

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Lynnhurst LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 471 Lynnhurst Avenue West Saint Paul, MN 55104	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584</p> <p>Based on observation, interview and document review, the facility failed to maintain a safe environment when a resident (R23) reported a safety grab bar in the second-floor shower room was loose and the grab bar was not repaired timely. This had the potential to affect all residents who used the second-floor shower. In addition, .</p> <p>Findings include:</p> <p>Grab bar</p> <p>R23's admission minimum data set (MDS) dated [DATE], indicated R23 was cognitively intact, required set up or clean-up assistance only with showers and had a history of falls prior to admission. R23's diagnoses included alcohol dependence, cervicalgia (neck pain) and anemia.</p> <p>R23's care plan dated 5/6/24, indicated R23 was at risk for falls related to alcohol use, vertigo and neck pain.</p> <p>R23's falls care area assessment dated [DATE], indicated R23 had a potential for falls related to history of falls within the previous six months prior to admission.</p> <p>R23's physician order report dated 7/1/24, included, Please check with pt if able to work with him on vertigo-possible [NAME]. maneuver[a procedure to re-align ear canal crystals to relieve vertigo]. And Meclizine HCl Oral Tablet 25 MG .by mouth every 6 hours as needed for dx [diagnoses]: Vertigo.</p> <p>During interview on 7/22/24 at 10:29 a.m., R23 stated the handle in the shower on the second floor has been broken for a while.</p> <p>During observation on 7/22/24 at 10:45 a.m., R23 pointed out the loose grab bar in the second-floor shower. One of the grab bar ends was missing a screw and had one screw hanging out of the wall. R23 grasped the grab bar and easily pulled it away from the wall.</p> <p>During observation and interview on 7/22/24 at 2:43 p.m., nursing assistant (NA)-A confirmed one screw was completely missing and the other one was falling out. NA-A further stated the grab bar was loose and was not sure how long it had been this way. NA-A stated any staff member could enter a work order into the maintenance system with an identified issue.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 7/23/24 at 10:42 a.m., NA-B stated he worked mainly on the first floor and remembered the first-floor shower being down for a short time about two weeks ago. NA-B stated during that time, residents on the first floor would have to go upstairs to use the second-floor shower. NA-B was unaware of the broken grab bar.</p> <p>During follow up interview on 7/23/24 at 10:51 a.m., AM NA-A stated residents would use the grab bar in the shower to assist with transfers to and from the shower chair. NA-A further stated some residents were independent with showers and may stand during the shower and the grab bar would be used for assistance as the soapy floor could be slippery. NA-A stated R23 was independent with showers and that the grab bar should be stable and secure.</p> <p>During observation and interview on 7/23/24 at 10:54 a.m., registered nurse (RN-A) confirmed the grab bar is not secure and it should be. RN-A stated the grab bar was used during patient transfers to and from the shower chair. Independent residents who may stand to shower need the bar for stability as the floor gets slippery from the soap. RN-A stated R23 was independent with showers but was at risk for falls due to his history with falls prior to admission.</p> <p>During observation and interview on 7/23/24 at 11:10 a.m., maintenance director (M)-A stated not aware of the broken grab bar. M-A reviewed the printed work order (WO) list and confirmed a WO for the grab bar with a priority of medium was entered on 6/29/24 and had not been addressed yet. M-A stated the person who entered the WO was the one to set the priority, but he could modify the priority if notified to do so. M-A further confirmed the grab bar was missing two screws and loose and stated it was an accident waiting to happen.</p> <p>During interview on 7/23/24 at 11:25 a.m., director of nursing (DON) stated being aware of the broken grab bar and entering a WO a while ago. DON stated the grab bar was discussed in morning stand up meeting and should have been upgraded to a high priority since it was a resident safety issue and should have been repaired right away. DON further stated the first-floor shower was not working for a short time about two weeks ago, and during that time all residents who desired a shower had to use the second-floor shower. DON confirmed this was after the broken grab bar was identified.</p> <p>During interview on 7/23/24 at 11:46 a.m., administrator stated expectation that [NAME] were reviewed regularly and re-prioritized appropriately. Administration stated a loose shower grab bar was a resident safety issue and should have been moved to a high priority and fixed right away.