DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DICARE/MEDICAID CERT								
	F I - TO BE COMPLETED		E SURVEY AGENCY	Facility ID: 00928					
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 24E508	3. NAME AND ADDRESS OF FA	ACILITY		4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification					
2.STATE VENDOR OR MEDICAID NO.	(L4) 1620 RANDOLPH AVEN	NUE		1. Initial 2. Recertification 3. Termination 4. CHOW					
(L2) 314243400	(L5) SAINT PAUL, MN		(L6) 55105	5. Validation 6. Complaint					
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATH 01 Hospital 05 HHA	EGORY 09 ESRD	<u>10</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint					
6. DATE OF SURVEY 03/15/2016 (L34)	02 SNF/NF/Dual 06 PRTF	10 NF	14 CORF						
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)					
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/S	P 12 RHC	16 HOSPICE	09/30					
11LTC PERIOD OF CERTIFICATION	10. THE FACILITY IS CERTIFIE	DAS:							
From (a):	X A. In Compliance With		And/Or Approved Waivers Of The	Following Requirements:					
To (b):	Program Requirements Compliance Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director					
12. Total Facility Beds 40 (L18)	1. Acceptable PO	С	4. 7-Day RN (Rural SNF)	8. Patient Room Size					
13.Total Certified Beds 40 (L17)	B. Not in Compliance with P	rogram	5. Life Safety Code	9. Beds/Room					
	Requirements and/or Applied	d Waivers:	* Code: A*	(L12)					
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS						
18 SNF 18/19 SNF 19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)					
40	(142)	(42)							
(L37) (L38) (L39)	(L42) (l	L43)							
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE)	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):								
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY APP	PROVAL Date:					
Mary Beth Lacina, HFE NE I	03/15/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist 02/24/2016 (L20)					
PART II - TO	BE COMPLETED BY HCF	FA REGIONAL	OFFICE OR SINGLE STATI						
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE W RIGHTS ACT:	TTH CIVIL	 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 						
_X 1. Facility is Eligible to Participate	Kiomoner.		3. Both of the Above :						
2. Facility is not Eligible (L21)									
22. ORIGINAL DATE 23. LTC AGREEM	ENT 24. LTC AGR	EEMENT	26. TERMINATION ACTION:	(L30)					
OF PARTICIPATION BEGINNING	DATE ENDING	6 DATE	VOLUNTARY 00						
01/01/1975			01-Merger, Closure	05-Fail to Meet Health/Safety					
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	06-Fail to Meet Agreement					
25. LTC EXTENSION DATE: 27. ALTERNATIV	E SANCTIONS		04-Other Reason for Withdrawal	OTHER					
A. Suspension			04-0ther Reason for windrawar	07-Provider Status Change 00-Active					
(L27) B. Rescind Sus	(L44) spension Date:			00-Active					
	(L45)								
28. TERMINATION DATE: 29	9. INTERMEDIARY/CARRIER NO		30. REMARKS						
(L28)		(L31)							
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF APPROVA 02/26/2016	AL DATE	Posted 04/01/2016 Co.						



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E508 March 23, 2016

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

Dear Ms. Reynolds:

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

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 3, 2016 the above facility is certified for or recommended for:

40 Nursing Facility II Beds

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

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

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

Please contact me if you have any questions.

Hayes Residence March 23, 2016 Page 2

Sincerely,

moton ato £

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 23, 2016

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

RE: Project Numbers SE508026, FE508026 & FE508025

Dear Ms. Reynolds:

On February 23, 2016, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 30, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 23, 2016, 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 30, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on December 30, 2015, and lack of verification of substantial compliance with the deficiencies at the time of our February 23, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 15, 2016 the MN Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2015 and a Federal Monitoring Survey completed January 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 3, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 30, 2015, as of March 3, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

Hayes Residence March 23, 2016 Page 2

letter of February 23, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 30, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 30, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 30, 2016, is to be rescinded.

In our letter of February 23, 2016, 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 30, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 3, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions.

Sincerely,

Tomston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
24E508 _{Y1}	B. Wing	Y2	2/17/2016	Y3
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).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. #	F0166 483.10(f)(2)		Correction Completed	ID Prefix Reg. #	F0174 483.10(k),(l)	Correction	ID Prefix Reg. #	F0244 483.15(c)(6)		Correction Completed
LSC			02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix	F0257		Correction	ID Prefix	F0279		Correction	ID Prefix	F0329		Correction
Reg. #	483.15(h)(6)		Completed	Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.25(l)		Completed
LSC			02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix	F0371		Correction	ID Prefix	F0428		Correction	ID Prefix	F0441		Correction
Reg. #	483.35(i)		Completed	Reg. #	483.60(c)	Completed	Reg. #	483.65		Completed
LSC			02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix	F0465		Correction	ID Prefix	F0466		Correction	ID Prefix	F0520		Correction
Reg. #	483.70(h)		Completed	Reg. #	483.70(n)(1)	Completed	Reg. #	483.75(0)(1)		Completed
LSC			02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
REVIEWE STATE AG		REVIEWE (INITIALS	_	date 03/23/2	2016	SIGNATURE OF SU		921		date 02	2/17/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO 15	OMPLETED	ON		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						6 🗌 NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	Г
00928	B. Wing	Y2	2/17/2016	Y3
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).

ITEI	N	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	30630	Correction	ID Prefix	31095		Correction	ID Prefix	31105		Correction
Reg. #	MN Rule 4655.34	00 Completed		MN Rule Subp. 1	e 4655.7400	Completed	Reg. #	MN Rule 4655.7810)	Completed
LSC		02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix	31235	Correction	ID Prefix	31455		Correction	ID Prefix	31880		Correction
Reg. #	MN Rule 4655.85	20 D Completed		MN Rule Subp. 1	e 4655.9000	Completed	Reg. #	MN Rule 144.651 S 20	ubd.	Completed
LSC		02/05/2016	LSC			02/05/2016	LSC			02/05/2016
ID Prefix	31945	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	MN Rule 144A.13 1	Subd. Completed	Reg. #			Completed	Reg. #			Completed
LSC		02/05/2016	LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) SR/KJ	date 03/23/2	2016	SIGNATURE OF S	URVEYOR 309)21		date 02/1	7/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 12/30/20 ⁻	JP TO SURVEY CO 15	DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT	
	A. Building UT - MAIN BUILDING UT			
24E508 _{Y1}	B. Wing	Y2	3/15/2016	Y3
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).

ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0052	Correction Completed 02/12/2016	ID Prefix Reg. # NFPA 1 LSC K0067	Correction 01 Completed 02/05/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)	DATE 03/23/2016 DATE	SIGNATURE OF SURVEYOR 3(TITLE	6536	date 03/15/2016 date
FOLLOW	JP TO SURVEY CO	DMPLETED ON	CHECK FOR UNCORRECT	YES NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER			DATE OF REVISIT	
IDENTIFICATION NOWIDER	A. Building 01 - MAIN BUILDING 01			
24E508 Y1	B. Wing	Y2	3/15/2016	Y3
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).

ITE	vi	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0050	Correction Completed 03/03/2016	Reg. #	NFPA 101 K0066	Correction Completed 03/03/2016	ID Prefix Reg. # LSC	NFPA 101 K0067	 Correction Completed 03/03/2016
ID Prefix Reg. # LSC	NFPA 101 K0144	Correction Completed 03/03/2016	Reg. #	NFPA 101 K0147	Correction Completed 03/03/2016	ID Prefix Reg. # LSC		 Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		 Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		 Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		 Correction Completed
REVIEWEI STATE AG REVIEWEI CMS RO FOLLOWU 2/8/2016		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) DMPLETED ON		TITL CK FOR ANY U	IATURE OF SURVEYOR E INCORRECTED DEFICIENCIES EFICIENCIES (CMS-2567) SENT		IMARY OF	5 🔲 NO ,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL ATE SURVEY AGENCY			ID: XRD5 Facility ID: 00928	
MEDICARE/MEDICAID PROVIDER N (L1) 24E508 2.STATE VENDOR OR MEDICAID NO. (L2) 314243400 5. EFFECTIVE DATE CHANGE OF OWN (L9)		3. NAME AND ADI (L3) HAYES RESI (L4) 1620 RANDO (L5) SAINT PAUL 7. PROVIDER/SUP 01 Hospital	IDENCE DLPH AVENUE 2, MN			5) 55105 .7) 22 CLIA	 TYPE OF ACTION Initial Termination Validation On-Site Visit Full Survey After C 	2. Recertification 4. CHOW 6. Complaint 9. Other	
6. DATE OF SURVEY 12/30 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	22 CLIA	FISCAL YEAR ENDING	G DATE: (L35)	
 LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	40 (L18)40 (L17)	B. Not in Com	ce With quirements	rs:	2. Te 3. 24 4. 7-	roved Waivers Of The echnical Personnel 4 Hour RN Day RN (Rural SNF) ife Safety Code A1*	Following Requirements: 6. Scope of Ser 7. Medical Dire 8. Patient Room 9. Beds/Room (L12)	vices Limit ector	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY	7 MEETS or 1861 (j) (1):	(L15)		
10 514 10/17 514	40	ici	IID		1001 (c) (1)	or 1001 (j) (1).	()		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	JRVEY AGENCY APP	PROVAL	Date:	
Sheryl Reed, H	IFE NE II		01/25/2016	(L19)	Kate Jo	hnsTon, Pro	ogram Speciali	<u>st</u> 02/24/2016 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR	R SINGLE STAT	EAGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part			PLIANCE WITH CI ITS ACT:	VIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 01/01/1975	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMEN ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Clo			Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI		(L25)			oluntary Termination	OTHER	Aeet Agreement	
25. LIC EXTENSION DATE.	A. Suspension of				04-Other Reaso	on for Withdrawal		r Status Change	
(L27)	B. Rescind Sus	pension Date:	(L44)				00-Active		
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C.	ARRIER NO.		30. REMARK	S			
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	E	Posted 02	/26/2016 Co.			
	(L32)			(L33)	DETERMIN	NATION APPROV	VAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					TON AND TRANSMITTAL ID: XRD5 STATE SURVEY AGENCY Facility ID: 00		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 24E508 2.STATE VENDOR OR MEDICAID NO. (L2) 314243400		3. NAME AND ADD (L3) HAYES RES (L4) 1620 RANDO (L5) SAINT PAUL	DRESS OF FACILI IDENCE DLPH AVENUE		(L6) 55105	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	 PROVIDER/SUF 01 Hospital 	PPLIER CATEGOR	Y 09 ESRD	<u>10</u> (L.7) 13 PTTP 22 CLIA	8. Full Survey After Complaint	
6. DATE OF SURVEY 12/30/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (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 ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) · To (b) :		10. THE FACILITY X A In Complian Program Rea Compliance	nce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director	
12. Total Facility Beds 13. Total Certified Beds	40 (L18) 40 (L17)	B. Not in Com	acceptable POC pliance with Program and/or Applied Waiv		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code:A1*	8. Patient Room Size 9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF 40	ICF	ID		15. FACILITY MEETS 1861 (e) (1) or 186i (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE	(L39) S (IF APPLICABLE S	(L42) HOW LTC CANCELL Date :	. (L43) ATION DATE):		18. STATE SURVEY AGENCY AP	PROVAL Date:	
Sheryl Reed, H	FE NE II		01/25/2016	(L19)	<u>Kate JohnsTon, Program Specialist</u> 02/24/2016		
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	· · · · · · · · · · · · · · · · · · ·	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible	icipate (L21)		IPLIANCE WITH C	CIVIL.	 I. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 		
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEM		24. LTC AGREEME ENDING DAT		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0(</u>		
01/01/1975 (L24)	(L41)		(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATIÓN DATÉ:	29	. INTERMEDIARY/C			30, REMARKS		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32 (L32)		OF APPROVAL DA	TE (L33)	DETERMINATION APPRC	WAL - Do who	
					• • • • • • • • • • • • • • • • • • • •		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted January 15, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SE508026

