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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTGH

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 **01/16/2014** (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

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

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

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, Supervisor 04/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Speicalist 05/19/2014 (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
03/21/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-E508

On 04/17/14, a second Post Certification Revisit (PCR) was completed by the Department of Health. Based on the second PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 01/16/14 standard survey, effective 04/11/14.

Refer to the CMS 2567B for both health and life safety code.

Effective 04/11/14, the facility is certified for 40 skilled nursing facility beds.

The facility's request for a continuing waiver involving the deficiency cited under tag K0067 at the time of the 01/16/14 standard survey has been approved.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E508

May 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.

Effective April 11, 2014, the above facility is certified for:

40 - Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of Tag 0067 has been approved based on the submitted documentation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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 about this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 8, 2014

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

RE: Project Number SE508024

Dear Ms. Reynolds:

On February 4, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 17, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 4, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b),your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2014.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on December 17, 2013 and continuing non-compliance at the time of a standard survey completed on January 16, 2014. The most serious health deficiencies in your facility at the time of the abbreviated standard survey of December 17, 2014 were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required. In addition, at the time of the standard survey completed on January 16, 2014, the most serious deficiencies in your facility were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F).

On March 7, 2014, the Minnesota Department of Health and on February 28, 2014, the Minnesota Department of Public Safety completed Post Certification Revisits PCRs to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on December 17, 2014 and the standard survey completed on January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 20, 2014. Based on our visit, we have determined that your facility had not obtained substantial compliance.

On March 31, 2014 we notified you that based on your facility's continuing non-compliance, we were imposing the following Category 1 remedy: State Monitoring (42 CFR 488.422), effective April 5, 2014.

In addition, the following action was recommended, related to the imposed remedy in our letter of February 4, 2014:

- Mandatory denial of payment for new Medicaid admissions, effective March 17, 2014 would remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of February 4, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 17, 2014, due to denial of payment for new admissions.

On April 17, 2014, the Minnesota Department of Health completed a second PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 16, 2014, as of April 11, 2014. As a result of the revisit findings, this Department is discontinuing the following Category 1 remedy of State Monitoring (42 CFR 488.422), effective April 11, 2014.

In addition, as a result of the PCR findings, this Department recommended to the Minnesota Department of Human Services (DHS) the following actions related to the remedies outlined in our letter of February 4, 2014. The DHS office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicaid admissions, effective March 17, 2014, be discontinued effective April 10, 2014 (42 CFR 488.417 (b))

As we notified you in our letter of February 4, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facilty is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2014.

Your request for a continuing waiver involving the deficiency cited under tag K0067 at the time of the January 16, 2014 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 PCR 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 about this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 8, 2014

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

Re: Project Number SE508024

Dear Ms. Reynolds:

On April 17, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a second reinspection of your facility, to determine correction of orders found on the original survey completed on January 16, 2014 and re-issued during the time of the March 7, 2014 reinspection.

State licensing orders issued pursuant to the survey completed on January 16, 2014 and found corrected at the time of this second revisit on April 17, 2014, are listed on the attached Revisit Report Form.

As you were notified in our letter dated March 31, 2014, state licensing orders issued pursuant to the survey completed on January 16, 2014, found not corrected at the time of the March 7, 2014 revisit are subject to a penalty assessment. Therefore, in accordance with Minnesota Statutes, section 144.653, you were assessed for the amount of $500.00. Payment was due on May 2, 2014; this fine is considered past due.

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 with any questions.

Sincerely,

Anne Kleppe

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

Enclosure
cc: Licensing and Certification File
Sue Reuss, Metro Team A Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building B. Wing	4/17/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/11/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/11/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/11/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/11/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/30/2014	32984	04/17/2014
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
1/16/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00928	A. Building B. Wing	4/17/2014

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **30565** Reg. # **MN Rule 4655.2600** LSC	Correction Completed **04/11/2014**	ID Prefix **30601** Reg. # **MN St. Statute 144.56 Subd** LSC	Correction Completed **04/11/2014**	ID Prefix **30945** Reg. # **MN Rule 4655.6400 Subp.** LSC	Correction Completed **04/11/2014**
ID Prefix **31145** Reg. # **MN Rule 4655.7830 Subp.** LSC	Correction Completed **04/11/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/30/2014	32984	04/17/2014
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
1/16/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTGH

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 **03/07/2014** (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:

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 :
Sheryl Reed, HFE NE II 03/19/14 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/12/14 (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
03/21/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-E508

On 03/07/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 02/28/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility has not achieved substantial compliance pursuant to the 01/16/14 standard survey. Refer to CMS 2567B for both health and life safety code.

A second Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited under tag K0067 at the time of the 01/16/14 standard survey has been forwarded to CMS for their review and determination. The facility's compliance is based on pending CMS approval of the request for waiver. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7468

March 31, 2014

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

RE: Project Number SE508024 and Complaint Number HE508004

Dear Ms. Reynolds:

On February 4, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 17, 2014. (42 CFR 488.417 (b))

Also, as we notified you in our letter of February 4, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2014.

This was based on the deficiencies cited by this Department for an abbreviated survey completed on December 17, 2013, where the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required, and deficiencies cited for a standard survey completed January 30, 2014, where the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 7, 2014, the Minnesota Department of Health and on February 28, 2014, the Minnesota Department of Public Safety completed Post Certification Revisits PCRs to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on December 17, 2014 and the standard survey completed on January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 20, 2014. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on March 7, 2014. The deficiencies not corrected are as follows:

- **F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals**
- **F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens**

In addition, at the time of this revisit, we identified the following deficiencies:

- **F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan**
  F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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

As a result of the revisit findings, this Department is imposing the following Category 1 remedy of:

- State Monitoring (42 CFR 488.422), effective April 5, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of February 4, 2014 and CMS concurred:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 17, 2014 remain in effect. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of February 4, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2014.

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.

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3793
Fax: (651) 201-3790

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.

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

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 June 17, 2014 (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,

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

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00928	A. Building B. Wing	3/7/2014

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 31455 Reg. # MN Rule 4655.9000 Subp. LSC	Correction Completed 02/20/2014	ID Prefix 31810 Reg. # MN Rule 144.651 Subd. 6 LSC	Correction Completed 02/20/2014	ID Prefix 32000 Reg. # MN Rule 626.557 Subd. 14 LSC	Correction Completed 02/20/2014
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:
	SR/AK	03/19/2014	22581	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/16/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building B. Wing	3/7/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **02/20/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0387** Reg. # **483.40(c)(1)-(2)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/20/2014**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	03/19/2014	22581	03/07/2014
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
1/16/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E508	A. Building 01 - MAIN BUILDING 01 B. Wing	2/28/2014

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 K0062	02/19/2014	ID Prefix Reg. # NFPA 101 LSC K0069	02/20/2014	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 03/27/2014	Signature of Surveyor: 12424	Date: 02/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/15/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

PRINTED: 03/19/2014
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 _____ B. WING _____	R 03/07/2014

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 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. An abbreviated standard survey was conducted to investigate complaint #HE508004.	{F 000}	Preparation, submission & implementation of this Plan of Correction does not constitute 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 regulations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the care plan addressing smoking interventions were followed for 1 of 1 (R35) in the sample reviewed for accidents. Finding include: R 35 was found smoking in the bedroom, and the facility failed to follow smoking interventions for the resident.	F 282	4/11/14 SER • R35 was given a 30 day notice to vacate the facility on 3/7/14 due to her inability to follow resident policies. She discharged from the facility on 4/1/14 with the assistance and support of family members and case management. • Care plans will be reviewed for remaining 38 residents by social services department and director of nursing. Those found to be needing update will be tagged for follow up. • Staff will be educated in the importance and necessity of the care planning process. Nursing staff shall be required to review resident care plans upon resident admission and upon care plan update. Director of Nursing or Social Worker shall inform staff of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-10-14

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 _____ B. WING _____	R 03/07/2014