</p> <p>The facility Open WO list printed 7/23/24, identified, 4168 - rail screw nails came off - medium priority, 2nd floor shower - 6/29/24.</p> <p>Facility policy regarding work orders was requested but not provided.</p> <p>Flies</p> <p>During interview on 7/22/24 at 10:29 a.m., R23 stated there were a lot of flies in the second-floor shower and throughout the building.</p> <p>During observation and interview on 7/22/24 at 10:45 a.m., several small flies noted in second- floor shower room. R23 stated being told they were [NAME] flies.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview on 7/22/24 at 2:43 p.m., nursing assistant (NA)-A confirmed the presence of flies in the second-floor shower room.</p> <p>During observation and interview on 7/23/24 at 11:25 a.m., director of nursing (DON) confirmed flies in her office which was adjacent to the second-floor shower room. DON stated the flies had been an issue for some time and the facility contracted with a pest control company to assist with issues like this.</p> <p>42586</p> <p>In addition, a resident (R1) was observed to have flies in his room and there were flies flying around throughout the facility.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, disorganized thinking, hallucinations, delusions, and a diagnosis of schizoaffective disorder. It further indicated, R1 required substantial assistance from staff with most activities of daily living (ADL) and mobility.</p> <p>During observation on 7/22/24 at 10:20 a.m., R1 was sitting in his room in his wheelchair. The light on the wall next to his closet had approximately 20-30 small flies on it and there were several flying around the room.</p> <p>During observation and interview on 7/22/24 at 10:25 a.m., licensed practical nurse (LPN)-A verified there were flies on the light in R1's room stating they are (the facility) working with an exterminator.</p> <p>During interview on 7/22/24 at 2:28 p.m., family member (FM)-A stated he visited R1 approximately every other day and the only issue he had with the facility was that it wasn't clean and R1 always had flies in his room.</p> <p>Plunkett's service summary report(s) indicated the following:</p> <p>-6/4/24 inspected interior insect light traps and found moderate catches, mostly small [NAME] flies with some other house/blow flies caught on the main level. Replaced glueboards as needed. Will be sending out a proposal soon to get the ball rolling for the fly/rodent cleanout.</p> <p>-6/19/24 I mentioned last visit that we need to get some areas cleaned up to help with fly numbers being seen. One area I highly recommend deep cleaning is the sink area in the breakroom. There is spilled trash and spilled liquids all over this area which is heavily attracting the flies. Eliminating these sources will help numbers being seen in this area as well as breeding sources.</p> <p>-7/11/24 tried to perform fly and rodent cleanout this morning, we need to reschedule due to maintenance scheduling issues.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview on 7/23/24 at 1:44 p.m., nursing assistant (NA)-B and surveyor went downstairs into the breakroom and over to the sink. There were approximately 10-15 small flies sitting on the sink and several flying around the break room. The sink had brown liquid spills on it in several locations. NA-B verified the flies and the unclean sink stating some of the staff spill and don't clean up after themselves, they don't care, it's not just a management problem, it's the employee's too. I try to tell them to clean up after themselves but some of them won't.</p> <p>During an interview on 7/23/24 at 1:48 p.m., the administrator (in training) stated he had been working at the facility for approximately 7 months and the flies have been there since he started. They haven't been there continuously but there seems to be a noticeable flareup every other week. The administrator also stated they've had an exterminator (Plunkett's) coming out once a month to get rid of the flies and the rodent problems. On 6/11/24 the exterminator company came to the facility but decided to reschedule due to a COVID-19 outbreak and having to don/doff personal protective equipment (PPE) between each room and they didn't have time to complete the service. The plan going forward, was for Plunkett's to perform their service and focus on some specific areas of the building such as drain cleaning. Another focus area was the sink in the breakroom. They are also focusing on some resident behaviors that may be contributing to the problem such as feeding the squirrels outside.</p> <p>The facility's pest control policy last revised May of 2008, indicated the facility shall maintain an effective pest control program.</p>		