

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER The Estates at Lynnhurst LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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. Findings include: R1's face sheet dated 8/12/25, identified diagnoses of alcohol dependence and bipolar disorder. 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. 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). R1's care plan did not identify any changes made on 7/31/25. R1's 15-minute handwritten checks began on 8/7/25 at 6:30 p.m. 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. 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. 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. 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. R4's face sheet dated 8/13/25, identified diagnoses of bipolar disorder, mood disorder, anxiety disorder, and post traumatic stress disorder. R4's care plan did not identify any changes made on 7/31/25. 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. 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. During an observation on 8/8/25 at 10:24 a.m., R1 and R4 had rooms directly across the hall from each other. 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. During an interview on 8/8/25 at 10:33 a.m., R4 stated R1 lied. 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, 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. 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. 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>		