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 282	Continued From page 1 The medical record was reviewed on 3/6/14 at approximately 11:00 a.m. Progress note, dated 3/5/14 at 3:45 p.m. read: "Resident was seen smoking in room. approached by nurse and she {resident} said "you go out there, it is cold, I am not going out there". The progress continues to explain the nurse told the resident she needed to smoke out on the back patio. The note indicated there was some physical altercation between the resident and the nurse. Another progress note, dated 3/5/14 with no time indicated, read "2nd nurse had to intervene during this time. Will monitor." Progress note 3/5/14 At 4:15 p.m., "resident has continued to be verbally aggressive/abusive to roommate saying "You don't belong here, you don't pay rent, you need to get out of here etc. and I wont stop. Writer told reside her behavior was inappropriate and if she continues the police will be called or she will be sent out to crisis. RN here and writer asked her to talk to resident after explaining what has happened since the start. She has refused accucheck and insulin at 4:45 p.m." Progress note dated: 2/?/14 (unable to read date), indicated resident was caught smoking in room, when asked where she got it from, she pointed to roommate who said she stole it from {resident's name}. Review of the current care plan, dated 2/14/14, indicated R35 would be compliant with smoking rules of the facility. The care plan directed staff to store all cigarettes with nursing staff, the resident was to ask for one cigarette at a time when smoking during allowed smoking hours and the	F 282	• updates. Upon resident admission or care plan change, staff will sign a form indicating he/she has read the resident care plan. This form shall be kept in the nursing station for a minimum of 3 months, and then moved to the residents' permanent file. • Random audits of care plan compliance will be completed by either Director of Nursing or Social Worker or designee on a quarterly basis and results will be reported to the Continuous Quality Care 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. Completion date of 4/11/14 RECEIVED APR 10 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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 _____	R 03/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 282	Continued From page 2 resident does not smoke anywhere inside the facility. The resident would smoke only in approved areas of the facility. On 3/6/14 at 11:40 a.m., licensed practical nurse (LPN-B) indicated R35 had been smoking in her room the previous afternoon. When R35 tried to dispose of the cigarettes in the trash bag (plastic bag), LPN-B tried to grab them. R35 grabbed at her arm and shirt. LPN-B was wearing a Band-Aid on her hand and indicated her underclothing had been ripped by R35. LPN-B indicated R35 had own cigarettes in her room. When asked LPN-B about what the current care plan indicated regarding staff storing the cigarettes, LPN-B indicated she was not aware R35 could not have cigarettes and stated that stopped awhile ago. LPN-B directed further questions to the social worker. On 3/6/14 approximately 2:00 p.m., the social worker was asked about the smoking incident and how did R35 have access to cigarettes. The social worker indicated nursing staff were to store the cigarettes and give one cigarette at a time to R35. R35 was directed to smoke in the back patio right off the main dining room. The social worker was not aware R35 had access to own cigarettes. The social worker clarified with LPN-B the cigarettes of R35 were to be stored in the office and R35 should not have access to the cigarettes. On 3/6/14 at approximately 3:50 p.m. the social worker confirmed the staff were not storing the cigarettes for R35 and therefore, not following the care plan for smoking.	F 282		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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 _____	R 03/07/2014

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 323 SS=D	Continued From page 3 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the care plan addressing smoking interventions were followed for 1 of 1 (R35) in the sample reviewed for accidents. Finding include: R 35 was found smoking in the bedroom, and the facility failed to follow smoking interventions for the resident. The medical record was reviewed on 3/6/14 at approximately 11:00 a.m. Progress note, dated 3/5/14 at 3:45 p.m. read: "Resident was seen smoking in room. approached by nurse and she {resident} said "you go out there, it is cold, I am not going out there". The progress note continued to explain the nurse told the resident she needed to smoke out on the back patio. The note indicated there was some physical altercation between the resident and the nurse. Another progress note, dated 3/5/14 with no time indicated, read "2nd nurse had to intervene during this time. Will monitor."	F 323	F323 • R35 was given a 30 day notice to vacate the facility on 3/7/14 due to her inability to follow resident policies. She discharged from the facility on 4/1/14 with the assistance and support of family members and case management. • Care plans will be reviewed for remaining 38 residents by social services department and director of nursing. Those found to be needing update will be tagged for follow up. • All staff will be re-educated regarding designated smoking areas and instructed to report to person in charge immediately if he/she suspects anyone is not following the policy. Residents will be re-educated of the designated smoking areas and consequences of failure to follow resident policies during the next resident council meeting. If a resident is found to be violating policy there will be an intervention by the social worker	

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 _____	R 03/07/2014

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 323	Continued From page 4 Progress note 3/5/14 At 4:15 p.m., "resident has continued to be verbally aggressive/abusive to roommate saying "You don't belong here, you don't pay rent, you need to get out of here etc. and I wont stop. Writer told reside her behavior was inappropriate and if she continues the police will be called or she will be sent out to crisis. RN here and writer asked her to talk to resident after explaining what has happened since the start. She has refused accucheck and insulin at 4:45 p.m." Progress note dated: 2/?/14 (unable to read date), indicated resident was caught smoking in room, when asked where she got it from, she pointed to roommate who said she stole it from {resident's name}. Review of the current care plan, dated 2/14/14, indicated R35 would be compliant with smoking rules of the facility. The care plan directed staff to store all cigarettes with nursing staff, the resident was to ask for one cigarette at a time when smoking during allowed smoking hours and the resident does not smoke anywhere inside the facility. The resident would smoke only in approved areas of the facility. On 1/6/14 a self administration of smoking assessment was completed for R35. The Assessment indicated the resident was evaluated as independent for a smoking plan, and wanted to reduce from 4 to 3 cigarettes a day. On 3/6/14 at 11:40 a.m., licensed practical nurse (LPN-B) indicated R35 had been smoking in her room the previous afternoon. When R35 tried to dispose of the cigarettes in the trash bag (plastic bag), LPN-B tried to grab them. R35 grabbed at	F 323	F323 • to determine if care plan interventions need to be updated. Staff will be re-educated in the importance and necessity of the care planning process. Director of Nursing or Social Worker shall inform staff of updates. Upon resident admission or care plan change, staff will sign a form indicating he/she has read the resident care plan. This form shall be kept in the nursing station for a minimum of 3 months, and then moved to the residents' permanent file. • Random audits of care plan compliance will be completed by either Director of Nursing or Social Worker or designee on a quarterly basis and results will be reported to the Continuous Quality Care committee. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring	

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 _____	R 03/07/2014

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 323	Continued From page 5 her arm and shirt. LPN-B was wearing a Band-Aid on her hand and indicated her underclothing had been ripped by R35. LPN-B indicated R35 had own cigarettes in her room. When mentioned to LPN-B about the current care plan indicated regarding staff storing the cigarettes, LPN-B indicated she was not aware R35 could not have cigarettes and stated that stopped awhile ago. LPN-B directed further questions to the social worker. On 3/6/14 approximately 2:00 p.m., the social worker was asked about the smoking incident and how did R35 have access to cigarettes. The social worker indicated nursing staff were to store the cigarettes and give one cigarette at a time to R35. R35 was directed to smoke in the back patio right off the main dining room. The social worker was not aware R35 had access to own cigarettes. The social worker clarified with LPN-B the cigarettes of R35 were to be stored in the office and R35 should not have access to the cigarettes. At 3:30 p.m., after the change of shift for the nursing staff, the social worker informed LPN-C that R35 should not have cigarettes in the private room and that staff should be handing out one cigarette and lighter at a time. On 3/6/14 at approximately 3:50 p.m. the social worker confirmed the staff were not storing the cigarettes for R35, not giving R35 one cigarette at a time and therefore, not following the care plan for smoking. The Smoking Policy, last revised on 5/9/13 with additional updates made by the social worker on 3/6/14, indicated that smoking was not permitted in any part of the building but was permitted on the south side of the screen porch or patio from	F 323	F323 • process based on compliance noted. • Completion date of 4/11/14	

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 _____	R 03/07/2014

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 323	Continued From page 6 4:00 a.m.-11:00 p.m. with the following exceptions for mealtimes: 7:00 - 8:00 p.m., 12:00 -12:30 p.m., and 5:00 p.m.-5:30 p.m. Smoking is not allowed in front of the building including on the landing, the front steps, or on the sidewalk leading to the city sidewalk. a smoking safety assessment is conducted with each resident smoker upon admission and quarterly thereafter. The assessment is used to determine a resident's need for and individualities smoking management plan.	F 323		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	{F 431}		

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 _____	R 03/07/2014

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 431}	Continued From page 7 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to ensure medications were labeled properly and discarded from use when discontinued for 2 of 2 residents. (R21 and R36). Findings include: During observation of the medication storage refrigerator, 10 bisacodyl suppositories were stored in a clear small plastic bag. The bag had a partial label on the exterior of the bag. Four letters of resident's name were noted as well as partial instructions were noted on the label. When LPN-B was asked about them, LPN-B identified what patient they were for and stated" he has not used them for awhile". During observation of the medication cart 1, two tubes of erythromycin ointment were found for R36. The order had been stopped on 11/08/13, however, the ointment tubes remained in the cart for dispensing. The trained medication assistant (TMA-B) wasn't sure why they remained in the cart. The items were removed from the refrigerator	{F 431}	F431 • The medications referenced were immediately removed from use and discarded as appropriate. • Director of Nursing or designee will go through each medication cart to ensure medications are labeled properly, not expired and current with physician's orders. Any expired medications found shall either be destroyed by the facility if possible or the pharmacy shall be contacted. Any medications found labeled improperly will be reported to pharmacy for proper labeling. • Nursing staff will be re-educated regarding the importance of destroying expired medication and proper labeling of medication. All medications will be audited weekly to ensure proper labeling and	

