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	07/16/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure sufficient dietary staff were available to prepare and serve meals in accordance with the planned menu and residents' physician-ordered diets for 5 of 5 residents (R1, R61, R52, R62, R23) interviewed regarding food services. This had the potential to affect all 68 residents resided in the facility. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, was able to eat regular diet and ate independently after setup. The facility Diet Type Report dated 7/13/26, identified R1 had ordered regular diet with regular texture. R61's quarterly Minimum Data Set (MDS) dated [DATE], identified R61 had intact cognition and was independent with eating. The facility Diet Type Report dated 7/13/26, identified R61 had ordered renal diet with regular texture. R52's quarterly MDS dated [DATE], identified R52 moderately impaired cognition and was independent with eating. The facility Diet Type Report dated 7/13/26, identified R52 had ordered regular diet with minced and moist texture. R62's quarterly MDS dated [DATE], identified R62 was able to communicate her needs and understand others. A Brief Interview for Mental Status was not conducted. R62 was independent with eating. The facility Diet Type Report dated 7/13/26, identified R62 had ordered regular diet with regular texture. R23's annual MDS dated [DATE], identified R23 had intact cognition, and ate independently. The facility Diet Type Report dated 7/13/26, identified R23 had ordered consistent carbohydrate diet with regular texture. During interview on 7/13/26, at 11:03 a.m., R61 stated the kitchen cook had left the day before, and residents did not receive supper until after 8:00 p.m. R61 stated the facility ordered pizza for everyone, but it was so late by the time they ate. R61 stated not having an evening cook had happened too many times. R61 stated the facility had asked the morning cook to stay and prepare supper, but she refused and went home. R61 stated that was not the first time that had happened.During interview on 7/13/26, at 12:04 p.m., R52 stated he did not receive supper until late the night before. R52 stated he received pizza soup, but it was not good and he could not eat it.When interviewed on 7/13/26, at 12:36 p.m., cook (CK)-A stated there had been no pm cook the day before. CK-A stated the facility could not mandate her to stay, so she left when her shift ended. CK-A stated she had done everything she was supposed to do by sending a group text notifying staff there was no pm cook. CK-A stated CK-B had been scheduled to work; however, CK-B told her he had notified the manager he would not be able to work. CK-A stated dietary aide (DA)-A asked dietary manager (DM)-A if he should make sandwiches, and DM-A instructed him to do so. CK-A stated staff were told the following morning that someone had come in and ordered pizza for all the residents. CK-A stated she did not know what residents with special diets had received because that was not her responsibility.During interview on 7/13/26, at 3:41 p.m., R1 stated there had been no cooks the night before, and residents did not receive supper until after 8:00 p.m., when the facility ordered pizza for them.During interview on 7/13/26, at 3:54 p.m., R23 stated he never received supper the night before. R23 stated that at approximately 7:00 p.m., residents began asking where supper was and complaining they were hungry, so staff handed out either one-half of a ham and cheese sandwich or a peanut butter and jelly sandwich. R23 stated one-half of a sandwich was not enough, (continued on next page)

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

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	07/16/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	so staff ordered pizza; however, he did not get to eat until approximately 9:00 p.m. R23 stated that was not the first time it had happened and he was sure it would not be the last.During interview on 7/13/26, at 4:47 p.m., dietary manager (DM)-A stated he completed the staffing schedules for the kitchen staff. DM-A stated he had regular staff and could also utilize a corporate float team. When there were staffing holes in the schedule, he requested corporate float staff. DM-A stated that if dietary staff did not report for their shift, nursing staff could contact him or the administrator, and many staff also knew how to contact the regional director. DM-A stated there had been unique situations when he could not come in to help. The director of nursing (DON) had a corporate credit card and could order pizza or other food in emergency situations, and nursing staff knew where the disposable dishes were kept. DM-A stated the day before had been a bad situation because neither he nor the administrator had been available when both scheduled pm cooks did not report for their shift. DM-A stated both day-shift cooks had attitudes and refused to stay when the next shift did not report. DM-A stated he was not sure when the pizza had been served to the residents and only knew there had been boxes of pizza in the kitchen. DM-A stated the nurses would know how to prepare pureed or minced and moist foods and believed some had been trained to do so. DM-A stated he did not know whether any residents had not received a supper meal the day before because meal percentages had not been completed. DM-A stated the aides documented who had been fed and how much they ate; however, he would not know that information because it was not his department.During interview on 7/15/26, at 3:34 p.m., R62 stated there had been no pm cook the day before. R62 stated residents did not receive supper until an hour or more after it was due. R62 stated one-half of a sandwich was distributed at approximately 6:30 p.m., and the facility ordered pizza about an hour later. R62 stated she did not notice what residents who could not eat pizza received. R62 stated she remembered a similar incident had occurred shortly after her admission when there had not been a cook for the evening shift. R62 stated she did not think the residents had received anything to eat that time.During interview on 7/15/26, at 4:13 p.m., DA-A stated the cook had not reported to work the day before. DA-A stated he prepared trays with sandwiches and fruit and sent them to the residents. DA-A stated the regional manager later came to the facility and brought pizza. The facility timecards and staffing schedules from June 11, 2026, through July 20, 2026, were reviewed and identified the following:6/12/26: The pm cook was scheduled to work from 12:00 p.m. to 8:00 p.m., punched in at 11:55 a.m., and punched out at 12:58 p.m.6/16/26: The pm cook was scheduled to work from 12:00 p.m. to 8:00 p.m., punched in at 1:39 p.m., and punched out at 2:30 p.m.7/12/26: No pm cook was scheduled, and no pm cook punched in or out for the pm shift. Dietary aide (DA)-A punched in for the scheduled shift from 2:00 p.m. to 8:00 p.m.During interview on 7/16/26, at 10:43 a.m. during interview on 7/16/26, at 10:43 a.m., DM-A stated he frequently had to fill in when the pm cook called in, which had been very difficult for him. DM-A stated the float director supplied float staff when they were available; however, there were only a limited number of float staff. DM-A stated the facility hired staff sporadically, and those hired were not always a good fit for the dietary department. DM-A stated he noted the pm cook had punched in on 6/12/26 and punched out an hour later, which may have been the problem. DM-A stated the pm cook who worked on 6/17/26 would have been a float. DM-A was unable to provide any evidence of a pm cook on the payroll for 6/12/26, 6/17/26, or 7/12/26. DM-A stated the plan when there was no pm cook was to attempt to contact him or the administrator. The administrator would then contact the corporate regional director. DM-A stated he took phone calls after work hours; however, he was not scheduled as formal on-call staff. During telephone interview on 7/16/26, at 11:33 a.m., the dietary regional director (RDM)-B stated she had been contacted by the regional administration and notified the facility did not have a cook for the pm shift on 7/12/26. The culinary director could not be reached, so she notified them she would order and bring pizza to the facility. Upon arrival, RDM-B had staff begin handing out pizza to residents on regular diets while she prepared the alternate diet meals. She filled to-go containers with the prepared alternate diet meals and taped each resident's meal ticket to the appropriate container. She prepared pureed pizza with (continued on next page)