Dear Ms. Reynolds:

The above facility was surveyed on December 28, 2015 through December 30, 2015 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 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.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 Nursing 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 are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES Hayes Residence January 15, 2016 Page 2

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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, Unit Supervisor 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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED B NO. 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED			
		24E508	B. WING		12/30/2015			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HAYES F	ESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 000	INITIAL COMMENT	ſS	F 00					
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance.						
F 166 SS=E	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TO PROMPT EFFORTS TO NCES	F 16	5	2/5/16			
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior						
	by: Based on observat review, the facility fa grievances were ac (R39) who voiced c Findings include: When interviewed of bedroom, R39 expr the room and unabl the bedroom becau thermostat on the w	NT is not met as evidenced ion, interview and document ailed to ensure unresolved ted on for 1 of 1 resident oncerns to facility staff. on 12/28/15, at 7:00 p.m. in the essed always being warm in le to spend too much time in use it was too warm. The vall was registering the room degrees Fahrenheit (F). R39		 R39 was offered an opportunity is bed change. R39 accepted the bed change and moved rooms on 1/10/1 Information regarding the update grievance policy and procedure shall announced at Resident Council mee individual care conferences, and admission. The Grievance Policy & Procedu has been updated. Grievance Form available on the Resident Bulletin Bo as well as in department offices. Sta were educated on the updated policy 	6. ed I be stings, ure s are pard, aff			
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE			

Electronically Signed

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/22/2016

PRINTED: 01/25/2016

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	1	0938-039 SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		24E508	B. WING			12/3	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES I	RESIDENCE				620 RANDOLPH AVENUE AINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 166	said the heat conce times to the facility resolution to the co always so tired feel do anything." Furthe being able to open because her windor smoking area so th During an observat 12/29/15, at 10:30 a registered at 86 deg the day room and e warm to stay in. When interviewed of licensed practical n R39 thought the root that a resident cond out for R39 and exp working at the facili concern form for ar resident had a cond notes. LPN-C did n to follow up with res did not know if ther concerns/grievance When interviewed of social service desig part time and had b months, was not av concern form, and When asked how a reported, SS-B said concern but did not	ern was reported numerous staff, but there wasn't any ncern. R39 stated, "I am ing because it is too warm to ermore R39 expressed not a window to the outside w opened into the resident ere was no access to fresh air. ion of R39's room temp on a.m. the wall thermometer grees F. R39 was sitting out in expressed, the room is too on 12/29/15, at 10:00 a.m. urse (LPN)-C verified knowing om was too warm but stated cern form had not been filled olained that in the 10 years ty had never filled out a ny resident. LPN-C said if a cern it would be in the chart ot know if there was a system sidents about concerns and e was a policy for es. on 12/29/15, at 11:30 p.m. gnee (SSD)-B, who worked been at the facility for 6 vare of a resident grievance or had not filled out any forms. a resident concern was d would verbally pass on a know what the outcome ified not knowing about a	F 1	66	how to fill out the forms at the all s meeting on 1/20/16. "Social Services Director or De shall maintain grievance logs and f up results. Social Services Director report a summary of concerns to O committee for additional direction. Administrator is responsible.	signee ollow or shall	

If continuation sheet Page 2 of 35

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	(3) DATE SUR COMPLETE	
		24E508	B. WING		12/30/20	115
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	12/30/20	15
HAYES F	RESIDENCE			620 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E COMP	(X5) PLETIC DATE
F 166 F 174 SS=D	When interviewed of director of social set the facility two year resident concerns/g 2015, there was no follow through with 483.10(k),(l) RIGH	on 12/29/15, at 2:46 p.m. the ervices (DSS) verified being at is and in that time did not log grievances and currently for it a system to document and	F 166 F 174		2/5/1	16
	access to the use of be made without be §483.10(I) Persona	ne right to have reasonable of a telephone where calls can eing overheard. Il Property				
	personal possession furnishings, and ap permits, unless to o	ne right to retain and use ons, including some propriate clothing, as space do so would infringe upon the I safety of other residents.				
	This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on reported missing property for 3 of 3 residents (R12, R26, R40) who reported to staff they were missing personal property.			 3 of 3 residents (R12, R26, R40) spoken to regarding the missing item and informed of the updated Missing Items Policy & Procedure. Information regarding the update Missing Items Policy & Procedure shows and the statement of the statem	is, ed all be	
	missing items and the missing items.	a system to document reported a system for following up on 69 p.m. during interview, R12		announced at Resident Council mee individual care conferences, and admission. " The Missing Items Policy & Proc has been updated. Missing Items Fo are available on the Resident Bulletin Board, as well as in department offic Staff were educated on the updated	edure orms n es.	

Facility ID: 00928

If continuation sheet Page 3 of 35

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE . 0938-039			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· · ·	E SURVEY IPLETED			
		24E508	B. WING		12/	30/2015			
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E				
HAYES I	RESIDENCE		1620 RANDOLPH AVENUE SAINT PAUL, MN 55105						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE			
F 174	12/26/15. R12 state reported to the hou housekeeper's nam laundry was done b had not been return On 12/28/15, at 03: 1 1/2 months ago a from their room. R2 reported verbally to that person was. R2 computer tablet wa and found form, an- unsure whether or n tablet. On 12/28/15, at 03: had taken a charge explained that the of in his room. At 3:26 were to write any m found sheet and sta back. That's life. I le keeping it plugged i On 12/29/15, at 1:3 (SSD-B) stated she missing socks for F charger for R40 or R26. At 1:35 p.m. th not being aware of R12, R26 or R40. T	ed the missing socks had been sekeeper and provided the ne. R12 explained that the by the facility and the socks ned. 46 p.m. R26 stated about 1 to a computer tablet was stolen 26 stated this had been staff but couldn't recall who 26 explained that the missing s not written down on the lost d no one followed up so was not anyone was looking for the 24 p.m. R40 stated someone er cord for their cell phone and charger had been plugged in, 5 p.m. R40 stated residents nissing items on the lost and ated, "I never heard anything earned my lesson about	F 17	*4 meeting on 1/20/16. "Social Services Director o shall maintain grievance logs up results. Social Services Di report a summary of concerns committee for additional direct Administrator is responsible.	and follow rector shall to CQI				

If continuation sheet Page 4 of 35

		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		24E508	B. WING			12/3	30/2015			
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
HAYES F	RESIDENCE				620 RANDOLPH AVENUE SAINT PAUL, MN 55105					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 174	Continued From pa	ige 4	F 1	74						
	At 2:05 p.m. LSW-/ R12's team notes of verified there was m missing socks. LSV report to staff if there staff were to docum LSW-A also stated on the bulletin boar complete for any m On 12/29/15, at 2:1 (LPN)-B stated she shift on the weeken her about any miss stated maybe the m reported to the day hour book and state 12/26/15 or 12/19/1 R12. The 24 hour b 10/31/15, and there about R12, R26 or and Found form on reviewed and docum however, there was missing tablet. Only charger cord was d on 12/7/15. At 2:27 p.m. LSW-/ missing items and i missing item was to Notes section of the R26's Team Notes Team Notes back to 12/4/15, revealed th	A reviewed with the surveyor, lated 12/18/15 to present and nothing documented about V-A stated residents were to re were any missing items and nent in the nursing notes. there was a missing item form id which residents were to								

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 174 Continued From page 5 F 174 Also at this time, LSW-A provided a copy of page three of an undated Admission Agreement, which indicated residents were responsible for safeguarding their own property and the facility was not reponsible for replacing lost or missing itmes including, but not limited to glasses. dentures, rings and watches. LSW-A also provided a copy of a 12/14 revised document titled Haves Residence Resident Handbook. which indicated there was a sheet on the bulletin board to report any lost or missing items. As soon as something was noticed as missing the resident was to write a description of the item on the list, along with their name and the date they noticed the item missing. The resident was also to notify staff and other residents so everyone could help find what was missing. LSW-A was unable to locate any other policy and procedure regarding missing items and how the facility was to respond or what actions were to be taken by the facility to find the missing items. On 12/30/15, at 7:40 a.m. maintenance supervisor (MS), who also was in charge of the laundry was asked if R12 had reported any missing socks MS stated, "there might have been something about red top socks, but I don't know if they are still missing." F 244 483.15(c)(6) LISTEN/ACT ON GROUP F 244 2/5/16 SS=E GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00928

