to the nift and would not provide ucation was completed. Staff on-call and/or not frequently nailed an education packet or ould be completed on the					

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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				, , , , , , , , , , , , , , , , , , ,		
21390	Continued From pa	ge 27	21390			
	phone Lastly audit	s had been conducted on the				
	above interventions					
	Review of facility po	olicy titled, Coronavirus				
		9/2021, indicated the facility				
		o minimize exposure to				
		ns, promptly identify residents				
		s and at risk for COVID-19				
		propriate infection control				
		egies indicated within this				
	policy would remain					
		Ith recommendations to				
		pond to the community spread				
		ease -2019 (COVID-19) healthcare management				
		inue to provide care for our				
		ed within their plan of care				
		ate level of care. Under Facility				
		to place residents in private				
		bathroom (if possible) and				
		contact precautions and				
	cohort residents ide					
		19 conformation, if possible.				
		, Equipment and Supplies:				
	Appropriate PPE (g	loves, gown, mask, eye				
	protection, per isola	ition precautions guidelines)				
		nd removed when entering or				
		esident rooms, per CDC and				
		lth donning and doffing				
		with known or suspected				
		e cared for using all				
		which included use of N95				
		irator. Facilities would optimize				
		ording to the CDC/CMS/				
	Department of Hea	lth current guidelines.				
	The facility docume	nt titled Fit Testing Steps,				
		the mask type for the next				
		ajor changes in facial				
		ain/loss, surgery etc). The				

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		DER/SUPPLIER/CLIA FICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED	
				A. BUILDING:			
		0094	5	B. WING	· · · · · · · · · · · · · · · · · · ·	<b>I</b>	C <b>25/2022</b>
NAME OF PROVIDER O	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT L	YNNHURS	T LLC		HURST AVE UL, MN 551			
PREFIX (EACH	DEFICIENC		DEFICIENCIES LECEDED BY FULL NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
documer different would ne documer mask over the facili Equipme Respirate identified mask used res "just in tire."  SUGGES The adm policies a infection COVID 1 followed staff coul infectious transmiss infection complian and spre	type of reset to be rest identified at identified at identified at identified at the resp. Typolicy tint-Contingors (COVII) during come included pirators. The fit test and procedured proc	ed if the facispirator for a se-tested for d some staff birator to make the designation of the facility of the facility of the policy in the facility of the facility	ility changed to a any reason, they the new type. The ff wore a surgical ake it last longer.  In al Protective Crisis Use of N-95 eak) dated 9/21, capacity the N95 any previously lentified adopting easible.  CORRECTION: could review sure proper ded up to date chniques are uidelines. Facility identifying potential enting appropriate hs, and auditing the veloped to ensure revent exposure infectious diseases.  CTION: seven (7)	21390			

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