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	07/16/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	applesauce and pudding or a sandwich with diced peaches for residents requiring alternate diets. RDM-B stated she had never previously been required to come in to cover for a pm cook. She stated she did not spend time determining why the shift had not been covered because her priority was to ensure the residents were fed. RDM-B stated that when a pm cook called in, the facility was usually aware by 2:00 p.m., allowing time to arrange coverage for the shift. However, on 7/12/26, the situation occurred at the last minute. RDM-B stated she received the call at approximately 7:00 p.m. and had all residents fed by 8:00 p.m. RDM-B stated she believed management was investigating the incident to determine what had occurred because they wanted to hold the employees accountable. When interviewed on 7/16/26, at 3:15 p.m., DM-A stated he remembered a pm cook had worked on 6/12/26 and 6/17/26; however, he was unable to provide the corresponding timecards. DM-A provided the Daily Labor Report dated 6/12/26, which identified culinary service employees' hours worked; however, the only cooks listed had worked the day shift, and the report did not identify a pm cook. DM-A also provided the Daily Labor Report dated 6/17/26, which identified culinary service employees' hours worked; however, the only cooks listed had worked the day shift, and the pm cook was documented as having worked only 0.75 hours. Another culinary services director was listed as having worked 3.50 hours; however, DM-A stated he believed that employee was in upper management and that the entry was an error because the employee had not worked at the facility that day. Although DM-A recalled pm cooks had worked those shifts, he was unable to provide schedules, timecards, payroll records, or other documentation to support that statement, and the Daily Labor Reports did not identify a pm cook working those shifts. During telephone interview on 7/16/26, at 5:19 p.m., the dietitian (D)-E stated she visited the facility one to two times per week. D-E stated she had not been aware of pm cook staffing issues other than occasionally overhearing DM-A state he had been filling in. D-E stated that if a pm cook did not report for the shift, she would expect the facility to attempt to obtain another cook. If that was not possible, the facility would need to notify the administrator. The administrator could order food, and at that point, the responsibility would fall to upper management. D-E stated that even without a pm cook, the facility would still need to follow the planned menus. She would expect the facility to order appropriate food items to prepare pureed and texture-modified meals. If the facility ordered food from a pizza restaurant, D-E stated staff could coordinate with her and she would assist in identifying menu items appropriate for residents with special diets, such as selecting a white sauce pizza for residents on low-sodium diets. D-E stated residents on renal diets should not receive pizza, although receiving it on one occasion would not be the end, but it was not something they should receive regularly. D-E stated she would assist the facility even if she was not on call. She stated she had not been aware the facility lacked a pm cook on 6/12/26, 6/17/26, or 7/12/26. D-E stated she would have wanted to know the facility's plan going forward and what staff should do if a pm cook did not report for a scheduled shift. D-E stated the facility should have had a written plan of action. The facility policy Food and Nutrition Services, dated October 2017, identified each resident would be provided with a nourishing, palatable, well-balanced diet that met daily nutritional and special dietary needs. Meals and nutritional supplements would be provided within 45 minutes of either the resident request or scheduled mealtimes. Food and nutrition staff would inspect food trays to ensure that the correct meal was provided to each resident and the food appeared palatable and attractive.

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	07/16/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 3 resident (R3) reviewed with an indwelling catheter; and the facility failed to ensure hand hygiene was performed during medication administration for 3 of 4 residents (R8, R44, R54) observed to receive their medications; and the facility failed to ensure laundry services were conducted in a manner to promote sanitary conditions. Findings include: R3 R3's annual Minimum Data Set (MDS) dated [DATE], identified R3 was rarely/never understood, had a cognitive impairment and had diagnoses that included obstructive and reflux uropathy (blockage of urine flow anywhere in the urinary tract), bladder neck obstruction and urine retention. R3 was always continent of bowel and used an indwelling catheter. R3's care plan, revised 6/8/26, identified R3 required EBP due to an indwelling Foley catheter. The care plan directed staff to follow infection control protocols, post an EBP sign on the resident's door, provide treatment for current infections as ordered, explain the reason for the precautions, communicate the need for EBP, and put on and take off appropriate personal protective equipment (PPE) when providing high-contact care. During an observation on 7/14/26 at 8:25 a.m., R3 was lying on the lower half of the bed on his right side wearing a hospital gown with no blankets covering him. R3's catheter leg bag was secured to his left leg. An EBP identifier was displayed next to R3's name on the doorway nameplate, and an EBP sign was posted on the resident's door. A plastic three-drawer tote located in the hallway outside R3's room contained surgical masks, disposable gowns, gloves, and eye protection. Licensed practical nurse (LPN)-C put on gloves and entered R3's room to obtain vital signs but did not put on a gown. R3 sat on the edge of the bed while LPN-C stood in close proximity and applied and removed the blood pressure cuff. LPN-C removed her gloves, performed hand hygiene using alcohol-based hand sanitizer, and retrieved R3's medications from the medication cart. LPN-C then returned to R3's room without putting on gloves or a gown, administered R3's medications, touched the overbed table, water mug, and personal belongings, and exited the room. During an observation on 7/15/26 at 10:31 a.m., NA-G entered R3's room without a gown or gloves and stood against R3's bed with the bed linens touching NA-G's uniforms. NA-G asked R3 if he wanted to freshen up but R3 said no. NA-G exited the room after using hand sanitizer. At 10:44 a.m., NA-G stated staff were made aware a resident needed EPB because EBP was on their doorway name plate and there was a sign on the resident's door. NA-G stated she should have put on a gown before going into R3's room but she was only asking him if he wanted to reposition. If R3 had said yes, NA-G would have put on a gown at that time. However, NA-G stated that her uniform was up against R3's linens and overbed table. Because of this, NA-G should have put on a gown prior to talking to R3. During an observation on 7/15/26 at 4:11 p.m., R3 was sitting at the edge of his bed and registered nurse (RN)-C applied a topical cream to R3's legs. RN-C was wearing gloves, but no gown. At 7/15/26 at 4:14 p.m., RN-C stated staff were only expected to wear a gown when they are emptying R3's catheter. Staff did not need to wear gowns any other time while caring for R3. During an interview on 7/16/26 at 11:27 a.m., RN-B stated she was the nurse manager for R3. All staff (continued on next page)

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	07/16/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were expected to wear a gown and gloves whenever coming into close with R3. During an interview on 7/16/26 at 3:50 p.m., the director of nursing (DON) stated all staff were expected to follow EBP per Centers for Disease Control and Prevention (CDC) guidelines to prevent the possible transmission of infections. During an interview on 7/16/26 at 3:51 p.m., the administrator stated staff to follow EBP per CDC guidelines to prevent possible infections. The facility policy Enhanced Barrier Precautions revised 7/2026, identified it was the practice of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms. EBP refers to the use of gowns and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a [NAME] as well as those at increased risk of [NAME] acquisition (e.g., residents with wounds or indwelling medical devices). 4. High-Contact resident care activities include a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing. HAND HYGEINE R8's diagnosis report dated 7/16/26, identified R8 had diagnoses of depressive disorder, hypothyroidism, dementia, unspecified psychosis, and vitamin D deficiency. R44's diagnosis report dated 7/16/26, identified R44 had diagnoses of chronic obstructive pulmonary disease (COPD) (a condition of the lungs), anxiety disorder, history of alcohol dependence, vitamin B12 deficiency, and epilepsy. R54's diagnosis report dated 7/16/26, identified R54 had diagnoses of neurocognitive disorder with Lewy Bodies (a type of dementia), depressive disorder, insomnia (difficulty sleeping), and high blood pressure. During observation and interview on 7/14/26 at 9:27 a.m., trained medication aide (TMA)-A was prepared medications for R44. TMA-A was not observed to wash or sanitize their hands. TMA-A brought R44 the medications and he took them without difficulty. TMA-A then returned to the medication cart and started to prepare medications for R54. TMA-A did not sanitize or wash their hands. TMA-A then brought R54 their medications and they took them without difficulty. TMA-A then returned to the medication cart and went across the hall to R8's room and prepared their medications. TMA-A did not sanitize or wash their hands. TMA-A entered R8's room and gave them their medications. Once back to the cart TMA-A stated she did not sanitize her hands and only did that if she had some powdery medications or was giving lactulose (a medication used for chronic constipation). During an interview on 7/15/26 at 10:26 a.m., the director of nursing (DON) stated it was expected that staff sanitized their hands before and after preparing medications for a resident and between residents. Washing or sanitizing hands between residents reduces the possibility of spreading illnesses and infections between residents. The facility's Medication Administration policy dated April 2018, identified good hand hygiene (continued on next page)

