DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5CLL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00928

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E508**

2.STATE VENDOR OR MEDICAID NO.
(L2) **314243400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAYES RESIDENCE**
(L4) **1620 RANDOLPH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55105**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 03/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/26/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 4/12/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24E508

At the time of the Health standard survey completed January 31, 2013 and at the time of the Life Safety Code standard survey completed on February 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 31, 2013, effective March 8, 2013. See the attached CMS-2567B form for the results of the March 19, 2013 revisit.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24E508

March 26, 2013

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, Minnesota 55105

Dear Ms. Reynolds:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 8, 2013 the above facility is certified for:

40 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 40 nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

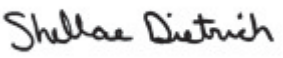
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, Minnesota 55105

RE: Project Number SE508023

Dear Ms. Reynolds:

On February 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health for a standard survey, completed on January 31, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 31, 2013, effective March 8, 2013 and therefore remedies outlined in our letter to you dated February 20, 2013, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File E508sr13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building B. Wing	3/19/2013

Name of Facility	Street Address, City, State, Zip Code
HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/08/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/08/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/08/2013**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/08/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/08/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/08/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/08/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/sd	03/26/13	16022	03/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/31/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, Minnesota 55105

RE: Project Number FE508022

Dear Ms. Reynolds:

On March 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Public Safety for a standard survey, completed on February 20, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the February 20, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File E508lscr13.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5CLL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00928

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E508**
2.STATE VENDOR OR MEDICAID NO.
(L2) **314243400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAYES RESIDENCE**
(L4) **1620 RANDOLPH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55105**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/31/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B***,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 03/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24E508

At the time of the standard survey completed February 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5CLL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L3) **HAYES RESIDENCE**
(L4) **1620 RANDOLPH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55105**

4. TYPE OF ACTION: **2** (L8)
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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/31/2013** (L34)

8. ACCREDITATION STATUS: __ (L10)
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7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
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__ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
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__ 8. Patient Room Size
__ 9. Beds/Room

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14. LTC CERTIFIED BED BREAKDOWN

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		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 03/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
3-22-13 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

CCN# 24E508

At the time of the standard survey completed February 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6171

February 20, 2013

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, Minnesota 55105

RE: Project Number SE508023

Dear Ms. Reynolds:

PLEASE NOTE: This survey is being processed in two seperate enforcement cycles. Attached is the health portion of the enforcement cycle.

On January 31, 2013, a standard 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 12, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 12, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 1, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 31, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

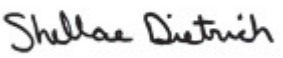
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File E508s13health.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F000: Preparation, submission & implementation of this Plan of Correction does not consitute an admission of or agreement with the facts & conclusions set forth on the survey report. Our Plan of Correction is prepared & executed as a means to continuously improve the quality of care & to comply with all applicable state & federal regulatory requirements.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility did not maintain sanitary, comfortable, and orderly rooms for bathing and activity programs, which had the potential to affect approximately 20 of the 38 residents in the facility. Findings include: During environmental tour observations on 1/31/13, at 9:30 a.m. the bathtub in room M11 contained surface gouges, chips, and protrusions caused by a chair lift apparatus used in this tub, resulting in rough and sharp surfaces on the tub interior. In the activity room, one blue reclining chair had	F 253 3/4/13 SER	F253: • Information regarding the bath-tub condition & condition of two chairs has been presented in education/re-education to all staff. • The two chairs in question have been disposed of immediately. All other chairs of similarity have been checked & no problems have been identified. • Service provider has been contacted for repair of bath-tub. All other bath-tubs have been checked & no problems have been identified. • The Maintenance Director/designee will conduct random audits to monitor compliance. Maintenance Director will report progress of audits to CQI Committee.	03/08/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/28/13

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 253	Continued From page 1 many rips and tears in the upholstery with large strips of upholstery hanging from the arms of the chair, and the seat of one straight back chair was heavily soiled with dark stain marks. The director of maintenance was present on the environmental tour and stated that he would take care of these issues.	F 253	F253 continued... • The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compiance noted. • Maintenance Director is responsible.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care planning interventions for 1 of 1	F 279	F279: • Information regarding the comprehensive plan of care has been presented in education/re-education to all staff. • Comprehensive plans of care for R(36) & R(38) have been updated. For all other residents that may be affected, care plans have been checked & no problems have been identified. • The DNS/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. • DNS is responsible	03/08/2013

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F 279	Continued From page 2 residents (R36) in the sample identified as having change in behaviors and 1 of 1 residents(R38) in the sample identified as having weight loss. R36 lacked care planning interventions related to refusal of evaluation or cares and the use of alcohol. R36 had diagnoses that included major depressive disorder, underweight and acute kidney failure. The most recent minimum data set (MDS), dated 12/20/12 identified R36 with no cognitive impairment, had increase verbal behaviors such as yelling, and resisting cares compared to the admission MDS dated 10/3/12. Progress notes in the medical record indicated behaviors with the use of alcohol. The progress note on 12/29/12 indicated " Res returned to facility getting out a light colored vehicle he was staggering out of and from the vehicle, as well as up facility stairs showing possibility of being intoxicated...' A progress note, dated 12/31/12 indicated "Administration has spoke to {resident's name} twice now in the last 10 days regarding ingestion of etoh..." Progress note dated 1/7/13, read "{resident's name} is viewed in hallway yelling about another resident being on the resident phone too long...In addition, when business office staff person went to {resident's name} room to deliver mail, there was smell of ETOH within room confines. Again Asst.Adm/owner spoke to {resident's name}. {resident's name} owned up to drinking beer, IDT mtg will meet regarding situation." Progress note on 1/8/13 indicated resident declined consult with	F 279		

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F 279	Continued From page 3 psychiatrist. R36'S care plan, dated 9/27/12, identified the problem of cognition and decision making impression due to depression,. Interventions included encourage him to express ideas in 1:1, become familiar with staff, medications as ordered, encourage use of relaxation techniques, encourage interaction with peers, and remain sober. The problem of Depression -isolate self in room was identified with approaches to included encourage activities, encourage/remain medication compliant and go to {mental health} appointments, monitor resident's commitment to safety and offer opportunity to see therapist as needed. The care plan did not identify behaviors of resisting cares, or the behaviors of using alcohol while at the facility. The medical record lacked documentation the use of alcohol was allowed or prohibited. The medical record lacked appropriate interventions to remain sober as care plan indicated. On 1/31/13 at 1:22 p.m., the social worker reported that everyone was responsible for the care plan, the resident had only been involved with alcohol one time and that the resident was going through a lot of things in his life such as a death in the family. On 1/31/13 at 1:30 p.m. the director of nursing reported she would review the care plan and was unsure what was missing regarding R36's behaviors.	F 279		

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F 279	Continued From page 4	F 279		

R38 had a 9 pound weight loss in 6 months with a BMI of 20 and the facility failed to further assess and revise a care plan for nutritional interventions to decrease the risk of further weight loss.

