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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 8KG3
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 **12/08/2014** (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:

X 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

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):
Documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K67, was previously forwarded and approval of the waiver request was recommended.

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 12/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/19/2014 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/11/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E508

Electronically Delivered: December 19, 2014

Ms. Laura Reynolds, Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, MN 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 CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective November 28, 2014 the above facility is certified for:

40 - Nursing Facility II Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K067.

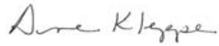
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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 Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 9, 2014

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

RE: Project Number SE508025

Dear Ms. Reynolds:

On November 4, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. 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 December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 5, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective November 28, 2014 and therefore remedies outlined in our letter to you dated November 4, 2014, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building B. Wing	12/8/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	**11/14/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**11/28/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**11/28/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**11/28/2014**	ID Prefix **F0313** Reg. # **483.25(b)** LSC	**11/28/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**11/28/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	**11/28/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KFD	12/09/2014	16022	12/08/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building 01 - MAIN BUILDING 01 B. Wing	12/5/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	10/21/2014	ID Prefix Reg. # NFPA 101 LSC K0050	10/22/2014	ID Prefix Reg. # NFPA 101 LSC K0144	10/22/2014
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	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	12/22/2014	12424	12/05/2014
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
10/21/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8KG3

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
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2014** (L34)

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	

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Sheryl Reed, HFE NEII 11/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/11/2014 (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
Emailed CMS AW K67 12/11/2014 Co.

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: 24-E508

On October 23, 2014 a standard survey was completed at this facility. Deficiencies were cited. The facility has been given an opportunity to correct before remedies would be imposed. Post Certificatoin Revist to follow. Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction.

In addition, Documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K67 (Corridors as a Plenum), was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page and email from Pat Sheehan recommending approval of the waiver.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 4, 2014

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

RE: Project Number SE508025

Dear Ms. Reynolds:

On October 23, 2014, 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:

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

Electronic Plan of Correction - 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;

<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.

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, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
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 December 2, 2014, 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 December 2, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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 January 23, 2015 (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 April 23, 2015 (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 an ePoC 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 electronic 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.

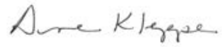
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questionsabout this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, November 12, 2014 12:25 PM
To:	rochi_lsc@cms.hhs.gov
Cc:	tom.linhoff@state.mn.us; 'colin.faulkner@hayesresidence.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	Hayes Residence (24E5080) 2014 K67 Annual Waiver Request - Previously Approved - No Change

This is to inform you that Hayes Residence is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 10-23-14.

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

11/5/2014

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,

Hayes Residence is again requesting a waiver for K067.
We are asking for the following reasons:

A. There will be no adverse affect on the residents safety in accordance with SOM 2480B because:

1. A complete supervised automatic sprinkler system was installed in accordance with section 9-7, NFPA 101 2000 edition, in July 2013.
2. The building is equipped with an approved corridor detection system.
3. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system.
4. Annual service and maintenance contracts require servicing of all the facilities' fire protection system semi-annually.
5. The response time of the St. Paul Fire and Rescue is approximately 3 minutes.
6. 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.
7. Fire drills are conducted monthly. An additional drill occurs each quarter totaling 16 drills per year.
8. As of March 2013 indoor smoking was prohibited. The designated outdoor smoking area is protected by the approved fire sprinkler system.

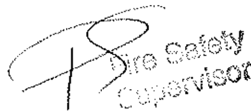
Hayes Residence

9. Emergency procedures as well as emergency exit routes are available; signage is posted.

B. Compliance with this provision would impose an unreasonable hardship in accordance with CMS SOM 2480C on the facility because:

1. The cost to install a complying HVAC system would be $55,650 (please see attached cost estimate).
2. 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.
3. LSC (00), sec 9.2, gives the AHJ authority to allow existing HVAC systems that do not comply with NFPA90A to be continued in service.
4. The installation of required ductwork would reduce the headroom in the corridor below the minimums required in LSC (00), sec, 7.1.5
5. There are concerns about whether the electrical system is adequate to handle the additional HVAC equipment required
6. There are concerns about whether the penetration of load bearing walls to install required ductwork would adversely affect the structural integrity of the building.
7. Residents would need to be displaced for their rooms for 2-3 full days per room. The construction may last in excess of 30 days to complete. This would not only affect the psychosocial wellbeing of current residents, but also would deny admissions.

