Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 23, 2024

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

RE: CCN: 245394
Cycle Start Date: June 4, 2024

Dear Administrator:

On July 19, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2024

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

Re: Reinspection Results
Event ID: MQBX12

Dear Administrator:

On July 19, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 4, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2024

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

RE: CCN: 245394
Cycle Start Date: June 4, 2024

Dear Administrator:

On June 4, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 4, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 4, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: MQBX11

Dear Administrator:

The above facility was surveyed on June 3, 2024 through June 4, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/3/24 and 6/4/24, 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. The following complaints were reviewed: H53943772C (MN00103388), H53945341C (MN00087866), and H53944261C (MN00087402) with a citation issued at F657. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		7/18/24

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

Electronically Signed | 06/27/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise and update a care plan to ensure it was individualized and comprehensive after a resident was admitted onto a locked behavioral unit for 1 of 1 resident (R1) reviewed for transfer from non-secure to secure unit. Findings include: R1's Minimum Data Set (MDS) dated 3/26/24, indicated R1 was admitted on 2/15/24 with diagnoses including non-Alzheimer's dementia, unspecified symptoms and signs with cognitive functions and awareness (an unspecified neurocognitive disorder), hoarding disorder, and other symptoms and sings involving appearance and behavior. R1 was cognitively intact. R1 was ambulatory and required assistance with bathing/showering and toileting hygiene but was otherwise independent with activities of daily living.	F 657	R1 care plan was updated to include resident specific behaviors and interventions. Orders and tasks were updated with resident□s specific behaviors and interventions so that all nursing staff have access to this information. Everyone that has behaviors have the potential to be affected. All residents identified with behaviors had care plans reviewed and revised to include resident specific behaviors and interventions. All residents identified had orders and tasks updated to include their specific behaviors and interventions. Social services and clinical leadership were educated regarding how to assess residents for individualized behaviors and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 R1's provider note dated 2/16/24, noted R1 had a history of "agitation and behavioral issues" and at a previous assisted living facility R1 "became combative, police were called and patient was transferred to hospital." R1's care plan included a focus on alteration in mood and behavior dated 2/19/24, and noted "alteration in mood and behavior" with goals of "resident's mood/behavioral state will remain stable" and "resident will response to interventions by staff to calm and redirect." Interventions dated 2/19/24 included be alert to mood and behavioral changes, monitor and document mood state/behaviors upon occurrence, and medications per doctor's order. Interventions dated 2/28/24 included safety checks as needed, encourage resident to verbalize feelings, praise positive behaviors, monitor and document on mood state, and encourage participation in therapy as this gets resident out of her room and provides socialization. There were no further interventions. R1's Care Conference Form dated 3/4/24, noted "Resident is visibly angry and upset. Her guardian/case worker is a trigger for her. Resident also is upset over house being sold as is dictated by her conservatorship." R1's Target Behavior Form dated 3/20/24, included a review of R1's behavior in the last quarter and noted "Resident has been involved in resident-to-resident altercations. Resident has been the victim of the altercations. Resident has been noted by residents and observed by staff antagonizing other residents in the dayroom. Res[ident] at times will accuse staff of using her	F 657	non- pharmacological interventions and how often to complete those assessments. They were also educated regarding how to enter the behaviors and interventions into the resident□s orders, tasks, and care plan so that all nursing staff members are able to visualize that information. Began education with all nursing staff regarding where to locate information regarding resident□s individualized behaviors and non- pharmacological interventions Will audit 5 residents and any new admit weekly x 5 weeks to ensure care plan, orders and tasks note resident□s specific behaviors and interventions. o The results of these audits will be shared with the facility QAPI committee for input to increase, decrease or discontinue the audits Administrator and/or Designee is responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3 signature to sell her house or not helping her with finding a more permanent placement. Additionally, res[ident] cannot recall conversations accurately. This presents as her believing staff are working against her resulting in her not communicating her needs. Refusing cares, labs, and vitals at times. Has hx [history] of calling 911 regarding her cares and feelings of safety." Potential causes or identified patterns related to behavior included "Subjects like resident's house, placement, and cares trigger resident[']s thinking that staff and others are working against her., When a change in resident[']s daily routine is disrupted or interactions with other residents happen can additionally trigger residents' [sic] thoughts or feelings of safety." Additional comments included "requested order for [psychology clinic] consult." The "care plan reviewed" box was checked and indicated "IDT [inter-disciplinary team] reviewed with no changes." R1's provider orders included an order dated 4/2/24 to monitor mood and behaviors and enter a progress note every shift. A progress note dated 4/5/24, indicated R1 was transferred to the hospital for feeling unsafe. The facility's social worker spoke with the resident's guardian and due to R1's behaviors and mental cognition and diagnosis, the guardian and inter-disciplinary team felt R1 was best suited to residing on the facility's locked unit and would return the next day and admit to the locked unit. A progress note dated 4/6/24, indicated R1 returned from the hospital and was admitted to the locked unit.