R38 was admitted to the facility in 2007 with diagnoses of paranoid schizophrenia. The annual MDS, dated, 9/6/12, indicated R38 had no cognitive impairment, weighed 133 pounds and was independent with meals. The quarterly minimum data set (MDS) dated, 11/22/12, indicated R38 weighed 128 pounds, but did not show a significant weight loss. R38 remained with cognition intact, and independent with eating meals after a set up.
On 1/30/13 during the noon meal, R38 was served a bacon lettuce and tomatoe sandwich, a small bowl of cottage cheese, and a small bowl of red jello. R38 consumed 100% of the meal, and then left the dining room. No further foods were offered before R38 left the dining room.
The weights flow sheet used by the facility to monitor weights indicated the following resident's weights for 2012 and 2013:
June: 135#, July 16: 133#, September 14: 134#, October 12: 130.5#, November 9: 128#, December 12: 128.25# and January 9, 2013: 124#. {no August 2013 was available}
The current plan of care, last updated 11/12, indicated the resident was at risk with nutrition with approaches that read: "1. enc. {encourage} adequate intake daily (3 Meals), 2. enc {encourage} H2O {water} intake daily (6-8 glasses), 3. enc {encourage} nutritional supplement bid {twice a day}, 4. enc. {encourage exercise daily, 5. enc {encourage fruits and

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F 279	Continued From page 5 veggies vs sugary intake." The current physician orders indicated the resident was to receive ensure one can orally daily. A review of the November, December and January medication administration records (MAR) on 1/30/13 indicated the resident was offered a supplement daily. However, for the month of November 2012, the resident refused 18 out of 30 offers of ensure citing "I don't want it any more", "No" or "it causes me diarrhea". December 2012 MAR indicated the resident refused 28 out of 31 offers and cited either "No" or "it makes me sick". January 2013 MAR indicated the ensure was refused all month and again cited "It makes me sick" or "no". There was no documentation or evidence that other nutritional supplements were tried for R38. The medical recorded lacked any notification of the physician, or the dietician. On a phone interview, on 1/31/13 at approximately 10:30 a.m., the staff dietician indicated not being aware of recent weight loss or of the resident refusing the nutritional supplement. The dietician added, she relies on the nursing staff to update on patient concerns. The dietician was not sure why R38 was losing weight and added R38 frequently goes to a neighboring Italian restaurant to eat. During an interview on 1/31/13 at 11:00 a.m., the director of nursing confirmed she was not aware of the current weight loss but surprised as the resident frequently goes to a neighboring Italian restaurant to eat. The DON indicated when a weight is taken and charted, the nursing staff should notice the weight loss and reweigh the resident. Nursing should notify the dietician and the director of nursing with changes. The DON was not aware of the medical doctor being	F 279		

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F 279	Continued From page 6 updated on the current weight loss. During the same interview on 1/31/13, the director of nursing verified the care plan identified the resident would skip meals and refuse a nutritional supplement. However, the care plan was not revised to indicate weight loss and interventions to prevent further weight loss.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement care planning interventions for 1 of 1 residents (R36) in the sample identified as having change in behaviors. R36 lacked care planning interventions related to refusal of evaluation or cares and the use of alcohol. R36 had diagnoses that included major depressive disorder, underweight and acute kidney failure. The most recent minimum data set (MDS), dated 12/20/12 identified R36 with no cognitive impairment, had increase verbal behaviors such	F 309	F309 • Information regarding care & services for behavior has been presented in education/re-eduacation to all staff. • Beharvior Monitoring Sheets R(36) has been implemented. For all other residents that may be affected, behavior monitoring sheets have been checked & no problems have been identified. • The DNS/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI Committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. • DNS is responsible	3/08/2013

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F 309	Continued From page 7 as yelling, and resisting cares compared to the admission MDS dated 10/3/12. Progress notes in the medical record indicated behaviors with the use of alcohol. The progress note on 12/29/12 indicated " Res returned to facility getting out a light colored vehicle he was staggering out of and from the vehicle, as well as up facility stairs showing possibility of being intoxicated...' A progress note, dated 12/31/12 indicated "Administration has spoke to {resident's name} twice now in the last 10 days regarding ingestion of etoh..." Progress note dated 1/7/13, read "{resident's name} is viewed in hallway yelling about another resident being on the resident phone too long...In addition, when business office staff person went to {resident's name} room to deliver mail, there was smell of ETOH within room confines. Again Asst.Adm/owner spoke to {resident's name}. {resident's name} owned up to drinking beer, IDT mtg will meet regarding situation." Progress note on 1/8/13 indicated resident declined consult with psychiatrist. A progress note from the Associated Clinic of Psychology, with date of service on 1/2/13, indicated the resident was angry with his family and decided to drink to cope. Coping strategies were reviewed and included volunteer opportunities, writing down personal goals and to continue to offer praise and positive feedback when resident was observed making healthy choices. R36'S care plan, dated 9/27/12, identified the problem of cognition and decision making impression due to depression. Interventions	F 309		

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F 309	Continued From page 8 included encourage him to express ideas in 1:1, become familiar with staff, medications as ordered, encourage use of relaxation techniques, encourage interaction with peers, and remain sober. The problem of Depression -isolate self in room was identified with approaches to included encourage activities, encourage/remain medication compliant and go to {mental health} appointments, monitor resident's commitment to safety and offer opportunity to see therapist as needed. The care plan did not identify behaviors of resisting cares, or the behaviors of using alcohol while at the facility. The medical record lacked documentation the use of alcohol was allowed or prohibited. The medical record lacked appropriate interventions to remain sober as care plan indicated On 1/31/13 at 1:22 p.m., the social worker reported that everyone was responsible for the care plan, the resident had only been involved with alcohol one time and that the resident was going through a lot of things in his life such as a death in the family. On 1/31/13 at 1:30 p.m. the director of nursing reported she would review the care plan regarding what was missing regarding R36's behaviors.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325	F325 • Information regarding care & services for nutrition has been presented in education/re-education to all staff.	3/08/2013

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F 325	Continued From page 9 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure R38 received planned interventions and/or accurately monitoring the effectiveness of the interventions to maintain appropriate nutritional parameters and minimize further weight loss for 1 of 3 (R38) in the sample with weight loss. Findings include: R38 had a 9 pound weight loss in 6 months with a BMI of 20 and the facility failed to further assess and revise a care plan for nutritional interventions to decrease the risk of further weight loss. R38 was admitted to the facility in 2007 with diagnoses of paranoid schizophrenia. The annual MDS, dated, 9/6/12, indicated R38 had no cognitive impairment, weighed 133 pounds and was independent with meals. The quarterly minimum data set (MDS) dated, 11/22/12, indicated R38 weighed 128 pounds, but did not show a significant weight loss. R38 remained with cognition intact, and independent with eating meals after a set up. On 1/30/13 during the noon meal, R38 was served a bacon lettuce and tomatoe sandwich, a small bowl of cottage cheese, and a small bowl of	F 325	F325 continued... • Care Plan (R38) has been updated to include more indivudualized information. For all other residents that may be affected, Care Plan has been checked & no problems have been identified. • The DNS/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI Committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted • DNS is responsible.	

