



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 2, 2025

Administrator  
The Estates at Lynnhurst LLC  
471 LYNNHURST AVENUE WEST  
SAINT PAUL, MN 55104

RE: CCN: 245394

Cycle Start Date: June 27, 2025

Dear Administrator:

On July 16, 2025, we notified you a remedy was imposed. On August 29, 2025, 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 August 26, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 27, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 16, 2025, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 26, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator  
The Estates at Lynnhurst LLC  
471 LYNNHURST AVENUE WEST  
SAINT PAUL, MN 55104

RE: CCN: 245394  
Cycle Start Date: June 27, 2025

Dear Administrator:

On August 15, 2025, we informed you of imposed enforcement remedies.

On August 13, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not 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.

## **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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 27, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 27, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 27, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

### **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 \$13,343, 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.

If you have not achieved substantial compliance by September 27, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility.

Therefore, The Estates at Lynnhurst LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

### **ELECTRONIC PLAN OF CORRECTION (ePOC)**

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

### **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:

**Lisa Krebs, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
Rochester District Office  
3425 40th Avenue NW, Suite 115  
Rochester, MN 55901  
Email: Lisa.Krebs@state.mn.us  
Office (507) 206-2728**

## **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 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 December 27, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

## **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov>

no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**tamika.brown@cms.hhs.gov**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490**

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [tamika.brown@cms.hhs.gov](mailto:tamika.brown@cms.hhs.gov).

### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:  
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator

THE ESTATES AT LYNNHURST LLC  
471 LYNNHURST AVENUE WEST  
SAINT PAUL, MN 55104

Re: Event ID: 1D3744-H1

Dear Administrator:

The above facility survey was completed on August 13, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/13/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Lynnhurst LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST , SAINT PAUL, Minnesota, 55104</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>On 8/8/25, 8/12/25, and 8/13/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H53941860C (2584309), H53941100C (2570499), H53941582C (2582292), and H53941860C (2584963) with a citation issued at F610.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F0000		08/26/2025
F0610 SS = D	<p>Investigate/Prevent/Correct Alleged Violation</p> <p>CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency,</p>	F0610	<p>Immediate Corrective Action:</p> <p>R1 was protected by placing him and the perpetrator on 15 minute checks, and a smoking schedule was made to keep them separated when smoking.</p> <p>An investigation took place which included gathering statements from those involved, gathering statements from other residents that go out to smoking patio, and also staff that were working that day.</p> <p>A trauma assessment, BIMS and PHQ-9 were completed with both residents and care plans were reviewed and updated.</p> <p>A police report was filed</p>	08/26/2025

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 reverse for further 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.