Respectfully,



State Fire Marshal

11-12-14

Colin Faulkner
Assistant Administrator

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 ______	10/23/2014

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		11/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/12/2014

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 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to make available personal funds on the weekends and during the off hours for 6 of 30 residents interviewed (R25, R4, R28, R17, R8, R24). This had the potential to affect all 39 residents who had a personal funds account. Findings include: During the initial interviews held on 10/20/14 and 10/21/14, R25, R4, R28, R17, R8, and R24, when asked about the availability of obtaining money from their personal account on the	F 159	" The Resident Funds Policy has been updated to include personal funds shall be available on weekends from nursing staff and a sign regarding such has been posted on the office door. " The new policy was discussed at the resident council held 10/27/14. It was also announced during a lunch time meal on 10/29/14, and for any resident not in attendance in a one-on-one session. It will be reviewed upon resident admission. " A small amount of resident funds is to be kept in the nursing office, and nursing	

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F 159	Continued From page 2 weekends or after normal business hours, indicated they were unaware money was available. When interviewed on 10/22/14 at 12:06 p.m. the administrator indicated funds are available Monday -Friday during normal hours. The administrator indicated there is an emergency petty cash fund of $20.00 the nurses have access to, but for personal needs, the residents really need to take their money out on Friday. The office manager indicated money is offered to residents on Friday to cover their weekend needs and she has not had any concerns. She did agree that residents should have access to their personal funds on the weekends and off hours should the need arise. The administrator agreed there was no posting for the residents indicating money was available on the weekends. The administrator stated the residents should have access to their personal accounts on the weekends and during off hours. When interviewed on 10/22/14 at 1:56 p.m., R17 indicated she would like money available on the weekends in case something came up. When interviewed on 10/22/14 at 2:09 p.m., R24 indicated she usually takes her money out on Friday but would like money available on the weekends if needed. Attempts to re-interview R28 were unsuccessful. Both R17 and R24 indicated the money had to be taken out on Friday before the office manager left or there was no money available on the weekends. In reviewing the personal fund records for the residents, the office manager indicated R25 usually withdraws money immediately when it comes in. R4 has funds available but usually	F 159	staff will be given a weekly line listing of residents with funds available. The policy shall be brought up at each monthly resident council meeting. Staff shall be educated regarding the updated visiting hours policy during the monthly all staff meeting. " Random audits will be conducted to ensure the line listing is given to nursing staff on Fridays and results shall be reported to the CQI committee. The Resident Council will provide direction for change when necessary. Administrator is responsible.	

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F 159	Continued From page 3 takes it out on Friday. R28 has funds available but usually takes it out on Friday. R17 usually withdraws funds when they arrive, but does have funds available. R8 has funds but the office manager limits access otherwise R8 overspends. R24 has funds which are withdrawn on Friday. The policy and procedure entitled, Resident Funds Policy, dated 12/13/13, indicated funds are available for withdrawal Monday-Friday from 8-4 in the main office. If requested, additional funds may be kept in the nursing office for withdrawal during off hours and weekends.	F 159		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consider sufficient choice of visiting hours for 4 of 30 residents (R13, R25,R26, R40) based on personal choice for individual residents. Findings include: During stage one interview, on 10/20/14 at 3:41 p.m., R13 stated there was a specific time frame for when he could have visitors, and felt the	F 242	" The visiting hours policy has been eliminated and re-created as visitor rules and guidelines. All Visiting Hours signs posted throughout the building have been removed. " The new guidelines were discussed at the resident council held 10/27/14. It was also announced during a lunch time meal on 10/29/14, and for any resident not in attendance in a one-on-one session. It will be reviewed upon resident admission.	11/28/14

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F 242	Continued From page 4 restriction was disrespectful. When asked if he had ever had visitors that were asked by staff to leave, he stated that he believed that his family may have been asked to leave at one time, and the reason may have been noise. When asked if he had ever relayed his concern to the facility about the restriction on visiting hours, he explained that there was a sign by the front door of the facility showing the allowed visiting hours at the facility and he thought that was the rule, and did not think that he could challenge that rule. When interviewed on 10/21/14, at 3:05 p.m. the facility social worker (FSW) stated that the facility did have a policy of restricting visitors to the facility at certain hours and that this policy was mostly for safety. She explained that the building is locked at night and visitors entering the building after it is locked could be a safety risk. She also stated that she was not aware of any incident that had occurred with visitors that was due to unlimited visiting hours. When asked if the neighborhood was unsafe, the FSW replied that this was a very nice neighborhood. FSW indicated not being aware that limited visiting hours was a concern for residents in the facility. On 10/21/14 at 9:30 a.m. R25 was asked about having visitors any time during the day or night. R25 indicated there was a posted sign in the hallway that identified visiting hours. R25 was not aware why visitors had to leave by 9:00 p.m. Although it had not affected him at this time, R25 reported visitors should be able to stay past the time posted. During stage one on 10/20/14 at 4:53 p.m. R26 was asked if he could have visitors anytime during the day or night, and R26's response was	F 242	" Staff shall be educated regarding the updated visiting hours policy during the monthly all staff meeting. It shall be continually brought up at resident council " A question regarding resident visitors shall be incorporated into the quarterly resident satisfaction interviews presented at the CQI committee meeting. The Resident Council will provide direction for change when necessary.	