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	07/16/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(washing hand or sanitizing hands) is to be done before medication was passed, prior to handling any medications, and after coming in contact with a resident. Laundry On 7/15/26 at 10:55 a.m., the soiled laundry room contained a large round yellow soiled laundry bin, two large grey round soiled laundry bins and a square soiled laundry bin. HSK-B stated the laundry shift started at 6:00 a.m., and linens were the first laundry items sorted. No gowns or gloves were available in the soiled laundry room and HSK-A opened the laundry washing room door and pointed out 2 washable gowns hanging from a hook behind the door. There were boxes of gloves as well. HSK-A stated she only wore a gown when she was removing items from the soaking bin, or the laundry was in a biohazard bag. All other times, HSK-A wore only gloves to sort soiled laundry items. During an interview on 7/16/26 at 8:34 a.m., HSK-C stated she was the supervisor for housekeeping, which included laundry. HSK-C stated staff were expected to wear a gown and gloves whenever they were working with dirty laundry and were also expected to remove the gown and gloves prior to working with clean laundry. During an interview on 7/16/26 at 4:56 p.m., the administrator stated staff were expected to follow facility policy regarding sorting of laundry to prevent the spread of infection. A laundry policy was requested but not received.

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	07/16/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide a calm, comfortable, low-stimulation environment appropriate to the needs of residents residing on the secured unit by allowing loud, violent television programming to be played in the common dining area for 2 of 2 residents (R2, R46) reviewed for quality of life. This deficient practice had the potential to adversely affect all 27 residents residing on the secured unit.Findings include:During an observation of the dining room and common area on the facility's secured unit on [DATE] at 11:52 a.m., a large-screen television was positioned in a central location of the dining room, with residents seated directly in front of and beside the television. The television volume was very loud while a movie played. The movie contained dark scenes that could not be clearly viewed unless a resident was seated directly in front of the television. Loud screaming, hollering, gunfire, crying, and weeping were heard throughout the movie, with sudden loud bursts of sound during action scenes.R2's admission Minimum Data Set (MDS) dated [DATE] identified R2 had moderate cognitive impairment. Diagnoses included hemiplegia, generalized anxiety disorder, mild neurocognitive disorder, and cerebral infarction (stroke). R2's care plan, revised [DATE], identified an alteration in mood and behavior. R2 had a history of agitation, verbal behaviors toward others, resident-to-resident altercations, and use of profanities. Interventions included providing written or verbal information about the area, encouraging discussion about the resident's social history, allowing R2 to sit in the hallway and look out the window, redirecting R2 to a quiet area when agitated, offering music with headphones when available, approaching R2 in a calm manner, and maintaining a consistent environment.On [DATE] at 4:17 p.m., R2 was seated in a wheelchair near the dining room/common area. R2 angrily talked to himself, stating he needed to leave the facility because the staff were so fucking stupid. R2 pointed toward the television and stated it was too loud and too dark to see or follow what was happening. R2 repeatedly expressed frustration with the television programming, stated no one could see what was playing, and continued to express a desire to leave the facility.R46's quarterly MDS dated [DATE] identified R46 had moderate cognitive impairment. Diagnoses included dysphagia, restlessness, agitation, seizures, and anxiety. R46's care plan, revised [DATE], identified an alteration in mood and behaviors. Interventions included redirecting R46 by bringing the resident to the day room to watch television and praising positive behaviors.During observation of the evening meal on the secured unit on [DATE] at 6:17 p.m., approximately twelve residents were seated in the dining room as supper was served. A large-screen television remained positioned in the center of the dining room, where residents seated throughout the room were exposed to the programming. The television volume was very loud while a movie played depicting an older man hanging by ropes while two other men repeatedly beat him in the torso. The man's shirt was bloodied, blood was visible on his face, and loud gunfire, shouting, crying, and wailing occurred throughout the scene. Only one resident occasionally looked toward the television.During the same observation, R46 repeatedly wheeled to the light switch and turned the dining room lights off. Several residents immediately shouted for the lights to be turned back on. After staff turned the lights back on, R46 again turned them off. This occurred two additional times. When an unidentified nursing assistant attempted to block R46 from reaching the light switch, R46 appeared increasingly frustrated and struck out at the nursing assistant.During an interview on [DATE] at 6:24 p.m., licensed Practical Nurse (LPN)-E stated the Activity Director selected the movies played in the dining/common area. LPN-E stated the movie playing during supper was not appropriate for residents with dementia and was not appropriate during the evening meal. LPN-E further stated loud, violent movies could contribute to resident anxiety and were not appropriate for dementia care.During an interview on [DATE] at 6:27 p.m., registered Nurse (RN)-A stated the movie was not an appropriate choice for residents and could contribute to increased (continued on next page)

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	07/16/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety.During an interview on [DATE] at 6:28 p.m., activity director (AD)-G stated the facility typically used a program called [NAME], which provided positive news, sports, and comedy programming. AD-G stated the movie playing in the dining room was not part of the [NAME] programming. Because residents often wanted different programming, nursing assistants had access to the television remote control and were permitted to change the channel. AD-G acknowledged residents residing on the secured unit had dementia, cognitive impairment, and aggressive behaviors and stated the facility had previously discussed appropriate television programming.During an interview on [DATE] at 6:36 p.m., LPN-D stated loud, violent movies did not help calm residents and could contribute to increased agitation. LPN-D further stated the dining room environment that evening had not been a low-stimulation environment.During an interview on [DATE] at 10:14 a.m., the director of nursing (DON) stated she believed the television had been programmed through the facility's [NAME] system and had not been aware nursing staff were selecting television programming. The DON stated residents residing on the secured unit had dementia diagnoses and aggressive behaviors and that providing a calm approach and calm environment was one of the primary interventions for dementia care. The DON further stated loud, dark, violent action movies would not create a calm environment and had the potential to increase resident anxiety.The facility's Dementia Training policy, revised [DATE], identified the facility's philosophy was to provide quality long-term care in a loving, caring, and safe environment. The policy further identified staff would receive training on caring for residents with dementia, cognitive impairment, behavioral symptoms, and standards of dementia care.