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

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/13/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Lynnhurst LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST , SAINT PAUL, Minnesota, 55104</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	<p>Continued from page 1 within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to immediately provide resident protections and initiate an investigation for an allegation of unwanted inappropriate physical contact for 1 of 3 residents (R1) who reported R4 inappropriately touched him.</p> <p>Findings include:</p> <p>R1's face sheet dated 8/12/25, identified diagnoses of alcohol dependence and bipolar disorder.</p> <p>R1's progress note dated 7/31/25, identified social service designee (SSD)-A and director of nursing (DON) met with R1 to ask if he was having an intimate relationship with anyone. R1 stated no and then proceeded to explain that another resident sat on his lap and was kissing on him. R1 stated that he asked this resident not to do that again. R1 stated that she stopped after that. This note was written by SSD-A.</p> <p>R1's care plan dated 11/19/24, identified R1 was at risk for decreased cognitive and physical abilities related to bipolar. R1 would remain free from abuse and neglect at the facility. Interventions included: monitor for signs of emotional distress or mood and behavior changes, safety monitoring implemented as needed to ensure resident safety (15-minute checks, 1:1 supervision).</p> <p>R1's care plan did not identify any changes made on 7/31/25.</p> <p>R1's 15-minute handwritten checks began on 8/7/25 at 6:30 p.m.</p> <p>R1's progress note dated 8/8/25 at 1:24 a.m., identified at the start of shift, nurse received report that police will be coming for an investigation about a resident who complained of being forcefully asked by another resident to kiss her. The police came, administrator was called and spoke with them. The police also spoke with the resident.</p> <p>R1's progress note dated 8/8/25 at 7:43 a.m., identified R1 was interviewed and asked if he felt safe in the facility and R1 responded that he did and that it had not happened since. A police report was filed.</p>	F0610	<p>Continued from page 1 Corrective Action as it applies to others:</p> <p>Full house audit was completed by interviewing all residents to determine if they had an incident occur that is reportable.</p> <p>Abuse prohibition/Vulnerable adult policy and the Sexual abuse allegations procedure was reviewed and no changes needed</p> <p>Education:</p> <p>All staff were educated regarding the Abuse prohibition/Vulnerable adult policy and the Sexual abuse allegations procedure.</p> <p>IDT was educated regarding actions to be taken to investigate abuse</p> <p>Date of Compliance: 8/26</p> <p>Recurrence will be prevented by:</p> <p>Audits to be completed 3x a week for 4 weeks to review notes since last audit to ensure any reportable incidents noted were reported to the administrator and the state agency. And if so, that these were investigated</p> <p>Audits to be completed with 5 residents 2x weekly for 4 weeks to ensure no incidents went unreported by interviewing them to determine if they had a reportable incident occur. If so, ensuring they were reported and investigation took place</p> <p>Audits to be completed with 5 staff weekly for 4 weeks by interviewing them to ensure they understand reporting procedures</p> <p>Audits to be completed with 3 IDT staff weekly for 4 weeks by interviewing them to ensure they understand investigating procedures.</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/13/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Lynnhurst LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST , SAINT PAUL, Minnesota, 55104</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	<p>Continued from page 2</p> <p>At 4:55 p.m., director of social service (DSS) spoke with R1 regarding changed in PHQ9 scores from a zero on 8/5/25 to a six on 8/7/25. R1 stated he was feeling more down and sad on 8/7/25 due to feeling uncomfortable after the incident. DSS offered to have R1 move rooms and he refused at this time.</p> <p>R1's care plan dated 8/9/25, identified R1 was a smoker. An intervention dated 8/11/25, identified R1 would smoke during a smoking schedule that ensures he is not on the patio with a resident he has had concerns regarding.</p> <p>R4's face sheet dated 8/13/25, identified diagnoses of bipolar disorder, mood disorder, anxiety disorder, and post traumatic stress disorder.</p> <p>R4's care plan did not identify any changes made on 7/31/25.</p> <p>R4's 15-minute handwritten checks began on 8/7/25 at 6:30 p.m. and ended at 11:45 p.m. One on one Safety Checks dated 8/8/25 began for R4 at 2:00 p.m. No 15-minute sign out sheet or completed one to one safety check was provided for the hours of midnight until 2:00 p.m. on 8/8/25.</p> <p>R4's care plan dated 8/12/25, identified R4 had a history of impulsive reactions, including being physically close to peers and engaging in non-consensual touching. Interventions included redirecting R4 from her peer/encouraging them to be more than arms length away from each other, risk/benefit form completed, provider updated.</p> <p>During an observation on 8/8/25 at 10:24 a.m., R1 and R4 had rooms directly across the hall from each other.</p> <p>During an interview on 8/8/25 at 11:44 a.m., R1 stated he was outside smoking and R4 came outside and put her on his leg, close to his groin and kissed him on the lips and then tried to kiss his cheek. R4 asked R1 to get a motel with her for a couple of nights. R1 refused and R4 told R1 it was his loss. R1 stated he reported the incident to management right after it happened.</p> <p>During an interview on 8/8/25 at 10:33 a.m., R4 stated R1 lied.</p> <p>During an interview on 8/8/25 at 12:17 p.m., SSD-A stated she went out to the smoking patio on 7/31/25, and brought R1 to her office to talk about a separate incident. SSD-A stated the DON was in her office to have this discussion with R1. During the conversation,</p>	F0610	<p>Continued from page 2</p> <p>The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits."</p> <p>Corrections will be monitored by:</p> <p>Administrator/designee</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/13/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Lynnhurst LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST , SAINT PAUL, Minnesota, 55104</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0610 SS = D	<p>Continued from page 3</p> <p>R1 stated that R4 was trying to kiss on him and tried to sit on his lap. He told her to knock it off and she did. We interviewed R4 and she said she would not do it again. The DON and [SSD-A] did not have further discussion about what R1 reported. SSD-A stated they did not interview other residents on 7/31/25, only the two involved in the incident because nobody else had come forward with concerns. Staff would know about the incident because it was in a progress note, that is a big part of reading the notes when the shift starts.</p> <p>During an interview on 8/12/25 at 10:30 a.m., with the DON and Administrator, the DON stated she was not present when R1 made a statement that R4 was physical with him. It would be the expectation that SSD-A would have notified us of the accusation so an investigation could have begun immediately.</p> <p>Facility policy on Abuse dated 4/2025, identified the purpose of the policy included to promptly report, document, and investigate all incidents of alleged abuse/neglect.</p>	F0610		



Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/13/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Lynnhurst LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST , SAINT PAUL, Minnesota, 55104</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.  The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		