DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					TE SURVEY AGENCY	Facility ID: 00928			
1. MEDICARE/MEDICAID PROVID (L1) 24E508 2.STATE VENDOR OR MEDICAID (L2) 314243400		3. NAME AND AL (L3) HAYES RES (L4) 1620 RAND ((L5) SAINT PAU	SIDENCE OLPH AVEN		(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. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	O1 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA Y 01/16/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF N STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC					8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30			
2 AOA 3 Other 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	40 (L18) 40 (L17)	Complianc1. A		gram	2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 	7. Medical Director			
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE	MARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):	18. STATE SURVEY AGENC	CY APPROVAL Date:			
Susanne Reuss, Supe			4/30/2014	(L19)	· · · · · · · · · · · · · · · · · · ·	forcement Speicalist 05/19/2014 (L20			
19. DETERMINATION OF ELIGIBI _X	LITY Participate	20. COM	BY HCFA RI			nancial Solvency (HCFA-2572) trol Interest Disclosure Stmt (HCFA-1513)			
22. ORIGINAL DATE OF PARTICIPATION 01/01/1975 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension	S DATE	ENDING DA (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat 04-Other Reason for Withdrawa	1NVOLUNTARY 05-Fail to Meet Health/Safety rsement 06-Fail to Meet Agreement tion OTHER			
(L27) 28. TERMINATION DATE:		aspension Date:	(L45) CARRIER NO.		30. REMARKS				
31. RO RECEIPT OF CMS-1539	(L28)	DETERMINATION	OF APPROVA	(L31)					
		03/21/2014							

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00928

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.



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.

Hayes Residence May 19, 2014 Page 2

Please contact me if you have any questions about this letter.

Sincerely,

Dore Klegepe

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



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))

Hayes Residence May 8, 2014 Page 2

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

Dore Klegge

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



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,

Done Klegge

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 24E508	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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
		C	Correction				Correction					Correction
ID Prefix	F0282		Completed 4/11/2014	ID Prefix	F0323		Completed 04/11/2014		ID Prefix	F0431		Completed 04/11/2014
	483.20(k)(3)(ii)				483.25(h)		-			483.60(b), (d),	(e)	_ ` ` ` ` `
				LSC			•					- -
		C	Correction				Correction					Correction
ID Prefix	E0441		Completed 4/11/2014	ID Profix			Completed		ID Profix			Completed
	483.65		4/11/2014	Reg. #			-		Reg. #			_
LSC				LSC			•					<u> </u>
		C	Correction				Correction					Correction
ID Dog fire		C	Completed	ID D. f.			Completed		ID Doctor			Completed
												<u> </u>
Reg. # LSC				Reg. # LSC			-		Reg. # LSC			
		C	Correction				Correction					Correction
ID Drafiv			Completed	ID Brofiv			Completed		ID Drofiv			Completed
ID Prefix							-			-		_
Reg. # LSC				Reg. # LSC			-		Reg. # LSC			_ _
		C	Correction				Correction					Correction
ID Profix			Completed	ID Profix			Completed		ID Profix			Completed
Reg. #				Reg. #					Reg. #			
							-					_ _
Reviewed I	By Re	viewed I	 Зу	Date:	Signature	of Su	veyor:				Date:	
State Agen	cy SR	/AK		04/30/201	4				3298	4	04/17	7/2014
Reviewed I	By Re	viewed E	Зу	Date:	Signature	of Su	veyor:				Date:	
CMS RO												
Followup t	o Survey Comple				Check for any					Summary of the Facility?	\ 	
	1/16/20	14			GIICOITECLE	a Deile	Jionoles (ON	.0-230	., Jeni 10	and I domity?	YES	NO

State Form: Revisit Report										
(Y1) Provider / Supplier / CLIA / Identification Number 00928	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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) Ite	em		(Y5)	Date
		Correction Completed			Correction Completed					Correction Completed
ID Prefix	30565	04/11/2014	ID Prefix	30601	04/11/2014	ID	Prefix	30945		04/11/2014
	IN Rule 4655.2600			MN St. Statute 14		ı	_	MN Rule 4655		
		Correction			Correction					Correction
ID Prefix	31145	Completed 04/11/2014	ID Prefix		Completed	ID	Prefix			Completed
	IN Rule 4655.7830 Sul		Reg. #							
LSC _			LSC				LSC			
		Correction			Correction					Correction
ID Profix		Completed	ID Profix		Completed	ID	Drofiv			Completed
		-								_
Reg. # LSC _			Reg. # LSC			1	Reg. # LSC			<u> </u>
		Correction			Correction					Correction
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		-				'	Reg. # LSC			<u> </u>
		Correction			Correction					Correction
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=		-					D 4			
Reg. # LSC			Reg. # LSC			,	Reg. # LSC			<u> </u>
Reviewed By	Reviewed	I Ву	Date:	Signature of	of Surveyor:				Date:	
State Agency	SR/AK		04/30/20	014		32	2984		04/17	/2014
Reviewed By	Reviewed	I Ву	Date:	Signature o	of Surveyor:				Date:	
	Survey Completed or	1:			Jncorrected Defi					
	1/16/2014				Deficiencies (CN	/13-256/) \$	sent to		YES	NO
STATE FORM	I: REVISIT REPORT (5	5/99)		Page 1 of 1				Event ID: 0	QTGH13	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: QTGH Facility ID: 00928

	IAKI I -	TO BE COMIT		IIIE SIAI	E SURVET AGENCI		racinty ii. 00928		
MEDICARE/MEDICAID PROVIDE (L1) 24E508 2.STATE VENDOR OR MEDICAID N (L2) 314243400		3. NAME AND AI (L3) HAYES RES (L4) 1620 RAND (L5) SAINT PAU	SIDENCE OLPH AVENI		(L6) 55105	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	ION: 7 (L8) 2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU	JPPLIER CATEO	09 ESRD	10 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 03/07 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/ 2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENI	DING DATE: (L35)		
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		A. In Complia			And/Or Approved Waivers Of		ments:		
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of S 7. Medical I			
12.Total Facility Beds	40 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN \underline{X} 5. Life Safety Code		om Size		
13.Total Certified Beds	40 (L17)	X B. Not in Con Requirement	npliance with Pro ents and/or Appl		* Code: B,5	(L12)			
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS				
18 SNF 18/19 SNF	19 SNF 40	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:		
Sheryl Reed, HFE NE	II	0	03/19/14	(L19)	Anne Kleppe, Enforcement Specialist 05/12/14 (L2				
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	(-2-)		
19. DETERMINATION OF ELIGIBIL _X 1. Facility is Eligible to F 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Str			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	[:	(L30)		
OF PARTICIPATION 01/01/1975	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		<u>JNTARY</u> o Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER			
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for Withdrawar	07-Provi 00-Activ	der Status Change		
(L27)	B. Rescind S	uspension Date:	(L45)						
28. TERMINATION DATE:	20	9. INTERMEDIARY/			30. REMARKS				
20. IDAMENTION DAIL.	23	. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	CARRIER NO.		oo. Rem ikito				
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE					
	(L32)	03/21/2014		(L33)	DETERMINATION APP	ROVAL			
			-				-		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00928

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.



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

Dre Klegge

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 00928	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/7/2014							
Name	e of Facility		Street Address, City, State, Zip Code								
HA	YES 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) D	ate
ID Prefix	31455	Correction Completed 02/20/2014	ID Prefix	31810	Correction Completed 02/20/2014		ID Prefix		557 O.J. d	Correction Completed 02/20/2014
	MN Rule 4655.9000 Sub			MN Rule 144.651 Subd				MN Rule 626.		
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix	-		Completed
Reg. # LSC			Reg. #				D "			
		Correction			Correction					Correction Completed
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			
Reg. # LSC			Reg. # LSC				Reg. # LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. # LSC			
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix			Correction Completed
Reg. #										
Reviewed E	y Reviewed	Ву	Date:	Signature of Sur	veyor:				Date:	
State Agend			03/19/20					22581	03/07/2	2014
Reviewed E CMS RO	Reviewed	Ву	Date:	Signature of Sur	veyor:				Date:	
	Survey Completed on 1/16/2014	:		Check for any Uncor Uncorrected Defic					YES	NO
STATE FOR	M: REVISIT REPORT (5.	/99)		Page 1 of 1				Event ID: 0	QTGH12	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 24E508	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/7/2014
Name	of Facility		Street Address, City, State, Zip Code	
HA	YES 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 Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 02/20/2014	ID Prefix Reg. # LSC	F0250 483.15(g)(1)		Correction Completed 02/20/2014		ID Prefix Reg. # LSC	F0313 483.25(b)		Correction Completed 02/20/2014
ID Prefix Reg. # LSC	F0356 483.30(e)		Correction Completed 02/20/2014	ID Prefix Reg. # LSC	F0387 483.40(c)(1)-(2)		Correction Completed 02/20/2014		ID Prefix Reg. #			Correction Completed 02/20/2014
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Reg. #				Reg. #					D "			
Reviewed E		eviewed	Ву	Date:	Signature	of Sur	veyor:			22501	Date:	7/2014
State Agen		SR/AK	D	03/19/20		- 4 0				22581		7/2014
CMS RO	By R	eviewed	БУ	Date:	Signature	ot Sui	veyor:				Date:	
Followup t	o Survey Comp 1/16/20		:		Check for any Uncorrected					Summary of the Facility?		NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 24E508	(Y2) Multiple Construction A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date ((Y4) Item	(Y5	5) Date	Э
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•	NFPA 101			NFPA 101		Reg. #			
LSC	K0062		LSC	K0069		LSC			
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			LSC			LSC			
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Reg. # LSC		-				LSC			
Reg. #		Correction Completed	Reg. #		Correction Completed	ID Prefix		Co	orrection ompleted
Reg. #			Reg. #						orrection ompleted
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	By Reviewed	I Ву	Date:	Signature of Sur	veyor:		D	ate:	
Followup t	o Survey Completed or 1/15/2014	1:		Check for any Unco			Han FanilikuO	YES N	10

PRINTED: 03/19/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
		24E508	B. WING			R
HAYES	NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			TREET ADDRESS, CITY, STATE, ZIF 620 RANDOLPH AVENUE 6AINT PAUL, MN 55105	CODE	07/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
- 55=D	The facility's plan of as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verification. Upon receipt of an acconsiste revisit of your validate that substant regulations has been your verification. An abbreviated stand to investigate completed as a completed as a completed by accordance with each care. The services provided by accordance with each care. This REQUIREMENT by: Based on document facility failed to ensure as moking interventions (R35) in the sample refinding include:	of correction (POC) will serve for compliance upon the plance. Because you are pur signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance. Acceptable electronic POC, and ar facility may be conducted to natial compliance with the mattained in accordance with the dard survey was conducted with the survey was conducted wi	(F 000)	Preparation, submission & this Plan of Correction doe admission of or agreement conclusions set forth on the Plan of Correction is preparated by the plan of continuously imported at the facility of the policies. She disches facility on 4/1/14 where inability to follow policies. She disches facility on 4/1/14 where and support of famility on the policies of the policies. Care plans will be remaining 38 resides services department of the policies of the policies of the policies of the policies of the policies. The plans will be remaining the policies of the policies of the policies of the policies. She disches facility on 4/1/14 when the policies of the policies o	s not constitute as with the facts & e survey report. The facts & executed a fact of the facts of the facts. Nursing it is in the facts of	of ng p.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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