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PRINTED: 01/25/2016

	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUUT	IPLE CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		24E508	B. WING _	à		30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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	(X5) COMPLETIO DATE
F 244	Continued From pa	ge 6	F 24	4		
		NT is not met as evidenced				
	facility did not have effectively acted up several residents in and for 1 of 30 resid stage one. Findings include: Review of the previ council meeting min August, November, minutes several res regarding toilet pap bathrooms. In the J October 2015 meet expressed about so the front entrance of designated non-sm near a porch where These resident cour reminders to reside smoke in front of th residents who do so reminded not to do details of resolution the resident council During stage one in	nt review and interview, the documentation that the facility on grievances voiced by resident council meetings dents (R14) interviewed in ous six months of resident nutes showed that in the and December 2015 meeting sidents expressed concerns er availability in resident uly, August, September, and ing minutes concerns were one residents smoking near of the building, which is a oking area of the facility and is e several residents like to sit. ncil meeting minutes included onts that they should not e building and noted that moke there have been so. There were no other to these concerns listed in meeting minutes. hterview, on 12/28/15 at 6:12 at there is not always enough		 R14 was spoken to regarding grievance and informed of the up Grievance Policy & Procedure. A Smoker s Meeting was held on that specified to resident s the designated areas and times for sit. This information shall be shall Resident Council at the next schemeeting. The Grievance Policy & Proce has been updated. Grievance For available on the Resident Bulletin as well as in department offices, a be available at Resident Council meetings. Staff were educated of updated policy and how to fill out forms at the all staff meeting on 1 Social Services Director or De shall maintain grievance logs and up results. Social Services Direction Administrator is responsible. 	dated /4/16 noking. ed with duled edure rms are Board, and shall n the /20/16. esignee follow or shall CQI	
to C re b	On 12/29/2015 at 2 resident council wa	e in resident bathrooms. :43 p.m. the president of the s interviewed and stated that s continue to be a problem in				

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		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		24E508	B. WING			12/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	620 RANDOLPH AVENUE		
HAYES F	RESIDENCE			S	SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	Continued From pa	ge 7	F 2	244			
	the activities staff m resident council me minutes, was asked of action the facility repeated concerns non-smoking areas availability of toilet p She stated that she council meeting min copies to all departs administrator of the aware of any action resident concerns, i in the following resi The director of nurs 12/30/15 at 9:56 a.r of concerns that res in resident council r she received a copy meeting minutes ar discussed in manag that all the docume issues was listed in minutes and was no location. She then grievance forms ha but apparently not of she just put a new s a facility bulletin bot been done to act up smoking in non-sm toilet paper availabit residents who smoth had been reminded and toilet paper was	on 12/29/2015 at 3:18 p.m., nember (A)-A who attends the beting and takes the meeting d if there was documentation had taken in response to the of residents smoking in of the facility and the baper in resident bathrooms. made copies of resident nutes and distributed those ment heads and the facility. When she was made is taken to respond to these she included that information dent council meeting minutes. Sing was interviewed on m. and asked if she was aware sidents had recently expressed meeting. She confirmed that y of the resident council nd that these minutes are gement meetings. She stated ntation of resolution to these resident council meeting of documented in any other explained that completing d been part of facility policy done in these situations, and supply of these blank forms on ard. When asked what had bon the concerns of residents oking areas of the facility and lity, she stated that some ke in the non-smoking area I not to smoke in that location s stacked in the nursing ing staff could hand out toilet					

If continuation sheet Page 8 of 35

		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED	
		24E508	B. WING	i		12/30/2015		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HAYES F	RESIDENCE		1620 RANDOLPH AVENUE					
				S	AINT PAUL, MN 55105		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 244	Continued From pa	ige 8	Fź	244				
F 257 SS=D	paper to residents wa added that there wa residents hoarding may not have affect was no documentat how that was mana The facility did not h regarding grievance social worker (SS)- 12/14 revised documentation Resident Handbook under the section the residents were advid Council, the care construction or other staff and compolicy also reference policy, which the fact 483.15(h)(6) COMF TEMPERATURE LE The facility must pro- temperature levels. after October 1, 198 temperature range This REQUIREMEN by: Based on observation failed to maintain act for 1 of 2 residents bedroom being too Findings include:	when it was needed. She then as an issue with some toilet paper, so handing it out ted the availability, but there tion of who was hoarding and aged. have a specific policy es. On 12/29/15, at 2:27 p.m. A also provided a copy of a ment titled Hayes Residence k. Page three of the document, tled Grievance Procedure ised to bring up at Resident onference, to the social worker omplaints or concerns. The ced a "Grievance Resolution" cility was not able to provide. FORTABLE & SAFE EVELS ovide comfortable and safe Facilities initially certified 90 must maintain a of 71 - 81°F NT is not met as evidenced tion and interview, the facility dequate room temperatures (R39) who expressed the		257	 R39 was offered an opportunity bed change. R39 accepted the bed change and moved rooms on 1/10/1 date. All resident rooms shall be chec for current temperature readings. Staff was educated on the requirement at the all staff meeting of 	l 16 cked	2/5/16	
	until 7:00 p.m. was	in the dining room area. When			1/20/16. The building was initially ce	ertified		

Facility ID: 00928

If continuation sheet Page 9 of 35

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 257 Continued From page 9 F 257 approached for an interview, R39 said we could before October 1, 1990. go to the bedroom for privacy. Maintenance Supervisor shall conduct random room temperature audits to During the initial interview of R39 on 12/28/15, at ensure compliance. The CQI Committee 7:00 p.m. the bedroom wall mounted will provide direction or change when thermometer read 90 degrees farenheit (F). R39 necessary & will dictate the continuation expressed always being warm in the room and or completion of this monitoring process unable to spend too much time in the bedroom based on compliance noted. because it was too warm. R39 said the heat Administrator is responsible. concern was reported numerous times to the facility staff, but there wasn't any resolution to the concern. R39 stated, "I am always so tired feeling because it is too warm to do anything in here." Furthermore R39 expressed not being able to open a window to the outside because her window opened into the resident smoking area.hermostat on the wall was registering the room temperature at 90 degrees Fahrenheit (F). During an observation of R39 room temp on 12/29/15, at 10:30 a.m. the wall thermometer registered at 86 degrees F. R39 was sitting out in the dining area and expressed, the room is too warm to stay in. When interviewed on 12/30/15, at 10:00 a.m. the maintenance supervisor (MS) verified the room was always warm because of being just above the boiler room downstairs, Furthermore the MS verified R39 could not open the window because the window opened up to the resident smoking area. During an observation of R39 room temperature on 12/30/15 at 11:00 a.m. the wall thermometer registered at 88 degrees F. R39 was sitting out in the dining area and expressed, the room is too warm to stay in.

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 01/25/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 10 F 279 483.20(d), 483.20(k)(1) DEVELOP F 279 F 279 2/5/16 COMPRÉHENSIVE CARE PLANS SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: ... Based on document review and interview the R44 has officially discharged from the facility did not develop an initial care plan for facility. wandering and for behaviors and mood for 1 of 1 Care Plans for residents admitted resident (R44) who was reviewed for accidents after 12/30/2015 date have been reviewed and hospitalization. for compliance with Initial Care Plan requirement. Findings include: Care Planning Policy & Procedure has been updated. Staff have been educated on the updated policy at the all staff The facility failed to develop an initial care plan for wandering and for mood and behavior for newly meeting on 1/20/16. admitted R44. R44 was rehospitalized within 15 Director of Nursing or Designee shall days of admission. conduct random audits to ensure

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00928

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		AND HUMAN SERVICES			FORM	01/25/2016 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED				
		24E508	B. WING		12/3	30/2015				
NAME OF F	PROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE							
HAYES F	RESIDENCE		1620 RANDOLPH AVENUE SAINT PAUL, MN 55105							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 279	Continued From pa	age 11 to the facility on 11/05/15 after	F 279	compliance. The CQI Committee v provide direction or change when	will					
	being hospitalized (outburst due to den included syncope e of neuropathic pain facility with medicat amiodipine, aspirin,	(72 hour hold) for behavior nentia. Other diagnoses pisodes and falls and history i. R44 was admitted to the tions that included: , atorvastin, citalopram donepezil, gabapentin and		necessary & will dictate the continu or completion of this monitoring pro based on compliance noted. Direc Nursing is responsible.	ocess					
	11/11/15, indicated wandering. The MD cognition impairment behaviors that inclu	imum data set (MDS) dated R44 was at risk for DS, indicated R44 had a nt with a BIMS score of 9 and uded delusions, and other ted at others such as pacing,								
	dated 11/8/15 read place-went out east walking around the his socks on with cl	dical record's progress note R44 was alert, disoriented to t door setting off alarms, found front of the building with just lothes on, was able to be e building and to the dining								
	had wandered off a approximately a blo reported he went fo to find the facility.	d 11/10/15 revealed resident and was found at a bus stop ock away from facility. R44 or a walk and did not know how Staff encouraged resident to puld arrange escort for his								
	services had discus with nursing staff ar	1/11/15 indicated social ssed resident's elopement risk nd concluded R44 would in a secure memory care								

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		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		24E508	B. WING			12/3	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAYES I	RESIDENCE				620 RANDOLPH AVENUE AINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	setting. The progres already wandered f since admission on Progress note on 1 "writer spoke wi/ (w option of providing Wanderguard to pr at Hayes. Agreed t security for his need called (technology of transmitter and barn Wanderguard w/ (re safe at Hayes Resid discharge plan has Progress note date "Resident was seen clothing sitting in th chair closest to the release bar which the was exiting the from redirected him back The initial electronic identification of modi interventions regard care plan lacked evelopement nor did i wandered from the identified including bracelet. On 12/28/15 at 11:0 conference, the dire indicated the most would be the electronic	ess note read: "Also he has rom Hayes at least 2 times 11/5/15." 1/19/15 at 2:00 pm. read ith) management staff re: (resident's name) w/ a rovide greater security for him hat this would be sufficient ds at current time. Writer company name) and ordered ids. We will be using esident's name) to keep him dence. At this time any been put on hold." d 11/19/15 at 10:43 p.m. read: n fully dressed in his street e front lobby "blue Room" in a door. He got up and push the riggered the door alarm as he it door. Staff ran and c into the building." c care plan lacked od or behaviors nor had any ding mood or behaviors. The ridence of the risk for t indicate R44 had already facility. No interventions were the use of a WanderGuard	F2	279			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 01/25/2016 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		24E508	B. WING			12/	30/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE				620 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	(LPN)-C reviewed t verified the care pla elopement or any ir R44 should have a medical record, how On 12/30/15 at 10:0 care plan did not id that mood and beha included in the care 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral interven	d licensed practical nurse the electronic care plan and an did not identify the risk for interventions. LPN-C indicated paper initial care plan in the wever, it was never located. 00 a.m the DON verified the lentify the risk for elopement or aviors and interventions were e plan. EGIMEN IS FREE FROM ORUGS ag regimen must be free from a care for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any		329			2/5/16