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 _____	R 03/07/2014

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 431}	Continued From page 8 and the medication cart. No audits, part of the correction plan, were available during the post certification survey. The director of nursing was not available during survey. On 3/5/14 at approximately 5:00 p.m., a registered nurse (RN-A) was called in to the facility to answer questions. On 3/5/14 at 5:00 p.m., the registered nurse (RN-A) was interviewed. RN-A was responsible for completing the minimum data sets for residents and completing all admissions and discharges for the facility. At this time, RN-A verified the suppositories and the eye ointment should have been disposed of earlier. RN-A would look for additional information regarding policy and procedures and correction steps and leave for further review. The Pharmacy Services policy, dated 1/16/2014, indicated the facility in coordination with Licensed Pharmacist, will ensure that medications and biological's are labeled with expiration date and expired medications are discarded per procedure. Review of R21 record revealed a diagnoses of constipation and a physician order for bisacodyl (ducal) 10 mg suppository for as needed basis. Review of R36's medical record revealed a physician order for erythromycin eye ointment and direct staff to instill a thin ribbon to each eye at bedtime for 90 days. The start date for the order was 8/13/13 and was discontinued 11/12/13.	{F 431}	• disposal of expired medications. • A medication cart audit required by person manning the cart went into effect on 3/11/14. Random audits of these audits and medications in use will be completed by Director of Nursing or designee on a quarterly basis and results will be reported to the Continuous Quality Care committee. Audit results will be maintained in the nursing office for a minimum of three months. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. • Completion date of 4/11/14.	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	{F 441}		

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 _____	R 03/07/2014

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 441}	Continued From page 9 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 (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.	{F 441}	F441 • Staff will be re-educated on the policy and procedure for infection control and the importance of using gloves and hand washing as a universal precaution. Staff shall be re-educated on the location and importance of the "Step by Step" policy/procedure book as well as the survey ready file located in the nursing office at all times. All staff shall sign documentation that they understand this information and documentation will be kept in the employees personnel file. • Employee personnel files will be audited by the Administrator for all new employees from the past three months to ensure that the TST documented results are properly maintained. • Gloves are placed next to glucometer machines and also next to nursing supplies. Reminder cards for proper glove use and hand washing techniques shall be placed with each	

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 _____	R 03/07/2014

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{F 441}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure glove changing and hand washing were completed during used during blood glucose monitoring to prevent the spread of infection for 5 of 6 residents(R3, R35, R2, R18, R10) and the facility failed to provide documentation of tuberculin skin tests (TST) for new employees per Center for Disease Control and Prevention (CDC) guidelines. Findings include: Five residents had their glucose monitoring and received insulin with assistance from the licensed practical nurse (LPN)and LPN-D did not provide consistent glove wearing or hand washing. On 3/4/14 at 4:45 p.m., LPN-D set out blood glucose supplies for R3 that included a glucometer, alcohol pad, lancet, cotton ball and monitoring slip. R3 does own stick but needs assistance with the monitoring slip from the LPN-D. LPN-D administers the medication, and removes gloves. LPN-D then wipes down the glucometer with an alcohol pad, puts it back in the case and then plastic bag. LPN-D then washes her hands. R35 comes into the nursing station to have blood sugar monitored. Again LPN-D set up equipment needed for monitoring the blood. After administering insulin to R35, LPN-D removed the gloves. LPN-D picked up the glucometer and wipes off with a alcohol pad without wearing gloves. The glucometer was then placed into a plastic zip lock bag.	{F 441}	• resident's glucometer machine. Random audits of glove use and hand washing procedures will be completed by Director of Nursing or designee on a quarterly basis and results will be reported to the Continuous Quality Care committee. Audit results will be maintained in the nursing office for a minimum of three months. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. A line listing of new employees, title, and hire date shall be kept in the nursing station along with a copy of his/her TB testing in accordance with the most recent TB policy. These copies shall be kept in the survey ready file for a minimum of 3 months. The permanent TB record will remain in the employee's confidential personnel file. • Completion date of 4/11/14.	

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 _____	R 03/07/2014

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 441}	Continued From page 11 R2 came into medication room for blood sugar monitoring. LPN-D set up supplies needed for blood sugar monitoring. After blood sugar was obtained, LPN picked up the glucometer and wiped it down with alcohol without wearing gloves. When completed, LPN-D placed the glucometer into a plastic zip lock bag. R18 comes into the medication room to do the blood sugar monitoring. After the resident does his blood sugar, LPN-D picked up the used cotton ball, the used monitoring strip and the used lancet without gloves. The LPN-D removed the gloves, then picked up the glucometer and cleanses with a alcohol swab. LPN-D was not wearing gloves while cleaning the glucometer. The glucometer was then placed in a plastic zip lock bag. R10 comes into the medication room to have blood sugars checked. LPN-D was wearing gloves while cleansed the resident ' s skin with alcohol, used a lancet to retrieve a blood droplet. When completed, LPN_D removed the gloves, and washed her hands. At that time, LPN-D picked up the used lancet and other used items such as cotton ball, lancet and monitoring stick without wearing gloves. LPN-D, still not wearing gloves, wiped down the glucometer with an alcohol pad and places in the resident ' s plastic bag. At 5:15 p.m. LPN-D was asked about the procedure of doing blood sugars on residents and the cleaning of the glucometers while not wearing gloves. LPN indicated every resident had their own glucometer. They are identical and were kept in labeled plastic zip lock bags. When asked about wearing gloves while cleaning up soiled items i.e. monitoring strip, and while cleaning the	{F 441}		

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{F 441}	Continued From page 12 individual glucometer, the LPN indicated gloves should be worn when picking things up, and while cleaning the glucometers. On 3/5/14 at 4:30 p.m., the registered nurse for MDS, (RN) was called in to assist with survey. After reviewing the procedure of obtaining blood sugars and dispensing insulin, picking up soiled items and cleansing the glucometers with alcohol, the RN verified the nurse conducting the finger sticks should have worn gloves while cleaning up soiled items, and should have worn gloves while cleaning the individual glucometers with a alcohol pad. At this time the RN was asked about policies regarding hand washing and glucometer cleansing. The RN indicated she would see what she could find and leave all policy/procedures that were developed for corrections. On 3/6/14 at 09:00 a.m. the Blood Glucose Monitoring Policy and Procedure , written 1/13/14, was reviewed. the policy statement indicated the facility will prevent cross contamination using transmission based precautions in addition to standard precautions. and Procedure statement indicated that each resident with a diagnosis of diabetes and wherein diabetic blood glucose monitoring is warranted, s/he will have their own blood glucose monitoring kit for blood glucose testing. The facility failed to provide documented results of a tuberculin skin test (TST) for new hires per Centers for Disease Control and Prevention (CDC) recommendations. On entrance on 3/4/14 at approximately 12:00 noon, the office manager was questioned regarding potential recent new hires. The office	{F 441}		

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{F 441}	Continued From page 13 manager indicated there had been at least one new hire of a housekeeper however, there was no access to the employee record. The office manager indicated the employee files were maintained in the Assistant Administrator ' s office. The Assistant Administrator was on annual leave, and the office was locked. No one working had access to the office. On 3/5/14 at 4:30 p.m., the registered nurse (RN), was interviewed about new and rewritten policies for infection control. It was agreed that she would look for additional policies and make them available for review the next day. When information provided by the RN was reviewed on 3/6/14 at 9:30 a.m., there was no policy identified for tuberculin skin test. The RN was not available for further interview at the facility. The Director of Nursing was not available during the three days of survey at the facility.	{F 441}		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR BOARDING CARE HOMES

Hand Delivered on **DATE HERE**. 4/17/2014

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

Re: Project Number SE508024 and Complaint Number HE508004

Dear Ms. Reynolds:

On March 7, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 16, 2014 with orders received by you on February 11, 2014.

State licensing orders issued pursuant to the last survey completed on January 16, 2014 and found corrected at the time of this March 7, 2014, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on January 16, 2014, found not corrected at the time of this March 7, 2014 revisit and subject to penalty assessment are as follows:

- **0601 - MN St. Statute 144.56 Subp. 2c - Tuberculosis Prevention And Control - No Fine**
- **0945 - MN Rule 4655.6400 Subp. 1 - Adequate Care; Care In General - $250.00**
- **1145 - MN Rule 4655.7830 Subp. 4 - Medication Containers;out Of Date Medications - $250.00**

The details of the violations noted at the time of this revisit completed on March 7, 2014 (listed above), are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144.653, you are assessed for the amount of **$500.00.** Fines shall be paid by check made payable to the Commissioner of Finance, Treasury Division and sent to the Department of Health, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900 within 15 days of the receipt of this notice.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Also, at the time of this reinspection completed on March 7, 2014, additional violations were cited as follows:

- **0565 -- MN Rule 4655.2600 -- Capability**

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Po Box 64900 St Paul Mn 55164-0900.