PRINTED: 03/19/2014

STATEME	NT OF DEFICIENCIES	A MEDICAID SERVICES			OMPNO	APPROVE
AND PLAN	NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		24E508	B. WING			R ·
	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP COD 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	03 E	/07/2014
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORDS		(X5) COMPLETION DATE
	The medical record approximately 11:00 3/5/14 at 3:45 p.m. r smoking in room. ap {resident} said "you g not going out there". explain the nurse told smoke out on the bathere was some physicsident and the nurse Another progress not indicated, read "2nd a during this time. Will Progress note 3/5/14 continued to be verbatommate saying "You don't pay rent, you ne and I wont stop. Write was inappropriate and will be called or she where and writer asked explaining what has has has refused accurate." Progress note dated: 2 date), indicated resided oom, when asked whe pointed to roommate were sident's name}. Review of the current on dicated R35 would be approximately approximately and the condicated R35 would be approximately	was reviewed on 3/6/14 at a.m. Progress note, dated ead: "Resident was seen proached by nurse and she go out there, it is cold, I am The progress continues to d the resident she needed to ck patio. The note indicated sical altercation between the see, dated 3/5/14 with no time nurse had to intervene monitor." At 4:15 p.m., "resident has ally aggressive/abusive to u don't belong here, you ed to get out of here etc. for told reside her behavior I if she continues the police ill be sent out to crisis. RN her to talk to resident after appened since the start. The check and insulin at 4:45 2/?/14 (unable to read ent was caught smoking in the she got it from, she who said she stole it from	F 28	DEFICIENCY)	ent admissi staff will sig e has read nis form sha station for s, and then s' permand plan ing or Social a quarterla e reported Care mmittee wange when e the tion of this ed on	ion gn a the all r a ent al y to
w	as to ask for one cina	e care plan directed staff to nursing staff, the resident rette at a time when smoking hours and the		COMPLIANCE MONITORING LICENSE AND CERTIFIC	DIVISION	-

LICENSE AND CERTIFICATION

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	STATEM	MENT OF DEFICIENCIES	T WEDICAID SERVICES		No. 1	OMPA	MAPPROVE
MAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 fried to dispose of the cigarettes in he trash bag (plastic bag). LPN-B bind 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 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 had yove 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 or 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.	AND PL	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) D	ATE SURVEY
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F 323 483.25(h) FREE OF ACCIDENT F 323		On 3/6/14 approximat worker was asked about and how did R35 have social worker indicated the cigarettes and give R35. R35 was directed pation right off the main worker was not aware cigarettes. The social the cigarettes of R35 woffice and R35 should cigarettes. On 3/6/14 at approximation worker confirmed the second care plan for smoking.	ely 2:00 p.m., the social put the smoking incident exacess to cigarettes. The dinursing staff were to store one cigarette at a time to did to smoke in the back dining room. The social R35 had access to own worker clarified with LPN-B were to be stored in the not have access to the ately 3:50 p.m. the social taff were not storing the therefore, not following the	And the second s			
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AND DI AN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MIII	TIDLE COLUMN	OMB IV	<u>0. 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		24E508	B. WING			R
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZI	0	3/07/2014
	RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	PCODE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			
TAG	I LOUD DEFICIENTLY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From page	7e 3				
SS=D	HAZARDS/SUPER	/ISION/DEVICES	F 32	23		
	Cont.			F323		
	as is possible; and e adequate supervisio prevent accidents. This REQUIREMENty: Based on document facility failed to ensure smoking interventions (R35) in the sample results.	sure that the resident is as free of accident hazards each resident receives in and assistance devices to it is not met as evidenced review and interview, the eight the care plan addressing is were followed for 1 of 1 eviewed for accidents.		 R35 was given a 30 vacate the facility of her inability to follow policies. She dischard facility on 4/1/14 with and support of familicase management. Care plans will be retremaining 38 resider services department nursing. Those found and the services will be a service. 	n 3/7/14 due w resident rged from the ith the assista ly members a viewed for nts by social and director d to be needige.	to nce nd
.	Finding include:			update will be tagged	d for follow u	p
a g T to be pin A in	he resident. The medical record was progress note, dated Resident was seen supproached by nurse as o out there, it is cold, he progress note consider the resident she mack patio. The note in hysical altercation between nother progress note.	3/5/14 at 3:45 p.m. read: moking in room. and she {resident} said "you I am not going out there". Itinued to explain the nurse eeded to smoke out on the idicated there was some tween the resident and the idicated 3/5/14 with no time arise had to interpope		 All staff will be reparding design areas and instruction person in charge he/she suspects a following the policy will be re-educated designated smoking consequences of resident policies of resident council in resident is found a policy there will be intervention by the 	eated smoking cted to report immediately anyone is not licy. Resident ed of the ing areas and failure to following the next to be violating to an	if sow kt

STATEME	ENS FOR MEDICARI	E & MEDICAID SERVICES			FORM	APPROVE
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		DENTIFICATION NUMBER:	A. BUILDING	3	(X3) DAT	E SURVEY
		24E508	D. WILLO		1	R
NAME OF	PROVIDER OR SUPPLIER	242000	B. WING			07/2014
HAYES	RESIDENCE		1	STREET ADDRESS, CITY, STATE, ZIP CODE		01/2014
			,	620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			
TAG	- Industrial Of E	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Progress note 3/5/1 continued to be vert	4 At 4:15 p.m., "resident has	F 323	F323		
	roominate Saying	Oll don't belong hore were		to determine il care pia	an	
	don't pay rent. voll n	leed to get out of hore		interventions need to b	e	
	" as mappingliale at	iter told reside her behavior nd if she continues the police	1	updated. Staff will be r	e-	
			İ	educated in the import	ance ar	nd
	THE WITE ASKE	ner to talk to recident to		necessity of the care pla	anning	
	one has refused acc	happened since the start. sucheck and insulin at 4:45		process. Director of Nu	arsing c	or
	p.m."	and mount at 4.45		Social Worker shall info	rm staf	f ,
	Progress note dated:	2/2/44/		of updates. Upon reside	ent	1.12
- 1	date), indicated resid	2/?/14 (unable to read dent was caught smoking in		admission or care plan of	hange,	- 2
	TOTAL WILLIAM ASKELL WI	THE COLO COL IT FROM	÷.i	staff will sign a form ind	icating	
	{resident's name}.	who said she stole it from		he/she has read the resi care plan. This form sha	dent	
-	Review of the current	care plan, dated 2/14/14,		kept in the nursing statio	n for a	
1.7	maidated H33 William	10 COMPLIANT WITH		minimum of 3 months, a	nd the	,
	aloo of the facility. If	he care plan directed staff to h nursing staff, the resident		moved to the residents'	ina tirici	.
	THE CITY OF THE CITY	arette at a timo when		permanent file.		
	awolik dililip bilinome	d cmoking haves	i	 Random audits of care pl 	an.	
10.00	COIGCITE GOES HOLSMA	KA animahara ingida da		compliance will be compl	all	
a	acility. The resident was proved areas of the	facility		either Director of Nursing	eted b	у
				Social Worker or de :	or	
	On 1/6/14 a self admin	istration of smoking	1	Social Worker or designed	e on a	1
	Socsometil was come	bleted for R35. The the resident was evaluated		quarterly basis and result	s will	
1	o midebelludili itili a ei	TIOKING NION and		be reported to the Contin	uous	
to	reduce from 4 to 3 ci	garettes a day.		Quality Care committee. 7	he CQ	
		74.5		Committee will provide di	rection	
1 1	" " " " Indicated Das	, licensed practical nurse had been smoking in her		or change when necessary	1liw &	
	THE DICTIONS AND	DOOD Whon Dort	1	dictate the continuation o	r	
	POUC OF THE CHAPTER	S In the track has /-!- "		completion of this monitor	ring	
CMS 0507/0	sy, LEIN-D tried to gra	b them. R35 grabbed at	1			

STATEMENT OF	DEFICIENCIES	(X1) BROWNER WILLIAM			OMPNO	MAPPRO	
AND PLAN OF CO	DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	OMB NO. 0938-0 (X3) DATE SURVEY	
	**		A. BOILD	ING	CO	MPLETED	
NAME OF PROV	IDER OR SUPPLIER	24E508	B. WING			R	
HAYES RESI				STREET ADDRESS, CITY, STATE, ZIP COD 1620 RANDOLPH AVENUE	<u> 03</u>	/07/2014	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		SAINT PAUL, MN 55105			
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	2111	COMPLETI DATE	
her Ban under indict Where care cigars R35 stopp quest on 3 worker and response to the cigare for the LPN-C private one cigaret a time a for smooth for smooth and properties of the cigaret and time a for smooth for smoot	erclothing had be cated R35 had or an mentioned to plan indicated rettes, LPN-B indicated rettes, LPN-B indicated and plan indicated rettes, LPN-B indicated and solved awhile ago. It is a state of the social formation of the social garettes and giver R35 was directed for the main retween the social garettes of R35 was directed for the main retween the social garettes of R35 was directed for R35 should the social garette and lighter that R35 should the social garette and lighter for R35, not go and therefore, not go and therefore, not go and the social updates made indicated that smart of the building art of the buildin	PN-B was wearing a and and indicated her been ripped by R35. LPN-B win cigarettes in her room. LPN-B about the current egarding staff storing the dicated she was not aware cigarettes and stated that LPN-B directed further all worker. Itely 2:00 p.m., the social out the smoking incident e access to cigarettes. The dinursing staff were to store e one cigarette at a time to ed to smoke in the back of dining room. The social R35 had access to own worker clarified with LPN-B were to be stored in the not have access to the, after the change of shift e social worker informed it not have cigarettes in the staff should be retained to the staff should be retained to the complete that the social worker informed	F 32				

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	Faculty	OMB NO	O. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		24E508	B. WING_			R
440000	F PROVIDER OR SUPPLIER RESIDENCE		S 1	TREET ADDRESS, CITY, STATE, ZIP CO	DDE 03	3/07/2014
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	5	AINT PAUL, MN 55105		
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOLLDE	(X5) COMPLETION DATE
F 323	4:00 a.m11:00 p.m exceptions for meal -12:30 p.m., and 5:0 not allowed in front the landing, the fron leading to the city sides assessment is cond smoker upon admissible The assessment is uneed for and individual.	n. with the following times: 7:00 - 8:00 p.m., 12:00 p.m5:30 p.m. Smoking is of the building including on the steps, or on the sidewalk dewalk. a smoking safety sucted with each resident sion and quarterly thereafter. Used to determine a resident's palities smoking management.	F 323			
(F 431) SS=D	LABEL/STORE DRU	GS & BIOLOGICALS	{F 431}			
1	of records of receipt a controlled drugs in su accurate reconciliation records are in order a	Who actablishes a sustain				(4)
i	Drugs and biologicals labeled in accordance professional principles appropriate accessory nstructions, and the e applicable.	and cautionany		55 240		
lo c h	ocked compartments on trols, and permit or ave access to the key] [th				
T p	he facility must provide ermanently affixed co	le separately locked, mpartments for storage of	1			
CMC DECT	20.001 5				1	1

