Electronically delivered
June 14, 2021

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

RE: CCN: 245394
Cycle Start Date: May 27, 2021

Dear Administrator:

On May 27, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 27, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 27, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 05/27/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5394117C (MN73188) and H5394118C (MN73151) , with a deficiency cited at F921. The following complaints were found to be UNSUBSTANTIATED: H5394116C (MN72776). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		7/8/21

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

Electronically Signed | 06/16/2021

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.

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F 921	Continued From page 1 Based on observation and interview, the facility failed to provide a safe and sanitary environment and free of rodent droppings for all residents who dine in the second floor dining room, residents who consume snacks from the dietary room, and residents whose trays were prepared in the Medical Records/Dietary room. On 5/27/21, at 9:49 a.m. rodent droppings were observed on the floor along the far wall of the Medical Records/Dietary room under a large metal rack which was eight feet in length and approximately 18 inches deep. The bottom shelf was 4 inches from the floor. The rack contained dry food storage that included cookies and crackers on the bottom three shelves. Visible droppings covered the floor under the entire rack, and stretched approximately one foot to the left of the rack, and reached the right edge of two stacked boxes that sat the floor. On 5/27/21, at 11:23 a.m. two three-tiered plastic carts were observed in the Medical Records//Dietary room located approximately 16 inches in front of the metal rack. One cart contained four resident serving trays, and the other contained five serving trays. Each tray was uncovered and contained a menu, napkin, utensils, and a ketchup packet. On 5/247/21, at 11:51 a.m. rodent droppings were observed on the second floor dining room floor in the corner around the resident scale. Additional droppings were found in the adjacent corner in the same dining room under the wall air conditioner next to two vending machines. On 5/27/21, at 12:27 p.m. the administrator confirmed there were mouse droppings along the	F 921	What did you do to protect the residents affected? " Resident rooms were de-cluttered, and cleaned on 5/26 and 5/28. " Residents who want to have food or drink in their rooms were provided plastic bins for their food. " New pest control company was contracted and started on 5/26/21 " Increased pest control visits effective 5/26/21 and on-going " Audit of areas where mice could come in from to be completed on 5/28/21 " Contracted housekeeping company came out and completed deep cleans on all rooms. " Facility pest control policy remains current. " Behind the vending machine did not have scheduled cleanings, scheduled cleanings to be scheduled every Friday AM. What did you do to identify other residents who have the potential to be affected? " Pest control and FMD walked through rooms where high activity is reported. " Audit completed in all rooms and offices to see where mice could be coming from on 5/28/21 " Staff education completed on residents who refuse housekeeping services, to involve clinical team to set times to complete cleanings. " Deep cleaning schedule provided to clinical team to assist with deep cleaning. What systematic changes are put in place to prevent recurrence? " Extra pest control company was contracted with facility and continues	

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F 921	Continued From page 2 wall in the Medical Records/Dietary room. On 5/27/21, at 12:28 p.m. registered nurse (RN)-A stated he would not consider the dining room floor to be sanitized. He stated housekeeping had a schedule to deep clean the dining room but did not know the last time it was done. He also stated he witnessed the presence of mice in the past, and maintenance was aware. On 5/27/21, at 12:34 p.m. the housekeeping manager said housekeeping was supposed to clean the Medical Records/Dietary room once a day but they had not cleaned it yet. She confirmed there were old mouse droppings and she would clean it herself. On 5/27/21, at 12:35 p.m. the housekeeping manager stated the dining room area was cleaned two or three times per day, and the area was mopped twice per day. She stated the dining room floor was scrubbed by a machine daily unless there were numerous residents present in the room. She stated the furniture was not moved but they shifted the chairs and mopped around them. She was unsure if they moved the scale in the corner. She observed the rodent droppings and stated that she was not sure when the area was last cleaned. When asked about the droppings next to the vending machines she stated she would not consider it clean. On 5/27/21, at 12:42 the maintenance staff person observed the rodent droppings in the Medical Records/Dietary room and stated that he did not know how long they had been there. He said housekeeping was doing the best they could and he did not know how often they cleaned in that room.	F 921	" Education to staff about decreasing pests in facility completed with staff on 5/27-5/28 " Education to staff regarding keeping back door shut completed on 5/27-5/28 " When sighting a pest, staff need to put exact location in pest control log completed on 5/27-5/28. How do you monitor the effectiveness of the changes? " Maintenance to follow up with pest control logs after each visit to ensure no new/increased activity " Facility will review during QAPI and review frequency and duration based off of results " Ad hoc QAPI was completed on 5/27/21	