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 R1's care plan focus on alteration in mood and behavior was revised on 4/8/24, and noted "Resident had recent altercation with another resident. Resident has hx [history] of saying she feels unsafe on the floor due to wanting to get out of the facility. Resident was moved from first floor to second floor due to stating she felt unsafe around residents." Interventions were not added or revised. A provider note dated 4/9/24, indicated R1 was "increasingly agitated." R1's care plan included a focus dated 4/9/24 indicating a risk/benefit form was in place for non-compliance with cares, treatments, lab draws, vital signs against provider orders, and refusing of meals at times. Interventions dated 4/9/24, included a risk/benefit form was completed and on file, provider was updated, to update responsible party if applicable, and update the form as needed. In an interview on 6/4/24 at 8:55 a.m., trained medication aid (TMA)-A stated R1 used to be downstairs but was moved upstairs after she went to the hospital because she had issues with residents downstairs. TMA-A stated R1 had issues with other residents and had behaviors. TMA-A noted R1 self-isolated, refused meals, refused cares, snapped at staff and wasn't verbally "gentle" when conversing with staff, was irritated by staff making noises like moving a chair when providing cares to her roommate, and did not use her call light to request assistance from staff when needed. In an interview on 6/4/24 at 9:11 a.m., the director of nursing (DON) noted R1 resided on the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 facility's locked unit where residents resided for reasons like being an elopement risk, having mental illnesses, or being unsafe in the community. The DON noted R1 couldn't be with other residents who were more cognitively intact, she needed to be on a behavioral unit because she kept having issues and behaviors and was not safe in the community. The DON stated the hospital and R1's guardian "decided she needed to be on the locked unit because of her behaviors." The DON noted R1's behaviors included not telling staff what was going on with her, calling 911, refusing medications, refusing cares, being "very verbally aggressive with staff when she is talking," and not getting along with roommates. The DON noted for residents on the locked unit, the facility did behavior care planning with interventions and for R1 this was about managing her behaviors. She stated she would expect the care plan to include interventions like offering choices, involving residents in their cares, re-approaching, re-directing, documenting risks and benefits, and having incentives or rewards if that worked. In an interview on 6/4/24 at 12:18 p.m., R1's guardian stated R1 had a large history of aggressive behaviors towards staff and he believed she had been beginning to target specific residents as well and this was a long-standing pattern of behaviors. The guardian indicated R1 was moved onto the locked unit in April upon return from the hospital because of increased behaviors. In an interview on 6/4/24 at 12:32 p.m., nursing aide (NA)-A stated she had worked at the facility for a long time and knew the residents inside and out. NA-A stated R1 was a very nice person when	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 she wanted to be nice, but when she wasn't she was "very very difficult." NA-A noted R1 could be aggressive with staff and would yell at them and was especially difficult regarding food. NA-A noted R1 would throw items like the cover on a plate of food she did not want, unused briefs, or her sheets. In an interview on 6/4/24 at 1:02 p.m., registered nurse (RN)-A stated he worked for a nursing staffing agency and had not worked many days at the facility. He noted he would look at R1's chart to see what behaviors and interventions work for her but wasn't sure off the top of his head what behaviors she had. RN-A stated the only thing he was told about is that sometimes R1 could yell about things or be demanding but he was not sure what interventions worked for her. RN-A stated he would look at R1's care plan to see what interventions work for her and noted sometimes interventions stop working over time and the care plan needs to be updated to be current. RN-A stated it would be helpful for him if the interventions that worked for R1 were in the care plan so, as a travel nurse, he would know because he hadn't known R1 that long. In an interview on 6/4/24 at 1:03 p.m., the DON stated staff did behavior care planning for all residents on the locked unit and they should include the resident's behaviors, their vulnerability, the interventions staff have, and outside services offered like psychology consults. The DON stated that depending on an individual resident's behaviors staff tried to come up with interventions that help. The DON confirmed that R1's behaviors were reviewed in the Target Behaviors Form dated 3/20/24 and were identified as involvement in resident-to-resident	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 altercations, refusing cares and labs and vital signs, calling 911 regarding cares and feelings of safety and identified triggers. The DON stated the specific behaviors and triggers should be on R1's care plan. The DON stated it would be important for staff to know R1's triggers and they were not on her care plan. The DON stated she was aware of R1's aggression with staff and noted R1's behavioral care plan did not include aggression towards staff. The DON stated she did not see rejection of cares on R1's