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	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Lynnhurst LLC	471 Lynnhurst Avenue West Saint Paul, MN 55104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility staff failed to report an allegation of sexual abuse to the administrator and to the State Agency (SA) within the two (2) hours for 1 of 1 (R4) resident reviewed who had allegations of sexual abuse. Findings include:Review of facility reported incident #360920, dated 6/25/25 at 1:45 p.m., indicated on 6/23/25 at 7:12 a.m. R4 reported to licensed practical nurse (LPN)-D a man put his fingers in her vagina and as also touching her daughter. R3's admission Minimum Data Set, dated [DATE], indicated R3 did not have impaired cognition and had diagnoses of stroke and metabolic encephalopathy. R3 had periods of inattention but no behaviors. Required partial assist with self-care and hygiene and was independent with mobility and transfers.During an interview on 6/27/25 at 9:40 a.m., LPN-D stated R4 informed her of the allegation of sexual abuse around 7:30 a.m., on 6/23/25 that some man was touching her and putting their fingers into R4's vagina. LPN-D attempted to get more information, but R4 was not able to say anything further. LPN-D told nurse manager (NM)-C immediately after she left R3's room. LPN-D explained when there was an allegation of abuse, the allegation would be communicated to her supervisor, then the supervisor would pass the information to director of nursing (DON) and to the administrator. The administrator, DON, and social services were responsible to reporting to the State Agency within two hours. During an interview on 6/26/25 at 3:14 p.m., NM-C stated she received report from LPN-D on 6/23/25 around 7:30 t0 7:45 a.m., NM-C was not aware she was responsible to report the allegations to the DON and administrator immediately. NM-C thought the time from for reporting was 24-hours and not 2-hours. During an interview on 6/27/25 at 9:22 a.m., Administrator stated he was made aware of the allegation of staff to resident sexual abuse on 6/23/25 at 12:42 p.m., 5.5 hours after staff was made aware of the allegation. Administrator had reported to the police immediately after becoming aware. Administrator had reviewed the facility's abuse prohibition policies/procedures and explained staff were supposed to report allegations within two hours of the allegations being made and acknowledged the facility missed the time frame of reporting within two hours. Facility policy titled Sexual Abuse Allegations Procedure, dated 2/2025, indicated:1. The charge nurse will verify that an allegation of criminal sexual conduct has been made, conduct an assessment of the alleged victim, initiate an incident report and immediately call the Administrator and/or DON to determine if 911 should be called.2. The charge nurse will take immediate steps appropriate to the situation to ensure the protection and safety of resident.3. The charge nurse will immediately notify the Administrator. 4. The Administrator, DON or social worker will notify the Department of health as soon as possible after learning of the allegation.6. The charge nurse/nurse manager or the social worker will arrange for a physician to examine the alleged victim as soon as

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise skin integrity care plan for 1 of 3 residents (R2) reviewed for pressure ulcers who had refusal of pressure relieving interventions. R2's face sheet dated 6/26/25, identified the following diagnoses, diabetes, heart failure, presence of prosthetic heart valve, chronic right heel wound, and status post open reduction internal fixation of right hip following a fall. R2's quarterly Minimum Data Set, dated [DATE], indicated intact cognition. R2 had limitations to one side of his lower extremities and used a walker and wheelchair. R2 required maximal assist for person and toilet hygiene, shower and bathing, and transfers. R4 did not walk due to medical condition. R2 had diabetic foot ulcer(s) and surgical wound(s) and received surgical wound cares and application of dressings to feet.R2's wound care order dated 5/29/25, indicated right heel ulcer, R2 to wear suspension boots when in bed.R2's wound care order dated 6/13/25, indicated to cleanse wound with wound cleanser and cover with bordered dressing daily in the morning. R2 to wear heel suspension boots when in bed. R2's alteration in skin integrity related to history of cellulitis to right foot, diabetic wound right heel care plan dated 12/28/24, identified the following interventions-Monitor skin integrity daily during cares and weekly skin inspection by nurse, dated 12/28/24.-Treatment to open areas per order, dated 12/28/24.-Monitor for skin breakdown for signs/symptoms of infection and report to physician, dated 12/28/24.-Document on skin condition and keep physician informed of changes, dated 12/28/24.-Followed by wound care, dated 12/28/24.R2's mood/behavior care plan dated 12/28/24 indicated R2's mood and behaviors would remain stable and R2 would respond to interventions by staff to calm and redirections, however, the care plan did not identify specific behaviors such as (but not limited to) rejection/refusal of care and/or physician ordered treatments. During an observation and interview on 6/25/25 at 1:46 p.m., R2 was lying in bed watching TV, without the suspension boots on as ordered by the physician. R2 stated he could only tolerate the boot for so many hours a day because it was too hot. Licensed practical nurse (LPN)-A completed dressing change to R2's right heel. After completion LPN-A asked R2 if he wanted his suspension boot on. R2 stated yes and LPN-A applied the suspension boots to both lower legs and feet. LPN-A stated R2 refused the suspension boot at times however did not know why R2 refused and did not