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F 242	Continued From page 5 "No, I would like to have visitors anytime I want." R26 added the facility had its own rules and that company had to leave at 9:00 p.m. On 10/22/14 at 8:09 a.m., the resident reported he should have visitors whenever he wants or can. R26 added the facility had a sign posted so visitors leave early, but added "they shouldn't have to." On 10/21/14 at 9:31a.m., R40 was asked about having visitors any time during the day or night and reported he was aware that he could not have visitors in the evening. On 10/22/14 at 10:25 a.m., R40 clarified that he was aware visitors could not stay past a certain time and added "it was not right". During entrance and throughout the days of the survey, October 20, 21, 22, and 23, 2014, a permanent sign was posted on the main hallway facing the entrance of the facility. The sign read "Visiting Hours 10:00 a.m. - 9:00 p.m." On 10/22/14 at 2:45 p.m., the FSW reported the visiting hours have been set for some time and added that the limited visiting hours were also for safety purposes and expressed concern regarding visitors staying all night. The undated, Rules and Guidelines for Visitors at Hayes Residence policy read, ..."4. Visitors must adhere to Hayes Residence Visiting Hours, which take place daily between the hours of 10:00AM and 9:00PM." The policy lacked any reference to a system to follow for exceptions to the posted visiting hours, considering resident preferences, fulfilling choices about aspects of life significant to the residents.	F 242		
F 278	483.20(g) - (j) ASSESSMENT	F 278		11/28/14

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F 278 SS=D	Continued From page 6 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility did not complete an accurate functional assessment for activities of daily living for 2 of 3 residents (R15, R45) for activities of daily living and for behavior status for 1 of 3 residents (R25) reviewed for accurate	F 278	" The assessments for R15, R25, & R42 were changed to accurately reflect documentation. " Most recent MDSs reflecting residents in need of assistance with ADLs or were documented to exhibit behaviors will be	

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F 278	Continued From page 7 assessments. Findings include: The facility failed to ensure R15's quarterly MDS reflected the care for dressing documented in the resident record. Review of R15's quarterly MDS, with target date 8/23/14, revealed R15 required limited assistance from staff with dressing and was cognitively intact. Review of the 7 day observation data collection tool for 8/23/14 revealed R15 was independent in dressing on all days of the assessment review dates, 8/22/14 through 8/29/14. Review of progress record notes from 8/22/14 through 8/29/14 revealed no instances of assistance with dressing. On 10/21/14 at 2:45 p.m. the nurse, (LPN)-C and trained medication aide, (TMA)-A reported R15 did not require assistance with dressing except rarely needed help with putting socks and shoes on. On 10/23/14 at 3:00 p.m. R15 reported she did not need assistance with dressing. On 10/21/14 at 3:15 p.m. the MDS coordinator, (RN)-A, reported R15 received assistance with getting her dress on, including zipping it up in the back. RN-A reviewed the chart and confirmed she did not find evidence this assistance occurred during the assessment review dates. The 7 day observation record policy, undated,	F 278	reviewed to determine that proper documentation is present. Any discrepancies will be flagged for follow up. " New behavior documentation sheets were put into place on 11/01/14. A key to the new behavior sheets has been placed in the behavior book to assist with proper coding. Staff will be re-educated regarding behavior documentation and ADL documentation at the all nurse staff meeting on 11/20/14 and documents shall also be available for review in the nursing office. " Random MDS audits shall be completed jointly with MDS Coordinator and DON to verify MDS coding correctly reflects documentation. DON 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. DON is responsible.	

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F 278	Continued From page 8	F 278		

directed staff "This form has been designed to assist staff in completing the MDS correctly by identifying cares and behaviors of the residents at Hayes. The MDS is the document that the state uses to base our room rates on so it is very important that the information on this record is correct."

The quarterly minimum data set (MDS) assessment dated 10/3/14 inaccurately reflected R42's ability to perform ADL's.

When observed on 10/20/14 at 12:00 p.m., R42 appeared in the dining room wearing a shirt that had numerous holes in it. His appearance appeared to be disheveled. On 10/21/14 when interviewed at 10:15 a.m. R42 was observed wearing a shirt with many holes in it and his teeth appeared blackened.