behavioral care plan and interventions would be to re-approach, but she did not see interventions for rejections of care on R1's care plan, she only saw the focus on risk/benefits with the intervention that the risk/benefit form for refusal of cares was completed. The DON noted R1 had been referred to the psychology clinic, but this was not on the care plan. The DON stated R1's care plan was "not very comprehensive and specific to her" and "it can be better." The DON stated she would like to add more to the behavioral care plan and be more specific about R1's behaviors with the inclusion of things like R1 refusing cares, the need to reapproach her three times, her known preferences regarding roommates and environment, and identification of why R1 felt unsafe. Facility policy titled Care Planning dated 1/6/22, included "each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs ... The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The goal of the person centered, individualized care plan is to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes."	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/3/24 and 6/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53943772C (MN00103388), H53945341C (MN00087866), and H53944261C (MN00087402) with a licensing order issued at 0565. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise and update a care plan to ensure it was individualized and comprehensive after a resident was admitted onto a locked behavioral unit for 1 of 1 resident (R1) reviewed for transfer from non-secure to secure unit. Findings include: R1's Minimum Data Set (MDS) dated 3/26/24, indicated R1 was admitted on 2/15/24 with diagnoses including non-Alzheimer's dementia, unspecified symptoms and signs with cognitive functions and awareness (an unspecified neurocognitive disorder), hoarding disorder, and other symptoms and sings involving appearance and behavior. R1 was cognitively intact. R1 was ambulatory and required assistance with bathing/showering and toileting hygiene but was	2 565	Corrected.	7/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 otherwise independent with activities of daily living. R1's provider note dated 2/16/24, noted R1 had a history of "agitation and behavioral issues" and at a previous assisted living facility R1 "became combative, police were called and patient was transferred to hospital." R1's care plan included a focus on alteration in mood and behavior dated 2/19/24, and noted "alteration in mood and behavior" with goals of "resident's mood/behavioral state will remain stable" and "resident will response to interventions by staff to calm and redirect." Interventions dated 2/19/24 included be alert to mood and behavioral changes, monitor and document mood state/behaviors upon occurrence, and medications per doctor's order. Interventions dated 2/28/24 included safety checks as needed, encourage resident to verbalize feelings, praise positive behaviors, monitor and document on mood state, and encourage participation in therapy as this gets resident out of her room and provides socialization. There were no further interventions. R1's Care Conference Form dated 3/4/24, noted "Resident is visibly angry and upset. Her guardian/case worker is a trigger for her. Resident also is upset over house being sold as is dictated by her conservatorship." R1's Target Behavior Form dated 3/20/24, included a review of R1's behavior in the last quarter and noted "Resident has been involved in resident-to-resident altercations. Resident has been the victim of the altercations. Resident has been noted by residents and observed by staff antagonizing other residents in the dayroom.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 Res[ident] at times will accuse staff of using her signature to sell her house or not helping her with finding a more permanent placement. Additionally, res[ident] cannot recall conversations accurately. This presents as her believing staff are working against her resulting in her not communicating her needs. Refusing cares, labs, and vitals at times. Has hx [history] of calling 911 regarding her cares and feelings of safety." Potential causes or identified patterns related to behavior included "Subjects like resident's house, placement, and cares trigger resident[']s thinking that staff and others are working against her., When a change in resident[']s daily routine is disrupted or interactions with other residents happen can additionally trigger residents' [sic] thoughts or feelings of safety." Additional comments included "requested order for [psychology clinic] consult." The "care plan reviewed" box was checked and indicated "IDT [inter-disciplinary team] reviewed with no changes." R1's provider orders included an order dated 4/2/24 to monitor mood and behaviors and enter a progress note every shift. A progress note dated 4/5/24, indicated R1 was transferred to the hospital for feeling unsafe. The facility's social worker spoke with the resident's guardian and due to R1's behaviors and mental cognition and diagnosis, the guardian and inter-disciplinary team felt R1 was best suited to residing on the facility's locked unit and would return the next day and admit to the locked unit. A progress note dated 4/6/24, indicated R1 returned from the hospital and was admitted to the locked unit.