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	07/16/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to replace a torn, stained mattress and ensure urine-soiled bedding was changed timely for 1 of 1 resident (R46) reviewed for activities of daily living; and failed to remove residents' meal plates, beverages, and utensils from institutional serving trays before meal service for all 27 residents residing on the secured unit.Findings include: R46's quarterly Minimum Data Set (MDS) dated [DATE], identified R46 had moderate cognitive impairment and required maximum assistance with dressing, grooming and toileting hygiene. R46 required moderate assistance with transfers and used a wheelchair for mobility. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety and schizophrenia. On 7/13/26, at 11:46 a.m. R46 was observed wheeling out of his room. R46 stated his bedsheet was wet with urine, and he was going to find staff to change his sheets. On 7/13/26, at 4:04 p.m. R46's room door was open and his bed was not made. A rumpled soiled top sheet was observed on top of R46's mattress. A strong urine odor was present in the room. On 7/15/26, at 11:23 a.m. nursing assistant (NA)-D was observed to wheel R46 to his room to change his soiled pants, provide peri care and change R46's soiled linen. When NA-D removed the soiled fitted sheet from R46's bed, the mattress had a 6-centimeter (cm) tear on the upper right side of the mattress. A large 12 x 12-inch-deep brown dry stain was covering the center of the mattress and various discoloration was scattered over the remaining areas of the mattress. NA-D stated R46's mattress was stained and the rip was in it for a while. NA-D stated he usually did a repair report on things like that. The staff used an online tells system to report broken equipment. NA-D was not sure if R46's mattress was reported or not but that he would be sure to fill one out when he was done with assisting with cares. During interview on 7/15/26, at 1:10 p.m. licensed practical nurse (LPN)-B stated staff put in request for repair to equipment in the facility tells system. That system notified maintenance at the facility, and they could see it right away. The maintenance person was really good about getting to staff request for repairs timely. LPN-B would put in a request to change R46's mattress right away. During interview on 7/15/26, at 3:45 p.m. the maintenance staff (maint)-A stated she had gotten a work order that day to replace the mattress for R46's bed. Maint-A stated they were not informed until that day about the mattress and would bring up a mattress and replace it. A policy was requested for equipment repair; however, none was received. Dining Room The undated facility list identified 27 residents resided on the unit. On 7/13/26, at 12:30 p.m. the noon meal was observed in the second-floor dining area. Ten residents were seated at various tables throughout the dining room. Each resident was eating their meal from a plastic tray which held their plate of food, silver ware and drinks. On 7/14/26, at 8:46 a.m. residents were observed in the second-floor dining area. Each resident was eating their meal from a plastic tray which held their plate of food, silver ware and drinks. On 7/14/26, at 12:10 p.m. residents were observed in the second-floor dining area. Each resident was eating their meal from a plastic tray which held their plate of food, silver ware and drinks. On 7/15/26, at 6:09 p.m. residents were observed in the second-floor dining area. Staff were removing the meal trays from the cart and placing them in front of the residents and did not remove the trays. Each resident ate their meal from a plastic tray which held their plate of food, silver ware and drinks. During interview on 7/15/26, at 6:41 p.m. NA-E stated they do try to serve each table and then go to the next table, that is how it was supposed to be done. He had also worked at other facility's where the plates and utensils were taken off the plastic serving trays and put on the table in front of each resident and it did look more home like when it was done that way, however they did not do that at this facility. When interviewed on 7/15/26, at 6:49 p.m. registered nurse (RN)-A stated the facility served the resident meals on the trays. She was not sure why. The staff used to take the plates off the trays and then put them on the tables in front of the residents, but they had stopped doing that for some reason. It would make the (continued on next page)

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	07/16/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dining room more homelike; she had just never noticed it before. During interview on 7/16/26, at 10:14 a.m. the director of nursing (DON) stated the staff were using the steam cart and dished up the food correctly in the dining area, but when it broke they went to serving resident meals on trays. Resident's meals should not be placed in front of the residents.

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	07/16/2026

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 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 interview and document review, the facility failed to develop and revise comprehensive, person-centered care plans to address resident-specific interventions for leaves of absence (LOAs), including interventions to promote resident safety and staff direction when residents left the facility without notifying staff or signing out, for 2 of 2 residents (R10, R37) reviewed for supervision. Findings include: R10 R10's admission Minimum Data Set (MDS) dated [DATE], identified modified independence with no issues with short term memory and was independent with ambulation. Diagnoses include medically complex condition, diabetic ulcer on foot, and wound infection. Identified did not have a history of falls. R10's elopement risk assessment dated [DATE] identified R10 was a low risk for elopement. R10's dated 4/21/26, identified R10 was a vulnerable adult while residing in the facility. R10 was at risk for decreased cognitive and physical abilities related to diagnoses including diabetes, alcohol use disorder, chronic suicidal ideation. R10 was at risk for decreased cognitive and physical abilities. Interventions included: Staff were directed to: Monitor for signs of emotional distress or mood and behavior changes. Safety monitoring would be implemented as needed to ensure R37's safety (i.e. 15-minute checks, 1:1, etc.) Staff would continue to follow the facility vulnerable adult and abuse reporting policy. The local Ombudsman, Adult Protection, Police and/or state/financial agencies would be notified of any suspected abuse or financial exploitation as needed. R10's progress notes dated 6/1/26 through 7/12/26 identified R10 went on eleven leaves of absence during that period and on three occasions R10 did not sign out. The medical record did not reflect any interventions for when R10 left the facility and what the interventions were in place when R10 did not sign out per the facility policy. During an interview on 7/15/26 at 6:10 p.m., nursing assistant (NA)-N stated R10 frequently left the facility in the evenings. Prior to leaving, the resident was expected to notify the nurse where he was going, provide an approximate return time, and sign the resident sign-out book. During an interview on 7/16/26 at 11:31 a.m., NA-E stated R10 was expected to check with the nurse before leaving to receive any medications needed during the leave and for nursing to determine whether it was safe for the resident to leave. NA-E further stated R10 had previously left without signing out. When staff discovered the resident was gone, they searched the facility and surrounding grounds, and if unable to locate him, they notified the nurse. During an interview on 7/16/26 at 3:15 p.m., licensed practical nurse (LPN)-C stated R10 frequently left the facility and was expected to notify nursing before doing so. LPN-C stated they were unsure whether the resident's frequent leaves of absence were included in the care plan but believed they should have been. (continued on next page)

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	07/16/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/26 at 3:57 p.m., the director of nursing (DON) further stated staff should be able to review the care plan and report sheets to understand the resident's routine and acknowledged that, for a resident who frequently left the facility, those expectations should be reflected in the care plan so staff would know what actions were required. R37: R37's quarterly MDS dated [DATE], identified R37 had mild cognitive impairment and R37 required partial/moderate assistance with bathing/showering and was independent with all other care areas. R37 exhibited no behavior during the assessment period. R37's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 3/24/26, identified R37 had a family for financial and healthcare decisions as needed. Risk factors included: diagnoses of unspecified dementia, agitation, and anoxic brain damage. Other risk factors may include pain, hearing/visual deficits, use of psych medications, communication problems, sleep disturbances, difficulty with activities of daily living, poor decision making, increased risk of safety concerns, mood concerns, and social isolation. R37 had impaired short-term recall and didn't recall what some outside professionals were visiting with him and for what purpose. R37 was his own decision maker and had family to assist with healthcare and financial decisions as needed. R37's MHM Elopement Risk Evaluation V5 dated 6/17/26, identified a score of 1 placing R37 at low risk for elopement. R37's care plan revised 6/24/26, identified R37 was categorically a vulnerable adult while R37 resides in a Skilled Nursing Facility. R37 was at risk for decreased cognitive and physical abilities related to diagnosis including: (list dx of HIV, Anoxic Brain Damage, Mild Intermittent asthma, acute kidney failure, epilepsy, syphilis, sepsis, chronic obstructive pulmonary disease (COPD), and metabolic encephalopathy). Staff were directed to: Monitor for signs of emotional distress or mood and behavior changes. Safety monitoring would be implemented as needed to ensure R37's safety (i.e. 15-minute checks, 1:1, etc.) Staff would continue to follow the facility vulnerable adult and abuse reporting policy. The local Ombudsman, Adult Protection, Police and/or state/financial agencies would be notified of any suspected abuse or financial exploitation as needed. R37's nursing notes identified the following: On 12/12/25 at 2:47 p.m., R37 On 12/12/25 at 2:47 p.m., R37 On 12/12/25, at 2:47 p.m., R37 had not returned from leave of absence (LOA). Writer placed call to R37's telephone number several times with message left. Writer placed call to provider that R37 had not returned from LOA and had not received scheduled medications. Writer updated administrator resident had not returned. On 5/28/26 at 12:35 a.m., R37 stepped out to smoke in the smoking area on the afternoon shift. During rounds, writer discovered R37 was not in the building and was not outside in the smoking area. A voicemail was left to call the facility back, so they were able to confirm R37's whereabouts. The medical record lacked any updates to the care plan regarding safety plans in the community and interventions when R37 did not sign out per facility policy. During an interview on 7/16/26 at 10:55 a.m., registered nurse (RN)-B stated R37's elopement assessment placed R37 at low risk because R37 had always come back before the 24-hour deadline. (continued on next page)