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F 325	Continued From page 10 red jello. R38 consumed 100% of the meal, and then left the dining room. No further foods were offered before R38 left the dining room. The annual nutritional assessment indicated the usual weight of R38 was 135-150 pounds, and BMI was 22.2. The assessment indicated the resident ' s appetite was normal, consumed 80-100% of foods and fluids offered. Weight was 136.5 and the past quarter received high calorie supplement every day. The short term goals on the annual assessment read " will attend breakfast 4-5 days per week to next cc {care conference} and the long term goals was to have updated lab values by July 2012 . The last review note by the registered dietitian was on 11/6/12 which read " no new labs, wt. {weight} stable 130.5# regular diet. 1 can ensure daily, continue with plan of care " . The weights flow sheet used by the facility to monitor weights indicated the following resident ' s weights for 2012 and 2013: June: 135#, July 16: 133#, September 14: 134#, October 12: 130.5#, November 9: 128#, December 12: 128.25# and January 9, 2013: 124#. The current plan of care, last updated 11/12, indicated the resident was at risk with nutrition with approaches that read: "1. enc. {encourage} adequate intake daily (3 Meals), 2. enc {encourage} H2O {water} intake daily (6-8 glasses), 3. enc {encourage} nutritional supplement bid {twice a day}, 4. enc. {encourage exercise daily, 5. enc {encourage fruits and veggies vs sugary intake." The current physician orders indicated the resident was to receive ensure one can orally daily. A review of the November, December and January medication administration records	F 325		

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F 325	Continued From page 11	F 325		

(MAR) on 1/30/13 indicated the resident was offered a supplement daily. However, for the month of November 2012, the resident refused 18 out of 30 offers of ensure citing "I don't want it any more", "No" or "it causes me diarrhea". December 2012 MAR indicated the resident refused 28 out of 31 offers and cited either "No" or "it makes me sick". January 2013 MAR indicated the ensure was refused all month and again cited "It makes me sick" or "no". There was no documentation or evidence that other nutritional supplements were tried for R38. The medical recorded lacked any notification of the physician, or the dietician.

On a phone interview, on 1/31/13 at approximately 10:30 a.m., the staff dietician indicated not being aware of recent weight loss or of the resident refusing the nutritional supplement. The dietician added, she relies on the nursing staff to update on patient concerns. The dietician was not sure why R38 was losing weight and added R38 frequently goes to a neighboring Italian restaurant to eat.

During an interview on 1/31/13 at 11:00 a.m., the director of nursing confirmed she was not aware of the current weight loss but surprised as the resident frequently goes to a neighboring Italian restaurant to eat. The DON indicated when a weight is taken and charted on the form, staff should notice the weight loss and reweigh the resident. Nursing should notify the dietician and the director of nursing with changes. The DON was not aware of the medical doctor being updated on the current weight loss.

During the same interview on 1/31/13, the director of nursing verified the care plan identified the resident would skip meals and refuse a nutritional supplement. However, the

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F 325	Continued From page 12 care plan was not revised to indicate weight loss and interventions to prevent further weight loss.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based of interview and document review, the facility failed to provide qualitative and quantitative monitoring of psychoactive medications for 8 of 11 residents (R8, R12, R16, R19, R22, R25, R26, R31) in the sample	F 329	F329 • Information regarding monitoring of psychoactive medications has been presented to staff & Consultant Pharmacist in education/re-education. • Records of monitoring psychoactive medications for (R25, R16, R8, R22, R26, R19, R31, and R12) have been updated. For all other residents that may be affected, monitoring has been checked & no problems have been identified. • Behavior monitoring policy has been implemented. • The DNS/Consultant Pharmacist/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI Committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted • DNS is repsonsible	03/08/2013

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F 329	Continued From page 13 reviewed for unnecessary medications. Finding include: R19 received an antianxiety, an antipsychotic and antidepressant and lacked monitoring of effectiveness. Review of R19's physician's order signed 1/11/13 indicated R19 had diagnoses including mental health disorder, schizoaffective disorder, generalized anxiety disorder, depression and OCD (obsessive compulsive disorder). Medications included: clonazepam (antipsychotic) 1 mg twice a day and 2 mg at bedtime, Lorazepam (antianxiety) .5mg 1 tablet orally 2 times daily (for anxiety), mirtazapine 15 mg (Remeron) (antidepressant) 1 tablet orally at bedtime (for depression), and Ziprasidone (antipsychotic) 20 mg orally daily and 40mg orally at bedtime. Review of R19's Medication Administration Record (MAR) for December 2012 indicated the staff was to monitor every shift, for the following: psychosis: such as paranoia, distractibility, hallucinations, delusional thoughts or agitation anxiety: such as handwringing, repetitive questions, repetitive physical movements or tearfulness, depression: such as flat affect, isolation, decrease in activities or appetite/sleep changes. The December MAR indicated under psychosis, the behavior occurred 28 times on the day shift, 0 times on the night shift and 15 times on the evening shift. Under anxiety, the behavior occurred 0 times on the night shift, 29 times on	F 329		

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F 329	Continued From page 14 the day shift and 16 times on the evening shift. Under the depression heading, the behavior occurred 2 times on the night shift, 7 times of the day shift and 21 times on the evening shift. The January MAR did not have any behavior monitoring on it. Interview on 1/31/13 at 9:15 a.m., Licensed Practical Nurse (LPN) A stated that behavior is recorded on behavior sheets as only occurred or not, with no information regarding what type of behavior, or frequency it occurred. No documentation noted on what approaches are attempted or the effectiveness of the medications used. Review of R19's 7 day observation data collection tool dated 12/7/12 - 12/13/12 indicated R19 exhibited physical behaviors once, pacing 4 times and talking to self 2 times during the observation period. R19 also resisted cares 4 times and wandered once during the observation period. Review of R19's plan of care indicated R 19 had chronic/persistent mental illness with schizoaffective d/o(disorder), OCD (obsessive compulsive disorder), anxiety, history of suicidal gestures - reports thoughts of self-harm with no plan for self injury , and makes calls to 911 when he perceives that his wants/needs are not being met to his satisfaction. The plan of care indicated approaches as: 1. meds (medications) as ordered 2. staff will keep MD (physician) updated of changes 3. Encourage participation in supportive activities.	F 329		