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					OMB NC	1 APPROVEI 0. 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED		
		24E508	B. WING _			/30/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
HAYES F	RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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) COMPLETIO DATE		
F 329	Continued From pa	ige 14	F 32	29				
	by: Based on interview facility failed to ens residents (R40, R14 and/or followed spe Findings include: R40 was admitted t the hospital with an involuntary movem tablet at bedtime ar if needed (prn.) The identified to determ or for what symptor was to be administe At the time of the co on 12/14/15, R40 h benztropine 0.5 mg Medication Adminis 12/15, revealed R4 0.5 mg on 12/26, 12 reasons for adminis shakiness or comp (EPS.) It could not and/or shakiness w administration of th Documentation of a completed on 12/9/ section of the medi from the visit indica reviewed, but there	onsulting pharmacist's review ad not used the prn However, a review of the stration Record (MAR) for 0 had received benztropine 2/27, 12/28, and 12/30/15. The stration were for resident laints of Extrapyramidal signs be determined if the EPS rere justified reasons for e benztropine 0.5 mg. a psychiatry visit having been (15, was found in the consult cal record. Documentation ted R40's medications were was no clarification sought by g the lack of parameters for		 Clarification was immerequested regarding parar for R40 & R14 PRN medic Consulting Pharmacis medication regimen review PRN Medication Polic has been updated. Staff heducated on the updated p staff meeting on 1/20/16. Director of Nursing or conduct random audits to compliance. The CQI Cor provide direction or chang necessary & will dictate the or completion of this monit based on compliance note Nursing is responsible. 	neters for use sations. t performed v on 1/19/2016. y & Procedure have been policy at the all Designee shall ensure nmittee will e when e continuation toring process			

		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		24E508	B. WING			12/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER	·	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAYES F	RESIDENCE				620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
			1	3			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 15	F:	329			
	(DON) stated nursin physician and aske medications. When parameters for use	55 a.m. the director of nurses ng staff typically contacted the d for parameters of use for prn pointed out there were no regarding the use of the prn DN had no comment.					
	R14 had an incomp frequency and no d	blete order for Tylenol with no aily dosage limit.					
	dated 11/28/14, for mg by mouth as ne medication adminis contained an entry same, with no frequ This medication administration	ealed a physician's order, Tylenol (acetaminophen) 650 eded. The December 2015 stration record for this resident for Tylenol that was listed the uency or daily dosage limit. ministration record also lenol was given to this resident ember 2015.					
	this resident's unit w at 10:17 a.m., and a frequently to give the were any daily dosa She replied that she standing orders as Tylenol. She was a these standing order showed the surveyor orders in the medic The order for Tylenor read, "Acetaminoph" (by mouth) of [sic] F as necessary for dis limit was listed. A c	tion aide (TMA)-A working on was interviewed, on 12/30/15 asked how she knew how his medication and if there age limits with this medication. e would use the facility's guidance for administering the tasked if there was a copy of ers available to her and she or a copy of the standing ration administration record. ol in these standing orders han [sic] 325 mg or 650 mg PO PR (per rectum) every 4 hours scomfort." No daily dosage copy of these standing orders the facility administrator					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
24E508		B. WING		12/30/2015					
NAME OF F	PROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE					
HAYES F	RESIDENCE		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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 329 F 371 SS=D	supplied a copy tha that read, "Acetami PO (by mouth) of [s hours as necessary over 3 GMS (grams The director of nurs 12/30/15 at 11:05 a orders are used for orders in the facility recently updated to daily limit on Tylend the facility standing the facility contracte a year ago. She that that R14's Tylenol of standing order beca been a specific phy included a 4000 mg would try to find tha pointed out that the medication adminis daily dosage limit fo she would put the u administration reco 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and	at contained a Tylenol order iniphan [sic] 325 mg or 650 mg sic] PR (per rectum) every 4 y for discomfort. Do not giver s) in 24 hours." sing was interviewed, on a.m., and stated that standing all the "as needed" Tylenol y and the standing orders were include a 3 gram (3,000 mg) ol. She went on to explain that orders were updated when ed with a new pharmacy about en stated that she believed order would not be used as a ause she thought there had visician's order for it that g daily dosage limit and she at original order. The surveyor e standing orders in the stration record did not contain a or Tylenol and she replied that updated copy in the medication irds immediately. ROCURE, /SERVE - SANITARY	F 329			2/5/16			

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		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		24E508	B. WING			12/30/2015				
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
				1620 RANDOLPH AVENUE						
HAYES F	RESIDENCE		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 PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 371	Continued From pa	ge 17	F3	871						
	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized appropriate hand hygiene during meal preparation procedures that would minimize the possibility of food borne illness for 1 resident (R39) of 39 residents who were served food out of the kitchen. Findings include: On 12/29/15 at 9:14 a.m. during a subsequent kitchen follow up tour, observed the dietary Cook (DC)-A put on gloves without washing hands, then proceeded to prepare a sandwich for (R46) to take to work. After DC-A was finished preparing the sandwich, DC-A placed the sandwich in a zip-lock bag, put in a paper bag, took gloves off, put her hands in her shirt pocket to reach for a pen, wrote on the paper bag, then placed the paper bag with the sandwich in the kitchen refrigerator. At 9:19 a.m. DC-A was approached by dietary manager (DM) who prompted her for hand washing and DC-A proceeded to wash hands. An interview conducted on 12/29/15 at 9:21 a.m. with DC-A. verified did not wash hands prior to gloves worn and stated, she did not wash her hands prior to wearing the gloves because she was hurrying but normally will wash hands prior to wearing gloves. During an interview with DM on 12/29/15 at 11:29 a.m. indicated, her expectation is staff should wash hands before applying gloves and after				 Staff member in violation of prowas immediately re-educated on haw washing technique and procedure. All dietary staff have been re-educated on hand washing technand procedure. The Handwashing and Glove UP Policy was reviewed for accuracy. A staff have been re-educated on the policies at the all staff meeting on 1 The policies have been integrated in initial department orientation. Director of Nursing or Designeet conduct random audits to ensure compliance. The CQI Committee we provide direction or change when necessary & will dictate the continuator completion of this monitoring probased on compliance noted. Director Nursing is responsible. 	and hique Ise All /20/16. nto e shall vill ation cess				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 18 F 371 During an interview with the director of nursing on 12/29/15 at 11:29 a.m. stated, her expectation is staff should wash hands before and after glove use. Glove changes between residents and between contaminated surfaces. Policy and procedure titled SINGLE GLOVE USE. dated 10/21/2013, directed staff, "Wash hands thoroughly before and after wearing gloves, and when changing to a new pair of gloves." Policy and procedure titled USE OF GLOVES-UNIVERSAL PRECAUTIONS, dated 4/2/2012, indicated, "Wash your hands immediately after removing gloves to avoid transfer of microorganism to others or environment." Policy and procedure titled HAND WASHING, reviewed dated 4/2012, and read, "When should you wash your hands? Before, during, and after preparing food." F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT F 428 2/5/16SS=D | IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the Clarification was immediately consulting pharmacist failed to identify medication requested regarding parameters for use

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E508		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			0MB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
							NAME OF PROVIDER OR SUPPLIER	
HAYES RESIDENCE				1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	0002			
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 428	irregularities assoc parameters for safe residents (R40, R1 necessary (prn), m Findings include: R40 was admitted the hospital with ar involuntary movem tablet at bedtime and if needed (prn.) The identified to determ or for what sympton was to be administ At the time of the c on 12/14/15, R40 h benztropine 0.5 mg Medication Adminis 12/15, revealed R4 0.5 mg on 12/26, 1 reasons for adminis shakiness or comp (EPS.) It could not and/or shakiness w administration of the The consulting pha lack of parameters 0.5 mg every six ho On 12/30/15, at 12 pharmacist verified The pharmacist wa lack of parameters benztropine 0.5 mg pharmacist stated in	iated with the lack of e medication use for 2 of 5 4) who had orders for, of when edications. to the facility on 12/4/15, from n order for benztropine (to treat ents) one milligram (mg) 1/2 a nd 1/2 a tablet every six hours ere were no parameters nine under what circumstances ms the prn benztropine 0.5 mg ered. onsulting pharmacist's review had not used the prn g However, a review of the stration Record (MAR) for 0 had received benztropine 2/27, 12/28, and 12/30/15. The stration were for resident laints of Extrapyramidal signs be determined if the EPS vere justified reasons for the benztropine 0.5 mg.	F 42	for R40 & R14 PRN medic "Consulting Pharmacist medication regimen review "PRN Medication Policy has been updated. Staff h educated on the updated p staff meeting on 1/20/16. "Director of Nursing or conduct random audits to o compliance. The CQI Com provide direction or change necessary & will dictate the or completion of this monit based on compliance note Nursing is responsible.	t performed y on 1/19/2016. y & Procedure ave been policy at the all Designee shall ensure nmittee will e when e continuation oring process			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 428 Continued From page 20 F 428 hours benztropine and "I missed it." The pharmacist stated they usually made a recommendation regarding the lack of parameter use, if during the review there are no parameters identified to justify use of a prn medication. The consulting pharmacist did not advise the facility of a Tylenol order for R14 that did not contain frequency or daily dosage limits. Record review revealed a physician's order, dated 11/28/14, for Tylenol (acetaminophen) 650 mg by mouth as needed. The December 2015 medication administration record for this resident contained an entry for Tylenol that was listed the same, with no frequency or daily dosage limit. This medication administration record also showed that the Tylenol was given to this resident nearly daily in December 2015. The trained medication aide (TMA)-A working on this resident's unit was interviewed, on 12/30/15 at 10:17 a.m., and asked how she knew how frequently to give this medication and if there were any daily dosage limits with this medication. She replied that she would use the facility's standing orders as guidance for administering the Tylenol. She was asked if there was a copy of these standing orders available to her and she showed the surveyor a copy of the standing orders in the medication administration record. The order for Tylenol in these standing orders read, "Acetaminophan [sic] 325 mg or 650 mg PO (by mouth) of [sic] PR (per rectum) every 4 hours as necessary for discomfort." No daily dosage limit was listed. A copy of these standing orders was requested and the facility administrator supplied a copy that contained a Tylenol order that read, "Acetaminiphan [sic] 325 mg or 650 mg