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES		i i	FORI	MAPPROVED
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY
				<u> </u>	co	MPLETED
NAME OF	PROVIDER OR SUPPLIER	24E508	B. WING _			R
	RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	/07/2014
HAILS	HESIDENCE		1	1620 RANDOLPH AVENUE		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	1000	SAINT PAUL, MN 55105		
TAG	(CAOI) DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F E E S S P I I I I I I I I I I I I I I I I I	controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when package drug distributed and the readily detected. This REQUIREMENT by: Based on observation staff interview, the factor use when discontrol and R21 and R36). Findings include: During observation of the efficient of resident's name artial label on the extention of the efficient what patient the has not used them for the soft erythromycin of the efficient of the efficient of the extention of the efficient of the extention of the efficient of the extention of t	ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can is not met as evidenced in, document review, and editity failed to ensure eled properly and discarded attinued for 2 of 2 residents. The medication storage dyl suppositories were plastic bag. The bag had a erior of the bag. Four me were noted as well as enoted on the label. Ed about them, LPN-B hey were for and stated or awhile. The medication cart 1, two interest were found for een stopped on 11/08/13, tubes remained in the cart ned medication assistant y they remained in the	{F 431}	• The medications were immediatel from use and disc appropriate. • Director of Nursin designee will go the each medication densure medication labeled properly, and current with producers. Any expired medications found either be destroyed facility if possible of pharmacy shall be any medications for labeled improperly reported to pharmacy proper labeling. • Nursing staff will be educated regarding importance of destroyed medication. All medication. All medication. All medication. All medication. All medication. All medication.	referency removes arded a sign or shrough cart to shall do by the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for the oying and dications divided to the contactor will be acy for	red n's
The	e items were removed	d from the refrigerator	1	ensure proper labeli	ng and	_
JIVIO-2567(02	-QQ1 Provious 17-					

STATEMEN	T OF DECIDIENCIES	T WIEDICAID SERVICES				MAPPRO	
ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	OMB NO	OMB NO. 0938-03	
		200 St 200	Joile		CO	MPLETED	
NAME OF	PROVIDER OR SUPPLIER	24E508	B. WING_			R	
				STREET ADDRESS OTH STREET	03	/07/2014	
HAYES F	RESIDENCE		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE			
(VA) ID				SAINT PAUL, MN 55105		750	
(X4) ID PREFIX	SUMMARY STATE	TEMENT OF DEFICIENCIES	ID			70	
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIC DATE	
(F 431)	Continued From pag	ne 8					
	and the medication of	nart	{F 431	 disposal of expire 	٦		
1				medications.	u		
	No audits, part of the correction plan, were available during the post certification survey. The director of pursing was not available.						
				 A medication cart 	audit		
				required by perso	n manni	ng	
1.0	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.			the cart went into	effect o	n	
	facility to answer que			3/11/14. Random	2114:4-	£	
			ii	these audits and n	audits C)T	
19	On 3/5/14 at 5:00 p.m	n., the registered nurse		in use will I	nedicatio	ons	
	· · · · · / Was IIIIEIVIEW	PU DVI V 1112		in use will be com	pleted by	/	
				Director of Nursing	gor		
	Soldering and Comple	TIDO all admination		designee on a qua	terly bas	sis	
vei	discharges for the facility. At this time, RN-A rerified the suppositories and the eye ointment hould have been disposed of the suppositories.			and results will be	renorted	1	
				to the Continuous	Ouglitu	•	
			i	Care committee. A	Quality		
1 1-	and bruceumas	and correction -t-	i	results will be	uait		
100	eave for further review	v.		results will be main	tained in	1	
T	he Pharmacy Service	es policy, dated 1/16/2014,		the nursing office for	or a		
				minimum of three i	nonths.	191	
			į	The CQI Committee	will		
	ological a ale langian	With ovniration !	1	provide direction or	change		
ex	pired medications ar	e discarded per procedure.	1	when necessary & v	cuange		
Re	eview of R21 record	rovocled - "		dictate the serti	VIII		
				dictate the continua	tion or		
(du	ical) 10 mg supposite	ory for as needed basis.	1	completion of this		*	
				monitoring process	based or	1	
ne	view of R36's medica	al record revealed a		compliance noted.			
Pili	sicial order for anth	romuoin aus	1	 Completion date of a 	1/11/14		
		a thin ribbon to each eye The start date for the		, and date of	7 11/14.	1	
11/	12/13.	vas discontinued					
41} 483 =D SPF	6.65 INFECTION COI READ, LINENS	NTROL, PREVENT	{F 441}	W:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MH		011101140	
		A. BUILD	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
NAME OF BEGIN	24E508	B. WING			R
NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CO 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	DDE 03	/07/2014
COOL DELICIENT AND	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORD	LIOURDE	(X5) COMPLETION DATE
to help prevent the deve of disease and infection. (a) Infection Control Prog The facility must establis Program under which it	ish and maintain an am designed to provide a ortable environment and elopment and transmission. gram sh an Infection Control sh an Infection Control sh and prevents infections ures, such as isolation, individual resident; and incidents and corrective ins. Infection Control sh and incidents and corrective ins. Infection Control sh and incidents and corrective ins. Infection Control sh and incidents and corrective ins. Infection Control Program in the disciplination to ection, the facility must be infected skin lesions is infected skin l	{F 44		re for infector and washing ion. Staff shithe location the "Step by lure book as eady file ng office at sign they ormation and be kept in the file. If files will be nistrator for the pasture that the ults are ext to s and also lies.	tion g as hall hall d he er st

STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T		OMB NO	M APPROVE 0. 0938-039
AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
NAME	OF BROWNER OF THE	24E508	B. WING			R
	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_ 03	/07/2014
(X4) IE	S RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		7 4
PREFI	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION DATE
	This REQUIREMEN by: Based on observation review, the facility far and hand washing with documentation of tube new employees per Cand Prevention (CDC). Findings include: Five residents had the received insulin with a practical nurse (LPN) acconsistent glove wear. On 3/4/14 at 4:45 p.m. glucose supplies for R. glucometer, alcohol paramonitoring slip. R3 do assistance with the modern plassistance with an alcohol plassistance with an alcohol plassistance with the modern plassistance with an alcohol plassistance with an alcohol plassistance with a alcohol plassistance with a plassistance with a plassistance with an alcohol plassistance with a plassista	T is not met as evidenced on, interview and document illed to ensure glove changing ere completed during used monitoring to prevent the property of the facility failed to provide exerculin skin tests (TST) for center for Disease Control (1) guidelines. Being glucose monitoring and essistance from the licensed and LPN-D did not provide ing or hand washing. LPN-D set out blood 3 that included a aid, lancet, cotton ball and es own stick but needs entitoring slip from the esters the medication, and D then wipes down the obol pad, puts it back in tic bag. LPN-D then sing station to have blood in LPN-D set up equipment the blood. After R35, LPN-D removed the	{F 44	DEFICIENCY)	nachine. use and es will be f Nursin rly basis ted to th will be g office nonths. provide he on of ased on listing nd hire ursing of dance olicy. in the mum ent TB	e g ne

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) D	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
NAMEO	OF PROVIDER OR SUPPLIER	24E508	B. WING			R	
HAYES	RESIDENCE	2		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	1 0:	3/07/2014	
PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT		(X5) COMPLET DATE	
{F 441	R2 came into medic monitoring. LPN-D shood sugar monitoring obtained, LPN picked wiped it down with all gloves. When comple glucometer into a plate R18 comes into the numble blood sugar monitoring his blood sugar, LPN-ball, the used monitor without gloves. The Lathen picked up the gluca alcohol swab. LPN-while cleaning the gluck was then placed in a property of the placed in a pl	ation room for blood sugar set up supplies needed for ng. After blood sugar was dup the glucometer and cohol without wearing eted, LPN-D placed the stic zip lock bag. Inedication room to do the ng. After the resident does D picked up the used cottoning strip and the used lancet LPN-D removed the gloves, acometer and cleanses with D was not wearing gloves cometer. The glucometer blastic zip lock bag.	{F 44				
	gloves while cleansed alcohol, used a lancet When completed, LPN and washed her hands picked up the used lansuch as cotton ball, lan without wearing gloves, gloves, wiped down the alcohol pad and places pag.	the resident 's skin with to retrieve a blood dropletD removed the gloves, . At that time, LPN-D cet and other used items cet and monitoring stick LPN-D, still not wearing glucometer with an in the resident 's plastic				10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
th g or ke ah ite	ne cleaning of the gluco loves. LPN indicated e wn glucometer. They a ept in labeled plastic zij bout wearing gloves wh	or sugars on residents and ometers while not wearing every resident had their are identical and were to lock bags. When asked hile cleaning up soiled of, and while cleaning the					

STATEMEN AND PLAN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) 14111		OMB N	OMB NO. 0938-0	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
NAME -		24E508	B. WING				
NAME OF	NAME OF PROVIDER OR SUPPLIER		1		03	3/07/2014	
HAYES I	RESIDENCE		- 1	STREET ADDRESS, CITY, STATE, ZIP COL	E		
			- 1	1620 RANDOLPH AVENUE			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	1	SAINT PAUL, MN 55105			
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	0111	COMPLET DATE	
i.	Cleaning the glucom On 3/5/14 at 4:30 p. MDS, (RN) was calle After reviewing the p sugars and dispensir items and cleansing the RN verified the n sticks should have w soiled items, and sho cleaning the individua bad. At this time the policies regarding har cleansing. The RN in she could find and lead were developed for co	er, the LPN indicated gloves en picking things up, and while leters. m., the registered nurse for ed in to assist with survey. Procedure of obtaining blooding insulin, picking up soiled the glucometers with alcohol, urse conducting the finger form gloves while cleaning up held have worn gloves while all glucometers with a alcohol RN was asked about and washing and glucometer indicated she would see what ave all policy/procedures that prrections.	{F 44				
w fa tra st in dia mo blo tes	vas reviewed. the polacility will prevent cross ansmission based presentandard precautions. dicated that each resabetes and wherein conitoring is warranted bod glucose monitoring sting.	m. the Blood Glucose Procedure, written 1/13/14, licy statement indicated the ss contamination using ecautions in addition to and Procedure statement sident with a diagnosis of diabetic blood glucose d, s/he will have their own ng kit for blood glucose				9 % 	
Ce (CI On	enters for Disease Co DC) recommendation	at approximately to a	- C				
reg		or was questioned					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391		
		IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		24E508	B. WING			R		
NAME OF	PROVIDER OR SUPPLIER		1 =		0	3/07/2014		
HAYES	RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP 1620 RANDOLPH AVENUE	CODE	2		
			V.	SAINT PAUL, MN 55105				
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	000000000000000000000000000000000000000			
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	(EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETION DATE		
{F 441}	Continued From pag	ne 13	98120 50					
	manager indicated t	here had been at locations	{F 441}					
	manager indicated there had been at least one new hire of a housekeeper however, there was			İ				
	no access to the em	Diovee record The office		*:				
	manager indicated th	ne employee files wore						
	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 efficient					1		
	had access to the off	fice.						
1.	On 3/5/14 at 4:30 p.n	n., the registered nurse						
	(1114), was interviewe	d about new and rowritton				1		
- 1	bourges in illection (CONTROL It was agreed that				-		
120	mem available for rev	Iditional policies and make view the next day. When		i				
10	inionnation provided	by the RN was reviewed an						
e 18	UIUI IT at 3.30 a.m. If	Tere was no policy identify						
	or runtile litterview at	t. The RN was not available the facility. The Director of						
	vas not avail	able during the three days						
,	of survey at the facility	/.		-		1 4 W		
				two controls of the control of the c				
				8		* * **		
					1	1		
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						1		
				I.		1		
				*				