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F 329	Continued From page 15 5. Encourage to report thoughts of self-harm to staff. 6. If reports thoughts of self-harm, review coping strategies(sic) such as resting, radio, or smoking. 8. Do not argue with and try to meet his many small demands in a timely manner. R19's plan of care also addressed anxiety as a problem with the approaches of: 1. Will assist him in finding WCCO on his radio, when he needs help (he asks) 2. Will invite/inform him of programs that may be of interest 3. Will pick up books for him from the public library as he requests. Problem 13 on the plan of care also addresses anxiety with the following approaches: 1. 2x each shift nursing staff to ask client about anxiety on scale of 1 - 5, if decreased give praise. 2. Encourage client to talk with staff daily prior and during anxious moments. 3. Engage client in conversations of his interest. 4. Monitor client for increased agitation and seek decrease methods. Review of R19's quarterly social services progress note on 12/13/12 indicated the client spoke of suicidal thoughts and that he would not carry the thoughts out, and one incident of a verbal outburst with physical aggression regarding cigarettes. No other behaviors, anxiety or mood discussed. R31 received an antianxiety, an antipsychotic and antidepressant and lacked monitoring of	F 329		

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F 329	Continued From page 16 effectiveness. Review of R31 physician orders signed 1/11/13 indicated R31 diagnoses included schizoaffective disorder, and bipolar disorder. Medications ordered included: Clozapine (anti psychotic) 100 mg , 3 tabs at bedtime, Lorazepam (antianxiety) .5mg orally 3 times daily, Risperidone (antipsychotic) 4mg tablet at bedtime, and Effexor (antidepressant) 150 mg , 2 caps every evening. Review of January 2013 Medication Administration Record (MAR) indicated no behavior monitoring on MAR. Review of December 2012 MAR indicated a target behavior of " psychosis: such as paranoia, destractibility, hallucinations, delusional thoughts, agitation." The behaviors were documented as occuring 0 times on the night shift, 17 times on the day shift and 19 times on the evening shift. Review of R31's plan of care dated 6/15/12 indicated the following problems: 1. chronic and persistent mental illness, schizophaffectvie DO (disorder), bipolar disorder, hallucinations/delusional thoughts, alcohol use, with appraoches including meds as ordered, regular follow up with psychiatrist, encourage participation in supportive activiteiess , don't get into power struggles, encourage to use calender and journal to compensate for memory impairment, watch for signs of alcohol use especially when she returns from LOA's (leave of absences). Review of Social Services quarterly note dated 12-5-12 indicated " stated has some thought that	F 329		

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F 329	Continued From page 17 she would be better off dead - but no thoughts/plan to hurt herself. She states 'I put a stop sign in my mind' (per therapist suggestion)... She goes to water aerobics 3 x wk. Also goes to church wkly (weekly) and to an art class at SFFD wkly. She continues to experience auditory hallucinations and reported restlessness esp (especially) in morning." Documentation lacked effectiveness of medications and monitoring of specific behaviors. R12's behavior monitoring did not include individualized and specific behaviors. Record review revealed R12 was admitted 8/22/11 with diagnoses including paranoid schizophrenia. Physician orders dated 1/11/13 included Zyprexa (an anti-depressant) 25 mg every evening, and Trileptal (an anti-psychotic) 450 mg twice daily. Behavior monitoring target behaviors listed on the January 2013 Medication Administration Record (MAR) were generic possibilities that read, " Psychosis such as paranoia, distractibility, hallucinations, delusional thoughts or agitation. Anxiety such as handwriting, repetitive questions, repetitive physical movements or tearfulness. Changes in mood such as increased depression or mania. " Plus signs or zeroes were recorded for each shift on the MAR, but there was no notation as to which behavior took place, the frequency of that behavior, or any other details related to the behaviors. When interviewed on 1/31/13, at 9:15 a.m. LPN-A stated that nurses are the staff that record resident behaviors in the MAR and these behaviors are recorded as occurred or not, with no information regarding what type or frequency	F 329		

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F 329	Continued From page 18	F 329		

of behavior. She went on to explain that she and the director of nursing discussed this process the previous day and going forward nurses will record details about behavior on the back of MAR sheets.
R22's behavior monitoring did not include individualized and specific behaviors.
Record review revealed R22 was admitted 9/17/07 with diagnoses including major depression, post-traumatic stress disorder, borderline personality disorder, and bi-polar disorder. Physician orders dated 1/11/13 included Abilify (an anti-depressant) 20 mg every bedtime, Wellbutrin XL (an anti-depressant) 450 mg every morning, Effexor (an anti-depressant) 75 mg four times daily, and Trazodone (an anti-depressant) 100 mg every night. Behavior monitoring target behaviors listed on the January 2013 Medication Administration Record (MAR) were generic possibilities that read, " Psychosis such as paranoia, distractibility, hallucinations, delusional thoughts or agitation. Anxiety such as handwriting, repetitive questions, repetitive physical movements or tearfulness. Changes in mood such as increased depression or mania. " Plus signs or zeroes were recorded for each shift on the MAR, but there was no notation as to which behavior took place, the frequency of that behavior, or any other details related to the behaviors.
When interviewed on 1/31/13, at 9:15 a.m. LPN-A stated that nurses are the staff that record resident behaviors in the MAR and these behaviors are recorded as occurred or not, with no information regarding what type or frequency of behavior. She went on to explain that she and the director of nursing discussed this process the previous day and going forward nurses will record

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F 329	Continued From page 19 details about behavior on the back of MAR sheets. R25 was admitted on 7/9/10 with diagnoses which included schizophrenia. For this mental health diagnoses, the physician ordered Haloperidol (anti-psychotic) 5 mg po twice a day, Haldol (antipsychotic)100 mg injection every four weeks and Seroquel (anti psychotic) at hours sleep. The facility did not monitor target behaviors of hallucinations, paranoia, distractibility, delusional thoughts or agitation. A review of the January medication administration record (MAR), where target behaviors were to be monitored, were generic. Listed on the MAR was: " Psychosis: such as paranoia, distractibility, hallucinations, delusional thoughts or agitation. The three shifts were identified and dates were marked with either zeros or a plus sign. The MAR lacked documentation of what behavior occurred, the frequency of the behavior or any other details related to the behaviors. The current care plan last updated 1/31/13, indicated R25 had schizophrenia with limited attention span and some delusional thoughts. Approaches included staff will report changes in mood or behavior to medical doctor., administer medications as ordered and maintain contact with mental health case manager. The current psychiatric progress note, dated 10/2/12 , indicated R25 was stable with symptoms and had no side effects of medications. When interviewed on 1/31/13 at 2:00 p.m., the director of nursing verified specific behavior monitoring was not being completed and the	F 329		