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 428 Continued From page 21 F 428 PO (by mouth) of [sic] PR (per rectum) every 4 hours as necessary for discomfort. Do not giver over 3 GMS (grams) in 24 hours." The director of nursing was interviewed on 12/30/15 at 11:05 a.m. and stated that standing orders are used for all the "as needed" Tylenol orders in the facility and the standing orders were recently updated to include a 3 gram (3,000 mg) daily limit on Tylenol. She went on to explain that the facility standing orders were updated when the facility contracted with a new pharmacy about a year ago. She then stated that she believed that R14's Tylenol order would not be used as a standing order because she thought there had been a specific physician's order for it that included a 4000 mg daily dosage limit and she would try to find that original order. The surveyor pointed out that the standing orders in the medication administration record did not contain a daily dosage limit for Tylenol and she replied that she would put the updated copy in the medication administration records immediately. The facility's consulting pharmacist was interviewed via telephone on 12/30/15 at 12:44 p.m. and was asked if he routinely reviewed Tylenol orders for frequency and daily dosage limit. He stated that reviewing for these aspects of a Tylenol order were definitely part of his routine and he was unsure how these issues were missed for the Tylenol order of R14. He stated that he was aware that the facility had changed the standing orders to include a 3000 mg daily dosage limit on Tylenol, but he was not part of that decision or process. F 441 483.65 INFECTION CONTROL, PREVENT F 441 2/5/16 SPREAD, LINENS SS=E

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PRINTED: 01/25/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
24E508		B. WING	ì		12/30/2015		
NAME OF F	PROVIDER OR SUPPLIER	•		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAYES F	RESIDENCE				1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From page 22		F،	441	1		
	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 			F 441			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · · ·	E SURVEY PLETED
		24E508	B. WING		12/;	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ	
HAYES F	RESIDENCE			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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 441	by: Based on observat	NT is not met as evidenced tion, interview and record	F 44	" A cleanable surface (tray)		
	control protocols we glucometer checks for 7 of 7 residents R1) who had glucon administration of ins	ailed to ensure infection ere implemented for and/or insulin administration (R15, R3, R14, R6, R4, R12, meter checks and/or sulin observed and failed to ere trained on handwashing		obtained to perform insulin admin Staff were re-educated on the nec wash hands for 20 seconds and g use. Bathrooms have been deep and the elevated seat has been re " A cleanable surface shelf has installed to replace old surface for administration. Bathrooms and shower/tub rooms have been dee	e necessity to nd glove eep cleaned en replaced. has been e for insulin nd	
	glucometer checks on 12/28/15, the sh individual resident g new and used cotto			 cleaned. Staff have been re-ended hand washing and glove use " The Handwashing and Glove use Policy was reviewed for accur have been re-educated on the the all staff meeting on 1/20/1 policies have been integrated department orientation. " Director of Nursing or Desconduct random audits to ense 	policy. ove Use racy. Staff e policies at 6. The into initial signee shall	
	At 11:40 a.m. R15 was observed to place a bloody cotton ball on a shelf where a clean cotton ball, alcohol package and a resident specific fingerstick pen were sitting. Once the check was completed, LPN-A placed the glucometer back in R15's own glucometer/fingerstick storage bag, removed gloves and cleansed hands. The shelf was not cleansed/disinfected before R3 began to do a glucometer check at 11:43 a.m.using own individual fingerstick pen and glucometer. After placing the bloody cotton ball on the shelf R3 eventually tossed it into the sharps container before doing the glucometer check. R3 then			compliance. The CQI Comm provide direction or change w necessary & will dictate the co or completion of this monitorin based on compliance noted. Nursing is responsible.	ittee will hen ontinuation ng process	

Facility ID: 00928

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		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		24E508	B. WING	i		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE				620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
			15	3			0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F.	441			
	and LPN-A did not I	eted the glucometer check have R3 cleanse hands					
		removed gloves and cleansed R3's glucometer back in the er storage bag.					
		began to do their glucometer a water bottle on the spot					
	where R15 had place began to pick up ar	ced the bloody cotton ball, and n unopened alcohol wipe and					
	uncleaned/undisinfe	hich had been placed on the ected shelf. R14 proceeded to					
	observed to pull out	neter check, and was t the bloody test strip with their the sharps container. LPN-A					
	did not have R14 cl LPN-A removed glo	eanse hands afterwards. oves, cleansed hands and					
	alcohol pack on the	n cotton ball and unopened e shelf which had not been d after R14's glucometer					
	check. The next res	sident, R6 picked up and pack to cleanse his finger,					
	his finger. LPN-A th	cotton ball and used it to dry en proceeded to do R6's					
	cleansed hands, bu	LPN-A removed gloves and it the shelf was not d after completion of R6's					
	glucometer check.						
	pack and a clean co began do do their g	A placed an unopened alcohol otton ball on the shelf and R4 plucometer check. After					
	alcohol wipe and pl picked up the finger	sing their finger with the acing it on the shelf, R4 rstick pen and stuck their the fingerstick pen on the					
	shelf and picked up	the used alcohol wipe with is it in the sharps container.					
		oves and cleansed hands, but					

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		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E508	B. WING			12/;	30/2015
NAME OF I	PROVIDER OR SUPPLIER	•	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE				620 RANDOLPH AVENUE AINT PAUL, MN 55105		
04015		TEMENT OF DEFICIENCIES					0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 444			n 				
F 441	Continued From pa	-	F 4	41			
	the shelf was not cleansed/disinfected after R4's glucometer check.						
	At 12:00 p.m. LPN-	A left the room where the					
	glucometer checks	had been completed and did					
	not cleanse/disinfed room.	ct the shelf before leaving the					
	100111.						
	On 10/00/15 at 4:0						
		8 p.m. an announcement was se intercom which instructed					
		o the nurses station for insulin					
		idents R15, R3, R12, R14					
		ved one by one, to come into n, to sit in the chair by the					
		as no sanitizing the work					
	station surface area	a inbetween resident contact.					
		ad worn away painted wood nable sanitary surface.					
	that was not a clear	Table Salinaly Sullace.					
		ion of blood glucose					
		ulin administration on 12/28/15,					
		ed practical nurse (LPN)-A assisted R15 with setting out					
	the glucometer. R1	5 did not alcohol gel or wash					
		hing into the container of					
		re fingers retrieved a lancet. with bare fingers touching					
		container. R15 moved a					
		syringes on the counter, and					
		d syringe. LPN-A with gloved blood used lancet from the					
		ed gloves, did not sanitize					
	hands and went to	the refrigerator for a vial of					
		A used alcohol gel to sanitize					
		a pair of gloves. LPN-A drew ount of insulin and handed the					
		self administered the insulin.					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 26 F 441 Without removing gloves, LPN-A picked up the pen and documented in the medical record administration. Wearing the same gloves LPN-A put back R15's glucometer supplies and then removed the gloves. LPN-A washed hands for seven seconds and donned a pair of gloves to assist R3 with insulin administration. R3 was observed to place hands and elbow on the surface area used by other residents. LPN-A administered R3's insulin wearing gloves, Then, LPN-A wearing the same gloves, returned the insulin vial to the package, and documented the administration prior to removing contaminated gloves. R12 came to the chair and rested left arm on the surface area where R15 and R3 had been in contact. Wearing gloves, LPN-A went through the medication sign out book, found the page for R12, and handed the individual glucometer supplies to R12 to self glucose check. R12 obtained the drop of blood, LPN-A removed the lancet, then wearing the same gloves drew up the insulin, administered the insulin, removed the gloves and used alcohol gel to sanitize hands. Next, R14 came and sat in the chair and using the same unsanitized surface set up the supplies to self administer glucose check and insulin. Finally, R1 was assisted by LPN-A who donned gloves for the procedure. R1 was observed touching the surface area where the prior 4 residents had been in contact. After insulin was administered LPN-A washed hands for eight seconds. During an observation of housekeeper (H)-A on 12/29/15 at 9:00 a.m. trash was being gathered from various rooms and H-A was going in and out of the rooms wearing a double pair of gloves. H-A says she always wears two pair of gloves to protect herself. H-A then removed the two sets of

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		AND HUMAN SERVICES				FORM	: 01/25/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		24E508	B. WING			12	/30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE				620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	When interviewed a not know how long A review of the facil Hand Washing, rea make a lather and s scrub the backs of fingers and under y your hands for at le hands with soap an reduce the number are not available, us sanitizer. A review of the facil Use of gloves, read immediately after re- transfer of microorg environment. During an interview (DON) on 12/29/15 handwashing is to b Furthermore, the D nursing station is no cleanable surface, s obtained immediate During observation west common bath of toilet paper stack the toilet. On 12/29/15, at 1:0 was conducted with supervisor (MS), the	hands for seven seconds. about handwashing H-A did hands were to be washed. lity policy dated, 1/11/07, titled, d, Rub your hands together to scrub them well; be sure to your hands, between your our nails. Continue rubbing ast 20 seconds. Washing id water is the best way to of germs. If soap and water se an alcohol-based hand lity policy dated 4/2/12, titled, I, Wash your hands emoving gloves to avoid ganisms to others or with the director of nursing , at 3:00 p.m. verified be for twenty seconds. ON verified the surface in the bt a cleanable area and a such as a tray, would be	F	441			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	D: 01/25/2016 MAPPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) D	ATE SURVEY OMPLETED	
		24E508	B. WING		1	2/30/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	ESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441 F 465 SS=F	M8 and M9 had a for build up of brown de behind the door and flooring. There was particles on the hea M1 toilet had a raise device that was high brown and dark bro interviewed on 12/3 maintenance super system to monitor of toilet rooms. 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro	et/ bathroom areas M1, M2, bul odor present and a heavy ebris, sand, particles, hair d along the edges of the a heavy build up of dust at registers and ceiling vents. ed seat/elevated portable hly permanently stained with wn splatters and stains. When 0/15, at 1:30 p.m. the visor verified there was not a br document the cleaning of ML/SANITARY/COMFORTABL	F 4	441		2/5/16	
	by: Based on observat failed to ensure resi bathing areas were sanitary manner for (R1, R3, R4, R5, R6 R13, R14, R15, R16 R24, R25, R26, R2 R33, R34, R35, R36 R45, and R46). Findings include: On 12/28/15, from 2	NT is not met as evidenced ion and interview, the facility ident rooms, bathrooms and 39 of 39 residents reviewed 5, R8, R9, R10, R11, R12, 5, R17, R19, R20, R22, R23, 7, R28, R29, R30, R31, R32, 6, R37, R38, R39, R40, R41, 2:00 p.m. until 7:30 p.m. and 5:00 a.m. until 11:00 a.m.			 Thorough cleaning has been initiate for the affected rooms. A detailed walk through of the buildin was conducted and a list compiled of necessary work. Housekeeping Policy & Procedures have been updated. Staff have been re-educated on the policies at the all sta meeting on 1/20/16. The policies have been integrated into initial department orientation. Director of Nursing or Designee sha conduct random audits to ensure compliance. The CQI Committee will 	ng	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 465 Continued From page 29 F 465 during the initial thirty resident interviews and provide direction or change when observations of resident rooms, toileting areas. necessary & will dictate the continuation and bathing areas there were unsanitary and or completion of this monitoring process malodorous areas identified. based on compliance noted. Director of Nursing is responsible. On 12/29/15, at 1:00 p.m. the environmental tour of the bathing areas was conducted with the maintenance supervisor (MS), the housekeeping supervisor (HS) and housekeeper (H)-A. During the tour the following concerns were verified: Shower Room M10 had a heavy build up of brown debris, sand, particles, hair behind the door and along the edges of the flooring. Tub room M11 and M3, had a heavy accumulation of dust on the heat register, window sill, window vertical blinds and floor moldings as well as all along the floor edging had an accumulation of dried dark substances with sand and hair particles. There was an accumulation of white substance on the tub water spigots and guard ring. There were numerous dried splatters of tan/brown/yellow substances on the walls. The resident call light string/cords were not a cleanable surface and they were discolored dark vellow and brown in areas of the string material. Room M3 had a chair that had chipped away paint and was rusted in numerous areas with dark rust color on the frame of the chair with multiple areas of duct tape on the chair pad. The tub lift in room M3 was dusty, visibly soiled with a dried on dark substance and there were rusty appearing dark areas on the underside of the seat and attachments to the mechanical lift tub chair. The public and resident shared toilet/ bathroom areas M1, M2, M8 and M9 had a foul odor present and a heavy build up of brown debris, sand, particles, hair behind the door and along the edges of the flooring. There was a heavy build