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,

Dre Klegge

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

ID: QTGH

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

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	I	Facility ID: 00928	
1. MEDICARE/MEDICAID PROVIDER (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 ACTIO 1. Initial 3. Termination 5. Validation				
5. EFFECTIVE DATE CHANGE OF O	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		10 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint				
6. DATE OF SURVEY 01/16/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDIR	NG DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	40 (L18) 40 (L17)	Complianc1. A X B. Not in Con	nce With equirements to Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B *	6. Scope of Ser 7. Medical Dir	rvices Limit ector	
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF (L37) (L38)	19 SNF 40 (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMA See Attached Remarks	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
Mary Heim, HFE NE l	Date : 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 REGIONA 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21. Facility is Eligible to Participate 22. Facility is not Eligible (L21)					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) 25. LTC EXTENSION DATE: (L27)	-	S DATE	4. LTC AGREEN ENDING DA (L25) (L44) (L45)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	0 INVOLUN 05-Fail to N sement 06-Fail to N on OTHER	L30) ITARY Meet Health/Safety Meet Agreement er Status Change	
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY	CARRIER NO.	(L31)	30. REMARKS AW K67 Emailed	l ROCHI 03/21/	2014	
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION	I OF APPROVAI	L DATE (L33)	Posted 03/21/20 DETERMINATION APP			
						· · · · · · · · · · · · · · · · · · ·		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

PART I - TO BE COMPLETED BY THE STATE SURVE

Facility ID: 00928

C&T REMARKS - CMS 1539 FORM

CCN: 24-E508

STATE AGENCY REMARKS

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 be be be be isolated 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.



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 be be lated 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.

Hayes Residence February 4, 2014 Page 2

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:

Hayes Residence February 4, 2014 Page 3

> 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.

Hayes Residence February 4, 2014 Page 5

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:

Hayes Residence February 4, 2014 Page 6

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 Weath

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

PRINTED: 02/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE : COMPL		
		24E508	B. WING _				01/1	16/2014
	ROVIDER OR SUPPLIER		•	1620 R	T ADDRESS, CITY, STATE, ZIP CO ANDOLPH AVENUE PAUL, MN 55105	DDE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TÁG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		" F0	00	5			
F 246 SS=D	as your allegation of of Department's accepta bottom of the first page be used as verification. Upon receipt of an acceptation of the substant regulations has been your verification. 483.15(e)(1) REASON OF NEEDS/PREFER A resident has the right services in the facility accommodations of in preferences, except with the individual or other endangered. This REQUIREMENT by: Based on observation review, the facility faile light was accessible for reviewed for environment of the prediction of the substant o	ance. Your signature at the ge of the CMS-2567 form will in of compliance. ceptable POC an on-site may be conducted to ial compliance with the attained in accordance with NABLE ACCOMMODATION ENCES Int to reside and receive with reasonable dividual needs and when the health or safety of residents would be is not met as evidenced in, interview and document and to ensure a resident call or 1 of 1 resident (R25) it accessible on the evening	'' Pla of or pr im	or agreed the sure pared prove policable	tion, submission & impleorrection does not considered to the facts & reverse report. Our Plan of & executed as a means the quality of care & to e state & federal regula. Information regarding accommodations of in preferences" has been education/re-educations accommodations of it preferences has been education for each of residents between to reasonably accommodations of the conduct random compliance as resider physical environment. The Director of Nursing will conduct random compliance. DNS will audits to CQI committed to the continuation or compliance when necessary the continuation or compliance in the conti	titute an a conclusion of Correction is to continuous comply with tions. If "reasonated the continuous on to all second to all	able needs & ed in as strivies ident's use of the monitor rogress of this ident's are with as ident's use of the monitor rogress of the ident's are will dictarn of this	in and a second of the second
<u> </u>	1	m., during interview, R25		•	noted. DNS is responsible. Completion date: Fel	bruary 20	, 2014	

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB MC	0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24E508	B. WING			01/	16/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COI	DE	
HAYES RE	ESIDENCE				RANDOLPH AVENUE IT PAUL, MN 55105		
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F 246	stated she was not a said that the last time she was not able to r nurse came into the hospital." She further give the facility a receive the call light close to reaching it." R25's colipped to a string that the head of the bed.	ble to reach the call light and e, when she had "A stroke" each it either, "But lucky a room and I was sent to the stated "I would like you to ommendation on how to get me as I have a hard time all light was observed to be at was attached to a light, by The string with the call light do be falling behind the	F	246	COMPLIANCE	EIVEL B 18 2014 MONITORING DI AND CERTIFICAT	VISION
	observations, R25's clipped onto the strin behind the bed head	a.m. and at 1:47 p.m., during call light continued to be g, hanging from the light, board. R25 was observed d the call light was not					
	accessible to R25 ar clipped to the beddin it as she spent most stated to the assistar the clip on the head want the call light to	the call light was not distated it should have been g where she was able to use of the time in her room. R25 and administrator, "Putting it to board was not accessible. I					
	Minimum Data Set (Nincluded degenerative Interview of Mental Season measure cognitive states was cognitively intaction.	tained from the quarterly MDS) dated 10/24/13, e joint disease. R25's Brief status (BIMS-tool used to atus) score indicated R25 t. In addition the MDS functional limitation in range					

CLIVILIN	J T OIL WILDIOMILE W	VILDIO/ IID OLI (VIOLO			OND 140. 0000-0001	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E508	B. WING		01/16/2014	
NAME OF PE	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 620 RANDOLPH AVENUE		
HAYES RE	SIDENCE			SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 246	extremities, used a w balance during transi	ment to both sides of lower	F 246			
	(DON) stated she wa light was a problem. call lights accessible capable of using the The Call Light policy "Call lights will be wit	a.m. the director of nursing s not made aware R25's call Her expectation was to have to all residents who are call light. revised 9/11/12, directed hin reach of all resident beds athrooms. Call lights will be				
F 250 SS=D	in working order." 483.15(g)(1) PROVIS RELATED SOCIAL S The facility must proviservices to attain or r	SION OF MEDICALLY ERVICE vide medically-related social naintain the highest mental, and psychosocial	F 250			
	by: Based on interview a facility failed to asses related to the family s	is not met as evidenced and document review, the sand care plan concerns support system for 1 of 2 ified as needing medically s.				
	Findings Include: R35's hospital admissindicated R35 current	sion history, dated 9/21/13, tly lives with a family				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	-	(X3) DATE SURVEY COMPLETED
		24E508	B. WING_			01/16/2014
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	`ID PREFI TAG	(EACH CORR	JE	
F 250	Revoew of the facility area assessment, da showed impairment in making due to menta included Paranoid Scoperession. An undated handwritt social worker, (LICSV care conference on 1 included concerns reservices in her prior li information had been the case manager du conference. Review of the Progre 12/31/13 at 1:55 p.m. of absence (LOA) De and it was discovered half days insulin R35 An attempt was made family member, include R35 takes her insulin member. A review of R35's me area assessment date care plan dated 9/30/9/30/13, revealed no to manage the risks a vulnerabilities.	ere is some question that bood housing situation. I's 35's most recent care ted 10/25/13, indicated, R35 in cognition and decision. I illness diagnoses, which chizophrenia and I's note was provided by the W, regarding R35's initial 0/17/2014. The note garding R35's care and iving arrangements. The provided to the facility by ring the initial care Is Record note, dated indicated R35 was on leave cember 21st to 26th 2013, if that there were three and a did not take while on LOA. It to discuss concerns with a ding a reminder to ensure while on LOA with the family dical record, including care ed 10/25/13, most recent 13 and Social History dated assessment or plan in place issociated with R35's related	F	 Information sufficient & are provided needs" has education. Social Serve the safety immediated that may be problems. The Social (SSD)/design audits to report procedure committee. The CQI Condition of will dictate completion based on a SSD is respective. 	on regarding "assured appropriate social ed to meet the resist been presented in presented in presented in presented in the resist of (R35) were imported in the resist of (R35) were imported in the resist of the resist of the concerns were identified in the resist of a conduct in the resist of a conduct in the resist of a conduct in the resist of a conduct in the conduct in the continuation of the continuation of this monitoric compliance noted	al services idents' n Il staff. to assure lemented esidents entified. random e. SSD will CQI vide ecessary & or ng process
	nurse, (LPN)-C, repor	/15/14 at 11:23 a.m., the red she was aware of the A's confirmed R35 missed 3				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24E508	B. WING			01/	16/2014
NAME OF PE	ROVIDER OR SUPPLIER			1620	ET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH AVENUE NT PAUL, MN 55105		
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F 250	over Christmas and recommendation to minimize risk for Recommendation involvement. LPN-C restrictions on R35's facility. During interview on 1 director of nursing (Dunaware of the concestives in R35's price however, reported strengthing three and a high visiting family over C medical record and cassessment or plant R35's family involved expectation would be	sulin while visiting her family reported she knew of no plan 35 in regards to her family reported there were no being able to leave the /15/14 at 1:51 p.m. the PON) reported she was erns regarding care and	F	250			
	During interview with LICSW, explained sh family involvement w was aware of the pric missed insulin while reviewed R35's medi and reported there w concerns regarding F plan to minimize R35 while residing at the 483.25(b) TREATME HEARING/VISION To ensure that reside and assistive devices hearing abilities, the	R35's family involvement or 's risk of family involvement	F	313			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTIO	N	(X3) DATE SURVEY COMPLETED
		24E508	B. WING			01/16/2014
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRES 1620 RANDOLPH SAINT PAUL, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	†D PREFIX TAG	(EAC	PROVIDER'S PLAN OF CORRECTIC CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	Continued From page by arranging for trans office of a practitione treatment of vision or office of a profession provision of vision or This REQUIREMENT by: Based on observation review, the facility fair glasses for 1 of 3 resvision impairment. Findings Include: R35's minimum data indicated R35 had into read large print, but newspapers or books used for the vision examples of the vision examples of the vision examples. The dated 10/25/13, indicated 10/25/13,	sportation to and from the respecializing in the hearing impairment or the all specializing in the hearing assistive devices. This not met as evidenced on, interview and document led to obtain prescription eye idents (R35) reviewed for set [MDS], dated 10/06/13 apaired vision and was able at not regular print in some corrective lenses were not sam. R35's Brief Interview for lindicated she was a care area assessment, ated "Patient denies need currently does not wear exhibited any vision out we have made o see a eye md [physician] er last time she had eye	F 3	 Informassis hear educe Glass Staff in gaserv Medithis DNS audithis reported commendation The direct will commendates 		eiving ain vision & presented in all staff. mediately. st resident(s) & hearing een notified of t random nce. DNS will to CQI rovide necessary & on or pring process
	with setting up appoin including "Eye" appointcluded "Staff will as appointments and tra	nsportation."		• Com	npletion date: Februar	y 20, 2014
	A Referral Form for the	ne eye clinic, dated 10/15/13,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		24E508	B. WING			c	1/16/2014	
NAME OF PE	ROVIDER OR SUPPLIER		•	1620	ET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH AVENUE IT PAUL, MN 55105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 313	included the following glasses, worn full tim was a prescription fo During initial interview at 4:46 p.m., R35 repread, and wanted glawearing glasses duri follow up interview of 11:45 a.m., R35 repote exam but has not her glasses. R35 reporte R35 was again obserglasses. The nurse, of	g recommendations "new be." Along with the referral reye glasses. w and observation on 1/13/14 ported she needed glasses to asses. R35 was observed not ng the interview. During a n 1/15/14 at approximately orted she went to an eye and anything about getting and she wanted eye glasses.	F	313				
	called to ask the eye glasses were ready. had lost the phone n R35's glasses were ready. On 1/16/14 at 9:30 a reported R35 saw the and went to order glahad not yet picked up reported she does not glasses are ready, be supplier to call and le ready. LPN-C reported.	.m., the nurse, (LPN)-C, e eye clinic on October 15th asses on October 18th. R35 p her glasses. LPN-C of call to ask when the ut waited for the eye glass et her know glasses are ed it typically took about 2-3 es to be ready for pick up						
	(DON) reported she eye glass supplier to	a.m. the director of nursing would expect staff to call the see if R35's glasses were reeks had passed and R35 glasses.	Op man op opposite the same of					