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F 329	Continued From page 20 facility did not have a policy on behavior monitoring. R16 was admitted on 12/22/12 with diagnoses which included non organic psychosis, insomnia and depression. For these mental health diagnoses the physician ordered Olanzapine 5 mg (antipsychotic) at bedtime for sleep/mood/depression, Zoloft (antidepressant) 75 milligrams daily for mood and depression and Trazodone (antidepressant) 50 mg at bedtime for sleep/mood/depression. The 7 day observation data collection tool for time period 12/20/12 thru 12/29/12 indicated R16 slept 5-6 hours a night and would sleep 2-4 hours during the day at least 4 out of 7 days. The seven day behavior look back revealed R16 had two day shifts and two evening shifts where behaviors of public disrobing out in hallway without appropriate covering was displayed, and screaming, yelling out and making disruptive sounds were displayed. Behaviors toward others were displayed 2 of the 7 days that included physical behaviors i.e. scratching, pushing and verbal behaviors such as screaming. A review of the December and January medication administration record where target behaviors were to be monitored, identified a lack of behavior monitoring and lacked ongoing sleep monitoring. The current care plan, dated 12/22/12 identified Mental Illness with nonorganic psychosis, depression, anxiety, personality disorder , mild cognitive impairment and unkind remarks to residents and staff and identified a problem with sleep disturbance/insomnia. Intervention	F 329		

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F 329	Continued From page 21 included medications as ordered, social services to visit as needed to monitor mood/listen to concerns, and speak slowly and clearly to prevent inaccurate information. For the insomnia, approaches included monitor hours of sleep nightly and quarterly, medications as ordered, keep medical doctor informed discourage daytime napping and encourage use of ear plugs. When interviewed, on 1/31/13 at 2:00 p.m., the director of nursing indicated the facility reviews only a seven day look back for insomnia and for antidepressants, therefore, there would be no ongoing monitoring for this person. The director of nursing (DON) was not aware of the monitoring of hours sleep nightly was placed on the care plan. The DON verified specific behavior monitoring was not being completed and the facility did not have a policy on behavior monitoring. The facility failed to monitor effectiveness of psychoactive medications for R8 and communicate behavioral health status to psychiatrist. Physicians orders, dated 1/11/13, indicated R8 was prescribed clozapine (antipsychotic) 300 milligrams (mg) daily at bedtime, divalproex (medication sometimes used to treat psychotic and manic symptoms) 750 mg 2 times daily and 250 mg at 4 p.m. and risperidone (an antipsychotic) 5 mg at bedtime. Diagnoses included hallucinations, delusions, religiously preoccupied, anxiety, schizoaffective disorder, depression, self injurious behavior and head banging. Care area assessment, dated 10/6/12, indicated "longstanding mental illness (schizophrenia), schizoaffectie disorder with auditory	F 329		

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F 329	Continued From page 22 hallucinations, delusion. She has at times command hallucinations and also can be very religiously focused. Mental illness also impairs decision making and follow through on cares. Also has hx (history) of SIB [self injurious behavior] (headbanging)."Social Service quarterly note, dated 12/20/12, did not refer to symptoms or behaviors displayed except to note R8 had minimal symptoms of depression per the PHQ-9 (a standardized depression screening inventory). During the seven day narrative team notes, dating from 12/14/12 to 12/20/12, R8 was noted to have no behavior issues on 19 of the shifts charted. On 12/20/12, R8 was noted as initially refusing a shower before staff encouraged her and on 12/17/12, R8 was noted as feeling "picked on" when staff encouraged her to wear undergarments. The Seven Day Observation tool notes "feeling tired or little energy" on four day shifts and four evening shifts and resisted cares on 12/20/12. No other symptoms or behavioral health concerns noted. A review of the team notes revealed, on 11/19/12, R8 was noted as experiencing anxiety related to discharge plans. On 1/24/13, R8 declined a shower. No other team notes included a description of symptoms or behvioral health concerns experienced by R8 during the month of November, December or January. Review of Medication Monitoring indicated during the month of November R8 experienced "mania/depression" once on 11/04/12. R8 experienced "Psychosis: such as paranoia, distractibility, hallucinations, delusional thoughts or agitation" fifty times. R8 experienced "head banging" no times. During the month of December R8 experienced "Psychosis: such as paranoia, distractibility, hallucinations, delusional	F 329		

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F 329	Continued From page 23	F 329		

thoughts or agitation" fifty two times. R8 experienced "Increased mania/depression" twenty seven times. R8 experienced "headbanging" zero times. January's behavior monitoring indicated R8 experienced "psychosis: such as paranoid, distractibility, hallucinations, delusional thoughts or agitation" sixty times. R8 was noted as experiencing "Increased Mania/Depression" fifteen times. R8 was noted as experiencing "head banging" zero times. Behaviors were monitored on all three shifts. No clarification was given as to specific behaviors R8 displayed or impact on R8's functioning and quality of life.

R8's psychiatric referral, dated 12/19/12, had under "describe problems to be evaluated" blank space. No symptoms, behavior observations or their impact on R8's quality of life were communicated to the psychiatrist, only ambulatory status and vital signs.

On 1/30/13 at 2:00 p.m. the day nurse, (LPN)-C, reported "it's vague" regarding R8's behavior monitoring. LPN-C reported more detail regarding behavior signs would be noted in the team notes, only during the seven day observation period and if there was a significant concern.

On 1/31/13 at 11:30 a.m. the social service director (SSD) reported she used the seven day observation tool and narrative charting for her assessments. SSD reported the behavior monitoring on the medication administration record was not accurate enough for her to use for her assessment. SSD reported the target behaviors listed were not specific enough to adequately describe R8's symptoms, behaviors or the impact on R8's life. SSD reported, regarding the target behavior "Mania/Depression", "that's

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HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

(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 329	Continued From page 24 everything". The facility failed to monitor R26 effectiveness of psychoactive medications for R26. R26's physician orders, dated 1/24/13, included the following medications: "risperidone 4 mg every evening and mirtazapine 15 mg at bedtime. Risperidone is an antipsychotic. Mirtazapine is an antidepressant. Diagnoses included: depression and schizophrenia. Care Area Assessment, dated 9/18/12, indicated R26 "carries dx [diagnosis] of schizoaffective d/o [disorder] [with] hallucinations and delusions. She is considered vulnerable & needs assist [with] decision making. She remains compliant [with] medications, thus keeping symptoms mild." Seven Day Observation Tool, dated 11/16/12 to 11/22/12, indicated "little interest in doing things, laying on bed much of shift" and "feeling tired or little energy" occurred twelve times. No other behavioral health concerns noted. No behavioral health concerns were noted on eighteen shifts charted. R26 was noted as spending much of her time in her room or bed on 11/17/2, 11/19/12 (day and evening) and 11/21/12. A quarterly social service note on 11/20/12 indicated mild depression on the PHQ-9 (standardized depression screening inventory) with no other symptoms noted. A review of the team notes for November, December and January does not describe any additional behavioral health concerns or impact on R26's life. A review of November's behavior monitoring on the Medication Administration Record, indicated	F 329		