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 with any questions related to this letter.

Sincerely,

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

Enclosure

cc: Licensing and Certification File
Susanne Reuss, Metro Team A Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QTGH

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 **01/16/2014** (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:
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)
__ 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*** (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 Heim, HFE NE II 02/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/21/2014 (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
AW K67 Emailed ROCHI 03/21/2014
Posted 03/21/2014 CO. QTGH

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

At the time of the standard survey completed 01/16/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies to beisolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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.

Documentation supporting the facility's request for a continuing waiver involving K0067 was previously forwarded to CMS. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8088

February 4, 2014

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

RE: Project Number HE508004 and SE508024

Dear Ms. Reynolds:

On January 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on December 17, 2013. This survey found the most serious deficiencies to beisolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 16, 2014, the Minnesota Departments of Health and Public Safety completed a standard survey a standard survey to verify that your facility had achieved and maintained compliance with federal certification requirements. The 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 corrects are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 17, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 17, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 17, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Hayes Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 17, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) from the January 16, 2014 standard survey is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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
Saint Paul, Minnesota 55164-0900

Phone: (651) 201-3793
Fax: (651) 201-3790

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.

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

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, Office of Health Facility Complaints 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 March 17, 2014 (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 June 17, 2014 (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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File E508s14ohfc&LCltr.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 _____	01/16/2014

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 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	Preparation, submission & implementation of this Plan of Correction does not constitute 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 regulations.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident call light was accessible for 1 of 1 resident (R25) reviewed for environmental concerns. Findings include: R25's call light was not accessible on the evening of 1/13/14 or during the day on 1/14/14. On 1/13/14, at 2:56 p.m., during interview, R25	F 246	• Information regarding "reasonable accommodations of individual needs & preferences" has been presented in education/re-education to all staff. 2/20/14 • Staff will ensure the call-lights are within reach of residents' bed as well as striving to reasonably accommodate resident's preference as resident makes use of the physical environment. 2/25/14 SER • The Director of Nursing (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. • Completion date: February 20, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/14/14

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
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F 246	Continued From page 1	F 246		

stated she was not able to reach the call light and said that the last time, when she had "A stroke" she was not able to reach it either, "But lucky a nurse came into the room and I was sent to the hospital." She further stated "I would like you to give the facility a recommendation on how to get the call light close to me as I have a hard time reaching it." R25's call light was observed to be clipped to a string that was attached to a light, by the head of the bed. The string with the call light clipped to it was noted to be falling behind the head board of the bed.

On 1/14/14, at 9:45 a.m. and at 1:47 p.m., during observations, R25's call light continued to be clipped onto the string, hanging from the light, behind the bed head board. R25 was observed sitting by the door and the call light was not accessible to R25.

On 1/14/14, at 1:48 p.m. the assistant administrator verified the call light was not accessible to R25 and stated it should have been clipped to the bedding where she was able to use it as she spent most of the time in her room. R25 stated to the assistant administrator, "Putting it to the clip on the head board was not accessible. I want the call light to be wrapped around something where I'm able to get hold of it when I need assistance."

R25's diagnoses, obtained from the quarterly Minimum Data Set (MDS) dated 10/24/13, included degenerative joint disease. R25's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score indicated R25 was cognitively intact. In addition the MDS indicated R25 had a functional limitation in range

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F 246	Continued From page 2 of motion with impairment to both sides of lower extremities, used a walker for mobility and balance during transitions and walking was not steady but was able to stabilize without assist of another person. On 1/15/14, at 11:40 a.m. the director of nursing (DON) stated she was not made aware R25's call light was a problem. Her expectation was to have call lights accessible to all residents who are capable of using the call light. The Call Light policy revised 9/11/12, directed "Call lights will be within reach of all resident beds and within resident bathrooms. Call lights will be in working order."	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and care plan concerns related to the family support system for 1 of 2 residents (R35) identified as needing medically related social services. Findings Include: R35's hospital admission history, dated 9/21/13, indicated R35 currently lives with a family	F 250		

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F 250	Continued From page 3 member, however, there is some question that this might not be a good housing situation. Revoew of the facility's 35's most recent care area assessment, dated 10/25/13, indicated, R35 showed impairment in cognition and decision making due to mental illness diagnoses, which included Paranoid Schizophrenia and Depression. An undated handwritten note was provided by the social worker, (LICSW) , regarding R35's initial care conference on 10/17/2014. The note included concerns regarding R35's care and services in her prior living arrangements. The information had been provided to the facility by the case manager during the initial care conference. Review of the Progress Record note, dated 12/31/13 at 1:55 p.m. indicated R35 was on leave of absence (LOA) December 21st to 26th 2013, and it was discovered that there were three and a half days insulin R35 did not take while on LOA. An attempt was made to discuss concerns with a family member, including a reminder to ensure R35 takes her insulin while on LOA with the family member. A review of R35's medical record, including care area assessment dated 10/25/13, most recent care plan dated 9/30/13 and Social History dated 9/30/13, revealed no assessment or plan in place to manage the risks associated with R35's related vulnerabilities. During interview on 1/15/14 at 11:23 a.m., the nurse, (LPN)-C, reported she was aware of the issues with R35's LOA's, confirmed R35 missed 3	F 250	2/20/14 • Information regarding "assuring that sufficient & appropriate social services are provided to meet the residents' needs" has been presented in education/re-education to all staff. • Social Services interventions to assure the safety of (R35) were implemented immediately. For all other residents that may be affected, no problems/concerns were identified. • The Social Services Director (SSD)/designee will conduct random audits to monitor compliance. SSD 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. • SSD is responsible. • Completion date: February 20, 2014	

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F 250	Continued From page 4 and a half days of insulin while visiting her family over Christmas and reported she knew of no plan to minimize risk for R35 in regards to her family involvement. LPN-C reported there were no restrictions on R35's being able to leave the facility. During interview on 1/15/14 at 1:51 p.m. the director of nursing (DON) reported she was unaware of the concerns regarding care and services in R35's prior living arrangement, however, reported she was aware of R35 not getting three and a half days of insulin while visiting family over Christmas. DON reviewed the medical record and confirmed there was no assessment or plan regarding the risks posed by R35's family involvement. DON explained her expectation would be for a safety plan to be developed so R35 would be safe while in the community. During interview with on 1/16/14 at 8:45 a.m., LICSW, explained she had concerns regarding family involvement with R35's personal funds, was aware of the prior living arrangement and missed insulin while R35 visited family. LICSW reviewed R35's medical record and her own files and reported there was no assessment of concerns regarding R35's family involvement or plan to minimize R35's risk of family involvement while residing at the facility.	F 250		
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	F 313		

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F 313	Continued From page 5 by arranging for transportation to and from the office of a practitioner specializing in the 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 obtain prescription eye glasses for 1 of 3 residents (R35) reviewed for vision impairment. Findings Include: R35's minimum data set [MDS], dated 10/06/13 indicated R35 had impaired vision and was able to read large print, but not regular print in newspapers or books. Corrective lenses were not used for the vision exam. R35's Brief Interview for Mental Status [BIMS] indicated she was cognitively intact. The care area assessment, dated 10/25/13, indicated "Patient denies need for eye glasses and currently does not wear glasses. She has not exhibited any vision problems as of late, but we have made appointment for her to see a eye md [physician] as she can't remember last time she had eye exam. We will follow any and all recommendations of this appointment, at this time resident is cooperative." The care plan, dated 9/30/13 directed staff "Needs assistance with setting up appointments to support health" including "Eye" appointments. Interventions included "Staff will assist with setting up appointments and transportation." A Referral Form for the eye clinic, dated 10/15/13,	F 313	2/20/14 • Information regarding receiving assistive devices to maintain vision & hearing abilities has been presented in education/re-education to all staff. • Glasses were received immediately. Staff will, if necessary assist resident(s) in gaining access to vision & hearing services. • Medical providers have been notified of this necessity. • 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. • Completion date: February 20, 2014	

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F 313	Continued From page 6	F 313		

included the following recommendations "new glasses, worn full time." Along with the referral was a prescription for eye glasses.

During initial interview and observation on 1/13/14 at 4:46 p.m., R35 reported she needed glasses to read, and wanted glasses. R35 was observed not wearing glasses during the interview. During a follow up interview on 1/15/14 at approximately 11:45 a.m., R35 reported she went to an eye exam but has not heard anything about getting glasses. R35 reported she wanted eye glasses. R35 was again observed not wearing eye glasses. The nurse, (LPN)-C was present during this interview and said she would call the eye glass supplier.

On 1/15/14 at 1:00 p.m., (LPN)-C, reported she called to ask the eye glass supplier if R35's glasses were ready. The supplier told LPN-C they had lost the phone number for the facility and R35's glasses were ready for pick up.