CENTERS FOR MEDICARE & MEDICAID SERVICES

FREETX TAG FREDIX RECULATORY OR LISC IDENTIFYING INFORMATION) F 356 SS=C INFORMATION 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 attegories 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 PREFIX TAG F 356 S=C Information regarding Nurse Staffing Information Data Requirement has been presented in education/re-education to all staff. 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 [Ine listing shift: 7-3, 3-11, 11-7, & total hours for each category of staff list plants 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. 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.	STATEMENT O	TATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
HAYES RESIDENCE SUMMARY STATEMENT OF DESICIENCIES SAINT PAUL, IMP 55105 PRETIX PREFIX PRECIDENCY MUST BE PRECIDED BY PULL PREFIX PREFIX PRECIDENCY TO STREET PRECIDED BY PULL PREFIX PREFIX PRECIDENCY TO THE APPROPRIATE DESICIENCY			24E508	B. WING		01/16/2014
PREFIX TAG SUMMINION (EACH DENTIFYING INFORMATION) F 356 483.30(e) POSTED NURSE STAFFING (INFORMATION) The facility must post the following information on a dily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unicensed 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 PREFIX TAG F 356 Information regarding Nurse Staffing linformation Data Requirement has been presented in education/ree-education to all staff. Information regarding Nurse Staffing linformation Data Requirement has been presented in education/ree-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 portion and ality 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. The CQI Committee. The CQI Committee. The CQI Committee will provide direction or change when necessary & will dictate the continuation				16 S.	320 RANDOLPH AVENUE AINT PAUL, MN 55105	NEON (NE)
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 Information regarding Nurse Staffing Information Data Requirement has been presented in education/re-education to all staff. 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, 8 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.	PREFIX	(FACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
review, the facility failed to post the required nurse staffing information to include the actual hours worked by nursing staff in the facility. This	F 356 SS=C	INFORMATION The facility must po a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per shape and the facility must possible and the facility must possible and readable or a prominent plane facility must, u make nurse staffing for review at a cost standard. The facility must must presidents and visited. The facility must, u make nurse staffing for review at a cost standard. The facility must must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must must facility must facility must must facility must facility must facility must must facility must faci	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). a aides. Set the nurse staffing data a daily basis at the beginning must be posted as follows: sele format. The posted are readily accessible to be selected as a daily accessible to be selected. The public and to exceed the community and the posted daily nurse ninimum of 18 months, or as aw, whichever is greater. Note the following information on the public and the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.	F 356	Information Data Requipeen presented in educe education to all staff. This form was immedia The facility staff will cont that the nurse staffing of 7-3, 3-11, 11-7, & total hours for staff) is posted on a daily readable format as well prominent place that is accessible to residents The DNS/designee will audits to monitor compreport progress of audicommittee. The CQI Committee will direction or change whe will dictate the continu completion of this monbased on compliance no DNS is responsible.	tely updated. ntinue ensure data (line listing shift: reach category of r basis, in clear, l as being in a readily & visitors. conduct random oliance. DNS will ts to CQI I provide en necessary & ation or litoring process oted.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CON	NSTRUCTION		E SURVEY IPLETED
		24E508	B. WING				1/16/2014
NAME OF PE	ROVIDER OR SUPPLIER	242300		1620 F	ET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH AVENUE T PAUL, MN 55105	1 0	710/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 356		e 8 ential to affect family, staff, sidents residing at the facility.	F	356			
	Findings include:						
	tour the Hayes Reside 1/13/14, was observed board in the first floot station. The form ide number of other unlied medication assistant worked and identified and Night. The posti	s), number of hours each d the shift as Day, Evening ng lacked documentation of ked in the facility by the					
	dated 11/30/13, thro	Residence Staffing forms ugh 1/15/14, revealed all on of the actual hours worked cility.					
	the the director of nu administrator verified	If the actual hours worked by acility was lacking and stated					
F 387 SS=D	the facility did not hat pertaining to the nur- 483.40(c)(1)-(2) FRE	o.m. the administrator stated ve a policy specifically sing staffing posting. EQUENCY & TIMELINESS IT	F	387			
	once every 30 days	e seen by a physician at least for the first 90 days after ast once every 60 days					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24E508	B. WING		01/16/2014
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	, 0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	√ID PREFIX TAĞ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 387	This REQUIREMENt by: Based on document the facility failed to experience of the facility failed to experience of the facility failed to experience of the facility failed to experience of the admission. Findings include: R26 was not seen by qualified medical prospecialist, physician practitioner) at least first 90 days after actinicated R26 was a 7/25/13. Review of the was seen by the physician of the facility of the first 90 days for 90 days for 90 days fo	onsidered timely if it occurs is after the date the visit was. T is not met as evidenced it review and staff interview, ensure 3 of 4 residents (R26, in by a physician at least once it is 90 days after. y a physician or other ovider (clinical nurse assistant or nurse once every 30 days for the limission. Document review idmitted to the facility on R26's record indicated R26 visician on 8/23/13 (29 days 10/8/13 (75 days after 10/25/13 (92 days after 10/25/1	F 38	 Information regarding physician visits has been education/re-education Staff will schedule visit (including R26, R35, and primary physician in accompletion of this mecessity. Medical providers have this necessity. The DNS/designee will audits to monitor comport progress of auccommittee. The CQI Committee will dictate the continuction of this mecessity on completion of this mecessity. The CQI committee will dictate the continuction of this mecessity. The CQI committee will dictate the continuction of this mecessity. DNS is responsible. Completion date: February completion /li>	en presented in n to all staff. for each resident nd R44) with coordance with days for the first n, and at once er." e been notified of conduct random pliance. DNS will dits to CQI ill provide hen necessary & uation or initoring process noted.
	į ·	ppointments had been made.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		24E508	B. WING			01	1/16/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, 1620 RANDOLPH SAINT PAUL, MI		-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	ROVIDER'S PLAN OF CORREC' H CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 387	days for the first 90 d review indicated R35 on 09/30/13. According Summary, R35 was a practitioner on 10/11/admission) and was a 12/20/13 (81 days aft 9:45 a.m., interview was were no further physical physician assistant via Summary. Interview with the Direct at 3:00 p.m., indicated policy regarding when seen by the physician provider, but her under the provider of the policy regarding when seen by the physician provider, but her under the policy regarding when seen by the physician provider, but her under the policy regarding when seen by the physician provider, but her under the policy regarding when seen by the physician provider, but her under the provider in the provider	y a physician or other vider at least once every 30 lays after admission. Record was admitted to the facility ng the the Clinic Visits seen by the nurse	F	387				
SS=D	The facility must emp a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is mareconciled.	oloy or obtain the services of at who establishes a system and disposition of all afficient detail to enable an any; and determines that drug and that an account of all aintained and periodically as used in the facility must be a with currently accepted s, and include the y and cautionary	F	431				

CENTER	S FOR WEDICARE &	WIEDICAID SERVICES			OND NO. 0936-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E508	B. WING _		01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVES DE	CIDENCE			1620 RANDOLPH AVENUE		
HAYES RE	ESIDENCE	,		SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION	
			1			
F 431	Continued From page	e 11	, F4	31		
					2/21/14	
		tate and Federal laws, the	•	•	100/1	
	t Table 1	drugs and biologicals in			-l 0	
	1	s under proper temperature only authorized personnel to	r	 Information regarding 	_	
	have access to the ke	•		biological used in the	facility for	
				residents must be labe	eled in accordance	
		vide separately locked,		with currently accepte	ed professional	
		compartments for storage of		principles, & include t		
		d in Schedule II of the g Abuse Prevention and		· · ·		
		and other drugs subject to		accessory & cautionar		
		the facility uses single unit		the expiration date w	nen applicable	
		ution systems in which the		along with discarding	medications per	
	quantity stored is minimal and a missing dose can		1	procedure has been p	resented in	
	be readily detected.		1	education/re-education		
				•		
				 Eye drops for R7 have 		
		Γ is not met as evidenced		For all other residents	that may be	
	by:	on, document review and		affected, no problems	/concerns have	
		cility failed to ensure expired		been identified.		
		carded and not administered		 The DNS/designee will 	Londuct random	
	for 1 of 1 residents (F	R7).		1.		
	Findings include:		:	audits to monitor com report progress of au		
				committee.		
		f medication cart 1 on				
		one vial of latanoprost eye glaucoma) was noted to be		 The CQI Committee w 	vill provide	
		v of the vial with trained		direction or change w	hen necessary &	
		A)-A, it was discovered to		will dictate the contin	uation or	
		o both eyes daily at bedtime.		completion of this mo		
		3." Interview with TMA-A		•		
		s eye drops every evening. nedication had an expiration		based on compliance	noted.	
		was used on R7. TMA-A		 DNS is responsible. 	i	
		ation should have been		 Completion date: Feb 	ruary 20, 2014	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		24E508	B. WING)1/16/2014
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 431	expiration date. TMA from the medication of Review of R7's recorglaucoma, and a phy	edication cart after the A removed the eye drops cart. d indicated a diagnosis of sician order for Latanoprost	F 4:	31		
	glaucoma).	each eye at bedtime (dx.	F 4	41		
	Infection Control Pro safe, sanitary and co	ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion.				
	Program under which (1) Investigates, confinithe facility; (2) Decides what proshould be applied to	ablish an Infection Control in it - irols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective				
	prevent the spread o isolate the resident. (2) The facility must communicable disea from direct contact w direct contact will tra (3) The facility must	n Control Program sident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if				