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F 329	Continued From page 25 R26 experienced "Psychosis: Such as paranoia, distractibility, hallucinations, delusional thoughts or agitation" thirty seven times. "Depression: such as flat affect, isolation, decrease in activities or appetite/sleep changes" was noted on fifty two times. In December Psychosis: Such as paranoia, distractibility, hallucinations, delusional thoughts or agitation" was noted forty three times. "Depression: such as flat affect, isolation, decrease in activities or appetite/sleep changes" was noted fifty two times. In January "Psychosis: Such as paranoia, distractibility, hallucinations, delusional thoughts or agitation" was noted twenty eight times. "Depression: such as flat affect, isolation, decrease in activities or appetite/sleep changes" was noted fifty seven times. No description of specific symptoms or behaviors were noted or how these symptoms impacted R26's life. On 1/30/13 at 2:00 p.m. reported that R26's primary behavioral health concern was isolating in her room. LPN-C verified it would be difficult to ascertain what symptoms R26 was experiencing or how staff determined R26 was experiencing psychosis or depression on each of the days indicated. LPN-C reported she would start noting symptoms more specifically in the notes section. On 1/30/13 at 11:21 a.m. SSD reported she has observed R26 speaking under her breath and having a flat affect when asked what symptoms she displayed. When asked if she would be able to ascertain behavioral health status from the documentation provided, SSD reported "I wouldn't unless I knew her". SSD explained she primarily used the seven day observation tool for her assessment purposes as the behavior monitoring	F 329		

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F 329	Continued From page 26 was "used by nursing staff documenting need for psychiatric medications"	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement cooling procedures for precooked foods, which had the potential to affect all 38 residents in the facility. Findings include: During the initial kitchen tour on 1/28/13 at 7:15 p.m. a large pan of boiled potatoes (still in skins) and boiled eggs (still in shells) were noted to be stored together, still warm upon touch of the pan. The pan of eggs and potatoes was stored in the refrigerator, covered with aluminum foil. Cook-A reported she was unsure of what time they were prepared, but stated the cook who made them left at 5:30 p.m. The potatoes and eggs would be served the next day as potato salad. Temperatures of six eggs and four potatoes were taken. The eggs were 95 F (degrees Fahrenheit), 95 F, 90 F, 82 F, 89 F and 90 F. The shells were	F 371	F371 • Information regarding cooling procedures of food has been presented to all staff in education/re-education. • Dietary staff will complete approved "safe serve" class. • Dietary Manager/designee will conduct random audits to monitor compliance. Dietary Manager will report progress of audits to CQI Committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. • Dietary Manager is responsible.	03/08/2013

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F 371	Continued From page 27	F 371		

cracked by Cook-A, who took the temperatures. The potatoes were 90 F, 98 F, 105 F and 100 F. The temperatures were taken again of four potatoes and six eggs at 7:40 p.m. in a similar fashion by Cook-A. The eggs were 80 F, 70 F, 74 F, 85 F, 85 F and 80 F. The potatoes were 90 F, 85 F, 93 F and 90 F. The potatoes and eggs were stored in a single layer, but somewhat overlapping. Cook-A, the only dietary personnel at the facility during the evening, reported she was not aware of cooling procedures of prepared foods, and it was not her duty.

On 1/29/13 at 10:48 a.m. Cook-B, reported she prepared the eggs and potatoes the previous afternoon, and was done preparing them at 4:00 p.m. Cook-B reported she boiled the potatoes and eggs separately in their own pots. She took the temperature of the eggs and potatoes after they were done being prepared. She then let them sit out at room temperature for 20-30 minutes, put them in the refrigerator, and covered tightly with aluminum foil. To her knowledge, no one had taken the temperature of the eggs and potatoes since she took them out of the boiling water at 4:00 p.m. the previous afternoon. When asked if there was a policy on cooling prepared foods, Cook-B reported "no, we should know though". Cook-C reported she was unaware of a policy on cooling foods prepared ahead of time. She reported she cooled food similar to Cook-B, but put it right in the refrigerator instead of sitting out a room temperature for 20-30 minutes first. Cook-B reported the eggs and potatoes would be served in a potato salad for supper.

On 1/29/13 at approximately 1:00 p.m. Cook-B was notified by surveyor of the potential hazard of

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F 371	Continued From page 28 serving food that had not cooled within the appropriate time frames. Cook-B then disposed of the eggs and potatoes. Cook-B reported she would have served the eggs and potatoes if survey team had not intervened. Cook-B reported she was not aware of methods to cool foods rapidly and still maintain good taste. Cook-B reported she would discuss with her consulting dietician. A policy on cooling, date unknown, was provided that directed staff to cool precooked foods to 70 degrees in 2 hours and from 70 degrees to 41 degrees within 2 hours. There was not further guidance provided on how to achieve this objective or measures to take if food was not cooling rapidly.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the the consultant pharmacist failed to identify and report to the physician and director of nursing the lack of qualitative behavior monitoring	F 428	F428 • Information regarding pharmacy recommendations & monitoring of psychoactve medications for irregularities has been presented to staff & Consultant Pharmacist. • Record of monitoring psychoactive medications for irregularities for (R25, R16, R8, R22, R26, R19, R31, R12) have been updated. For all other residents that may be affected, monitoring has been checked & no problems have been identified. • Behavior monitoring policy has been implemented.	03/08/2013

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F 428	Continued From page 29 for ongoing use of the psychotropic medication for 8 of 11 residents (R8, R12, R16, R19, R22, R25, R26, R31) reviewed for unecessary medications. Findings include: R25 received physician ordered Haloperidol (antipsychotic) 5 mg po twice a day, Haldol (antipsychotic)100 mg injection every four weeks and Seroquel (antipsychotic) at hours sleep. The facility did not monitor target behaviors of hallucinations, paranoia, distractibility, delusional thoughts or agitation. There were no individualized target behaviors identified, or individualized non-pharmacological interventions identified for staff to monitor for the effectiveness for continued use of the antipsychotic medication. The current psychiatric progress note, dated 10/2/12 , indicated R25 was stable with symptoms and had no side effects of medications. The consulting pharmacist had not identified the irregularity. When interviewed on 1/31/13 at 2:00 p.m., the director of nursing verified specific behavior monitoring was not being completed and the facility did not have a policy on behavior monitoring. A review of the Record of Medication Regimen Review, completed by the consulting pharmacist, noted "no irregularity" for previous months. The medical record lacked any form of documentation regarding monitoring of behaviors while on antipsychotic medications.	F 428	F428 continued... • The DNS/Consultant Pharmacist/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI Committee. • The CQI committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted • DNS is repsonsible.	