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	07/16/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It's not that he doesn't want to be here or he wanted to leave against medical advice. He just goes out and forgets to sign out. RN-B stated R37's care plan should have been updated with interventions to address R37's failure to sign out and to direct staff on what should occur when R37 did not let staff know when he was leaving and when he was returning. During an interview on 7/16/26 at 3:02 p.m., the DON stated R37 hadn't left the building for greater than 24 hours without notifying staff. It was generally because R37 had forgotten to sign out and staff re-educated R37 when he returned. R37's care plan should have been updated to address R37's failure to sign out and to direct staff on what should occur when R37 did not let staff know when he was leaving and when he was returning. During an interview on 7/16/26 at 3:55 p.m., the administrator stated he expected the resident care plans to be resident centered to ensure the resident's safety. The facility policy Care Planning – Interdisciplinary Team dated 7/21/23, identified the Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: a. The resident's Attending Physician. b. The Registered Nurse who has responsibility for the resident. c. The Dietary Manager/Dietician. d. The Social Services Worker/Social Services Designee responsible for the resident. e. The Activity/TR Director. f. Therapists (speech, occupational, physical ect. (as applicable). g. Consultants (as applicable). h. The Director of Nursing (as applicable). i. The Floor Nurse responsible for resident care (as applicable). j. Nursing Assistants responsible for the resident's care (as applicable0. k. Others as appropriate or necessary to meet the needs of the resident.

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	07/16/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure licensed nursing staff followed manufacturers recommendations when preparing insulin via a NovoLog FlexPen for 1 of 2 residents (R63) reviewed for insulin administration.Findings include: The manufacturer's instructions for the NovoLog injection pen dated March 2023, identified when preparing to administer insulin using the pen clean the end where the needle attaches, install the needle and remove the cap. Dial pen to two units of insulin until you see a drop of insulin coming out of the needle and then dial up the correct dosage. Failure to do so could cause the resident to not receive the correct dosage of insulin. R63's quarterly Minimum Data Set (MDS) dated [DATE], identified R63 had moderate cognitive impairment and a diagnosis of diabetes mellitus (a condition where the body had difficulty regulating its blood sugars). R63's provider's orders dated 6/9/26, identified R63 received NovoLog injection pen (insulin) 100 units/1 milliliter (ml) on a sliding scale (dosage based on blood sugar level) three times a day. On 7/16/26 at 8:25 a.m., licensed practical nurse (LPN)-B reviewed the order for insulin in R63 chart and stated her blood sugar this morning was 183 and would require 4 units of insulin today. LPN-B obtained R63's NovoLog flex pen and supplies and entered the room. LPN-B dialed the pen to two units and depressed the injection button before attaching the needle. LPN-B then cleansed the rubber stopper, attached the needle, dialed four units, and administered the insulin without priming the pen after the needle was attached or verifying that insulin flowed from the needle. LPN-B stated that was the way she always primed the pen. During an interview on 7/16/26 at 11:20 a.m., the director of nursing (DON) stated the expected procedure to administer insulin using a flex pen was to take the cap off the pen, sanitized the top, attach the needle, prime the needle by dialing up two units and watch for a drop of insulin and then dial up the correct dosage and administer to the resident. The facility's Medication and Treatment Orders policy dated 2/2024, and the Medication Pass Checklist Tool dated 1/28/26, did not identify preparing and administering insulin using a NovoLog flex pen.

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	07/16/2026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide assistance with toileting and elimination by ensuring a resident's urinal was emptied and removed before the resident entered common areas for 1 of 4 residents (R33) reviewed for activities of daily living (ADL).Findings include: R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 had moderately impaired cognition. R33 was independent with toilet transfers, required supervision with toilet hygiene and maximum assistance with grooming. R33 was occasional incontinent of bladder. Diagnoses included hemiplegia (paralysis on one side) anxiety, psychotic disorder, unspecified intracranial injury with loss of consciousness, restlessness and agitation. R33's care plan revised 3/30/26, directed staff to assist R33 with toileting every two to three hours and as needed. Staff were to keep the urinal within reach of the bed and offer to bring the resident to the bathroom after meals to prevent voiding on himself. On 7/14/26, at 3:41 p.m. R33 was seated in his wheelchair in the dining room playing bingo with activity staff and other residents. R33 had an uncovered urinal hanging off the left side of his wheelchair arm rest that was a quarter full of yellow liquid. The urinal was open without a lid over the top. During interview on 7/14/26, at 3:55 p.m. registered nurse (RN)-A stated she had not noticed R33 had a urinal hanging off his wheelchair and now noticed that he did and it did have urine in it. RN-A stated the urinal should not be hanging there and should remain in R33's room. There would be a potential for infection if the urinal splashed or spilled. On 7/15/26, at 5:51 p.m. R33 was observed seated in his wheelchair in the dining room eating supper with a number of other residents. A urinal was hanging off the left side of his wheelchair arm rest that was half full of yellow liquid. The urinal was open to the air with no cap to cover it. Nursing assistant (NA)-J approached R33 and asked if he was finished eating. NA-J removed R33's supper tray, urinal was visible hanging off the left side of R33's wheelchair; however, never acknowledged the urinal. During interview on 7/15/26, at 6:51 p.m. RN-A stated she just now noticed R33 had an open urinal with urine in it that was hanging off his wheelchair arm rest. RN-A stated R33 should not have an open urinal with urine in it in the dining room; however, made no attempt to remove the urinal or the resident from the dining room. On 7/15/26, at 6:54 p.m. licensed practical nurse (LPN)-E approached R33 in the dining room, put on gloves and took the half full urinal off of the wheelchair. R33 became very angry and was hollering and attempting to grab the urinal back. The director of nursing (DON) entered the dining room and attempted to reassure and soothe R33. LPN-E was able to remove the urinal from the dining room area. During interview on 7/16/26, at 10:14 a.m. the DON stated R33 should not have a urinal in a common area. Staff should have assisted him to the bathroom and removed the urinal from his wheelchair before he exited his room to go to the dining area. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy updated 3/31/23, identified the facility would provide care and services for hygiene, mobility, elimination, dining, and communication. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.