The admission MDS dated 7/3/14, indicated R42, was totally independent with dressing and was independent with supervision of staff for personal hygiene, which included teeth care. The quarterly MDS, dated 10/3/14, indicated R42 needed supervision and assist of one staff with dressing and grooming. The 7 day look back documentation by the staff, prior to the quarterly MDS did not support the assistance needed.

When interviewed on 10/22/14 at 11:00 a.m. regarding personal hygiene and dressing, the MDS nurse indicated the quarterly MDS was an inaccurate assessment of the resident. The resident is very capable of doing for himself, however he needs much encouragement but no hands on assist.

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F 278	Continued From page 9 The facility failed to ensure the current minimum data assessment accurately reflected R25's behavior. R25 was admitted to the facility with diagnoses that included cerebrovascular disease, sleep disorder and depression. During stage one on 10/21/14 at 9:32 a.m., R25 was interviewed. R25 appeared alert, with appropriate speech, answered survey questions and interacted with surveyor. Review of the annual minimum data set (MDS)dated 6/27/14 indicated the resident exhibited no behaviors such as rejection of care and showed no signs of delusions. The quarterly minimum data set (MDS) dated 9/27/14, indicated the resident had exhibited signs of delusions (misconception or belief that are firmly held, contrary to reality) and had exhibited signs of rejecting of evaluation of care such as blood work, taking medications and assistance with activities of daily living, that is necessary to achieve the resident's goals for health and well being. This was displayed more than 3-? times a week, but not daily. A review of the 7 Day Observation Data Collection Tool for the observation period of 9/21/14 - 9/27/14 indicated there were no observations of negative behaviors such as hit or scratched self, pacing, screaming or delusions. The observation period also revealed no evidence of wandering or resisting of cares for all shifts. The August and September 2014 Medication Administration Record (MAR)	F 278		

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F 278	Continued From page 10 indicated R25 was monitored for behaviors that included delusional thoughts. For both months, the MAR lacked documentation of any displayed behavior. During an interview on 10/21/14 at 8:53 a.m., the minimum data set registered nurse (RN)-A reviewed the information and agreed the quartly minimum data set did not accurately reflect R25's status and that the quarterly MDS was inaccurate.	F 278		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain or improve 1 of 3 residents (R42) reviewed for activities of daily living. Findings include: When observed on 10/20/14 at 12:00 p.m., R42 appeared in the dining room wearing a shirt that had numerous holes in it. His appearance appeared to be disheveled. On 10/21/14 when interviewed at 10:15 a.m. the resident was observed wearing a shirt with many holes in it and his teeth appeared blackened. The admission MDS dated 7/3/14, indicated R42, was totally independent with dressing and was	F 311	" The care plan for R42 was changed to reflect resident specific ADL requirements. " Any care plans reflecting resident s independent with ADLs will be reviewed for accuracy and updated if necessary to maintain appropriate level of dependence with ADLs. " Nursing staff will be reeducated on ADLs coding at all nursing meeting on 11/20/14. " Random ADL coding audits shall be completed jointly with MDS Coordinator and DON to verify coding correctly reflects resident needs. DON will report progress of audits to CQI committee. The CQI Committee will provide direction or change when necessary & will dictate the	11/28/14

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 ______	10/23/2014

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 311	Continued From page 11 independent with supervision of staff for personal hygiene, which included teeth care. The quarterly MDS, dated 10/3/14, indicated R42 needed supervision and assist of one staff with dressing and grooming. The 7 day look back documentation by the staff, dated 9/19/14 through 10/3/14 and completed prior to the quarterly MDS, does not support the assistance needed. For dressing and personal hygiene on all shifts the staff indicated no assistance needed or the activity did not occur. The nurses notes dated 9/27/14 indicated independent with ADL's. The nurses notes dated 9/28/14 indicated independent with ADL's. Staff to make sure he is clean and odor free. The nurses notes dated 10/2/14 indicated, during a conversation with [R42] the resident indicated he needs a lot of prompting and help from staff to remind him to do personal hygiene. When interviewed on 10/22/14 at 11:00 a.m. about personal hygiene and dressing the MDS nurse indicated the quarterly MDS was an inaccurate assessment of the resident. The resident is very capable of doing for himself, however he needs much encouragement but no hands on assist. She indicated staff need "to be on him" about his clothing and personal hygiene.	F 311	continuation or completion of this monitoring process based on compliance noted. DON is responsible.	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the	F 313		11/28/14