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F 428	Continued From page 30	F 428		

The facility consulting pharmacist failed to provide written guidance on monitoring effectiveness of psychoactive medications for R8 and communicating behavioral health status to psychiatrist.
R8 received, per physicians orders dated 1/11/13, clozapine (antipsychotic) 300 milligrams (mg) daily at bedtime, divalproex (medication sometimes used to treat psychotic and manic symptoms) 750 mg 2 times daily and 250 mg at 4 p.m. and risperidone (an antipsychotic) 5 mg at bedtime. Diagnoses included hallucinations, delusions, religiously preoccupied, anxiety, schizoaffective disorder, depression, self injurious behavior and head banging.
On 1/30/13 at 2:00 p.m. the day nurse, (LPN)-C, reported "it's vague" regarding R8's behavior monitoring. LPN-C reported more detail regarding behavior signs would be noted in the team notes, only during the seven day observation period and if there was a significant concern.

On 1/31/13 at 11:30 a.m. the social service director (SSD) reported the target behaviors listed were not specific enough to adequately describe R8's symptoms, behaviors or the impact on R8's life. SSD reported, regarding the target behavior "Mania/Depression", "that's everything".

A review of the Record of Medication Regimen Review, completed by the consulting pharmacist noted "NI" for "No irregularity" for the months of October, November and December 2012 and January 2013. No notation guided staff regarding monitoring of psychiatric symptoms.

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F 428	Continued From page 31	F 428		

The facility failed to provide written guidance regarding monitoring effectiveness of psychoactive medications for R26.

R26's physician orders, dated 1/24/13, included the following medications: "risperidone 4 mg every evening and mirtazapine 15 mg at bedtime. Risperidone is an antipsychotic. Mirtazapine is an antidepressant. Diagnoses included: depression and schizophrenia.

There were no individualized target behaviors identified and no description of specific symptoms or behaviors noted to reflect how these symptoms impacted R26's life.

A review of Record of Medication Regimen Review, completed by the consulting pharmacist, noted "NI" for "No irregularity" for the months of April, May, June, July, and August, September, October, November and December of 2012 and January 2013. In September a memo was sent to the physician regarding a medication for gastrointestinal discomfort and in November a note was written to obtain the psychiatric progress notes from the psychiatrist. No notation guided staff regarding monitoring of psychiatric symptoms.

A policy on mood and behavior monitoring was requested from the director of nursing on 1/30/13 at approximately 9:30 a.m., however, it was not provided.

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F 428	Continued From page 32 R19 received an antianxiety, an antipsychotic and antidepressant and lacked monitoring of effectiveness. Review of R19's physician's order signed 1/11/13 indicated R19 had diagnoses including mental health disorder, schizoaffective disorder, generalized anxiety disorder, depression and OCD (obsessive compulsive disorder). Medications included: clonazepam (antipsychotic) 1 mg twice a day and 2 mg at bedtime, Lorazepam (antianxiety) .5mg 1 tablet orally 2 times daily (for anxiety), mirtazapine 15 mg (Remeron) (antidepressant) 1 tablet orally at bedtime (for depression), and Ziprasidone (antipsychotic) 20 mg orally daily and 40mg orally at bedtime. Interview on 1/31/13 at 9:15 a.m., Licensed Practical Nurse (LPN) A stated that behavior is recorded on behavior sheets as only occurred or not, with no information regarding what type of behavior, or frequency it occurred. No documentation noted on what approaches were attempted or the effectiveness of the medications used. There were no individualized target behaviors identified, or individualized non-pharmalogical interventions identified for staff to monitor for effectiveness of the continued use of the antipsychotic medication. The consulting pharmacist had not identified the irregularity. R31 received an antianxiety, an antipsychotic and antidepressant and lacked monitoring of effectiveness.	F 428		

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F 428	Continued From page 33	F 428		

Review of R31 physician orders signed 1/11/13 indicated R31 diagnoses included schizoaffective disorder, and bipolar disorder. Medications ordered included: Clozapine (anti psychotic) 100 mg , 3 tabs at bedtime, Lorazepam (antianxiety) .5mg orally 3 times daily, Risperidone (antipsychotic) 4mg tablet at bedtime, and Effexor (antidepressant) 150 mg , 2 caps every evening.

Review of January 2013 Medication Administration Record (MAR) indicated no behavior monitoring on MAR. Review of December 2012 MAR indicated a target behavior of " psychosis: such as paranoia, destractibility, hallucinations, delusional thoughts, agitation." The behaviors were documented as occuring 0 times on the night shift, 17 times on the day shift and 19 times on the evening shift. Review of Social Services quarterly note dated 12-5-12 lacked effectiveness of medications and monitoring of specific behaviors.

Review of behavior record monitoring revealed no individualized target behaviors and non pharmacological interventions related to the use of the medications. The consulting pharmacist had not identified the irregularity.

R12's behavior monitoring did not include individualized and specific behaviors.
Record review revealed R12 was admitted 8/22/11 with diagnoses including paranoid schizophrenia. Physician orders dated 1/11/13 included Zyprexa (an anti-depressant) 25 mg every evening, and Trileptal (an anti-psychotic) 450 mg twice daily. Behavior monitoring target

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F 428	Continued From page 34	F 428		

behaviors listed on the January 2013 Medication Administration Record (MAR) were generic possibilities that read, " Psychosis such as paranoia, distractibility, hallucinations, delusional thoughts or agitation. Anxiety such as handwriting, repetitive questions, repetitive physical movements or tearfulness. Changes in mood such as increased depression or mania. " Plus signs or zeroes were recorded for each shift on the MAR, but there was no notation as to which behavior took place, the frequency of that behavior, or any other details related to the behaviors.
When interviewed on 1/31/13, at 9:15 a.m. LPN-A stated that nurses are the staff that record resident behaviors in the MAR and these behaviors are recorded as occurred or not, with no information regarding what type or frequency of behavior. The consulting pharmacist had not identified the irregularity.

R22's behavior monitoring did not include individualized and specific behaviors.
Record review revealed R22 was admitted 9/17/07 with diagnoses including major depression, post-traumatic stress disorder, borderline personality disorder, and bi-polar disorder. Physician orders dated 1/11/13 included Abilify (an anti-depressant) 20 mg every bedtime, Wellbutrin XL (an anti-depressant) 450 mg every morning, Effexor (an anti-depressant) 75 mg four times daily, and Trazodone (an anti-depressant) 100 mg every night. Behavior monitoring target behaviors listed on the January 2013 Medication Administration Record (MAR) were generic possibilities that read, " Psychosis such as paranoia, distractibility, hallucinations, delusional thoughts or agitation. Anxiety such as

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handwriting, repetitive questions, repetitive physical movements or tearfulness. Changes in mood such as increased depression or mania. " Plus signs or zeroes were recorded for each shift on the MAR, but there was no notation as to which behavior took place, the frequency of that behavior, or any other details related to the behaviors.
When interviewed on 1/31/13, at 9:15 a.m. LPN-A stated that nurses are the staff that record resident behaviors in the MAR and these behaviors are recorded as occurred or not, with no information regarding what type or frequency of behavior. The consulting pharmacist had not identified the irregularity.