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	07/16/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide assistance with dressing and personal hygiene, including offering a clean gown and morning grooming, for 1 of 4 residents (R3) reviewed for activities of daily living (ADLs). Findings include:R3 R3's annual Minimum Data Set (MDS) dated [DATE], identified R3 was rarely/never understood and R3 had a severe cognitive impairment. R3 had diagnoses that included ichthyosis vulgaris (a common inherited skin disorder characterized by dry, thick, and scaly skin resembling fish scales. It is primarily caused by a mutation in the FLG gene, which is responsible for producing filaggrin (a protein that helps your skin retain moisture and forms a healthy protective barrier)), major depressive disorder, mixed obsessional thoughts and acts, bipolar disorder, candidiasis of skin and nails (a yeast infection) and anxiety. R3 was always continent of bowel, used an indwelling catheter and partial to moderate assistance with personal hygiene, lower and upper dressing and putting on and taking off footwear.R3's care plan revised 6/8/26, identified R3 was continent of bowel, required assistance of one staff member for dressing and personal hygiene. Staff were directed to provide assistance with peri-cares every morning, at bedtime and as needed. Staff were directed to offer assistance with clothing. R3 often preferred to wear a hospital gown.During an observation on 7/15/26 at 5:52 p.m., R3 was lying in bed on his right side wearing a hospital gown with another hospital gown as a robe and red gripper socks. During an observation on 7/16/26 at 7:20 a.m., R3 was lying in bed wearing the same hospital gown observed the previous evening. The gown and red gripper socks were visibly soiled. R3 was unshaven with approximately one-quarter inch of beard growth, his hair was disheveled, and his room smelled strongly of urine. The catheter leg straps remained attached to R3's left leg while the catheter drainage bag was lying on the floor beside the bed. At 7:24 a.m., nursing assistant (NA)-F entered R3's room and asked R3 if he wanted to put on clothes. R3 responded nightgown. NA-F put on a disposable gown and gloves and stated he was going to change R3's catheter bed bag to a leg bag.At 7:27 a.m., NA-F exchanged R3's catheter bed bag for a leg bag. After cleaning the catheter bed bag, NA-F removed his gown and gloves and told R3 he would see him later. NA-F did not offer to change R3's gown or to provide morning cares for R3. During an interview on 7/16/26 at 7:39 a.m., NA-F stated R3 was already provided morning cares earlier that morning but R3 did not want to shave. NA-F stated he did not know why the catheter leg bag had not been connected during morning cares.During an interview on 7/16/26 at 11:27 a.m., registered nurse (RN)-B stated she was the nurse manager for R3. R3 liked things the same and would become very upset if staff took his things. RN-B stated she believed R3 refused morning cares and that was why R3 was wearing the same gown as the day prior. RN-B stated staff should have offered a clean gown and cares when the catheter leg bag was connected but would speak with staff to determine why it was not done.During an interview on 7/16/26 at 3:50 p.m., the director of nursing (DON) stated staff were expected to offer cares to residents and, if refused, to continue to offer and document. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, identified the facility would provide care and services for the following activities of daily living: bathing, dressing, grooming, and oral care.

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	07/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the care and services needed to safely manage diabetes for 1 of 3 residents (R23) reviewed for diabetes management by failing to assess and monitor the resident after the resident reported concern about low blood sugar during the night following a rapid decrease in blood glucose.Findings include:R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had a mild cognitive impairment and diagnoses that included insulin-dependent type 2 diabetes.R23's care plan revised 2/5/26, identified R23 had a potential for alteration in blood sugar related to diabetes. Staff were directed to monitor for signs and symptoms of high and low blood sugar, monitor blood glucose as ordered, administer scheduled and sliding scale insulin as ordered, encourage bedtime diabetic snacks, and provide ongoing diabetic foot care.R23's nursing progress note dated 7/15/26 at 12:25 a.m., identified R23 had a blood glucose reading of 330 before dinner and received 4 units of sliding scale insulin as ordered. R23 expressed concern about receiving the full insulin dose because of fear the blood sugar would drop during the night. Approximately one hour later, R23's blood glucose had decreased to 97. Staff provided 15 grams of carbohydrates and one glass of juice, after which the blood glucose increased to 160. R23 requested blood glucose checks every two hours during the night because R23 was afraid the blood sugar would fall below 50. The nurse documented the night nurse was notified. However, R23's medical record failed to identify blood glucose monitoring, reassessment, or follow-up during the night.During an interview on 7/15/26 at 3:58 p.m., R23 stated blood sugar problems had occurred the previous evening. R23 stated concern that the blood sugar would continue to drop overnight and requested nursing check the blood sugar twice during the night. R23 stated staff did not check the blood sugar until breakfast the following morning and stated, They don't like checking it.During an interview on 7/16/26 at 11:05 a.m., RN-B stated staff believed the night nurse provided education to R23 and that was why blood glucose was not checked overnight. RN-B stated staff were expected to document resident education, and residents could request blood glucose monitoring if they felt it was needed.During an interview on 7/16/26 at 3:50 p.m., the director of nursing (DON) stated staff were expected to document resident education and provide reassurance when R23 expressed concerns regarding blood sugar levels.During an interview on 7/16/26 at 3:51 p.m., the administrator stated he expected staff to document resident care and provide the care necessary to ensure resident quality of life.The facility Medication Not Available in Medication Cart or in Medication Room in Overflow Bin algorithm undated, identified when a medication/supply was not available staff were to notify the provider and obtain further instruction; call the pharmacy to ensure the medication/supply would be sent on the next delivery and document in the resident medical record. The floor nurse and/or clinical leader was to complete a communication form to update what had happened.The facility policy Combined Federal and Minnesota State [NAME] of Rights undated, identified residents had the right to a prompt and reasonable response to their questions and requests. Residents had the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allowed.

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	07/16/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a television power cord was properly secured and maintained so it did not create an environmental accident hazard for 1 of 1 resident (R46) reviewed for accident hazards; and the facility failed to ensure fall interventions were followed for 1 of 4 residents (R13) reviewed for accidents. Findings include: R46 R46's quarterly Minimum Data Set (MDS) dated [DATE], identified R46 had moderate cognitive impairment and required maximum assistance with dressing, grooming and toileting hygiene. R46 required moderate assistance with transfers and used a wheelchair for mobility. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety and schizophrenia. During observation on 7/13/26, at 11:50 a.m. R46 was in his wheelchair in his room. R46 rummaged through his bedside dresser, looking for items. R46's television was mounted on a wall between the bathroom and his closet. The power cord of the television ran across the closet doors and across the upper drawer of the fixed dresser to plug into a surge protector on the top of the dresser. R46 attempted to open the closet doors in his room to pick out a pair of pants. The television power cord was stretched tightly across the closet doors, preventing the closet door from opening fully unless the cord was lifted away from the doorway. During observation on 7/15/26, at 11:32 a.m. nursing assistant (NA)-D was assisting R46 change his clothes and bedding. NA-D attempted to open R46's closet door to obtain clothing. NA-D had to lift the television power cord up above the closet door in order to open it and pull out the needed clothes. NA-D stated the cord had been positioned that way for approximately one year and could be dangerous because if R46 pulled on the cord in an attempt to open the closet, the television or electrical cord could be damaged or create an injury hazard. NA-D did not know if it had been reported to maintenance or not, but he had never reported it. During interview on 7/15/26, at 1:10 p.m. licensed practical nurse (LPN)-B stated staff were supposed to put a request for repairs in the facility Tells system and that notified maintenance. LPN-B did not know if maintenance was aware of the power cord and she would put in a request right away for it to be fixed. During interview on 7/15/26, at 3:45 p.m. the maintenance staff (maint)-A stated staff put in a work order in the computer in the facility's Tells system. and also kept track by writing the work orders in a notebook. Maint-A stated she had just been notified that day the television for R46 needed to be fixed. Maint-A stated R46 previously had a longer power strip that allowed the television cord to reach the outlet without obstructing the closet doors, and someone had replaced it with a shorter power strip, causing the television cord to be stretched tightly across the closet doorway. The undated facility policy Awair Policy/Procedure identified supervisors would make impromptu inspection tours and effective corrective action and do hazard analysis of their work areas. Employees would report all safety hazards, make safety suggestions and take care of their equipment. (continued on next page)