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 24E508 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1620 RANDOLPH AVENUE** HAYES RESIDENCE SAINT PAUL, MN 55105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 465 Continued From page 30 F 465 up of dust particles on the heat registers and ceiling vents. M1 toilet had a raised seat/elevated portable device that was highly permanently stained with brown and dark brown splatters and stains. The open area by the front door labeled, Employee closet, stored two wheel chairs and the foot rests to the wheel chairs were on the floor and there was a heavy accumulation of dust, hair, sand, a rubber band, and paper particles throughout the small open storage cubicle. This area was observed on 12/28/14 at 10:30 a.m. until 7:30 p.m., on 12/29/15 from 8:00 a.m. until 4:30 p.m. and on 12/31/15 from 7:00 a.m. until 1:30 p.m.. On 12/30/15, at 1:00 p.m. H-A verified R1, R3, R4, R5, R6, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R19, R20, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R45, and R46 had a heavy accumulation of dust on the heat register, bed frames, window sill, window vertical blinds and floor moldings as well as all along the floor edging especially at the head of each bed and behind the bedroom doors had an accumulation of dried dark substances with sand and hair particles. During an interview with R14 on 12/30/15 at 1:00 p.m. expressed living at the facility for years, and never having the bed frame washed nor having the carpet vacuumed behind and under the furniture in all of the years living at the facility. When interviewed on 12/30/15, at 1:30 p.m. the MS verified there was not a system to monitor or document the cleaning of bedrooms,

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		AND HUMAN SERVICES			FOR	D: 01/25/2016 MAPPROVED D. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	(X3) DATE SURVEY COMPLETED		
		24E508	B. WING		12	2/30/2015		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HAYES F	RESIDENCE		1620 RANDOLPH AVENUE					
		TEMENT OF DEFICIENCIES		5	AINT PAUL, MN 55105 PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 465 F 466 SS=C	heat registers, vent There was not a po cleaning the facility list for deep cleanin facility. Policies and proced auditing, deep clean the resident bedroot treatments, vents, h and bathing/tub root the time of survey e 483.70(h)(1) PROC WATER AVAILABIL The facility must es	eas, bed frames, window sills, s, or any area of the facility. licy and procedure for and there was not a check off og of the resident rooms in the dures were requested for the ning and general cleaning of oms, bed frames, window neat registers, toileting rooms oms, but were not received at exit. EDURES TO ENSURE .ITY tablish procedures to ensure ble to essential areas when		465		2/5/16		
	by: Based on interview facility failed to ens water needs for the planned for, should occur. This had the residents residing in Findings include: The facility's emerg requested upon ent updated policy entit	NT is not met as evidenced y and document review, the ure potable and non-potable facility were estimated and loss of normal water supply e potential to affect all 39 in the facility. ency water supply policy was trance. On 12/30/15 an led Emergency Water Supply, s provided. The procedure did			 A contract for emergency water delivery was obtained on 1/6/16. Policy & Procedures for Emergency Water Supply have been updated. Staff have been re-educated on the policy at the all staff meeting on 1/20/16. Administrator or Designee shall ensure contract stays current. The CQI Committee will provide direction or change when necessary. Administrator is responsible. 	5		

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		AND HUMAN SERVICES			FORM	01/25/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HAYES F	RESIDENCE			620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 466 F 520 SS=E	not specify a metho potable/nonpotable estimating the gallo meet the needs of t there be a loss of th On 12/30/15 at app administrator indica contracts with the c provide a method for a contract with a loo calculations were in provided if the facili could be obtained fit 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must main assurance committen nursing services; a facility; and at least facility; staff. The quality assess committee meets a issues with respect and assurance actividevelops and imple action to correct ide A State or the Secr disclosure of the re- except insofar as su	 ad for distributing water nor calculations for ons of water required daily to the residents and staff should ne water supply. broximately 1:30 p.m. the ated not being aware of any sity department that would or distribution of water but had cal water delivery. No ncluded. Per the policy ity had a water shortage, water rom local stores. MBERS/MEET NS tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies. retary may not require cords of such committee uch disclosure is related to the n committee with the 	F 466			2/5/16

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		AND HUMAN SERVICES			FORM	01/25/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE			620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	and correct quality a basis for sanction This REQUIREMEN by: Based on interview the quality assurance implemented meas identified quality co- identified quality co- identified in consec Findings include: The facility failed to maintain a plan for during glucose mor included hand wash review of previous of 10/23/14, 1/16/14, 3 non-compliance in in See F441: The fac control protocols we glucometer checks for 7 of 7 residents R1) who had glucor administration of inse ensure that staff we technique. During an interview administrator identif	by the committee to identify deficiencies will not be used as as. NT is not met as evidenced w, the facility failed to ensure ce and assessment committee ures to improve upon ncerns in infection control, utive surveys. develop, implement and infection control measures hitoring of residents which hing and glove changing. A certification surveys, exited 3/29/12, identified concerns of	F 520	 Updated Infection Control Polic Procedure shall be emailed to CQI committee members for committee approval and discussion. Updated Infection Control Polic Procedure shall be discussed at ne meeting for committee approval an discussion. Survey results and trends shall integrated into the quarterly meetin discussion. The CQI Committee will provid direction or change to policies when necessary based upon current tren Administrator is responsible. 	e ext CQI d be gs for e n	
	recently, such as a	e changes had been made new ice machine. The d that education had been				

If continuation sheet Page 34 of 35

		AND HUMAN SERVICES				FORM	01/25/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	E SURVEY PLETED	
		24E508	B. WING	i		12/3	30/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HAYES F	RESIDENCE		1620 RANDOLPH AVENUE SAINT PAUL, MN 55105					
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 520	concern with the fa	infection control has been a cility and apparently more ining would be necessary.	F	520				

Facility ID: 00928

		AND HUMAN SERVICES	FESC	8075	FORM	APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		24E508	B, WING		01/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE			1620 RANDOLPH AVENUE		
0(0)15	SUMMARY STA			SAINT PAUL, MN 55105	011	015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 00	0		Ð
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOU COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	AN ONSITE REVIS BE CONDUCTED SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		.2		
	Minnesota Departm time of this survey, not in substantial correquirements for pa CFR, Subpart 483.4 and the 2000 editio Association (NFPA)	Survey was conducted by the nent of Public Safety. At the Hayes Residence was found ompliance with the articipation in Medicaid at 42 470 (j), Life Safety from Fire, n of National Fire Protection 9 Standard 101, "The Life 9, Chapter 19 Existing Health				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EPOC		
5.	HEALTHCARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145				
	Or by email to: Marian.Whitney@s	tate.mn.us				
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 01/22/2016

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRD521

Facility ID: 00928

PRINTED: 01/28/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/28/201 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY IPLETED
		24E508	B. WING		01/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAYES F	RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 00	0	×	
	or Angela kappenman	@state.mn.us				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr	oposed, completion date.				
	basement. The buil and was determine	s a 1-story building with a full ding was constructed in 1958 d to be of Type II(111) building is divided into 3 smoke				
	detection in the com corridor. The alarm department notifica have either heat de that are connected	re alarm system with smoke ridors and spaces open to the is monitored for automatic fire tion. Other hazardous areas tection or smoke detection to the fire alarm system in e Minnesota State Fire Code.				
	The building is fully	sprinkled per NFPA 13.				
	The facility has a ca census of 39 at the	apacity of 40 beds and had a time of the survey.				
K 052 SS=F	is NOT MET as evid	42 CFR, Subpart 483.470(j), denced by: FETY CODE STANDARD	K 05	2		2/12/16
	installed, tested, an	required for life safety is d maintained in accordance nal Electrical Code and NFPA				

Event ID: XRD521

Facility ID: 00928

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES		F	TED: 01/28/2016 ORM APPROVED NO: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		24E508	B. WING		01/08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAYES F	RESIDENCE			1620 RANDOLPH AVENUE SAINT PAUL, MN 55105	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 052		s an approved maintenance n complying with applicable	K 05	2	
	Based on observat revealed that the fa maintain the fire ala the requirements of 19.3.4.1 and 9.6, as Sections 7.1. This adversely affect the system, and could of and emergency act	s not met as evidenced by: tion and staff interview, it was cility had failed to install and arm system in accordance with f 2000 NFPA 101, Sections s well as 1999 NFPA 72, deficient condition could functioning of the fire alarm delay the timely notification ions for the facility thus all residents, staff, and y.		 Sensitivity Test was conducted by Nardini on 1/15/2016. During the test Nardini□s equipment failed. A subsequent test will be conducted no I than 2/5/2016. A copy of the completed test will be submitted to the State Fire Marshal no later than 2/12/2016. Steve Smieja, Maintenance Superv and Colin Faulkner, Assistant Administrator. 	
	01/08/2016, the followere found affecting system, The records did not tests for the smoke	veen 10:00 am to 12:30 pm on owing deficient conditions g the facility's fire alarm reflect any current sensitivity alarms. ce was verified by the			
K 067	Maintenance Super		K 067	7	2/5/16