R16 was admitted on 12/22/12 with diagnoses which included non organic psychosis, insomnia and depression. For these mental health diagnoses the physician ordered Olanzapine 5 mg (antipsychotic) at bedtime for sleep/mood/depression, Zoloft (antidepressant) 75 milligrams daily for mood and depression and Trazodone (antidepressant) 50 mg at bedtime for sleep/mood/depression.

A review of the December and January medication administration record where target behaviors were to be monitored, identified a lack of behavior monitoring and lacked ongoing sleep monitoring.
When interviewed, on 1/31/13 at 2:00 p.m., the director of nursing indicated the facility reviews only a seven day look back for insomnia and for antidepressants, therefore, there would be no ongoing monitoring for this person. The DON identified specific behavior monitoring was not

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F 428	Continued From page 36 being completed and the facility did not have a policy on behavior monitoring. When interviewed on 2/1/13, at 2:45 p.m. the facility's consulting pharmacist stated that he started consulting at the facility in October 2012, has identified a problem with behavior monitoring of residents taking psychoactive medications, and has discussed these concerns with the director of nursing and also at the facility's quality assurance meeting in December 2012. He feels that the facility is in the early stages of developing a better system of behavior monitoring of residents taking psychoactive medications.	F 428		

HAYES RESIDENCE
1620 RANDOLPH AVE
ST. PAUL, MN 55105
651 690-4458

2/28/2013

Susanne Reuss -Unit Supervisor
Division of Compliance Monitoring
Minnesota Department of Health
PO Box 64900
Saint Paul, MN 55164-0900

Via: US Mail - **Certified Return Receipt:** 7009 1680 0000 8317 8075

Re: Plan of Correction

Dear Susanne

Please find enclosed our Plan of Correction for Henry Hagen Residence.

Should you have any questions, please do not hesitate to contact me, or Mary Rachuy, Director of Nursing.

Sincerely

Laura Lee Reynolds
Administrator

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3798

March 4, 2013

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, Minnesota 55105

RE: Project Number FE508022

Dear Ms. Reynolds:

PLEASE NOTE: This survey is being processed in two seperate enforcement cycles. Attached is the Life Safety Code portion of the enforcement cycle.

On February 20, 2013, a standard survey was completed at your facility by the Minnesota Department of 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 1, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 1, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 20, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File E508s13lsc.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FES080zz

PRINTED: 03/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Hayes Residence was found not in substantial compliance with the requirements for participation in Medicaid at 42 CFR, Subpart 483.470 (j), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POC ok w/AW for K67 3-11-13	

DC: 03.12.2013

EXIT: 1.31.2013

RECEIVED
MAR 11 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3/7/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYES RESIDENCE	**1620 RANDOLPH AVENUE** **SAINT PAUL, MN 55105**

(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
K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Hayes Residence is a 1-story building with a full basement. The building was constructed in 1958 and was determined to be of Type II(111) construction. The building is divided into 3 smoke zones. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The alarm is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are connected to the fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms have battery operated smoke detectors. The building is not protected by a fire sprinkler system. The facility has a capacity of 40 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.470(j), is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

(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
K 067	Continued From page 2 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Observations and interview with staff revealed that the facility is using the corridor as a make-up air plenum. Using the corridor as part of the air distribution system could allow the products of combustion to travel throughout the facility and negatively impact the residents, guests and staff. Findings include: On facility tour between 09:00 AM and 01:00 PM on 02/20/2013, it was observed and during an interview with the Assistant Administrator (CF), it was revealed that the corridors are being used as part of the air distribution system for make-up air. A waiver has been previously approved. *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 067	K 067: A request for renewal of current waiver will be sent to Mr. Patrick Sheehan with the State Fire Marshal Division no later than Monday, March 11, 2013. The building will be protected by a fire sprinkler system by August 2013. Viking Automatic Sprinkling, Co. has been contracted to install the sprinkler system and has already begun its preliminary preparations. Colin Faulkner, Assistant Administrator, is responsible.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, March 11, 2013 1:59 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Linhoff, Tom (DPS); 'colin.faulkner@hayesresidence.com'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Hayes Residence (24E508) K67 Annual Waiver Request

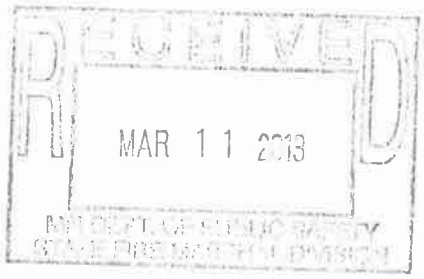
This is to inform you that Hayes Residence is requesting an annual waiver for K67, corridors as a plenum. The exit date was 1-31-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Hayes Residence
1620 Randolph Ave, St. Paul, MN 55105
Main: 651.690.4458 Fax: 651.690.2787

3/7/2013



Attn: Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, MN 55101-5145

RE: Hayes Residence
1620 Randolph Ave
St. Paul, MN 55105

Dear Mr. Sheehan,

Please accept this request for waiver regarding K067.

A. There will be no adverse effect on the health and safety of the residents and staff since:
    a. The building is equipped with an approved corridor smoke detection system.
    b. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system.
    c. Resident rooms are equipped with battery operated smoke detectors that are checked weekly for proper operation. Batteries are changed quarterly.
    d. Service and maintenance contracts include servicing all the facility's fire protection systems biyearly.
    e. Fire safety training is provided for all employees on an annual basis and during orientation for new hires. Hands on use of extinguishers will be available yearly.
    f. Fire drills are conducted monthly. An additional drill occurs each quarter, totaling 16 yearly.
    g. The response time of the St. Paul Fire and Rescue is approximately 3 minutes.
    h. The building is in the process of having a sprinkler system installed which will be completed by August 2013.
B. Compliance with this provision would impose an unreasonable hardship on the facility since:

B. Compliance with this provision would impose an unreasonable hardship on the facility since:
   a. The installation of required ductwork would reduce the headroom in the corridor below the minimums required in LSC (00), sec, 7.1.5.
   b. There are concerns about whether the electrical system is adequate to handle the additional HVAC equipment required.
   c. There are concerns about whether the penetration of load bearing walls to install required ductwork would adversely affect the structural integrity of the building.
   d. It has been determined that the ceiling tiles would need to be removed to install required ductwork contain asbestos, the abatement of which would add additional cost to the project.
   e. LSC (00), sec 9.2, gives the AHJ authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service.

Respectfully,

Fire Safety Supervisor State Fire Marshal 3-11-13

Colin Faulkner
Assistant Administrator