On 1/16/14 at 9:30 a.m., the nurse, (LPN)-C, reported R35 saw the eye clinic on October 15th and went to order glasses on October 18th. R35 had not yet picked up her glasses. LPN-C reported she does not call to ask when the glasses are ready, but waited for the eye glass supplier to call and let her know glasses are ready. LPN-C reported it typically took about 2-3 weeks for eye glasses to be ready for pick up after they were ordered.

On 1/16/14 at 10:00 a.m. the director of nursing (DON) reported she would expect staff to call the eye glass supplier to see if R35's glasses were ready after several weeks had passed and R35 still did not have her glasses.

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

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to post the required nurse staffing information to include the actual hours worked by nursing staff in the facility. This

2/20/14

- Information regarding Nurse Staffing Information Data Requirement has been presented in education/re-education to all staff.
- This form was immediately updated. The facility staff will continue ensure that the nurse staffing data (line listing shift: 7-3, 3-11, 11-7, & total hours for each category of staff) is posted on a daily basis, in clear, readable format as well as being in a prominent place that is readily accessible to residents & visitors.
- 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.
- Completion date: February 20, 2014

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F 356	Continued From page 8 practice had the potential to affect family, staff, visitors and all 38 residents residing at the facility. Findings include: On 1/13/14, at 12:23 p.m. during the initial facility tour the Hayes Residence Staffing posting dated 1/13/14, was observed pinned on the bulletin board in the first floor across from the nursing station. The form identified the charge nurse, number of other unlicensed staff (trained medication assistants), number of hours each worked and identified the shift as Day, Evening and Night. The posting lacked documentation of the actual hours worked in the facility by the licensed and unlicensed nursing staff. Review of the Hayes Residence Staffing forms dated 11/30/13, through 1/15/14, revealed all lacked documentation of the actual hours worked by the staff at the facility. During interview on 1/15/14, at 11:42 a.m. both the the director of nursing (DON) and administrator verified the actual hours worked by nursing staff at the facility was lacking and stated this would be corrected moving forward. On 1/15/14, at 2:44 p.m. the administrator stated the facility did not have a policy specifically pertaining to the nursing staffing posting.	F 356		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 387		

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

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(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 387	Continued From page 9	F 387		

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:
Based on document review and staff interview, the facility failed to ensure 3 of 4 residents (R26, R35, R44) were seen by a physician at least once every 30 days for the first 90 days after admission.
Findings include:
R26 was not seen by a physician or other qualified medical provider (clinical nurse specialist, physician assistant or nurse practitioner) at least once every 30 days for the first 90 days after admission. Document review indicated R26 was admitted to the facility on 7/25/13. Review of R26's record indicated R26 was seen by the physician on 8/23/13 (29 days after admission), on 10/8/13 (75 days after admission),and on 10/25/13 (92 days after admission). R26 was not seen 60 days after admission. Interview with LPN -C verified on 1/15/14 at 2:30 p.m., R26 was not seen 60 days after admission. LPN -C telephoned the nurse practitioner who verified the resident was not seen between 8/28/13 and 10/8/13.
R 44 was not seen by a physician or other qualified medical provider at least once every 30 days for the first 90 days after admission. Document review indicated R44 was admitted to the facility on 11/14/13, and was seen by the physician on 12/27/13 (43 days after admission). Interview with LPN C verified on 1/15/14 at 2:30 p.m. and scheduled a physician appointment for R44, as no further appointments had been made.

2/20/14

- Information regarding frequency of physician visits has been presented in education/re-education to all staff.
- Staff will schedule visit for each resident (including R26, R35, and R44) with primary physician in accordance with "at least once every 30 days for the first 90 days after admission, and at once every 60 days thereafter."
- Medical providers have been notified of this necessity.
- 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.
- Completion date: February 20, 2014

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 _____	01/16/2014

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 387	Continued From page 10 R 35 was not seen by a physician or other qualified medical provider at least once every 30 days for the first 90 days after admission. Record review indicated R35 was admitted to the facility on 09/30/13. According the the Clinic Visits Summary, R35 was seen by the nurse practitioner on 10/11/13 (11 days after admission) and was seen by the physician on 12/20/13 (81 days after admission). On 1/16/14 at 9:45 a.m., interview with LPN- C verified there were no further physician, nurse practitioner or physician assistant visits listed on the Clinic Visits Summary. Interview with the Director of Nursing on 1/14/14 at 3:00 p.m., indicated there was not a facility policy regarding when a new admission was to be seen by the physician or other qualified medical provider, but her understanding was the resident needed to be seen 30 days, 60 days, and 90 days after admission.	F 387		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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 _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 11 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to ensure expired medications were discarded and not administered for 1 of 1 residents (R7). Findings include: During observation of medication cart 1 on 1/14/14 at 2:30 p.m., one vial of latanoprost eye drops (medication for glaucoma) was noted to be expired. Upon review of the vial with trained medication aide, (TMA)-A, it was discovered to read "instill 1 drop into both eyes daily at bedtime. discard after 11/20/13." Interview with TMA-A indicated R7 receives eye drops every evening. TMA- A verified the medication had an expiration date of 11/20/13, and was used on R7. TMA-A confirmed the medication should have been	F 431	2/20/14 • Information regarding drugs & biological used in the facility for residents must be labeled in accordance with currently accepted professional principles, & include the appropriate accessory & cautionary instructions, & the expiration date when applicable along with discarding medications per procedure has been presented in education/re-education to all staff. • Eye drops for R7 have been replaced. For all other residents that may be affected, no problems/concerns 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. • Completion date: February 20, 2014	

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F 431	Continued From page 12 removed from the medication cart after the expiration date. TMA A removed the eye drops from the medication cart. Review of R7's record indicated a diagnosis of glaucoma, and a physician order for Latanoprost sol 0.005%, 1 drop to each eye at bedtime (dx. glaucoma).	F 431		
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 (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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 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, staff interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 5 of 5 residents (R3, R4, R18, R20, R35) observed who required blood glucose monitoring. This had the potential to effect 16 residents in the facility who required blood glucose monitoring. The facility failed to document results of a tuberculin skin test (TST) for 2 of 5 employees reviewed, S2 and S3, per Centers for Disease Control and Prevention (CDC) recommendations. Also, the facility policy failed to provide direction on how to properly perform, read and document results of a TST. Findings include The facility failed to ensure that the process for conducting blood glucose monitoring was conducted in a manner to prevent the spread of blood borne pathogens. The following was observed in the medication room on 1/13/14: At 4:30 p.m LPN-A was observed to conduct a blood glucose check for R35 in the medication	F 441	2/20/14 • Information regarding blood glucose monitoring machines has been presented in education/re-education to all staff. • Each resident including (R3, R4, R18, R20, R35) that has a diagnosis of diabetes & wherein, diabetic blood glucose monitoring is warranted was immediately supplied with his/her own blood glucose monitoring machine/kit for blood glucose testing. • Pharmacy & Medical providers have been notified of this necessity. • 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. • Completion date: February 20, 2014	

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F 441	Continued From page 14	F 441		

room. After the procedure was completed, LPN-A used an alcohol wipe to clean the glucometer (machine used to check blood sugars) for approximately 4 seconds.
At 4:34 p.m. LPN-A was interviewed regarding cleaning of the glucometer and stated the facility used alcohol wipes to clean the glucometer after each use and did not use anything else. LPN-A stated the same glucometer was used for all the residents residing at the facility that required blood glucose monitoring.

At 4:40 p.m., R18 was observed to complete blood glucose monitoring on the facility's True Track Blood Glucose Meter. Licensed Practical Nurse (LPN)-A wiped the machine with an alcohol wipe, after use.
At 4:44 p.m., LPN-A was observed to complete R3's blood glucose monitoring, and wiped the machine with an alcohol wipe, after use.
At 4:50 p.m. LPN-A was observed to complete R20's blood glucose monitoring, and wiped the machine with an alcohol wipe, after use.
At 4:55 p.m, LPN-A was observed to complete R4's blood glucose monitoring, and wiped the machine with an alcohol wipe, after use.
Interview with LPN-A indicated germicidal wipes are used to clean the blood glucose machine, but none could be found.