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HAYES RESIDENCE	**1620 RANDOLPH AVENUE** **SAINT PAUL, MN 55105**

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F 313	Continued From page 12 treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure services were provided for 2 of 3 (R15, R40) residents reviewed in the sample for vision. Findings include: R40 was admitted to the facility on 8/12/14 with diagnoses that included schizophrenia, head injury, and orbital floor closed fracture. The current care plan, updated, 8/28/14 indicated the resident needed assistance with set up and support for health maintenance including vision. Care plan approaches included staff will assist with setting up appointments and transportation and encourage resident to comply with all appointments. A review of resident's admission fall protocol, undated, indicated an eye appointment would be scheduled. The initial minimum data set, dated 8/13/14 indicated R40 had impaired or moderately impaired vision and did not have corrective lenses. The activity form, dated 8/14/14, indicted the resident liked to read the new and old testament every morning and night. During random observations during stage II, R40 was observed without wearing glasses. On 10/22/14 at 11:30 a.m. the registered nurse (RN)-A indicated the fall protocol was completed at time of admission and a eye appointment was to be scheduled for R40. RN-A indicated when the admission paperwork was completed, the appointment scheduling would be done by the nursing staff.	F 313	" R15 was reminded that her glasses were available for pick up, but she again declined to go. A vision appointment was made for R40. " All resident files have been reviewed to determine if any resident is in need of an appointment for hearing and visions services, or follow up for assistive devices. Nursing staff have set up appointments and, when necessary, transportation for any resident noted. " The Vision & Hearing Policy & Procedure has been updated to reflect the process required to ensure that all residents are receiving proper cares. The updates to the policy and procedure will be reviewed at the all nursing staff meeting on 11/20/14, and will be available for review in the nursing office. " The Director of Nursing (DON)/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. DON is responsible.	

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HAYES RESIDENCE	**1620 RANDOLPH AVENUE SAINT PAUL, MN 55105**

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F 313	Continued From page 13 On 10/23/14 at 9:24 a.m. the licensed practical nurse (LPN)-A indicated the resident did not currently have an eye appointment scheduled. On 10/23/14 at 9:52 the director of nursing (DON) verified an eye appointment had not been scheduled for the resident, but one would be made soon. The facility failed to assist R15 with obtaining prescription corrective lenses [glasses]. Review of R15's minimum data set [MDS], dated 8/23/14, revealed R15 had impaired vision and did not use corrective lenses for assessing vision for the MDS. R15's care plan, last updated 9/25/13 directed staff R15 required help for set up and support for health maintenance, which included Eye appointments and indicated R15 often refuses appointments, after being made. Interventions included, "Staff will assist with setting up appointments and transportation" and "Encourage to attend appointments" Review of R15's referral form, dated 12/5/13 revealed R15 was prescribed glasses and recommended to return to the clinic in one year for further monitoring. During observation and interview on 10/21/14 at 3:00 p.m. R15 was observed wearing glasses. R15 reported those glasses were 2-3 years old. She did not pick up her new prescription from last year because of icy weather conditions. On 10/22/14 at 8:44 a.m. a nurse, (LPN)-A confirmed R15 was prescribed glasses at an eye exam on 12/5/13. LPN-A added R15 never did go	F 313		

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F 313	Continued From page 14 to pick up glasses because it was too icy for her to go outside. After reviewing R15's record, LPN-A confirmed the facility did not further assist R15 in obtaining prescription glasses, even after the ice had cleared off sidewalks and roads. On 10/22/14 at 10:00 a.m. the director of nursing [DON] reported she would have expected staff to inform R15 of the risks and benefits of not wearing her glasses, reapproach, review different options and document interventions attempted at assisting R15 with obtaining prescription glasses. The Vision and Hearing policy, dated 01/16/14, directed staff :" To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident(s) in gaining access to vision and hearing services." The policy did not further explain the process of obtaining vision services or responsibilities of each staff member in assisting the resident.	F 313		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		11/28/14

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F 441	Continued From page 15 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to appropriately clean and disinfect blood glucose meters for 5 of 5 residents (R3, R13, R15, R32, R39) observed to have blood glucose testing. The facility failed to properly dispose of items used with the blood glucose meters that were contaminated with blood, which had the potential to affect 17 residents in the facility who used blood glucose meters of the 40 residents residing in the facility. The facility also failed to appropriately clean shared electric razors in-between resident use for 1 of 3 residents (R16) observed who shared	F 441	" The house blood glucometers will be sanitized with and according to PDI Sani-Cloths/Instructions by November 14, 2014. All electric razors will be sanitized, per policy and procedure by November 14, 2014. Contaminated materials were safely removed from trash and disposed of in appropriate biohazard container on October 20, 2014. " All glucometers will be sanitized with and according to PDI Sani-Cloths/Instructions by November 14, 2014. All electric razors will be sanitized,	