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	07/16/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13 R13's quarterly MDS dated [DATE], identified R13 had severe cognitive impairment with disorganized thinking and inattention. R13 had verbal behaviors directed towards others 1 to 3 day per week. R13 was dependent on staff for putting on footwear and partial to moderate assist with dressing. It identified R10 as independent with bed mobility and ambulation. Diagnoses included Huntington's disease (an inherited, progressive neurodegenerative disorder that causes nerve cells in the brain to break down over time), psychotic disorder, restlessness and agitation. R13 did not have any falls since the last quarter. R13's care plan dated 6/26/26, identified was at risk for falls and included interventions of ambulating with resident, encourage resident to gripper sock, obtain slip-on shoes, reduce noise, offer snacks with observed running in the hallway and assist her back to her room, offer wheelchair when observed running in the hallway, and redirect resident to slow down when running in the hallway. The undated nurse's aide care sheet identified interventions to try with R10 included to ensure wearing gripper socks. During observation on 7/13/26 at 5:11 p.m., R13 repeatedly exited her room barefoot and ran through the hallway. Staff observed the behavior but did not provide gripper socks or shoes, walk with the resident, redirect her to slow down, or offer other care-planned interventions. During observations on 7/14/26, over approximately 11/2 hours, R13 repeatedly ran in and out of her room fourteen times while barefoot. Staff did not provide footwear, redirect her to slow down. During an interview on 7/14/26 at 4:30 p.m., NA-I stated R13 was difficult to redirect when she was out walking, when staff got closer to her, she would become more agitated. Staff usually step back because we did not want to agitate her and cause a fall. During an interview on 7/15/26 at 4:28 p.m., NA-E and NA-M stated they attempted to get her to wear gripper socks, but R13 became agitated, and would step back and try to reapproach. During an interview on 7/16/26 at 8:03 a.m., The DON stated R10's care plan should be followed to ensure safety.

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	07/16/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure urinary drainage bags were maintained in a manner that reduced the risk of contamination during catheter care for 1 of 2 residents (R3) reviewed for indwelling catheter care.Findings include:R3's annual Minimum Data Set (MDS) dated [DATE], identified R3 was rarely/never understood and R3 had a severe cognitive impairment. R3 had diagnoses that included ichthyosis vulgaris (a common inherited skin disorder characterized by dry, thick, and scaly skin resembling fish scales. It is primarily caused by a mutation in the FLG gene, which is responsible for producing filaggrin (a protein that helps your skin retain moisture and forms a healthy protective barrier)), major depressive disorder, mixed obsessional thoughts and acts, bipolar disorder, candidiasis of skin and nails (a yeast infection) and anxiety. R3 used an indwelling catheter.R3's care plan revised 6/8/26, identified R3 had an alteration in elimination due to has indwelling catheter 16 French (F) 10 milliliter (mL) related to bladder neck obstruction. Staff were directed with the following:Ensure catheter bag is hung on the bed frame and not placed directly on the floor.Use of privacy bag at all times.R3 wears leg bag during day and night bag at night. R3 notifies staff when he wishes staff to switch them from leg bag to night bag and vice versa.During an observation on 7/15/26 at 5:35 p.m., registered nurse (RN)-D entered R3's room with R3's meal tray and stated he was going to empty R3's catheter leg bag. RN-D put on a gown and gloves, then got R3's urine graduate from the bathroom.At 5:37 p.m., RN-D placed the urine graduate directly on the floor prior to draining the catheter bag into the graduate. RN-D opened the drainage port, emptied the urine, and closed the outlet without cleansing the outlet with an alcohol swab. RN-D took the graduate into the bathroom, poured the urine into the toilet then rinsed the graduate with water from the sink.During an observation on 7/16/26 at 7:20 a.m., R3 was lying in bed on his right side. R3 was wearing a catheter leg bag secured to his left leg, while the catheter drainage bag was lying directly on the floor beside the bed. At 7:24 a.m., nursing assistant (NA)-F put on a disposable gown and gloves and stated he was going to change R3's catheter bed bag to a leg bag.At 7:27 a.m., NA-F exchanged R3's catheter bed bag for a leg bag. After cleaning the catheter bed bag, NA-F removed his gown and gloves and told R3 he would see him later.During an interview on 7/16/26 at 7:39 a.m., NA-F stated R3 catheter bed bag should not have been lying on the floor but R3 could have put the catheter bed bag on the floor himself. R3 did not know why the catheter bed bag was not in a privacy bag to act as a barrier.During an interview on 7/16/26 at 3:50 p.m., the director of nursing (DON) stated staff were expected to put R3's catheter bag into a privacy bag to prevent the bag from lying on the floor. The DON stated the catheter kits even came with a privacy bag so one was always available. The facility policy Indwelling Catheter Care Procedure revised 5/2025, identified when emptying the catheter bag, put on new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab and recap the outlet. Measure urine and dispose of it in toilet. Remove gloves and wash hands.

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	07/16/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide appropriate dementia care treatment and services by failing to comprehensively evaluate repeated resident-to-resident altercations, identify behavioral triggers, and develop and implement individualized interventions to prevent recurrence for 1 of 6 residents (R41) reviewed for dementia care; and failed to follow established dementia care interventions for 1 of 6 residents (R13) reviewed for dementia care. Findings include: R41 R41's significant change Minimum Data Set (MDS) dated [DATE], identified R41 had moderate cognitive impairment, required supervision or setup with grooming and eating and was independent with dressing, transfer, ambulation and toileting. R41 exhibited behaviors of rejection of care and wandering one to three days in the observation period. Diagnoses included insomnia, dementia, and anxiety. R41's care plan dated 6/4/26, identified R41 had an alteration in mood and behavior which included repetitive questions, wandering into other's rooms and being involved in resident-to-resident altercations in which R41 was the victim. Interventions included to have psychology clinic to follow, monitor and document mood and behavior on occurrence, praise positive behaviors, approach in a calm manner, if became anxious, to remove from crowded areas, one to one visit and to introduce R41 to other residents with similar interests. A self-care deficit was also identified. R41 was provided with a different color of pillow to carry for forgetfulness and accidentally picking up other resident's pillows. Staff were directed to offer reminders for R41 to carry his special pillow when they saw him carrying a white pillow. R41's progress notes identified the following: 5/6/26, R41 was moved to a new room due to a disagreement with his roommate R6. R6 stated R41 struck him in the eye. R6 calmed significantly after R41 was moved to a different room. 6/20/26, R41 and R60 almost began physically fighting and needed to be separated. R60 claimed R41 took his pillow and then hit him. R41 was restricted to his room until R60 calmed down. 6/25/26, R41 slapped another resident on the hand in the dining room during supper. 7/3/26, R41 kicked R60 in the groin and took his pillow. R60 complained of not feeling safe with R41 and R41 was moved to the room next door. When R41 tried to return to his original room he became combative when nurse attempted to redirect him to his new room. R41 was sent to the emergency room to be evaluated. Review of the medical record following the resident-to-resident altercations on 6/20/26, 6/25/26, and 7/3/26 failed to identify evidence staff reassessed the underlying causes of the behaviors, evaluated the effectiveness of prior interventions, identified individualized behavioral triggers, or revised the resident's dementia care plan with new person-centered interventions. (continued on next page)