Interview with the director of nursing (DON) at 5:30 p.m. on 1/13/14, indicated the blood glucose machine owners booklet directs the cleaning with "70% isopropyl alcohol". Upon reading the owner's booklet, page 3 reads "The TRUEtrack Blood Glucose Monitoring System is for one person use ONLY. DO NOT share your Meter or

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F 441	Continued From page 15 your Lancing Device with anyone, including family members. DO NOT use on more than one person . ALL parts of your Blood Glucose Monitoring System could carry blood-born disease after use, even after cleaning and disinfection. Interview with the DON at 6:00 p.m., she indicated the administrator had been notified and a staff member was going to the nearby pharmacy to purchase blood glucose machines for every resident who required blood glucose monitoring. The facility failed to document results of a tuberculin skin test (TST) for S2 and S3, per Centers for Disease Control and Prevention (CDC) recommendations. S2 was hired on 08/26/13. TST results on 7/24/13 with number of mm (millimeters) of induration was 0. However, no interpretation was documented such as positive or negative. S3 was hired on 10/1/13. TST results on 4/14/13 with interpretation negative. However no number of millimeters of induration was recorded. During interview on 1/14/14, at 1:43 p.m. DON reported both TSTs were done by a different provider. She had no other explanation as to why some components were lacking. The facility lacked a policy on how to correctly perform, read and document TST results. An interview conducted with DON on 1/16/14, at 9:10 a.m. in query of policy and procedure instruction of TST documentation that include the	F 441	2/20/14 • Information regarding completion of TB Screening Questionnaire & recording of mm of indurations along with evidence of positive or negative findings documentation has been presented in education/re-education to all staff. • TB screening for (s1, S2, S3), as well as TB Screening policy & procedure has been updated. • 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. • Completion date: February 20, 2014	

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F 441	Continued From page 16 date of the test (month, day, year), the number of millimeters (mm) of induration and interpretation (positive or negative), DON replied, "We don't currently have an instruction policy and procedure for TST but will work on one." The policy and procedure titled Mantoux (PPD) Policy with date reviewed 06/12/2012, indicated, "Employees will have a 2-step Mantoux upon hire unless contraindicated. Any employee with a history of a positive Mantoux or having had tuberculosis (TB) is not to have another Mantoux (a TB risk Assessment form will be completed annually). This information will be part of the employee's personnel record." It further reads, "III. New hire employees will follow the same procedures as listed above. The only exception would be if new hire has evidence of one Mantoux recorded within the last 12 months, then only a repeat Mantoux would be necessary."	F 441		
F 465 SS=E	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 resident enviroment was maintained and in a clean manner for 4 of 4 residents (R1, R25, R24 and R43) reviewed for environmental concerns. Findings include:	F 465		

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F 465	Continued From page 17 On 1/13/14 at 2:55 p.m. during interview surveyor observed under both the beds for R25 and R1 a thick layer of fluffy grey substance. Additionally, the return air flow vent next to the dresser was observed with build-up dusty-grey fluffy substance. R25 stated it was so dusty in the room and she and her roommate did not know what to do about it. On 1/14/14, at 9:45 a.m. observed under the beds, bed frames and return air flow vent still with built-up grey fluffy substance. On 1/14/14, at 1:47 p.m. during the environmental tour, the assistant administrator and maintenance supervisor (MS) both verified the room floor, bed frames and the return air vent had build-up dust. The assistant administrator called in one of the housekeeping staff and requested the staff to clean the room, after the concerns were brought to his attention. He further stated he would look into other rooms to see if this was a concern/issue and stated the dust was unacceptable and an issue that needed to be looked at. On 1/14/14, at 2:25 p.m. interviewed the maintenance supervisor who stated he and the other staff in the department usually go around the facility and clean the vents and would look for documentation logs. On 1/14/14, at 2:48 p.m. the maintenance supervisor approached surveyor and stated there was no cleaning log records for the return air flow vents, as he had thought earlier. On 1/15/14, at 11:42 a.m. the administrator stated	F 465	2/20/14 • Information regarding "providing a safe, functional, sanitary, & comfortable environment for residents, staff & the public" has been presented in education/re-education to all staff. • (R24, R43) resident(s) room was immediately refurbished. While in (R1, R25) resident(s) room vents were replaced immediately. There has been an ongoing improvement of resident rooms, offices, common areas, storage areas & equipment replacement. • The Administrator/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. • Completion date: February 20, 2014	

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 _____ B. WING _____	01/16/2014

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F 465	Continued From page 18	F 465		

house keeping had just started to deep clean the rooms on the opposite side of the hallway but the staff were facing a challenge with the residents. She acknowledged that was not an excuse for dust build-up.

Review of the Planner Calendar dated 2014, revealed multiple tasks/duties were assigned to each day since 1/1/14, to 1/14/14, however cleaning on return air flow vents was not listed, which the maintenance supervisor verified.

The undated Hayes Residence Housekeeping/Maintenance Policies indicated the resident's room offers the only privacy that 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. In addition, the policy directed exhaust venting should be checked and cleaned quarterly in order to ensure adequate airflow in the resident's rooms and bathrooms.

On 1/16/14 at 11:36 a.m. R24 reported the carpet in her room was "awful." The carpet was observed to have worn spots, a seam splitting, approximately an inch apart, across the length of the room and stains. The director of nursing (DON) confirmed findings and reported the carpeting needed to be removed for this room. DON reported she was not aware of any current plans to replace the carpet for R24 and her roommate, R43.

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

FE508023

PRINTED: 02/03/2014
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 _____	01/15/2014

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 000	INITIAL COMMENTS	K 000		

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:

POC ok w/AW for K67 PS 2-25-14

RECEIVED
FEB 18 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

EXIT: K16 - 1-16-14 DC: 1-26-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/14/14

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 _____	**01/15/2014**

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 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 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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 _____	**01/15/2014**

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 062	Continued From page 2 continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 09:00 AM and 01:00 PM on 01/15/2014, it was revealed during review of available fire sprinkler records that there was no documentation of quarterly sprinkler flow testing testing in the last 6 months. During an interview with facility staff (SS), this was a new sprinkler system installed in June of 2013, and was unaware of quarterly testing.	K 062	3-19-14 The annual inspection will be completed on February 19 by Viking Automatic Sprinkler Co. A contract has been signed with Viking including the terms that they will perform the inspections annually. Viking will also instruct the maintenance director to perform quarterly drain/alarm testing. Please reference attached proposal. Colin Faulkner, Assistant Administrator, is responsible.	
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 that the facility is using the corridor as a make-up	K 067	AW A request for renewal of current waiver will be sent to Mr. Patrick Sheehan with the State Fire Marshal Division no later than Thursday February 20, 2014. Colin Faulkner, Assistant Administrator, is responsible.	

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 _____	01/15/2014

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 3 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 01/15/2014, 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		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to properly maintain the automatic fire extinguishing system protecting the kitchen cooking equipment and is not protected in accordance with 2000 NFPA 101 Sec. 9.2.3. This deficient practice could affect all residents, visitors and staff in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 01/15/2014, t was observed, and by review of available documentation for past 12 months. reveled, that the kitchen hood extinguishing system has not been inspected / tested in the past 6 months. Last recorded service date was September 2012..	K 069	• Kitchen hood extinguishing system was immediately inspected and tested. • A contract with Nardini is maintained that specifies kitchen hood extinguishing system will be inspected and tested annually. • Administrator is responsible. • Completion date: February 20, 2014	

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	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2014**

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 069	Continued From page 4 This deficient practice was verified by facility staff (SS).	K 069		

VIKING AUTOMATIC SPRINKLER CO.

301 York Ave
St. Paul, MN 55130
(651) 558-3300
Fax: (651) 558-3310
www.vikingsprinkler.com

PROPOSAL

PROPOSAL SUBMITTED TO	ATTENTION	PHONE	DATE
HAYES RESIDENCE	COLIN FAULKNER	(651) 690-4458	FEBRUARY 13, 2014
STREET	EMAIL		
1620 RANDOLPH AVE	COLIN.FAULKNER@HAYESRESIDENCE.COM		
CITY, STATE, ZIP CODE	JOB NAME & LOCATION		
ST. PAUL, MN 55105	SAME		
INSPECTION FREQUENCY	SYSTEM(S) TYPE & NUMBER		
ANNUAL 2014	1 WET		

We propose to perform the following services on the frequency noted above:

1. Perform a visual examination of readily accessible areas of your sprinkler system(s) or portions thereof, from the ground/floor level of the building to verify that the system(s) appear to be in operating condition and is/are free of physical damage.
2. Test flow, tamper & pressure switches.
3. Perform a main drain test(s).
4. Inspect packing glands on all system control valves.
5. Lubricate control valve stems.
6. Provide written documentation of known deficiencies found during the inspection.
7. Prepare and file Report of Inspection.

PER OUR CONVERSATION TODAY, WE WILL PERFORM YOUR ANNUAL FIRE INSPECTION ON FEBRUARY 19TH. DURING THAT TIME, WE ALSO WILL SHOW YOU HOW TO PERFORM A QUARTERLY DRAIN/ALARM TEST. EACH YEAR WE WILL CALL YOU TO SCHEDULE THE ANNUAL FIRE INSPECTION.