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F 441	Continued From page 16 electric razors. Findings include: During observation of resident blood glucose testing with blood glucose meters, on 10/20/14 beginning at 4:30 p.m., licensed practical nurse (LPN)-B assisted R32, R39, and R15 with blood glucose meter tests, individually and privately in the nursing office. LPN-B assisted each resident at a desk in the nursing office that had a hard-sided biohazard container for sharp items on it, and a small waste basket with a clear plastic liner on the floor next to the desk. LPN-B covered the work area on the desk with sheets of paper towels. Residents waited in line outside the nursing office for their turn to enter. As the resident turns approached, the office door was closed and the resident took a seat at the desk to be assisted by LPN-B with the blood glucose testing and insulin administration. Each resident had a dedicated blood glucose meter that LPN-B wiped with a Super Sani-Cloth for 15-20 seconds, before and after use. After the blood glucose meter checks for R32 and R39 were completed, LPN-B removed the bloodied test strip from each of the blood glucose meters and dropped the bloodied test strip into the waste basket with the clear plastic liner. After the blood glucose meter for R15 was used, a drop of blood was observed on the paper towel on the desk. LPN-B invited the next resident into the office to sit by the desk for a blood glucose test. The surveyor pointed out the drop of blood on the paper towel and LPN-B picked up the paper towel with bare hands and dropped it into the waste basket with disposed of bloodied test strips. During interview on 10/20/14, at 5:05 p.m. LPN-B was asked by surveyor if the small waste basket next to the desk in the nursing office was used as a biohazard container. LPN-B replied that it was	F 441	per policy and procedure by November 14, 2014. " Glucose Monitoring and Glucose Testing policies and procedures were updated. Biohazard bags will be available in the nurse s station for the disposal of any biohazard material, including bloody glucose strips and paper towels used during glucometer use. Disinfecting Equipment Surfaces policy and procedure was updated. Staff shall be re-educated regarding the updates policy and procedure at the all nursing staff meeting on 11/20/14. " The Director of Nursing (DON)/designee will conduct random audits to monitor compliance. DON 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. DON is responsible.	

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F 441	Continued From page 17 not. When observed on 10/20/14, at 6:30 p.m. the same soiled materials, with blood, remained in this waste basket. During observation of blood glucose tests with blood glucose meters on 10/22/14, at 11:30 a.m., LPN-A assisted R3 and R13 with blood glucose meter tests, individually and privately in the nursing office. The dedicated blood glucose meter for R3 was not working, so LPN-A used the house blood glucose meter for R3's blood glucose testing. After this blood glucose meter was used for R3, LPN-A wiped it with a Super Sani-Cloth for nine seconds and set it down on the counter in the nursing office. R13's dedicated blood glucose meter was used, and after it was used LPN-A wiped the blood glucose meter with a Super Sani-Cloth for four seconds, then returned it to its black case, and put the black case in its dedicated plastic container. The facility's Blood Glucose Monitoring policy, dated 4/17/14, read, "To Clean [sic] the meter (removing blood or soil): To clean and disinfect meter, use PDI Super Sani-Cloth Germicidal Disposable wipes (active ingredients-55% Isopropyl alcohol/Isopropanol, 5,000ppm (Parts Per Million) quarternary [sic] ammonium chlorides) Viraguard/Virahold wipes (active ingredient-70% Isopropyl alcohol/isopropanol) or disinfectants with identical active ingredients...Never use meter in liquids or allow any liquids to enter the test ports. Let meter air dry thoroughly before testing. Please dispose of wipes after cleaning/disinfecting..." When interviewed on 10/22/14 at 9:30 a.m., the director of nursing (DON) was asked if the policies provided for the surveyor were the complete policies regarding cleaning of the blood glucose testing meters. DON stated that the policies provided were the complete policies.	F 441		

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F 441	Continued From page 18 When asked about the waste basket with the clear plastic liner being used to dispose of the bloodied items, DON explained that red plastic biohazard bags are available to the staff in the facility to use for disposal of bloodied items and should be used for bloodied items. DON was also aware that there were no time requirements listed for cleaning the facility's blood glucose testing meters with Super Sani-Cloths in the facility policies, but that information was clearly provided in the manufacturers's instructions for the Super Sani-Cloths and printed on the container of the Super Sani-Cloths. Printed instructions on the Super Sani-Cloth container read, "To disinfect nonfood contact surfaces only: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time. Let air dry..." The facility failed to thoroughly clean a shared razor after used by a resident. During observation on 10/21/14 at 9:17 a.m. R16 entered the nursing station and requested "the blue shaver". R16 then left the room. At 9:22 a.m., the same resident entered the nursing station, indicated he had shaved and placed the used blue shaver on the counter. A staff nurse, (LPN)-A picked up the razor and placed it into a plastic container placed on the counter. The container contained two other facility shared razors, plus at least two razors with missing parts. At 9:45 a.m. the soiled razor remained in the plastic container with other electric razors.	F 441		

