



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
July 14, 2020

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

**SUBJECT:** SURVEY RESULTS  
CCN: 245394  
Cycle Start Date: July 10, 2020

Dear Administrator:

### **SURVEY RESULTS**

On July 10, 2020, the Minnesota Department of Health completed a complaint investigation at The Estates At Lynnhurst Llc to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the electronically delivered form CMS 2567.

No additional action is required on the facility's part.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <https://qioprogram.org/>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <https://qioprogram.org/locate-your-qio>.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Licensing and Certification Program  
Minnesota Department of Health  
P.O. Box 64900  
St. Paul, MN 55164-0900  
Telephone: (651) 201-4112 Fax: (651) 215-9697  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT LYNNHURST LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>471 LYNNHURST AVENUE WEST</b> <b>SAINT PAUL, MN 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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 7/9/20 and 7/10/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaint was found to be SUBSTANTIATED: H5394091C. However NO deficiencies were cited due to actions implemented by the facility prior to survey.</p> <p>The following complaints were found to be unsubstantiated: H5394090C</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00945</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2020</b>
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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, MN 55104</b>
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 7/9/20 and 7/10/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.</p> <p>The following complaint found to be SUBSTANTIATED: H5394091C, however NO</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>licensing orders were issued.</p> <p>The following complaints were found to be unsubstantiated: H5394090C</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		