

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UQ8S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00928

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 24E508 2.STATE VENDOR OR MEDICAID NO. (L2) 314243400 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 2/11/2020 (L34) 8. ACCREDITATION STATUS: ___ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	3. NAME AND ADDRESS OF FACILITY (L3) HAYES RESIDENCE (L4) 1620 RANDOLPH AVENUE (L5) SAINT PAUL, MN (L6) 55105 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30										
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 40 (L18) 13.Total Certified Beds 40 (L17)	10.THE FACILITY IS CERTIFIED AS: <input checked="" type="checkbox"/> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ___ 1. Acceptable POC ___ 2. Technical Personnel ___ 6. Scope of Services Limit ___ 3. 24 Hour RN ___ 7. Medical Director ___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size ___ 5. Life Safety Code ___ 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)											
14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; border: none;"> <tr> <td style="text-align: center;">18 SNF</td> <td style="text-align: center;">18/19 SNF</td> <td style="text-align: center;">19 SNF</td> <td style="text-align: center;">ICF</td> <td style="text-align: center;">IID</td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">40 (L39)</td> <td style="text-align: center;">(L42)</td> <td style="text-align: center;">(L43)</td> </tr> </table>	18 SNF	18/19 SNF	19 SNF	ICF	IID	(L37)	(L38)	40 (L39)	(L42)	(L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
18 SNF	18/19 SNF	19 SNF	ICF	IID								
(L37)	(L38)	40 (L39)	(L42)	(L43)								

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

17. SURVEYOR SIGNATURE <u>Roy Kingsley, State Fire Marshal</u> Date : 02/19/2020 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Health Program Representative</u> Date: 02/19/2020 (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY ___ 1. Facility is Eligible to Participate ___ 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT: ___	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : ___
22. ORIGINAL DATE OF PARTICIPATION 01/01/1975 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)	
26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. (L31)	30. REMARKS DETERMINATION APPROVAL
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 19, 2020

CMS Certification Number (CCN): 24E508

Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, MN 55105

Dear Administrator:

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

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

Effective February 7, 2020 the above facility is certified for:

40 Nursing Facility II Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 19, 2020

Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, MN 55105

RE: CCN: 24E508
Cycle Start Date: January 23, 2020

Dear Administrator:

On February 11, 2020, the Minnesota Department(s) of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the January 23, 2020 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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7013 3020 0001 8869 2583

January 27, 2020

Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, MN 55105

RE: CCN: 24E508
Cycle Start Date: January 23, 2020

Dear Administrator:

On January 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

**Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Hayes Residence

January 27, 2020

Page 3

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 23, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 23, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Hayes Residence

January 27, 2020

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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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2020
NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
F 000	<p>A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 1/21/20 through 1/23/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.</p> <p>INITIAL COMMENTS</p> <p>On 1/21/20 through 1/23/20, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were found to be NOT SUBSTANTIATED: HE508013C HE508014C HE508015C HE508016C HE508017C</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 000	<p>INITIAL COMMENTS</p> <p>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 WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Hayes Residence was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC)</p>	K 000			

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K 000	<p>Continued From page 1 Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. <p>Hayes Residence is a 1-story building with a full basement. The building was constructed in 1958 and was determined to be of Type II(111) construction. The building is divided into 3 smoke zones.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The alarm is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are connected to the fire alarm system in accordance with the Minnesota State Fire Code.</p> <p>The building is fully sprinkled per NFPA 13.</p> <p>The facility has a capacity of 40 beds and had a census of 34 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p>	K 000			

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K 346 SS=F	<p>Fire Alarm System - Out of Service CFR(s): NFPA 101</p> <p>Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to Maintain Fire Alarm - Out of Service in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 9.6.1.6. This deficient practice could affect all 34 of residents.</p> <p>Findings include: On a facility tour between the hours of 9-1pm on 1/22/2020, it was revealed that the Facility does not have a current out of service policy for the fire alarm system stating the (4) hours out of service.</p> <p>This deficient practice was verified by the Facility Maintenance Director at the time of discovery.</p>	K 346			
K 354 SS=F	<p>Sprinkler System - Out of Service CFR(s): NFPA 101</p> <p>Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having</p>	K 354			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 354	Continued From page 3 jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to Maintain Sprinkler System - Out of Service in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25). This deficient practice could affect 34 of residents. Findings include: On a facility tour between the hours of (9-1pm) on 1/22/2020, it was revealed that the Facility does not have a current out of service policy for the fire sprinkler system stating the (10) hours out of service. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 354			
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521			

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K 521	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Maintain HVAC in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 19.5.2.1, 9.2. This deficient practice could affect all 34 of residents. Findings include: On a facility tour between the hours of (9-1pm) on 1/22/2020, it was revealed that we found the corridors throughout the building are used as an air supply/return plenum and need a wavier.	K 521			
K 918 SS=F	This deficient practice was verified by the Facility Maintenance Director at the time of discovery. Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E508	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2020
NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	Continued From page 5 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to Maintain Electric System Maintenance and Testing in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). This deficient practice could affect all 34 of residents. Findings include: On a facility tour between the hours of 9-1pm on 1/22/2020, it was revealed that the Facility does not have a current record of generator weekly inspection for month of January 2020. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 918			
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920			

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

PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
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K 920	Continued From page 6 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Maintain Power Cords and Extension Cords in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. This deficient practice could affect 20 of residents. Findings include: On a facility tour between the hours of 9-1pm on 1/22/2020, it was revealed that we found a non-UL1363 power tap in room #10.	K 920			

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NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
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K 920	Continued From page 7 This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 920			



Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7013 3020 0001 8869 2583

January 27, 2020

Administrator
Hayes Residence
1620 Randolph Avenue
Saint Paul, MN 55105

Re: Event ID: UQ8S11

Dear Administrator:

The above facility survey was completed on January 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2020
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NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/21/20 through 1/23/20,, surveyors of this Department's staff visited the above provider for a standard survey. Complaints were also investigated.</p> <p>The following complaints were found to be NOT SUBSTANTIATED:</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2020
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NAME OF PROVIDER OR SUPPLIER HAYES RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105
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2 000	<p>Continued From page 1</p> <p>HE508013C HE508014C HE508015C HE508016C HE508017C</p> <p>No correction orders were issued.</p> <p>The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.</p>	2 000		