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F 441	Continued From page 19 On 10/23/14 at approximately 2:45 p.m. trained medication aide (TMA)-A indicated there were three residents who used the facility's shared electric razors and verified there were two other razors available. The razors were kept in the container on the counter. On 10/23/14 at 9:46 a.m. the director of nursing (DON) verified the shared resident equipment should be thoroughly cleaned after use and before storing with other razors. The DON added the usually practice was to clean after every use by removing the razor heads and soaking them. The facility did not have a policy that identified how or when to clean shared electric razors.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents reviewed for room odors, (R34, R26) had a room free of odors. Findings include: During observation periods on 10/21/14 at 9:55 a.m; 10/22/14 at 11:48 a.m. and 10/23/14 at 10:45 a.m. an odor of stale urine, body odor and stale cigarette smoke were noted upon entrance	F 465	" The reviewed room (#18) was again deep cleaned and a Pure Non-Scent activated charcoal product ordered and placed in the room to help absorb the odors. " All other rooms were inspected and any found to be to contain odors marked for immediate follow up. " TMA s shall monitor room #18 each shift and inform housekeeping staff of any odors noted. The room is being cleaned	11/28/14

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F 465	Continued From page 20 to R34 and R26's room. During an environmental tour on 10/23/14 at 10:45 a.m. the maintenance supervisor (MS) confirmed there frequently was an odor of urine, body odor and stale cigarette smoke from R34 and R26's room. MS reported R34 and R26 frequently kept their door shut, which may inhibit fresh air from coming in from the hallway. When asked what was being done to manage odors, MS reported the facility was doing mopping, linen changes and taking the garbage out on a daily basis. On 10/23/14 at 11:06 a.m. a nurse (LPN)-C, housekeeper (H)-A and the housekeeping supervisor (HS) confirmed there was frequently an odor of urine and body odor in R26 and R34's room. The facility had tried methods to decrease odor such as different soaker pads, chemical cleaning products and more frequent linen, room cleaning, laundry washing and garbage disposal. However, the room continued to have an unpleasant odor. Review of the Hayes Residence Housekeeping and Maintenance Policies, undated, directed staff "The resident's room offers the only privacy the resident has. It is the resident's home within the home, and thus it is especially important that the rooms be kept clean and pleasant. In order to achieve this, dust all surfaces, sweep and mop hard floors, vacuum carpets and empty trash containers. Inspect the bedding daily and change as needed but no less than once a week. " A review of the housekeeping progress notes, indicated R26 and R34's room had last been deep cleaned on 10/20/14 and urine was noted on the floor. Deep cleaning included a more	F 465	daily and deep cleaned bi-weekly, or more if needed. Housekeeping Supervisor shall weekly audit rooms for odors. " The Housekeeping Supervisor/designee will conduct random audits to monitor compliance. Administrator 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. Administrator is responsible.	

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F 465	Continued From page 21 thorough cleaning than daily cleaning.	F 465		

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

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	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/21/2014**