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE COMF	SURVEY
		24E508	B. WING _			01/	/16/2014
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				162	0 RANDOLPH AVENUE		
HAYES RE	ESIDENCE	• •		SA	INT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	i .		٠,	-	53		
F 441	Continued From pag	e 13	,, F4	141			
	hand washing is indi	cated by accepted					2/2/14
	professional practice	. · · · · · · · · · · · · · · · · · · ·	**				7/20/17
	(c) Linens	31		•	Information regarding blood g	lucose	
		dle, store, process and sto prevent the spread of	,		monitoring machines has been	า	
	infection.	s to prevent the spread of			presented in education/re-ed	ucation	to
			1	1	all staff.		
					Each resident including (R3, R	4. R18.	
	This REQUIREMEN	T is not met as evidenced		Ţ	R20, R35) that has a diagnosis		
	by:						
		on, staff interview and			diabetes & wherein, diabetic		
		e facility failed to implement			glucose monitoring is warrant	ed was	
	procedures to preve during blood glucose	nt the spread of infection			immediately supplied with his	her ov	vn
		18, R20, R35) observed who			blood glucose monitoring ma		
	•	se monitoring. This had the			-	sitilite/ Ki	
		residents in the facility who			for blood glucose testing.		
		se monitoring. The facility		•	Pharmacy & Medical provider	s have	
		esults of a tuberculin skin test			been notified of this necessity	/ .	
		oloyees reviewed, S2 and S3, ase Control and Prevention	1		The DNS/designee will condu		nm
	· ·	ions. Also, the facility policy	1.1		•		5
		ction on how to properly	••	- }	audits to monitor compliance		VIII
	perform, read and do	ocument results of a TST.		i	report progress of audits to C	QI	
			!		committee.		
	Findings include	•••			The CQI Committee will provi	do	
	The facility failed to a	ensure that the process for		•			
	conducting blood glu	•	Lo.		direction or change when ne	cessary	&
		ner to prevent the spread of			will dictate the continuation	or	
	blood borne pathoge	· · · · · · · · · · · · · · · · · · ·	!		completion of this monitoring	g proces	s _i s
				:	based on compliance noted.		
		served in the medication					
	room on 1/13/14:		:		DNS is responsible.		
	At 4:30 p m PN-A v	was observed to conduct a			Completion date: February 2	0, 2014	
	·	for R35 in the medication			,		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED		
		24E508	B. WING _		01	/16/2014
-	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 441	used an alcohol wi (machine used to approximately 4 se At 4:34 p.m. LPN-cleaning of the gliu used alcohol wipe each use and did stated the same gresidents residing blood glucose more and the same gresidents residing blood glucose machine with an at 4:44 p.m., LPN-R3's blood glucose machine with an at 4:55 p.m. LPN-R20's blood glucose machine with an all the same with an all the same with LPN are used to clean none could be four linterview with the 5:30 p.m. on 1/13/machine owners be "70% isopropyl alcowner's booklet, p	pocedure was completed, LPN-A ipe to clean the glucometer check blood sugars) for econds. A was interviewed regarding icometer and stated the facility is to clean the glucometer after not use anything else. LPN-A lucometer was used for all the at the facility that required nitoring. It was observed to complete intering on the facility's True is Meter. Licensed Practical is machine with an alcohol in alcohol wipe, after use. A was observed to complete is monitoring, and wiped the interior ing, and wiped the interior interior ing, and wiped the interior interior interior interior interior interior interior interior interior interior interior interior interior inter	F	141		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		24E508	B. WING_		01/16/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION SHOUNDER CORRECTIVE ACTION OF THE APPROPRIES OF T	ILD BE COMPLETION
F 441	members. DO NOT . ALL parts of your System could carry even after cleaning Interview with the D indicated the admin a staff member was pharmacy to purcha for every resident w monitoring. The facility failed to tuberculin skin test Centers for Disease (CDC) recommenda S2 was hired on 08 7/24/13 with number induration was 0. H documented such a S3 was hired on 10 with interpretation of millimeters of ind During interview on reported both TSTs provider. She had r some components The facility lacked a perform, read and of An interview condur 9:10 a.m. in query of	e with anyone, including family use on more than one person Blood Glucose Monitoring blood-born disease after use, and disinfection. ON at 6:00 p.m., she instrator had been notified and a going to the nearby ase blood glucose machines who required blood glucose. document results of a (TST) for S2 and S3, per expectation and Prevention actions. /26/13. TST results on ear of mm (millimeters) of owever, no interpretation was as positive or negative. ////13. TST results on 4/14/13 negative. However no number furation was recorded.	F	 Information regarding of Screening Questionnairs mm of indurations along of positive or negative f documentation has bee education/re-education TB screening for (s1, S2, TB Screening policy & probeen updated. The DNS/designee will condition audits to monitor comport progress of audit committee. The CQI Committee will direction or change whe will dictate the continuation completion of this monitors based on compliance noted. DNS is responsible. Completion date: February 	e & recording of g with evidence indings in presented in to all staff. S3), as well as rocedure has indicedure has indicedure in a conduct random in ance. DNS will so to CQI in provide in necessary & stion or toring process oted.

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24E508	B. WING		01/16/2014
NAME OF PF	ROVIDER OR SUPPLIER		16	TREET ADDRESS, CITY, STATE, ZIP CODE 520 RANDOLPH AVENUE AINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 441	millimeters (mm) of ir (positive or negative) currently have an ins for TST but will work	th, day, year), the number of induration and interpretation, DON replied, "We don't truction policy and procedure on one."	F 441		
	"Employees will have unless contraindicate history of a positive Muberculosis (TB) is r (a TB risk Assessme annually). This informemployee's personne "III. New hire employ procedures as listed would be if new hire Mantoux recorded wonly a repeat Mantou 483.70(h)	ewed 06/12/2012, indicated, a 2-step Mantoux upon hire ad. Any employee with a Mantoux or having had not to have another Mantoux at form will be completed mation will be part of the el record." It further reads, ees will follow the same above. The only exception has evidence of one ithin the last 12 months, then ax would be necessary."	F 465		
		vide a safe, functional, table environment for ne public.			
-	by: Based on observation review, the facility factorioment was main manner for 4 of 4 res	T is not met as evidenced on, interview and document eled to ensure resident national and in a clean electric (R1, R25, R24 and evironmental concerns.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		24E508	B. WING		01/16/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 465	observed under both thick layer of fluffy grethe return air flow ver observed with build-us ubstance. R25 state and she and her room do about it. On 1/14/14, at 9:45 a beds, bed frames and built-up grey fluffy sulfull-up grey fluffy grey fluffy sulfull-up grey fluffy grey	m. during interview surveyor the beds for R25 and R1 a by substance. Additionally, it next to the dresser was p dusty-grey fluffy dit was so dusty in the room inmate did not know what to the dresser. m. observed under the director air flow vent still with obstance. m. during the environmental ministrator and maintenance verified the room floor, bed a air vent had build-up dust. Strator called in one of the indirector and maintenance verified the staff to the concerns were brought of the stated he would look be if this was a lated the dust was issue that needed to be m. interviewed the sor who stated he and the lattment usually go around the vents and would look for the maintenance and surveyor and stated there ecords for the return air flow	F 46	 Information regarding "profunctional, sanitary, & comenvironment for residents public" has been presente education/re-education to (R24, R43) resident(s) room immediately refurbished. R25) resident(s) room ven replaced immediately. Than ongoing improvement rooms, offices, common a areas & equipment replace The Administrator/designs conduct random audits to compliance. Administrator progress of audits to CQI of the CQI Committee will pudirection or change when will dictate the continuation completion of this monito based on compliance note. Administrator is responsible. Completion date: Februare 	ifortable , staff & the d in all staff. was While in (R1, ts were ere has been of resident reas, storage ement. ee will monitor r will report committee. rovide necessary & on or ring process ed. ole.

CLIVILITY	OT OIL MEDICA TILE G						
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		E SURVEY IPLETED
		24E508	B. WING			01	/16/2014
NAME OF DE	ROVIDER OR SUPPLIER	1 12000		STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 0	710/2014
NAME OF PR	OVIDER OR SUPPLIER				ANDOLPH AVENUE		
HAYES RE	SIDENCE				PAUL, MN 55105		
	OUR MAR DV C	TATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLÉTION DATE
F 465	Continued From pag	ne 18	F	465			
,		ust started to deep clean the					
		te side of the hallway but the		1			
		hallenge with the residents.					i
		hat was not an excuse for	1				1
	dust build-up.						
	Paviow of the Plann	er Calendar dated 2014,		:			1 magne
		sks/duties were assigned to					
		14, to 1/14/14, however					
		ir flow vents was not listed,					
	which the maintenar	nce supervisor verified.					
	The undated Hayes	Residence					
		tenance Policies indicated the		1			: : 1
	, -	rs the only privacy that the					
		e resident's home within the					
		especially important that the					i
		and pleasant. In order to surfaces, sweep and mop					
		carpets and empty trash					
		on, the policy directed					
		uld be checked and cleaned			1		
	•	ensure adequate airflow in					
	the resident's rooms	and bathrooms.		\$			
		a.m. R24 reported the carpet					6
	in her room was "aw						
		orn spots, a seam splitting,					
		ch apart, across the length of . The director of nursing					
		dings and reported the					
		be removed for this room.					
	DON reported she w	as not aware of any current					
	•	carpet for R24 and her	1				
1	roommate, R43.					•	
ł				:			
							:

FE508023

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 24E508 B. WING 01/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 MAN So K 67 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: FEB 1 8 2014 HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION DEPT. OF PUBLIC SAFET 445 MINNESOTA STREET, SUITE 145 STATE FIRE MARSHAL DIVISION ST. PAUL, MN 55101-5145 Or by email to:

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.