**** The Report of Inspection contains a section (Owners Section) that must be, per code, completed, to the best of knowledge and signed by owner/owners rep., customer, or occupant prior to inspection. If the owner/owners rep., occupant or customer is not or will not be on site at the time of inspection, an electronic version of the Owners Section will be provided for completion, signature and return to Viking Automatic Sprinkler Co. prior to inspection. ****

WE PROPOSE HEREBY TO FURNISH MATERIAL AND LABOR - COMPLETE IN ACCORDANCE WITH THE ABOVE SPECIFICATION, FOR THE SUM OF

TWO HUNDRED FIFTY-SIX & No/100 DOLLARS ($256.00)

PAYMENT TO BE MADE TO THE VALUE OF 100 (%) PERCENT OF ALL MATERIAL AND WORK COMPLETED. THE ENTIRE AMOUNT OF THE CONTRACT SHALL BE PAID WITHIN 30 DAYS AFTER COMPLETION OF INSPECTION. NOTE: THIS PROPOSAL MAY BE WITHDRAWN BY US IF NOT ACCEPTED WITHIN 30 DAYS.

AUTHORIZED SIGNATURE: Roxann M. Pletscher
ROXANN PLETSCH INSPECTIONS

ACCEPTANCE OF PROPOSAL

THE ABOVE PRICES AND SPECIFICATIONS AND THE TERMS AND CONDITIONS FOUND OF THE FINAL PAGE OF THIS PROPOSAL ARE SATISFACTORY AND ARE HEREBY ACCEPTED. YOU ARE AUTHORIZED TO DO THE WORK AS SPECIFIED. PAYMENT WILL BE MADE AS OUTLINED ABOVE.

PLEASE DATE, SIGN AND RETURN ALL PAGES OF THE PROPOSAL TO VIKING AUTOMATIC SPRINKLER CO.

DATE OF ACCEPTANCE: 2/13/14 SIGNATURE: [signature] TITLE: Owner

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8088

February 4, 2014

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE508024 and HE508004

Dear Ms. Reynolds:

The above facility survey was completed on January 16, 2014 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 Saint Paul Minnesota 55164-0900.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

PRINTED: 02/03/2014
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00928	A. BUILDING: _____ B. WING _____	01/16/2014

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

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 13th to January 16th 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of	3 000	2/25/14 SER Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/14/14

STATE FORM 6899 QTGH11 If continuation sheet 1 of 18

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3 000	Continued From page 1 Health, Division of Compliance Monitoring, Licensing and Certification Program; Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification P.O. Box 64900, St. Paul, Minnesota 55164-0900.	3 000	The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in	3 601		

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3 601	Continued From page 2 CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by: The facility failed to document results of a tuberculin skin test (TST) for 2 of 5 employees reviewed, S2 and S3, per Centers for Disease Control and Prevention (CDC) recommendations. Also, the facility policy failed to provide direction on how to properly perform, read and document results of a TST. The facility lacked a policy on how to correctly perform, read and document TST results. An interview conducted with DON on 1/16/14, at 9:10 a.m. in query of policy and procedure instruction of TST documentation that include the date of the test (month, day, year), the number of millimeters (mm) of induration and interpretation (positive or negative), DON replied, "We don't currently have an instruction policy and procedure for TST but will work on one."	3 601		

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3 601	Continued From page 3 The policy and procedure titled Mantoux (PPD) Policy with date reviewed 06/12/2012, indicated, "Employees will have a 2-step Mantoux upon hire unless contraindicated. Any employee with a history of a positive Mantoux or having had tuberculosis (TB) is not to have another Mantoux (a TB risk Assessment form will be completed annually). This information will be part of the employee's personnel record." It further reads, "III. New hire employees will follow the same procedures as listed above. The only exception would be if new hire has evidence of one Mantoux recorded within the last 12 months, then only a repeat Mantoux would be necessary." SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate documentation of results of tuberculin skin test (TST) per Centers for Disease Control and Prevention (CDC) recommendations. The director of nursing and/or designee could assure facility policies are current, implemented and monitored and provide direction on how to properly perform, read and document results of a TST. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 601		
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and	3 945		

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3 945	Continued From page 4 interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 5 of 5 residents (R3, R4, R18, R20, R35) observed who required blood glucose monitoring. This had the potential to effect 16 residents in the facility who required blood glucose monitoring. The facility also failed to ensure a resident call light was accessible for 1 of 1 resident (R25) reviewed for environmental concerns. Findings include The facility failed to ensure that the process for conducting blood glucose monitoring was conducted in a manner to prevent the spread of blood borne pathogens. The following was observed in the medication room on 1/13/14: At 4:30 p.m LPN-A was observed to conduct a blood glucose check for R35 in the medication room. After the procedure was completed, LPN-A used an alcohol wipe to clean the glucometer (machine used to check blood sugars) for approximately 4 seconds. At 4:34 p.m. LPN-A was interviewed regarding	3 945		

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3 945	Continued From page 5	3 945		

cleaning of the glucometer and stated the facility used alcohol wipes to clean the glucometer after each use and did not use anything else. LPN-A stated the same glucometer was used for all the residents residing at the facility that required blood glucose monitoring.

R25's call light was not accessible on the evening of 1/13/14 or during the day on 1/14/14.

On 1/13/14, at 2:56 p.m., during interview, R25 stated she was not able to reach the call light and said that the last time, when she had "A stroke" she was not able to reach it either, "But lucky a nurse came into the room and I was sent to the hospital." She further stated "I would like you to give the facility a recommendation on how to get the call light close to me as I have a hard time reaching it." R25's call light was observed to be clipped to a string that was attached to a light, by the head of the bed. The string with the call light clipped to it was noted to be falling behind the head board of the bed.

On 1/14/14, at 9:45 a.m. and at 1:47 p.m., during observations, R25's call light continued to be clipped onto the string, hanging from the light, behind the bed head board. R25 was observed sitting by the door and the call light was not accessible to R25.

On 1/14/14, at 1:48 p.m. the assistant administrator verified the call light was not accessible to R25 and stated it should have been clipped to the bedding where she was able to use it as she spent most of the time in her room. R25 stated to the assistant administrator, "Putting it to

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3 945	Continued From page 6 the clip on the head board was not accessible. I want the call light to be wrapped around something where I'm able to get hold of it when I need assistance." R25's diagnoses, obtained from the quarterly Minimum Data Set (MDS) dated 10/24/13, included degenerative joint disease. R25's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score indicated R25 was cognitively intact. In addition the MDS indicated R25 had a functional limitation in range of motion with impairment to both sides of lower extremities, used a walker for mobility and balance during transitions and walking was not steady but was able to stabilize without assist of another person. On 1/15/14, at 11:40 a.m. the director of nursing (DON) stated she was not made aware R25's call light was a problem. Her expectation was to have call lights accessible to all residents who are capable of using the call light. The Call Light policy revised 9/11/12, directed "Call lights will be within reach of all resident beds and within resident bathrooms. Call lights will be in working order." SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate use and cleaning of the glucometer, then audit this service to ensure that it care is being provided as indicated and take action as needed. The director of nursing or designee could monitor to assure policy and procedures are current, implemented and monitored to assure call lights are within reach and in working order.	3 945		

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3 945	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 945		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration. This MN Requirement is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to ensure expired medications were discarded and not administered for 1 of 1 residents (R7). Findings include: During observation of medication cart 1 on 1/14/14 at 2:30 p.m., one vial of latanoprost eye drops (medication for glaucoma) was noted to be expired. Upon review of the vial with trained medication aide, (TMA)-A, it was discovered to read "instill 1 drop into both eyes daily at bedtime. discard after 11/20/13." Interview with TMA-A indicated R7 receives eye drops every evening. TMA- A verified the medication had an expiration date of 11/20/13, and was used on R7. TMA-A confirmed the medication should have been removed from the medication cart after the expiration date. TMA A removed the eye drops from the medication cart. Review of R7's record indicated a diagnosis of glaucoma, and a physician order for Latanoprost sol 0.005%, 1 drop to each eye at bedtime (dx.	31145		

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31145	Continued From page 8 glaucoma). SUGGESTED METHOD FOR CORRECTION: The director of nursing could monitor to assure policy and procedures are current, implemented and assessed to assure expired medications are discarded and not administered to residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31145		
31455	MN Rule 4655.9000 Subp. 1 Housekeeping; General Requirements Subpart 1. General requirements. The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident enviroment was maintained and in a clean manner for 4 of 4 residents (R1, R25, R24 and R43) reviewed for environmental concerns. Findings include: On 1/13/14 at 2:55 p.m. during interview surveyor observed under both the beds for R25 and R1 a thick layer of fluffy grey substance. Additionally, the return air flow vent next to the dresser was observed with build-up dusty-grey fluffy	31455		

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	00928	A. BUILDING: _____ B. WING _____	01/16/2014

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31455	Continued From page 9	31455		

substance. R25 stated it was so dusty in the room and she and her roommate did not know what to do about it.