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	07/16/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/14/26, at 8:37 a.m. R41 was observed seated in the dining room eating breakfast at a table by himself. An unidentified nursing assistant (NA) removed another resident's breakfast tray to return to the cart. The tray had some food remaining on it as well as a full glass of orange juice. R41 got up and followed the NA, tapping him on the shoulder in a forceful manner and stated give me the f**king juice, give me the f**king juice. R41 was verbally redirected to go back to his table. R41 approached another resident, attempting to take a glass off his tray and stated, you did not want your juice, can I have it? R41 was again redirected to his table. On 7/14/26, at 11:52 a.m. R41 was observed walking to the dining area carrying a pillow with a white pillowcase. R41 put the pillow in a chair in the dining room to sit on. Registered nurse (RN)-E was also seated in the dining room at another table. RN-E stated R41 always liked to have a pillow with him to sit on. As far as she knew, it was a comfort thing for him. During interview on 7/14/26, at 2:39 p.m. NA-H stated R41 was independent with most of his care, although needed reminders at times. R41 did sometimes take things from other rooms and that could set the other residents off. During interview on 7/14/26, at 4:06 p.m. NA-I stated he had seen R41 hit other residents in the past. R41 would go and take things from the other residents such as a pillow and the other resident would want it back. He had seen when R41 had taken R60's pillow and when R60 tried to get it back R41 had kicked R60. The facility put R41 on one-to-one supervision and moved him to a different room, then he would start with that roommate and would have to move rooms again and so on. The staff did one to one supervision with R41 and tried to anticipate what he needed to prevent resident to resident altercations. When interviewed on 7/14/26, at 4:39 p.m. licensed practical nurse (LPN)-B stated R41 accelerated when other residents got loud. The staff tried to keep him away from certain residents. When altercations did occur, they separated the residents and did 15-minute checks. Then they notified the director of nursing (DON) or the administrator and/or call the emergency room. R41 had frequent room changes due to not getting along with his roommates, but she thought the last room change had helped. With the other rooms he resided in, he was by the window and had to go past the roommate's space to go out or to the bathroom and that kind of got the behaviors going. Now R41 did not have to do that, as his bed was by the door and the bathroom. During interview on 7/15/26, at 1:12 p.m. R60 stated he had been R41's roommate but then R41 had come up to R60 when he was in bed and pulled the pillow from under his head and tried to leave the room with it. When R60 tried to get his pillow back, R41 had punched him in the stomach and kicked him in the balls. It had hurt at the time, enough to know he had been punched. R60 reported it to the nurse, and they took R41 out of the room, then the police came and took him, but he came right back. They did put him in the room next door to him after that. R60 stated he was not afraid of R41 but he did not want to be around him or be near him. R60 stated R41 was crazy. When interviewed on 7/15/26, at 4:03 p.m. LPN-D stated she was working when R41 hit R60. R41 liked to wander with his pillow, and he would take other's pillows if he could not find his. R41 took R60's pillow and when R60 tried to get it back, R41 kicked him. R60 reported the incident to her and said he did not feel safe rooming with R41. When R41 was in the common area, LPN-D changed his room. When LPN-D tried to direct R41 to his new room he became combative and punched her in the chest and shoved her into the wall. LPN-D stated R41 had scared her, so she left the room and got the roommate out of the room and called the DON, who instructed her to call 911. LPN-D had filled out a (continued on next page)

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	07/16/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk management report on the incident. LPN-D stated she thought there was a team who reviewed and investigated all the risk management reports in order to prevent further incidents. During interview on 7/16/26, at 10:14 a.m. the director of nursing (DON) stated she was sure R41's care plan addressed his behaviors and what triggered resident to resident altercations, however, was unable to provide documentation of the updated plan of care. The DON stated staff had tried different colored pillowcases in the past, but then other residents wanted that pillow. If they had assigned him a chair in the dining room with a pillow on it, other residents would have just sat in that chair. R41 had a number of room changes but would have altercations with the new roommates as well. The staff had tried a number of things to prevent the resident-to-resident altercations, however, was not able to provide documentation of care planned behaviors, triggers and interventions to try to prevent R41's behaviors. R13's R13's quarterly MDS dated [DATE], identified R13 had severe cognitive impairment with disorganized thinking and inattention. R13 had verbal behaviors directed towards others 1 to 3 day per week. R13 was dependent on staff for putting on footwear and partial to moderate assist with dressing. It identified R10 as independent with bed mobility and ambulation. Diagnoses included Huntington's disease (an inherited, progressive neurodegenerative disorder that causes nerve cells in the brain to break down over time), psychotic disorder, restlessness and agitation. R13's care plan dated 6/26/26, identified R13 had an alteration in mood and behavior related to Huntington's disease as evidenced by running in the hallway, hitting out at staff, refusal of medications and dressing. Interventions included when there was increased activity in the dining room she may benefit from sensory-based activities, providing resident with a calm and quiet environment during periods of agitation. If resident was becoming physical with staff, they should give R10 some space and reapproach or have a different staff help her. In addition, the care plan identified was at risk for falls and included interventions of ambulating with resident, encourage resident to gripper sock, obtain slip-on shoes, reduce noise, offer snacks with observed running in the hallway and assist her back to her room, offer wheelchair when observed running in the hallway, and redirect resident to slow down when running in the hallway. The undated nurse's aide care sheet identified interventions to try with R10 included to ensure wearing gripper socks, offer snacks when meals are late and in between meals when she was running, ensure a quiet environment, offer wheelchair when running in hall. For behavioral episodes ensure R10 and other residents are safe, move R10 out of sight of what or who she was agitated with. Offer some food or drink when agitated (oatmeal products are the most successful). During observation on 7/13/26 at 5:11 p.m., R13 repeatedly exited her room barefoot and ran through the hallway. Staff observed the behavior but did not provide gripper socks or shoes, walk with the resident, redirect her to slow down, or offer other care-planned interventions. During the same observation, the dining room television was playing violent scenes at a volume loud enough to interfere with conversation, despite the care plan identifying the need to reduce environmental stimulation and provide a calm environment during periods of agitation. During observations on 7/14/26, over approximately 11/2 hours, R13 repeatedly ran in and out of her room fourteen times while barefoot. Staff did not provide footwear, ambulate with the resident, redirect her to slow down, or implement other behavioral interventions outlined in the care plan. The (continued on next page)

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	07/16/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was redirected back to her room only once and resumed running again after approximately four minutes, with no additional interventions attempted. During an interview on 7/14/26 at 4:30 p.m., nursing assistant (NA)-I stated R13 was difficult to redirect when she was out walking, when staff got closer to her, she would become more agitated. Staff usually, would step back because we did not want to agitate her and cause a fall. During an interview on 7/15/26 at 4:28 p.m., NA-E and NA-M stated sometimes we offered cookies or pudding when R13 was running around because it seemed like she did that more when she was hungry. They attempted to get her to wear gripper socks, but R13 became agitated, and would step back and try to reapproach. Licensed practical nurse (LPN)-E stated he would check the care plan when he got to work to see if there were any changes. During an interview on 7/16/26 at 8:03 a.m., the DON stated R10 was receptive of help from different staff from time to time. We would approach each day and assess who R10 would prefer that day. When R10 was out and running around we just monitored her, when we tried to intervene R10 would strike out at staff. Sometimes we would offer cookies or snacks to resident to help her calm down or we would have a different staff person approach. New staff were directed to the nurse aide care sheets to identify R10's needs. The DON stated R10's care plan should be followed to ensure good dementia care and safety. A policy for resident assessment was requested; however, none was received.