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F 921	Continued From page 3 On 5/27/21, at 1:26 p.m. a dietary staff person stated she did not observe any mice in the dietary room in the past two weeks, and would report any rodent sightings to management. She stated it was standard practice at the facility to set up resident breakfast trays on three tiered carts in the dietary room early before the next meal, and the breakfast trays were set up the evening before the morning meal was served. On 5/27/21, at 1:30 p.m. the area under the metal rack in the Medical Records/Dietary room was observed to have been partially cleaned in the easily accessible areas. Small amounts of droppings were still present along the wall under the rack, and more droppings were observed when the two boxes on the floor were moved. Upon further review of the room, additional rodent droppings were noted under the windows on the wall opposite the door. A service report from pest control company-A dated 4/28/21, with a facility entry time of 3:05 p.m. indicated the kitchen exit door that lead outside was open at the time of the inspection. Pest control technician (PCT)-A recommended to keep the door closed when not in use. PCT-A added glue boards in the dietary room for mice activity. The facility pest sighting log contained documentation of rodent sightings on the following dates and facility locations: 4/1/21, laundry room 4/7/21, business office 4/19/21, social services office 4/19/21, two resident rooms, room numbers not documented 5/6/21, dietary office, storage room, kitchen	F 921		

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F 921	Continued From page 4 5/9/21, resident rooms 101 and 102 5/12/21, social services office on first floor 5/24/21, first floor administration office A service report from pest control company-A dated 5/26/21, at 8:55 a.m. indicated the kitchen door was wide open at the time of the inspection, and two mice were removed from the kitchen. The report contained a reminder to keep the kitchen doors closed when not in use to prevent pest entry. PCT-A removed two mice from the Medical Records/Dietary room, replaced the glue boards, and recommended maintenance fix holes in the heat registers and foundation issues. Targeted pests included rates and mice. A service report from pest control company-B dated 5/26/21, noted PCT-B completed an inspection at 12:44 p.m. PCT-B treated wall boards where baseboard heat piping entered the wall and placed glue board traps in high activity areas in the building including four resident rooms and a second floor office.	F 921		

Electronically delivered
June 14, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: OXX411

Dear Administrator:

The above facility was surveyed on May 27, 2021 through May 27, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 05/27/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 05/27/2021, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will	2 000	NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not	

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: H5394117C (MN73188) and H5394118C (MN73151) with a licensing order issued at 1695. The following complaint was found to be UNSUBSTANTIATED: H5394116C (MN72776).	2 000	corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced	21695		7/8/21

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21695	Continued From page 2 by: Based on observation and interview, the facility failed to provide a safe and sanitary environment and free of rodent droppings for all residents who dine in the second floor dining room, residents who consume snacks from the dietary room, and residents whose trays were prepared in the Medical Records/Dietary room. On 5/27/21, at 9:49 a.m. rodent droppings were observed on the floor along the far wall of the Medical Records/Dietary room under a large metal rack which was eight feet in length and approximately 18 inches deep. The bottom shelf was 4 inches from the floor. The rack contained dry food storage that included cookies and crackers on the bottom three shelves. Visible droppings covered the floor under the entire rack, and stretched approximately one foot to the left of the rack, and reached the right edge of two stacked boxes that sat the floor. On 5/27/21, at 11:23 a.m. two three-tiered plastic carts were observed in the Medical Records//Dietary room located approximately 16 inches in front of the metal rack. One cart contained four resident serving trays, and the other contained five serving trays. Each tray was uncovered and contained a menu, napkin, utensils, and a ketchup packet. On 5/247/21, at 11:51 a.m. rodent droppings were observed on the second floor dining room floor in the corner around the resident scale. Additional droppings were found in the adjacent corner in the same dining room under the wall air conditioner next to two vending machines. On 5/27/21, at 12:27 p.m. the administrator confirmed there were mouse droppings along the	21695	corrected	