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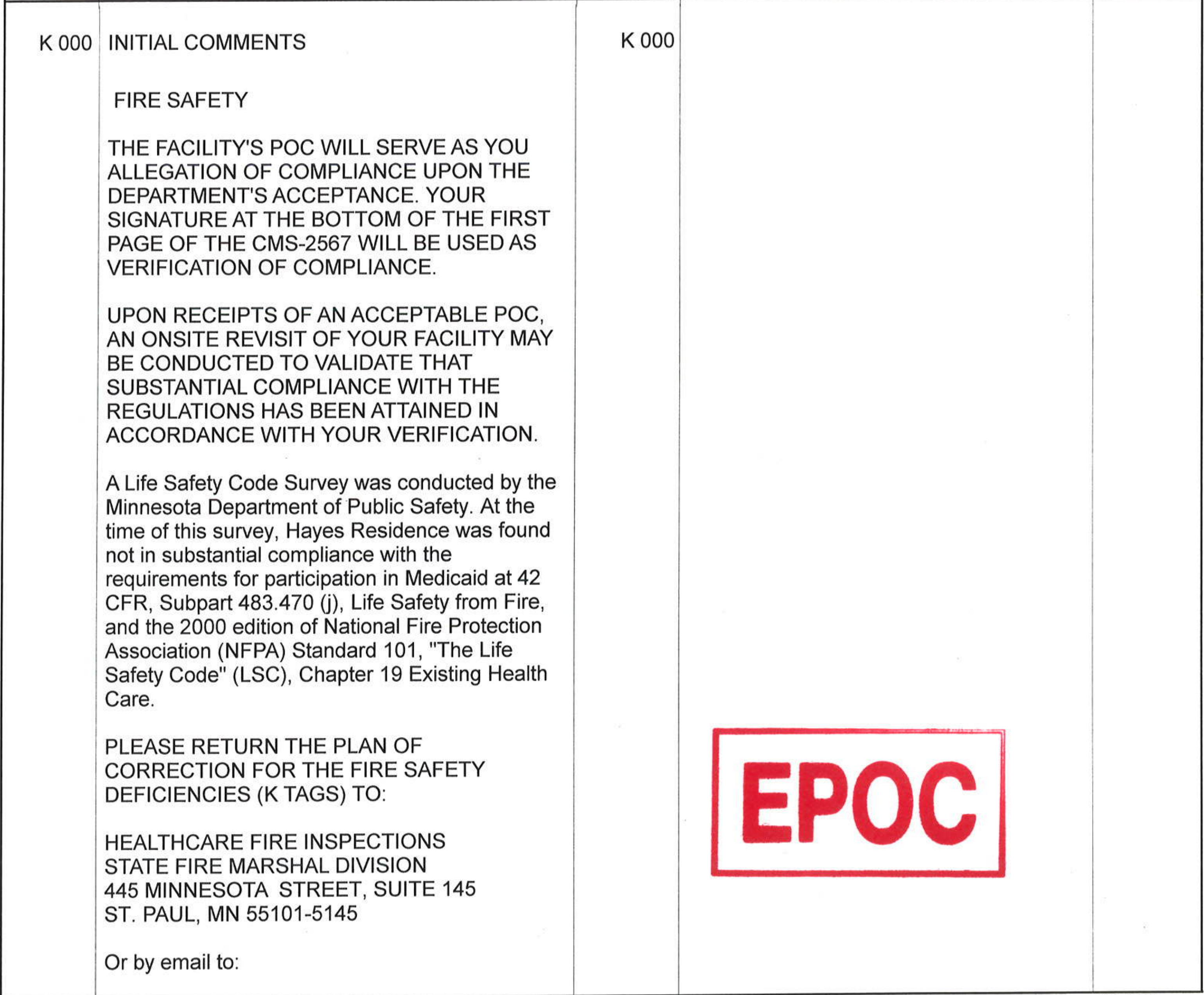

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2014

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.

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

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 ____	10/21/2014

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 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 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.470(j), is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		10/21/14

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	24E508	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025	Continued From page 2 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observationand and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 10/21/2014, it was observed that the Smoke Barrier doors did not fully close when tested on the 1st floor near room M-12. This deficient practice was verified by facility staff (SS).	K 025	1. Door was sanded down so it now operates properly as a barrier. All barrier doors have been checked and are operating properly. 2. Correction completed 10/21/2014. 3. Steve Smieja, Maintenance Supervisor	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050		10/22/14

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	24E508	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 050	Continued From page 3 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 10/21/2014, based on review of available documentation it was reveled that fire drills were not conducted on the night shift during the 2nd quarter of 2014. This deficient practice was verified by facility staff (SS).	K 050	1. Maintenance has developed a fire drill schedule based upon shifts. Only the shift (1st, 2nd, or 3rd) is scheduled, the actual time of the drill will remain open so as to remain unexpected by staff. 2. Completion of drill schedule on 10/22/2014. 3. Steve Smieja, Maintenance Supervisor	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 067	1. A waiver will be requested from the	11/14/14

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	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/21/2014**

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

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K 067	Continued From page 4 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 10/21/2014, it was observed and during an interview with facility staff (SS), 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.	K 067	state fire marshal and CMS. A waiver has been previously approved. 2. The request for waiver will be mailed to the State Fire Marshal no later than 11/14/14. 3. Colin Faulkner, Assistant Administrator	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on review of records,the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM	K 144	1. Due to a leak from a drain above the log book, maintenance test logs were destroyed. Generator test logs do provide evidence that test had been conducted on a weekly and monthly basis dating back to 2004. Maintenance testing logs for the emergency generator will be moved to a location that is protected from potential leaks. Additionally, the maintenance	10/22/14

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	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/21/2014**

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

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K 144	Continued From page 5 on 01/15/2014, it was revealed during review of available emergency generator documentation that: 1) No documentation was provided for monthly testing of the emergency generator since May 2014. 2) No documentation was provided for weekly inspection of the emergency generator since May 2014. This deficient practice was verified by facility staff (SS).	K 144	supervisor will make monthly copies of all logs and give them to the assistant administrator for a back-up record. 2. New log book created and stored in a safe place on 10/22/2014. Copies of logs provided to the assistant administrator on 11/5/2014. 3. Steve Smieja, Maintenance Supervisor and Colin Faulkner, Assistant Administrator.	