On 1/14/14, at 9:45 a.m. observed under the beds, bed frames and return air flow vent still with built-up grey fluffy substance.

On 1/14/14, at 1:47 p.m. during the environmental tour, the assistant administrator and maintenance supervisor (MS) both verified the room floor, bed frames and the return air vent had build-up dust. The assistant administrator called in one of the housekeeping staff and requested the staff to clean the room, after the concerns were brought to his attention. He further stated he would look into other rooms to see if this was a concern/issue and stated the dust was unacceptable and an issue that needed to be looked at.

On 1/14/14, at 2:25 p.m. interviewed the maintenance supervisor who stated he and the other staff in the department usually go around the facility and clean the vents and would look for documentation logs.

On 1/14/14, at 2:48 p.m. the maintenance supervisor approached surveyor and stated there was no cleaning log records for the return air flow vents, as he had thought earlier.

On 1/15/14, at 11:42 a.m. the administrator stated house keeping had just started to deep clean the rooms on the opposite side of the hallway but the staff were facing a challenge with the residents. She acknowledged that was not an excuse for dust build-up.

Review of the Planner Calendar dated 2014,

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31455	Continued From page 10	31455		

revealed multiple tasks/duties were assigned to each day since 1/1/14, to 1/14/14, however cleaning on return air flow vents was not listed, which the maintenance supervisor verified.

The undated Hayes Residence Housekeeping/Maintenance Policies indicated the resident's room offers the only privacy that 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. In addition, the policy directed exhaust venting should be checked and cleaned quarterly in order to ensure adequate airflow in the resident's rooms and bathrooms.

On 1/16/14 at 11:36 a.m. R24 reported the carpet in her room was "awful." The carpet was observed to have worn spots, a seam splitting, approximately an inch apart, across the length of the room and stains. The director of nursing (DON) confirmed findings and reported the carpeting needed to be removed for this room. DON reported she was not aware of any current plans to replace the carpet for R24 and her roommate, R43.

SUGGESTED METHOD FOR CORRECTION: The director of nursing, maintenance director and/or designee could monitor to assure policy and procedures are current, implemented and assessed to assure resident enviroment is maintained in a clean, sanitary, and orderly condition throughout the facility.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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31810	MN Rule 144.651 Subd. 6 Patients & Residents of HCF Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain prescription eye glasses for 1 of 3 residents (R35) reviewed for vision impairment. Findings Include: R35's minimum data set [MDS], dated 10/06/13 indicated R35 had impaired vision and was able to read large print, but not regular print in newspapers or books. Corrective lenses were not used for the vision exam. R35's Brief Interview for Mental Status [BIMS] indicated she was cognitively intact. The care area assessment, dated 10/25/13, indicated "Patient denies need for eye glasses and currently does not wear glasses. She has not exhibited any vision problems as of late, but we have made appointment for her to see a eye md [physician] as she can't remember last time she had eye exam. We will follow any and all recommendations of this appointment, at this time resident is cooperative." The care plan, dated 9/30/13 directed staff "Needs assistance	31810		

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31810	Continued From page 12	31810		

with setting up appointments to support health" including "Eye" appointments. Interventions included "Staff will assist with setting up appointments and transportation."

A Referral Form for the eye clinic, dated 10/15/13, included the following recommendations "new glasses, worn full time." Along with the referral was a prescription for eye glasses.

During initial interview and observation on 1/13/14 at 4:46 p.m., R35 reported she needed glasses to read, and wanted glasses. R35 was observed not wearing glasses during the interview. During a follow up interview on 1/15/14 at approximately 11:45 a.m., R35 reported she went to an eye exam but has not heard anything about getting glasses. R35 reported she wanted eye glasses. R35 was again observed not wearing eye glasses. The nurse, (LPN)-C was present during this interview and said she would call the eye glass supplier.

On 1/15/14 at 1:00 p.m., (LPN)-C, reported she called to ask the eye glass supplier if R35's glasses were ready. The supplier told LPN-C they had lost the phone number for the facility and R35's glasses were ready for pick up.

On 1/16/14 at 9:30 a.m., the nurse, (LPN)-C, reported R35 saw the eye clinic on October 15th and went to order glasses on October 18th. R35 had not yet picked up her glasses. LPN-C reported she does not call to ask when the glasses are ready, but waited for the eye glass supplier to call and let her know glasses are ready. LPN-C reported it typically took about 2-3 weeks for eye glasses to be ready for pick up after they were ordered.

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31810	Continued From page 13 On 1/16/14 at 10:00 a.m. the director of nursing (DON) reported she would expect staff to call the eye glass supplier to see if R35's glasses were ready after several weeks had passed and R35 still did not have her glasses. SUGGESTED METHOD FOR CORRECTION: The director of nursing, and/or designee could monitor to assure policy and procedures are current, implemented and assessed to assure prescription eye glasses and/or appropriate medical and personal care is provided based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31810		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care	32000		

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32000	Continued From page 14 agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess and care plan concerns related to the family support system for 1 of 2 residents (R35) identified as needing medically related social services.	32000		

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32000	Continued From page 15 Findings Include: R35's hospital admission history, dated 9/21/13, indicated R35 currently lives with a family member, however, there is some question that this might not be a good housing situation. Revoew of the facility's 35's most recent care area assessment, dated 10/25/13, indicated, R35 showed impairment in cognition and decision making due to mental illness diagnoses, which included Paranoid Schizophrenia and Depression. An undated handwritten note was provided by the social worker, (LICSW) , regarding R35's initial care conference on 10/17/2014. The note included concerns regarding R35's care and services in her prior living arrangements. The information had been provided to the facility by the case manager during the initial care conference. Review of the Progress Record note, dated 12/31/13 at 1:55 p.m. indicated R35 was on leave of absence (LOA) December 21st to 26th 2013, and it was discovered that there were three and a half days insulin R35 did not take while on LOA. An attempt was made to discuss concerns with a family member, including a reminder to ensure R35 takes her insulin while on LOA with the family member. A review of R35's medical record, including care area assessment dated 10/25/13, most recent care plan dated 9/30/13 and Social History dated 9/30/13, revealed no assessment or plan in place to manage the risks associated with R35's related vulnerabilities.	32000		

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32000	Continued From page 16 During interview on 1/15/14 at 11:23 a.m., the nurse, (LPN)-C, reported she was aware of the issues with R35's LOA's, confirmed R35 missed 3 and a half days of insulin while visiting her family over Christmas and reported she knew of no plan to minimize risk for R35 in regards to her family involvement. LPN-C reported there were no restrictions on R35's being able to leave the facility. During interview on 1/15/14 at 1:51 p.m. the director of nursing (DON) reported she was unaware of the concerns regarding care and services in R35's prior living arrangement, however, reported she was aware of R35 not getting three and a half days of insulin while visiting family over Christmas. DON reviewed the medical record and confirmed there was no assessment or plan regarding the risks posed by R35's family involvement. DON explained her expectation would be for a safety plan to be developed so R35 would be safe while in the community. During interview with on 1/16/14 at 8:45 a.m., LICSW, explained she had concerns regarding family involvement with R35's personal funds, was aware of the prior living arrangement and missed insulin while R35 visited family. LICSW reviewed R35's medical record and her own files and reported there was no assessment of concerns regarding R35's family involvement or plan to minimize R35's risk of family involvement while residing at the facility. SUGGESTED METHOD FOR CORRECTION: The director of nursing, director of social service and/or designee could monitor to assure policy	32000		

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32000	Continued From page 17 and procedures are current, implemented and assessed to assure residents identified as needing medically related social services, specifically concerns related to the family support system are assessed, care planned, implemented and monitored to assure the facility's ongoing assessments of the vulnerable adult(s). TIME PERIOD FOR CORRECTION: Twenty One (21) days.	32000		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, February 25, 2014 3:56 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 (24E508) K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Hayes Residence is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-16-13 based on an Office of Health Facility Complaints survey.

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 is again requesting a waiver for K067. It was approved in 2013. 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. The building is equipped with an approved corridor detection system.
2. The building has an automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system.
3. Annual service and maintenance contracts require servicing of all the facilities' fire protection system semi-annually.
4. The response time of the St. Paul Fire and Rescue is approximately 3 minutes.
5. 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.
6. Fire drills are conducted monthly. An additional drill occurs each quarter totaling 16 drills per year.
7. As of March 2013 indoor smoking was prohibited. The designated outdoor smoking area is protected by the sprinkler system.
8. A complete supervised automatic sprinkler system was installed in accordance with section 9-7, NFPA 101 2000 edition.
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.

Fire Safety Supervisor

State Fire Marshal

2-25-14

02/2014

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FEB 18 2014
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STATE FIRE MARSHAL DIVISION