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	00945	A. BUILDING: _____ B. WING _____	C 05/27/2021

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THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 3 wall in the Medical Records/Dietary room. On 5/27/21, at 12:28 p.m. registered nurse (RN)-A stated he would not consider the dining room floor to be sanitized. He stated housekeeping had a schedule to deep clean the dining room but did not know the last time it was done. He also stated he witnessed the presence of mice in the past, and maintenance was aware. On 5/27/21, at 12:34 p.m. the housekeeping manager said housekeeping was supposed to clean the Medical Records/Dietary room once a day but they had not cleaned it yet. She confirmed there were old mouse droppings and she would clean it herself. On 5/27/21, at 12:35 p.m. the housekeeping manager stated the dining room area was cleaned two or three times per day, and the area was mopped twice per day. She stated the dining room floor was scrubbed by a machine daily unless there were numerous residents present in the room. She stated the furniture was not moved but they shifted the chairs and mopped around them. She was unsure if they moved the scale in the corner. She observed the rodent droppings and stated that she was not sure when the area was last cleaned. When asked about the droppings next to the vending machines she stated she would not consider it clean. On 5/27/21, at 12:42 the maintenance staff person observed the rodent droppings in the Medical Records/Dietary room and stated that he did not know how long they had been there. He said housekeeping was doing the best they could and he did not know how often they cleaned in that room.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00945	A. BUILDING: _____ B. WING _____	C 05/27/2021

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21695	Continued From page 4 On 5/27/21, at 1:26 p.m. a dietary staff person stated she did not observe any mice in the dietary room in the past two weeks, and would report any rodent sightings to management. She stated it was standard practice at the facility to set up resident breakfast trays on three tiered carts in the dietary room early before the next meal, and the breakfast trays were set up the evening before the morning meal was served. On 5/27/21, at 1:30 p.m. the area under the metal rack in the Medical Records/Dietary room was observed to have been partially cleaned in the easily accessible areas. Small amounts of droppings were still present along the wall under the rack, and more droppings were observed when the two boxes on the floor were moved. Upon further review of the room, additional rodent droppings were noted under the windows on the wall opposite the door. A service report from pest control company-A dated 4/28/21, with a facility entry time of 3:05 p.m. indicated the kitchen exit door that lead outside was open at the time of the inspection. Pest control technician (PCT)-A recommended to keep the door closed when not in use. PCT-A added glue boards in the dietary room for mice activity. The facility pest sighting log contained documentation of rodent sightings on the following dates and facility locations: 4/1/21, laundry room 4/7/21, business office 4/19/21, social services office 4/19/21, two resident rooms, room numbers not documented 5/6/21, dietary office, storage room, kitchen 5/9/21, resident rooms 101 and 102	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21695	Continued From page 5 5/12/21, social services office on first floor 5/24/21, first floor administration office A service report from pest control company-A dated 5/26/21, at 8:55 a.m. indicated the kitchen door was wide open at the time of the inspection, and two mice were removed from the kitchen. The report contained a reminder to keep the kitchen doors closed when not in use to prevent pest entry. PCT-A removed two mice from the Medical Records/Dietary room, replaced the glue boards, and recommended maintenance fix holes in the heat registers and foundation issues. Targeted pests included rates and mice. SUGGESTED METHOD OF CORRECTION: The administrator or designee could create policies and procedures, educate staff on perform environmental rounds/audits periodically to ensure building maintenance is adequately completed. The administrator or designee could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		