LABORAT

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administratix

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OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				MB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED
		24E508	B, WING_			01/15/2014
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT CICIENCY)	
K 000	Continued From page	e 1	К (000		
	Marian.Whitney@stat		1			j
	THE PLAN OF CORF DEFICIENCY MUST FOLLOWING INFOR	INCLUDE ALL OF THE				9 300000
	to correct the deficient 2. The actual, or prop 3. The name and/or tiresponsible for correct prevent a reoccurrence. Hayes Residence is a basement. The building and was determined to construction. The alarmine detection in the corridor. The alarmine service was a simple construction.	tosed, completion date. Itle of the person Itle of the person Itle of the deficiency. It is a 1-story building with a full It is a 1958				
1	have either heat dete that are connected to accordance with the M The sleeping rooms h	ction or smoke detection the fire alarm system in Minnesota State Fire Code. lave battery operated smoke g is not protected by a fire				
	The facility has a capa census of 38 at the tir	acity of 40 beds and had a ne of the survey.	i I			
	The requirement at 42 is NOT MET as evide	2 CFR, Subpart 483,470(j), nced by:				
K 062 , SS=F		ETY CODE STANDARD	KO	062		
30-1	Required automatic s	prinkler systems are				

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OMB NO. 0938-0391

TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		24E508	B. WING_		01/15/2014
HAYES RE		TATEMENT OF DEFINITION		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	· ID PREFI TAĞ		SHOULD BE COMPLETION
K 062	Continued From page	<u> </u>	K	062	
1. 002	continuously maintair condition and are ins	ned in reliable operating		8	9-19-11
			,	The annual inspection completed on Februar	I WIII DE
K 067	Based on record rev complete automatic f being maintained in 25(99) Section 9.2.7, effect all occupants o were to fail under fire Findings include: On facility tour betwe on 01/15/2014, it was available fire sprinkle documentation of quatesting in the last 6 m with facility staff (SS system installed in Juunaware of quarterly	en 09:00 AM and 01:00 PM arevealed during review of records that there was no arterly sprinkler flow testing conths. During an interview), this was a new sprinkler one of 2013, and was	ko	Automatic Sprinkler C been signed with Vikin terms that they will po- inspections annually. instruct the maintena perform quarterly dra Please reference attac Colin Faulkner, Assista is responsible.	ng including the erform the Viking will also nce director to sin/alarm testing. ched proposal.
SS=F	Heating, ventilating, a	and air conditioning comply section 9.2 and are installed e manufacturer's	30	A request for renewal will be sent to Mr. Pat the State Fire Marsha than Thursday Februa	trick Sheehan with I Division no later
1		, 5			
	Observations and int	not met as evidenced by: erview with staff revealed g the corridor as a make-up		Colin Faulkner, Assista	ant Administrator,

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OMB NO. 0938-0391

		THE OLIVIOLO			OND 140, 0930-033
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		24E508	B, WING _		01/15/2014
	ROVIDER OR SUPPLIER	ie .		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	7 30.10.200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
K 067	distribution system conbustion to travel to	e 3 corridor as part of the air ould allow the products of hroughout the facility and residents, guests and staff	КОС	57.	
	on 01/15/2014, it was interview with facility	en 09:00 AM and 01:00 PM observed and during an staff (SS), it was revealed being used as part of the air r make-up air.	#: #: #:		
K 069 SS=F		eviously approved. ETY CODE STANDARD protected in accordance	K 06	 Kitchen hood extinguish immediately inspected 	
i	Based on observation facility failed to proper fire extinguishing syst cooking equipment ar	not met as evidenced by: In and record review, the Ity maintain the automatic Ity maintain the automat		 A contract with Nardini that specifies kitchen he extinguishing system with and tested annually. Administrator is responsible. Completion date: February 	ood ill be inspected sible.
4	on 01/15/2014, t was available documentation reveled, that the kitchesystem has not been it	en 09:00 AM and 01:00 PM observed, and by review of on for past 12 months. The nen hood extinguishing inspected / tested in the ecorded service date was		4	T

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		24E508	B. WING		01/15/2014
HAYES RI	ROVIDER OR SUPPLIER ESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
K 069		4 was verified by facility staff	К	069	
			Þ		
				*	
					4
					100 H
					1



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

PROPOSAT

PROPOSAL SUBMITTED TO	ATTENION	I PHONE	T DATE
HAYES RESIDENCE	COLIN	(651) 690-4458	FEBRUARY 13, 2014
STREET	FAULKNER		. 2.5103.1011 15, 2014
1620 RANDOLPH AVE	COLIN.FAULKN	ER@HAYESRESIDENC	TE.COM
	JOB NAME & LOCATION		
ST. PAUL, MN 55105 INSPECTION PREQUENCY	SAME SYSTEM(S) TYPE & NUX	7077	
ANNUAL 2014	1 WET	ABER	

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 SHALLBE PAID WITHIN 30 DAYS AFTER COMPLETION OF INSPECTION NOTE. THE PROPOSAL MAY BE WITHIN AND BY US IF NOT ACCEPTED WITHIN 30 DAYS.

> Rose mi Pilles AUTHORIZED SIGNATURE_ ROXANN PLETSCIF 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.



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.

Hayes Residence February 4, 2014 Page 2

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 Weath

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

E508s14lic.rtf

PRINTED: 02/03/2014 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00928		B. WING		OOMPLEIED	
NAME OF PROMOTE OF GUIDALIES		ADDRESS, CITY, STATE, ZIP CODE		01/16/2014		
HAYES R	ESIDENCE		NDOLPH AVE			
,		SAINT PA	UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDED TO THE APPROID	DDE	(X COMP DA
3 000	INITIAL COMMENTS		3 000			
,	*****ATTENTION	V W Strand Stran				
	BOARDING CARE LICENSING CORREC	HOME CTION ORDER				
1	pursuant to a survey. found that the deficien herein are not corrected shall be	nnesota Statute, section on order has been issued If, upon reinspection, it is beyor deficiencies cited ed, a fine for each violation assessed in accordance is promulgated by rule of ment of Health.	2/25/16	\		
	corrected requires con requirements of the rul number and MN Rule rul When a rule contains se comply with any of the lack of compliance. La re-inspection with any in result in the assessment.	e provided at the tag number Indicated below. several items, failure to items will be considered	SEP			
C 11	nat may result from not	ring on any assessments n-compliance with these written request is made to 5 days of receipt of a r non-compliance.				
II C o p is si	NITIAL COMMENTS: In January 13th to January 13th to January 13th to January 1sta this Department's state rovider and the following sued. When correction gn and date, make a cetum the original to the	uary 16th 2014 suprevors		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursi Homes.		
TORY BIR	ment of Health	PLIER REPRESENTATIVE'S SIGNATURE		Administrator	(Xe	DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		00928	B. WING		01/16/2014					
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	RESS, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	_D BE COMPLETE					
3 000	Continued From page 1		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.			The assigned tag number appears in a far left column entitled "ID Prefix Tag The state statute/rule out of compliance listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state statu after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correction and Time period for Correction and Time period for Correction Endeath of Correction." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION IN VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	." ce is e "To er. s ute met ors stion. G OF					
3 601	MN St. Statute 144.50 Prevention And Contr	6 Subp. 2c Tuberculosis ol	3 601							
	maintain a compreher control program acco tuberculosis infection issued by the United Control and Prevention Division	States Centers for Disease								

Minnesota Department of Health

STATE FORM QTGH11 If continuation sheet 2 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00928	B. WING	 -	01	/16/2014
	ROVIDER OR SUPPLIER	1620 RA	NDOLPH AVENUE AUL, MN 55105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
3 601	tuberculosis infection that covers all paid and ur contractors, students volunteers. The Department of H assistance regarding of The guidelines. (b) Written compliance be maintained by the care home. This MN Requirement by: The facility failed to d tuberculin skin test (T reviewed, S2 and S3, Control and Prevention Also, the facility policy on how to properly peresults of a TST. The facility lacked a p perform, read and do An interview conducte 9:10 a.m. in query of instruction of TST do date of the test (mont millimeters (mm) of in (positive or negative)	Mortality Weekly is program must include a control plan inpaid employees, in residents, and realth shall provide technical implementation. The with this subdivision must boarding implementation implementation The with this subdivision must boarding implementation in the commentation	3 601			

6899

Minnesota Department of Health STATE FORM

QTGH11 If continuation sheet 3 of 18

Minnesota Department of Health

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01/16	6/2014
	ROVIDER OR SUPPLIER	1620 RANE	RESS, CITY, STA OOLPH AVENU IL, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
3 601	Policy with date revie "Employees will have unless contraindicate history of a positive M tuberculosis (TB) is n (a TB risk Assessmer annually). This inform employee's personne "III. New hire employe procedures as listed a would be if new hire h Mantoux recorded wit only a repeat Mantou. SUGGESTED METH The director of nursin staff on appropriate d tuberculin skin test (T Control and Preventic The director of nursin assure facility policies and monitored and pr properly perform, rear TST.	dure titled Mantoux (PPD) wed 06/12/2012, indicated, a 2-step Mantoux upon hire d. Any employee with a flantoux or having had ot to have another Mantoux at form will be completed nation will be part of the I record." It further reads, ees will follow the same above. The only exception	3 601			
3 945	Subpart 1. Care in resident shall receive and custodial care an individual needs. Pat	Gubp. 1 Adequate Care; general. Each patient or nursing care or personal d supervision based on ients and residents shall be ive, to develop techniques evelop hobbies and	3 945			

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00928	B. WING		01/	16/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E, ZIP CODE		
HAYES RI	ESIDENCE		NDOLPH AVENUE AUL, 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
3 945	out of bed as much as attending physician st	me patients shall be up and	3 945			
	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.					
	conducting blood gluc conducted in a manne blood borne pathoger The following was ob- room on 1/13/14: At 4:30 p.m LPN-A w blood glucose check to room. After the proces	er to prevent the spread of its. served in the medication as observed to conduct a for R35 in the medication dure was completed, LPN-A to clean the glucometer ck blood sugars) for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00928	B. WING		01	/16/2014
	ROVIDER OR SUPPLIER	1620 RA	DDRESS, CITY, STATE NDOLPH AVENUE	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	AUL, MN 55105 ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
3 945	used alcohol wipes to each use and did not stated the same gluc- residents residing at blood glucose monito	meter and stated the facility of clean the glucometer after use anything else. LPN-A cometer was used for all the the facility that required ring.	3 945			
	of 1/13/14 or during the On 1/13/14, at 2:56 p stated she was not all said that the last time she was not able to renurse came into the reduced hospital." She further give the facility a receive the call light close to reaching it." R25's callipped to a string that the head of the bed.	.m., during interview, R25 ble to reach the call light and c, when she had "A stroke" each it either, "But lucky a soom and I was sent to the stated "I would like you to commendation on how to get me as I have a hard time all light was observed to be at was attached to a light, by The string with the call light d to be falling behind the				
	observations, R25's of clipped onto the string behind the bed head sitting by the door an accessible to R25. On 1/14/14, at 1:48 p administrator verified accessible to R25 and clipped to the bedding it as she spent most of clipped some string to the str					