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 R1's care plan focus on alteration in mood and behavior was revised on 4/8/24, and noted "Resident had recent altercation with another resident. Resident has hx [history] of saying she feels unsafe on the floor due to wanting to get out of the facility. Resident was moved from first floor to second floor due to stating she felt unsafe around residents." Interventions were not added or revised. A provider note dated 4/9/24, indicated R1 was "increasingly agitated." R1's care plan included a focus dated 4/9/24 indicating a risk/benefit form was in place for non-compliance with cares, treatments, lab draws, vital signs against provider orders, and refusing of meals at times. Interventions dated 4/9/24, included a risk/benefit form was completed and on file, provider was updated, to update responsible party if applicable, and update the form as needed. In an interview on 6/4/24 at 8:55 a.m., trained medication aid (TMA)-A stated R1 used to be downstairs but was moved upstairs after she went to the hospital because she had issues with residents downstairs. TMA-A stated R1 had issues with other residents and had behaviors. TMA-A noted R1 self-isolated, refused meals, refused cares, snapped at staff and wasn't verbally "gentle" when conversing with staff, was irritated by staff making noises like moving a chair when providing cares to her roommate, and did not use her call light to request assistance from staff when needed. In an interview on 6/4/24 at 9:11 a.m., the director of nursing (DON) noted R1 resided on the facility's locked unit where residents resided for	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 reasons like being an elopement risk, having mental illnesses, or being unsafe in the community. The DON noted R1 couldn't be with other residents who were more cognitively intact, she needed to be on a behavioral unit because she kept having issues and behaviors and was not safe in the community. The DON stated the hospital and R1's guardian "decided she needed to be on the locked unit because of her behaviors." The DON noted R1's behaviors included not telling staff what was going on with her, calling 911, refusing medications, refusing cares, being "very verbally aggressive with staff when she is talking," and not getting along with roommates. The DON noted for residents on the locked unit, the facility did behavior care planning with interventions and for R1 this was about managing her behaviors. She stated she would expect the care plan to include interventions like offering choices, involving residents in their cares, re-approaching, re-directing, documenting risks and benefits, and having incentives or rewards if that worked. In an interview on 6/4/24 at 12:18 p.m., R1's guardian stated R1 had a large history of aggressive behaviors towards staff and he believed she had been beginning to target specific residents as well and this was a long-standing pattern of behaviors. The guardian indicated R1 was moved onto the locked unit in April upon return from the hospital because of increased behaviors. In an interview on 6/4/24 at 12:32 p.m., nursing aide (NA)-A stated she had worked at the facility for a long time and knew the residents inside and out. NA-A stated R1 was a very nice person when she wanted to be nice, but when she wasn't she was "very very difficult." NA-A noted R1 could be	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 aggressive with staff and would yell at them and was especially difficult regarding food. NA-A noted R1 would throw items like the cover on a plate of food she did not want, unused briefs, or her sheets. In an interview on 6/4/24 at 1:02 p.m., registered nurse (RN)-A stated he worked for a nursing staffing agency and had not worked many days at the facility. He noted he would look at R1's chart to see what behaviors and interventions work for her but wasn't sure off the top of his head what behaviors she had. RN-A stated the only thing he was told about is that sometimes R1 could yell about things or be demanding but he was not sure what interventions worked for her. RN-A stated he would look at R1's care plan to see what interventions work for her and noted sometimes interventions stop working over time and the care plan needs to be updated to be current. RN-A stated it would be helpful for him if the interventions that worked for R1 were in the care plan so, as a travel nurse, he would know because he hadn't known R1 that long. In an interview on 6/4/24 at 1:03 p.m., the DON stated staff did behavior care planning for all residents on the locked unit and they should include the resident's behaviors, their vulnerability, the interventions staff have, and outside services offered like psychology consults. The DON stated that depending on an individual resident's behaviors staff tried to come up with interventions that help. The DON confirmed that R1's behaviors were reviewed in the Target Behaviors Form dated 3/20/24 and were identified as involvement in resident-to-resident altercations, refusing cares and labs and vital signs, calling 911 regarding cares and feelings of safety and identified triggers. The DON stated the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 specific behaviors and triggers should be on R1's care plan. The DON stated it would be important for staff to know R1's triggers and they were not on her care plan. The DON stated she was aware of R1's aggression with staff and noted R1's behavioral care plan did not include aggression towards staff. The DON stated she did not see rejection of cares on R1's behavioral care plan and interventions would be to re-approach, but she did not see interventions for rejections of care on R1's care plan, she only saw the focus on risk/benefits with the intervention that the risk/benefit form for refusal of cares was completed. The DON noted R1 had been referred to the psychology clinic, but this was not on the care plan. The DON stated R1's care plan was "not very comprehensive and specific to her" and "it can be better." The DON stated she would like to add more to the behavioral care plan and be more specific about R1's behaviors with the inclusion of things like R1 refusing cares, the need to reapproach her three times, her known preferences regarding roommates and environment, and identification of why R1 felt unsafe. Facility policy titled Care Planning dated 1/6/22, included "each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs ... The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The care plan shall be used in developing the resident's daily care	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 06/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 9 routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures related to comprehensive care planning. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit to ensure all resident care plans used by staff members are comprehensive and person centered and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		