explain an alternative approach/intervention for when he did refuse. LPN-A reviewed R2's care plan and physician orders and indicated the care plan did not address the suspension boot refusals and confirmed the suspension boot was physician ordered. During an interview on 6/25/25 at 4:00 p.m., director of nursing (DON), stated that with skin concerns the floor nurse is to notify the nurse manager or supervisor of any skin related concerns so that the physician could be notified so that an appropriate wound treatment intervention could be developed, implemented, and monitored. The care plan was to be updated by the nurse manager, DON, or MDS coordinator. DON verified R2's order for the suspension boots and the care plan address the address R2's refusals to wear the suspension boots. The facility policy title Care Planning dated 11/2024, indicated 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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and implement pressure relieving interventions to prevent and/or reduce the risk of re-current pressure ulcers, new pressure ulcers, and/or deterioration for 1 of 3 residents (R3) reviewed for pressure ulcers. Deep-Tissue Injury: Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler than adjacent tissue.Unstageable pressure ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.R3's quarterly Minimum Data Set, dated [DATE], indicated severe impaired cognition, with diagnoses of Alzheimer's left femur fracture and schizophrenia. R3 was noted to be inattentive and have disorganized thinking that comes and goes and continuous altered level of consciousness. R3 was incontinent of bowel and bladder, had an unstageable pressure ulcer, required total assist with cares but did rejected cares 1-3, days during look back period. R3 had pressure reducing device on chair and bed, was on a turning and repositioning program, received nutritional. hydration interventions to manage skin problems, received pressure ulcer care, non-surgical dressing to areas other than feet and application of ointment/medication to areas other than feet. R3 was on hospice. R3's care plan dated 8/1/23, indicated R3 was at risk for alteration in skin integrity due to schizoaffective disorder and dementia. R3 refused podiatry services, nail trims, turn and repositioning, showers, incontinent cares and skin assessments. R3 had an unstageable wound on coccyx/right buttock. Interventions included: -Document on skin condition and keep MD or PA-C informed of changes, dated 8/1/23.-Treatment to open areas per orders, dated 12/14/23.-Air mattress on bed, check function every shift, dated 12/14/23.-Pressure redistribution cushion to wheelchair and chair, dated 12/14/23. R3's progress note dated 6/11/25 at 11:37 p.m., indicated R3's old coccyx wound reopened, measure 3.0 centimeters (cm). Family, hospice and physician notified with orders received to cleanse with wound cleaner and apply dressing, continue to monitor. In review of R3's record, at the time of discovery, there was no indication a comprehensive assessment that defined characteristics of the wound that would include (but not limited to) full measurements, peri-wound condition, sign/symptoms of infection, drainage, and pain. Additionally, aside from the prescribed treatment, there were no immediate pressure relieving interventions added to the care plan. R3's hospice progress notes noted 6/12/25 at 11:45 a.m., indicated R3 was seen by house wound consultant for coccyx wound. Hospice nursing assistant reported redness on left heel, hip, shoulder and ear. Hospice educated facility staff on the importance of repositioning and management of pain. In review of R3's record there was no indication at the time of discovery, comprehensive assessments were completed to the newly discovered wounds to R3's left heel, hip, shoulder and ear nor evident pressure relieving interventions were developed and implemented. R3's Wound physician note dated 6/12/25 indicated the visit was for evaluation and treatment recommendation regarding pressure ulcer to sacrum. She has pain which increases with pressure and movement that is relieved by offloading, rest, and medication. She appears more cachectic and is less aware than her previous visits. The note further described the wound as covered in bruising and therefore will consider it unstageable. No signs/symptoms of infection. Wound measured 1.2 x 3.3 x 0.5 cm depth with Heavy Serosanquinous drainage. The treatment orders included: Cleanse with wound cleanser, apply silicone foam, change every day and as needed. Reposition every 2 hours, alternating pressure mattress, Prostat 30cc (cubic cm) twice per day if this is within patient's goals. It is possible that this is the start of skin failure in the end of life. The physician note did not address any other wounds that were identified on 6/12/25. R3's physician orders included the aforementioned orders however, the only order that was transcribed into R3's Point Click Care (PCC) electronic health record (EHR) on 6/12/25 was Right buttocks, coccyx wound monitor signs and symptoms of infection every shift till resolved, dated 6/12/25. The order for repositioning and Prostat were not transcribed until 6/17/25, and the order for sacral dressing change was not transcribed until 6/20/25. R3's corresponding Treatment administration orders that included the physician orders indicated R3's dressing change was completed from 6/14/25 through 6/19/25, no documentation the dressing change was completed on 6/13/25. R3's Wound physician note dated 6/19/25 indicated reason for visit was the pressure ulcer to sacrum. Wound continues to deteriorate. Now with evolving eschar. No signs/symptoms of infection. Per hospice noteand this writer's observation her overall condition continues to decline. The assessment of the wound identified it as a Stage