Event ID: XRD521

Facility ID: 00928

If continuation sheet Page 3 of 4

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	1	0938-03
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		PLETED
		24E508	B. WING		01/	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 RANDOLPH AVENUE		
IAYES F	RESIDENCE			SAINT PAUL, MN 55105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
K 067 SS=F	Continued From pa	ge 3	K 06	7		
00-1	with the provisions in accordance with	, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,				
	This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation			 A waiver will be requested to state fire marshal and CMS. To waiver request was approved by marshal and granted by CMS in 2. The request for waiver will by the State Fire Marshal no later 2/5/2016. Colin Faulkner, Assistant Action 	he last by the fire n 2015. be mailed to than	
	Findings include:					
	During the facility tour between 10:00 am and 12:30 pm on 01/08/2016, an interview with the Facility Administrator (CF), a review of documentation and observations revealed that the HVAC system is using tthe corridors as a return plenum.					
	This deficient practi Maintenance Super	ce was verified by the visor. (SS)				
	An annual waiver ha	as been previously granted.				



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted January 15, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SE508026

Dear Ms. Reynolds:

The above facility was surveyed on December 28, 2015 through December 30, 2015 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 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.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 Nursing 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 are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES Hayes Residence January 15, 2016 Page 2

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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, Unit Supervisor 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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 00928 B. WING 12/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/30/2015 HAYES RESIDENCE 1620 RANDOLPH AVENUE SAINT PAUL, MN 55105 VAND 55105 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETED	Minnesc	ta Department of He	alth			FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE HAYES RESIDENCE 1620 RANDOLPH AVENUE SAINT PAUL, IMN 55105 (X1) D PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SMOLLD BE PROVIDER/S PLAN OF CORRECTION SMOLLD BE (EACH CORRECTIVE ACTION SMOLLD BE PROVIDER/S PLAN OF CORRECTION OF DER In accordance with Minnesota Statute, section 144A 10, this correction, order has been corrected, shall be assessed in accordance with a schedule of fines provulgated by rule of the Minnesota Department of Health. 3 000 Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag rumber and MN Rule number indicated below. When a rule contains several fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance upon re-inspection with any item equest is made to the Department of Health. Vou may request a hearing on any assessments that may result from non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minesota Department of Health Informational Bulletin 14-01, available at thtp://www.health.state.mn.us/divis/foc/profiniforint	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
1620 PANDULPH AVENUE SIMIT PAUL, MN 55105 PPETRA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) Description Description <thdescription< th=""> Description <thd< th=""><th></th><th></th><th>00928</th><th>B. WING</th><th></th><th>12/3</th><th>30/2015</th></thd<></thdescription<>			00928	B. WING		12/3	30/2015
MATES SAINT PAUL, MN 55105 (Xi) ID PRETX TAS ISAMARY STATEMENT OF DEFICENCES (EACH DERCEMENT MUST EE PRECEDED BY FULL REGULATORY ON LISC DENTFYING INFORMATION) ID PREVX TAG PROVIDER'S PLAN OF CORRECTIVE ACTOR SHOLLD BE CROSS-REFERENCY (M) DEFICIENCY 3 000 INITIAL COMMENTS 3 000 INITIAL COMMENTS 3 000 Image: Comparison of the Commentation of the Commentation DEFICIENCY Image: Commentation DEFICIENCY DEFICIENCY BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a file for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health informational Bulletin 14-01, available at	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL BEDILING VOID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DEFICIENCY) 3 000 INITIAL COMMENTS 3 000 ****ATTENTION***** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected fines provided at the tag number and MN Rule number indicated below. WW who 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 encer it the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at htp://www.health.state.mu.avdivs/fbc/profinin/inf	HAYES F	RESIDENCE					
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144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that may request a hearing on any assessments that may result from non-compliance with these order of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf							
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You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf		that may result from orders provided tha the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
		You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf				
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 01/22/1	ABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 01/22/16

If continuation sheet 1 of 30

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00928	B. WING		12/	12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510	-			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
3 000	Continued From pa	age 1	3 000				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the					
	this Department's s and the following co Please indicate in y correction that you	29, and 30, 2015, surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, we when they will be completed					
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00928	B. WING		12/30	/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAYES F	RESIDENCE		DOLPH AVE UL, MN 551	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLET DATE
3 000	Continued From pa	ge 2	3 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
3 630	MN Rule 4655.3400) Medical Record	3 630			2/5/16
		ord shall be initiated for each within 72 hours in accordance).				
	by: Based on document facility did not devel wandering and for b	ent is not met as evidenced It review and interview the lop an initial care plan for behaviors and mood for 1 of 1 was reviewed for accidents		Corrected		
	Findings include:					
	wandering and for r	develop an initial care plan for mood and behavior for newly was rehospitalized within 15				
	being hospitalized (outburst due to den included syncope e of neuropathic pain facility with medicat amiodipine, aspirin,	atorvastin, citalopram lonepezil, gabapentin and				
	The admission mini	imum data set (MDS) dated				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 630	Continued From pa	ge 3	3 630			
	wandering. The MD cognition impairment behaviors that inclu	R44 was at risk for OS, indicated R44 had a nt with a BIMS score of 9 and ided delusions, and other ted at others such as pacing,				
	dated 11/8/15 read place-went out east walking around the his socks on with cl	dical record's progress note R44 was alert, disoriented to t door setting off alarms, found front of the building with just othes on, was able to be e building and to the dining				
	had wandered off a approximately a blo reported he went fo to find the facility.	d 11/10/15 revealed resident nd was found at a bus stop ock away from facility. R44 or a walk and did not know how Staff encouraged resident to buld arrange escort for his	/			
	services had discus with nursing staff an benefit from being i setting. The progre	1/11/15 indicated social sed resident's elopement risk nd concluded R44 would n a secure memory care ess note read: "Also he has rom Hayes at least 2 times 11/5/15."				
	"writer spoke wi/ (w option of providing Wanderguard to pr at Hayes. Agreed t security for his need called (technology of transmitter and ban	1/19/15 at 2:00 pm. read ith) management staff re: (resident's name) w/ a rovide greater security for him hat this would be sufficient ds at current time. Writer company name) and ordered ids. We will be using esident's name) to keep him				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/3	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
HAYES I	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 THE APPROPRIATE	(X5) COMPLET DATE
TAG 3 630	Continued From parsafe at Hayes Resid discharge plan has Progress note date "Resident was seer clothing sitting in the chair closest to the release bar which the was exiting the from redirected him back The initial electronic identification of modi interventions regard care plan lacked evelopement nor did i wandered from the identified including bracelet. On 12/28/15 at 11:0 conference, the dire indicated the most would be the electron On 12/29/15 at 3:10 director (SSD) and (LPN)-C reviewed the verified the care plate elopement or any in R44 should have a medical record, how On 12/30/15 at 10:0 care plan did not id	age 4 dence. At this time any been put on hold." d 11/19/15 at 10:43 p.m. read: n fully dressed in his street e front lobby "blue Room" in a door. He got up and push the riggered the door alarm as he at door. Staff ran and k into the building."	3 630			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
HAYES F	RESIDENCE		NDOLPH AVI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLET DATE
3 630	Continued From pa	ge 5	3 630			
	The director of nurs and procedures are assure that tempora admitted residents The director of nurs temporary care plan	HOD FOR CORRECTION: ing could assure that policies e current and educate staff to ary care plans for all newly are initiated within 72 hours. ing or designee could review as for appropriateness and pertinent information has been				
31095	TIME PERIOD FOF (21) days. MN Rule 4655.7400	R CORRECTION: Twenty One	31095			2/5/16
	Equipment/Supplies Subpart 1. Equip Cabinets and other provided and identit equipment and sup					
	by: Based on observati review, the facility fa control protocols we glucometer checks for 7 of 7 residents R1) who had glucor administration of ins	ent is not met as evidenced on, interview and record ailed to ensure infection ere implemented for and/or insulin administration (R15, R3, R14, R6, R4, R12, neter checks and/or sulin observed and failed to ere trained on handwashing		Corrected		
	Findings include:					
	During observation	of insulin administration and				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HAYES F	RESIDENCE		IDOLPH AVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
31095	Continued From pa	ge 6	31095			
	on 12/28/15, the sh individual resident on new and used cotto	from 11:40 a.m. to 12:00 p.m. elf where alcohol packets, glucometer's, fingerstick pens, in balls, was placed without fected after each glucometer				
	At 11:40 a.m. R15 was observed to place a bloody cotton ball on a shelf where a clean cotton ball, alcohol package and a resident specific fingerstick pen were sitting. Once the check was completed, LPN-A placed the glucometer back in R15's own glucometer/fingerstick storage bag, removed gloves and cleansed hands. The shelf was not cleansed/disinfected before R3 began to do a glucometer check at 11:43 a.m.using own individual fingerstick pen and glucometer. After placing the bloody cotton ball on the shelf R3 eventually tossed it into the sharps container before doing the glucometer check. R3 then picked up the alcohol wipe with a bloody finger, tossed it into the sharps container, and pulled the bloody test strip out of the glucometer by pulling on the bloody end. The shelf was not wiped off after R3 had completed the glucometer check and LPN-A did not have R3 cleanse hands afterwards. LPN-A removed gloves and cleansed hands after placing R3's glucometer back in the individual glucometer storage bag. At 11:50 a.m. R14 began to do their glucometer check. R14 placed a water bottle on the spot					
	began to pick up ar clean cotton ball, w uncleaned/undisinfe do their own glucon observed to pull out hand and toss it in t	ced the bloody cotton ball, and a unopened alcohol wipe and hich had been placed on the ected shelf. R14 proceeded to neter check, and was t the bloody test strip with their the sharps container. LPN-A				
	did not have R14 cl	eanse hands afterwards.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31095	Continued From pa	age 7	31095			
	then placed a clear alcohol pack on the cleansed/disinfecte check. The next res opened the alcohol then picked up the his finger. LPN-A th glucometer check. cleansed hands, bu cleansed/disinfecte glucometer check. At 11:55 a.m. LPN- pack and a clean c began do do their g opening and cleans alcohol wipe and pl picked up the finge finger. R4 then put shelf and picked up soiled fingers to tos LPN-A removed gl the shelf was not cl glucometer check. At 12:00 p.m. LPN- glucometer checks not cleanse/disinfer room.	oves, cleansed hands and n cotton ball and unopened e shelf which had not been ed after R14's glucometer sident, R6 picked up and pack to cleanse his finger, cotton ball and used it to dry nen proceeded to do R6's LPN-A removed gloves and ut the shelf was not ed after completion of R6's A placed an unopened alcohol otton ball on the shelf and R4 glucometer check. After sing their finger with the lacing it on the shelf, R4 rstick pen and stuck their the fingerstick pen on the o the used alcohol wipe with as it in the sharps container. oves and cleansed hands, but leansed/disinfected after R4's -A left the room where the had been completed and did ct the shelf before leaving the				
	residents to come t administration. Res and R1 were obser	to the nurses station for insulin sidents R15, R3, R12, R14 ved one by one, to come into m, to sit in the chair by the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			
		00928	B. WING		12/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
31095	Continued From pa	ige 8	31095			
s - t	nurse, and there was no sanitizing the work station surface area inbetween resident contact. The surface area had worn away painted wood that was not a cleanable sanitary surface.					
	monitoring and insu at 4:28 p.m. license donned gloves and the glucometer. R1 hands prior to reac lancets and with ba R15 was observed other lancets in the container of insulin	ion of blood glucose ulin administration on 12/28/15 ed practical nurse (LPN)-A assisted R15 with setting out 5 did not alcohol gel or wash hing into the container of the fingers retrieved a lancet. with bare fingers touching container. R15 moved a syringes on the counter, and d syringe. LPN-A with gloved	,			
	hands removed the pen. LPN-A remove hands and went to insulin. Then LPN-// hands and donned up the required am syringe to R15 who	blood used lancet from the ed gloves, did not sanitize the refrigerator for a vial of A used alcohol gel to sanitize a pair of gloves. LPN-A drew ount of insulin and handed the self administered the insulin. gloves, LPN-A picked up the				
	pen and document administration. We put back R15's glue removed the gloves seven seconds and	ed in the medical record aring the same gloves LPN-A cometer supplies and then s. LPN-A washed hands for I donned a pair of gloves to in administration. R3 was				
	observed to place I surface area used administered R3's LPN-A wearing the	hands and elbow on the by other residents. LPN-A insulin wearing gloves, Then, same gloves, returned the ackage, and documented the				
	administration prior gloves. R12 came on the surface area	to removing contaminated to the chair and rested left arm a where R15 and R3 had been gloves, LPN-A went through				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF OOTHEOTION	DENTITION TONIDET.	A. BUILDING: _			
		00928	B. WING		12/	30/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
31095	Continued From pa	ge 9	31095			
	supplies to R12 to so obtained the drop of lancet, then wearing insulin, administere gloves and used all Next, R14 came and the same unsanitized to self administer g Finally, R1 was ass gloves for the proce touching the surfact residents had been	he individual glucometer self glucose check. R12 if blood, LPN-A removed the g the same gloves drew up the d the insulin, removed the cohol gel to sanitize hands. d sat in the chair and using ed surface set up the supplies lucose check and insulin. isted by LPN-A who donned edure. R1 was observed e area where the prior 4 in contact. After insulin was A washed hands for eight				
	12/29/15 at 9:00 a.r from various rooms of the rooms wearin says she always we protect herself. H-A gloves and washed When interviewed a	ion of housekeeper (H)-A on m. trash was being gathered and H-A was going in and out ng a double pair of gloves. H-A ears two pair of gloves to then removed the two sets of hands for seven seconds. about handwashing H-A did hands were to be washed.				
	Hand Washing, rea make a lather and s scrub the backs of fingers and under y your hands for at le hands with soap an reduce the number	lity policy dated, 1/11/07, titled, d, Rub your hands together to scrub them well; be sure to your hands, between your our nails. Continue rubbing ast 20 seconds. Washing d water is the best way to of germs. If soap and water se an alcohol-based hand				
	Use of gloves, read	lity policy dated 4/2/12, titled, l, Wash your hands emoving gloves to avoid				