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00928	B. WING		01/16/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HAYES RE	ESIDENCE		DOLPH AVENU	E	
		SAINT PA	UL, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
3 945	Continued From page 6		3 945		
	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.				
	"Call lights will be with	revised 9/11/12, directed nin reach of all resident beds athrooms. Call lights will be			
	The director of nursin staff on appropriate u glucometer, then aud it care is being provid action as needed. The designee could monit procedures are current.	call lights are within reach			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MINO			
		00928	B. WING		01/16/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
HAYES RE	SIDENCE		DOLPH AVENU UL, MN 55105	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
3 945	Continued From page 7		3 945			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.					
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.		31145			
	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:					
	drops (medication for expired. Upon review medication aide, (TM, read "instill 1 drop into discard after 11/20/13 indicated R7 receives TMA- A verified the m date of 11/20/13, and confirmed the medica removed from the me	one vial of latanoprost eye glaucoma) was noted to be of the vial with trained A)-A, it was discovered to both eyes daily at bedtime. B." Interview with TMA-A seye drops every evening. The dication had an expiration was used on R7. TMA-A without should have been edication cart after the A removed the eye drops				
	glaucoma, and a phys	d indicated a diagnosis of sician order for Latanoprost each eye at bedtime (dx.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00928	B. WING		01	/16/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
HAYES RE	ESIDENCE		NDOLPH AVENUE AUL, MN 55105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
31145	Continued From page	e 8	31145			
	glaucoma).					
	The director of nursin policy and procedures and assessed to assudiscarded and not ad	OD FOR CORRECTION: g could monitor to assure s are current, implemented ure expired medications are ministered to residents. CORRECTION: Twenty One				
31455	MN Rule 4655.9000 S General Requirement	Subp. 1 Housekeeping; ts	31455			
	facility, including walls fixtures, equipment, a maintained in a clean condition throughout offensive odors, dust, hazards. Accumulation	al requirements. The entire s, floors, ceilings, registers, and furnishings shall be , sanitary, and orderly and shall be kept free from rubbish, and safety on of combustible material ed areas is prohibited.				
	by: Based on observatior review, the facility fail environment was main manner for 4 of 4 resi	t is not met as evidenced n, interview and document ed to ensure resident tained and in a clean idents (R1, R25, R24 and vironmental concerns.				
	Findings include:					
	observed under both thick layer of fluffy gre	m. during interview surveyor the beds for R25 and R1 a ey substance. Additionally, at next to the dresser was p dusty-grey fluffy				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01/	16/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA DOLPH AVENU	·		
HAYES RE	ESIDENCE		UL, MN 55105	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
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.					
	other staff in the depart	.m. interviewed the sor who stated he and the artment usually go around the vents and would look for				
		ed surveyor and stated there ecords for the return air flow				
	house keeping had ju rooms on the opposite staff were facing a ch She acknowledged the dust build-up.	a.m. the administrator stated st started to deep clean the e side of the hallway but the allenge with the residents. at was not an excuse for				

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		SURVEY PLETED
		00928	B. WING		01	/16/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	•		
HAYES RI	ESIDENCE		NDOLPH AVENUI AUL, MN 55105	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	each day since 1/1/14 cleaning on return air which the maintenance. The undated Hayes F Housekeeping/Mainteresident's room offers resident has. It is the home, and thus it is erooms be kept clean achieve this, dust all hard floors, vacuum of containers. In addition exhaust venting should quarterly in order to ethe resident's rooms of the resident's rooms of the room was "awf"	ks/duties were assigned to 4, to 1/14/14, however flow vents was not listed, ce supervisor verified. Residence enance Policies indicated the sthe only privacy that the resident's home within the especially important that the and pleasant. In order to surfaces, sweep and mop carpets and empty trash in, the policy directed ald be checked and cleaned ensure adequate airflow in and bathrooms.				
	approximately an include the room and stains. (DON) confirmed find carpeting needed to be DON reported she was plans to replace the commate, R43. SUGGESTED METH The director of nursin and/or designee could and procedures are consistent assessed to assure remaintained in a clean condition throughout	n apart, across the length of The director of nursing lings and reported the peremoved for this room. The as not aware of any current carpet for R24 and her OD FOR CORRECTION: In its peremoved for this room. The arrow of any current carpet for R24 and her OD FOR CORRECTION: In its peremoved for the arrow of monitor to assure policy current, implemented and the arrow of the ar				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HAYES RE	ESIDENCE		IDOLPH AVENU	E		
	T		UL, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
31810	of HCF Bill of Rights Subd. 6. Appropriate and residents shall had medical and personal needs. Appropriate a care designed to enal highest level of physical This right is limited with the subdivided in the sub	bd. 6 Patients & Residents riate health care. Patients ave the right to appropriate I care based on individual eare for residents means ble residents to achieve their cal and mental functioning. here the service is not ic or private resources.	31810			
	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,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00928	B. WING		01/16/	2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HAYES R	ESIDENCE		OOLPH AVENU JL, MN 55105	E		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
31810	including "Eye" appoin included "Staff will as appointments and train A Referral Form for the included the following glasses, worn full time was a prescription for During initial interview at 4:46 p.m., R35 reported, and wanted glasse wearing glasses during follow up interview on 11:45 a.m., R35 reported R35 was again obsert glasses. R35 reported R35 was again obsert glasses. The nurse, (It this interview and said glass supplier. On 1/15/14 at 1:00 p. called to ask the eye glasses were ready. Thad lost the phone nure R35's glasses were ready. Thad lost the phone nure R35's glasses were ready. The phone nure R35's glasses were ready and went to order glashad not yet picked up reported she does no glasses are ready, busupplier to call and lei ready. LPN-C reported	atments to support health" Intments. Interventions Interve	31810	DETICITIENCE!)		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
HAYES RE	ESIDENCE		NDOLPH AVENU AUL, MN 55105	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	E
31810	(DON) reported she weye glass supplier to ready after several we still did not have her of	a.m. the director of nursing would expect staff to call the see if R35's glasses were eeks had passed and R35 glasses.	31810			
	The director of nursin monitor to assure policurrent, implemented prescription eye glass medical and personal individual needs. Appreans care designed	OD FOR CORRECTION: g, and/or designee could cy and procedures are and assessed to assure ses and/or appropriate care is provided based on propriate care for residents to enable residents to level of physical and mental				
32000	TIME PERIOD FOR (21) days. MN Rule 626.557 Sul	CORRECTION: Twenty One	32000			
32000	Maltreatment of Vulner Subd. 14. Abuse p (a) Each facility, excee and personal care attributes and personal care attributes prevention plant assessment of the phenvironment, and its pwhich may encourage statement of specific minimize the risk of a with any rules govern the licensing agency.	prevention plans. pt home health agencies endant services providers, liforce an ongoing written n. The plan shall contain an	32000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01/16/2014	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIR CODE	1 01/10/2014	
NAME OF T	NOVIDER OR GOLF EIER		OOLPH AVENU			
HAYES RE	ESIDENCE		JL, MN 55105	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
32000	providers, shall devel prevention plan for eathere or receiving ser shall contain an indivithe person 's suscep individuals, including the person's risk of at adults; and (3) statem measures to be taker abuse to that person For the purposes of the "abuse" includes self- (c) If the facility, ex and personal care att knows that the vulner violent crime or an act toward others, the inceptant must detail the minimize the risk that reasonably be expect facility and persons of unsupervised. Under of a vulnerable adult's misconduct or physics such information from authority or through a another facility, another facility, another facility is ongoing vulnerable adult. This MN Requirement by:	care attendant services op an individual abuse ach vulnerable adult residing vices from them. The plan dualized assessment of: (1) tibility to abuse by other other vulnerable adults; (2) busing other vulnerable nents of the specific a to minimize the risk of and other vulnerable adults. his paragraph, the term habuse. cept home health agencies endant services providers, able adult has committed a act of physical aggression dividual abuse prevention heasures to be taken to the vulnerable adult might had to pose to visitors to the sutside the facility, if this section, a facility knows as history of criminal all aggression if it receives a a law enforcement medical record prepared by er health care provider, or	32000			
	facility failed to asses related to the family s	s and care plan concerns upport system for 1 of 2 fied as needing medically				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		01	/16/2014	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	01	110/2014	
	ESIDENCE	1620 RAN	DOLPH AVENU UL, MN 55105				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
32000	Continued From page	2 15	32000				
	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.						
	12/31/13 at 1:55 p.m. of absence (LOA) De and it was discovered half days insulin R35 An attempt was made family member, includ R35 takes her insulin member. A review of R35's mearea assessment date care plan dated 9/30/9/30/13, revealed no	as Record note, dated indicated R35 was on leave cember 21st to 26th 2013, I that there were three and a did not take while on LOA. The to discuss concerns with a ding a reminder to ensure while on LOA with the family dical record, including care and 10/25/13, most recent 13 and Social History dated assessment or plan in place associated with R35's related					

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Minnesot	<u>a Department of Health</u>	1				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
00928		B. WING		04/46/2044		
		00926			01/16/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1620 RAN	IDOLPH AVENU	E		
HAYES RE	ESIDENCE	SAINT PA	UL, MN 55105			
0/10 15	QUMMADV QT.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
32000	Continued From page	16	32000			
32000	Continued From page	2 10	32000			
	During interview on 1	/15/14 at 11:23 a.m., the				
	_	rted she was aware of the				
		A's, confirmed R35 missed 3				
		ulin while visiting her family				
	1	eported she knew of no plan				
		35 in regards to her family				
		reported there were no				
		being able to leave the				
	facility.	being able to leave the				
	idomity.					
	During interview on 1	/15/14 at 1:51 p.m. the				
	_	ON) reported she was				
		erns regarding care and				
	services in R35's prio					
		e was aware of R35 not				
		alf days of insulin while				
		nristmas. DON reviewed the				
		onfirmed there was no				
		egarding the risks posed by				
		nent. DON explained her				
	I	for a safety plan to be				
	T	ould be safe while in the				
	community.					
	During a intermilation with	on 4/40/44 of 0:45 or m				
		on 1/16/14 at 8:45 a.m.,				
	•	e had concerns regarding				
		th R35's personal funds,				
	•	or living arrangement and				
		R35 visited family. LICSW				
		cal record and her own files				
	and reported there wa					
		235's family involvement or				
		's risk of family involvement				
	while residing at the f	acility.				
		OD FOR CORRECTION:				
		g, director of social service				
	and/or designee could	d monitor to assure policy				

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00928		B. WING		01/	01/16/2014		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HAYES RESIDENCE 1620 RANDO SAINT PAUL,				E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
32000	and procedures are c assessed to assure re needing medically rel- specifically concerns system are assessed and monitored to assi assessments of the vi	urrent, implemented and esidents identified as ated social services, related to the family support, care planned, implemented ure the facility's ongoing	32000				

Minnesota Department of Health

STATE FORM QTGH11 If continuation sheet 18 of 18

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

Theelm