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00928			12/	30/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST NDOLPH AVEN			
HAYES R	RESIDENCE		AUL, MN 5510			
(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 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
31095	Continued From pa	age 10	31095			
	transfer of microorgenvironment.	ganisms to others or				
	(DON) on 12/29/15 handwashing is to I Furthermore, the D nursing station is no	with the director of nursing b, at 3:00 p.m. verified be for twenty seconds. ON verified the surface in the ot a cleanable area and a such as a tray, would be ely.				
	west common bath	on 12/30/15, at 9:06 a.m. the room toilet tank had two rolls ked on the top of the tank of				
	was conducted with supervisor (MS), th (HS) and housekee resident shared toil M8 and M9 had a fibuild up of brown d behind the door and flooring. There was particles on the hea M1 toilet had a rais device that was hig brown and dark bro interviewed on 12/3 maintenance super	00 p.m. the environmental tour n a surveyor, the maintenance le housekeeping supervisor eper (H)-A.The public and let/ bathroom areas M1, M2, oul odor present and a heavy lebris, sand, particles, hair d along the edges of the s a heavy build up of dust at registers and ceiling vents. .ed seat/elevated portable hly permanently stained with own splatters and stains. When 80/15, at 1:30 p.m. the rvisor verified there was not a or document the cleaning of				
	The director of nurs	THOD FOR CORRECTION: sing could educate nursing e use and cleaning of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 12/30/2015		
		00928	B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
HAYES F	RESIDENCE		IDOLPH AVE UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
31095	Continued From pa	ge 11	31095				
	this service to ensu as directed and tak director of nursing of	ent and shelving, then audit re that it is being implemented e action as needed. The or designee could monitor to procedures are current, nonitored.					
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.						
31105	MN Rule 4655.7810	Distribution of Medications	31105			2/5/16	
	care home to assur distributed safely ar shall be distributed by the physician. A resident reactions s	e developed in each boarding re that all medications are nd properly. All medications and taken exactly as ordered my medication errors or shall be reported to the nd an explanation made in the care record.					
	by: Based on interview facility failed to ensi- residents (R40, R14 and/or followed spe- addition, the consul- identify medication the lack of paramet 2 of 5 residents (R4 when necessary (pr	ent is not met as evidenced and document review, the ure medications for 2 of 5 4) were administered safely ecific parameters for use. In ting pharmacist failed to irregularities associated with ers for safe medication use for 40, R14) who had orders for, of rn), medications.		Corrected			
	Findings include:						
		o the facility on 12/4/15, from order for benztropine (to treat					

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	•	DDRESS, CITY, ST	TATE, ZIP CODE		
HAYES R	ESIDENCE		NDOLPH AVEN AUL, MN 5510	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31105	Continued From pa	lge 12	31105			
	tablet at bedtime ar if needed (prn.) The identified to determ or for what symptor was to be administed At the time of the c on 12/14/15, R40 h benztropine 0.5 mg Medication Adminis 12/15, revealed R4 0.5 mg on 12/26, 1 reasons for adminis shakiness or comp (EPS.) It could not and/or shakiness w administration of the Documentation of a completed on 12/9/ section of the medi from the visit indica	onsulting pharmacist's review ad not used the prn However, a review of the stration Record (MAR) for 0 had received benztropine 2/27, 12/28, and 12/30/15. The stration were for resident laints of Extrapyramidal signs be determined if the EPS vere justified reasons for e benztropine 0.5 mg. a psychiatry visit having been (15, was found in the consult cal record. Documentation ted R40's medications were was no clarification sought by g the lack of parameters for				
	(DON) stated nursi physician and aske medications. When parameters for use benztropine, the DO	55 a.m. the director of nurses ng staff typically contacted the d for parameters of use for prr pointed out there were no regarding the use of the prn DN had no comment.				
	R14 had an incomp frequency and no d	blete order for Tylenol with no laily dosage limit.				
	Record review reverse epartment of Health	aled a physician's order,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
			-			
		00928	B. WING		12/	30/2015
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ NDOLPH AVEI			
IAYES F	RESIDENCE		AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
31105	Continued From pa	ge 13	31105			
	dated 11/28/14, for mg by mouth as ne medication adminis contained an entry same, with no frequ This medication ad showed that the Tyl nearly daily in Dece The trained medicat this resident's unit va at 10:17 a.m., and a frequently to give th were any daily dosa She replied that she standing orders as Tylenol. She was a these standing orders as Tylenol. She was a these standing orders as these standing orders as the order for Tylen read, "Acetaminoph (by mouth) of [sic] F as necessary for di limit was listed. A c was requested and supplied a copy tha that read, "Acetamin PO (by mouth) of [si hours as necessary over 3 GMS (grams The director of nurs 12/30/15 at 11:05 a orders are used for orders in the facility recently updated to daily limit on Tylend the facility standing	Tylenol (acetaminophen) 650 eded. The December 2015 stration record for this resident for Tylenol that was listed the uency or daily dosage limit. ministration record also lenol was given to this resident ember 2015. ttion aide (TMA)-A working on was interviewed, on 12/30/15 asked how she knew how his medication and if there age limits with this medication. e would use the facility's guidance for administering the asked if there was a copy of ers available to her and she or a copy of the standing ation administration record. ol in these standing orders han [sic] 325 mg or 650 mg PC PR (per rectum) every 4 hours scomfort." No daily dosage copy of these standing orders the facility administrator tt contained a Tylenol order niphan [sic] 325 mg or 650 mg sic] PR (per rectum) every 4 v for discomfort. Do not giver				

STATEMENT OF DERIGENCIES NAME PLANOF CORRECTION (X1) PROVIDERSUPPLIERCULA DENTIFICATION NUMBER: 00928 (X2) MULTIFILE CONSTRUCTION A. BUILDING:	Minneso	ta Department of He	alth			PORM	APPROVE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STATE, ZIP CODE HAVES RESIDENCE IE20 RANDOL PH AVENUE SAINT PAUL, MN 55105 MANUE OF CONTRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE USAL DRAY OF CONRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE USAL DRAY OF CONRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE USAL DRAY OF CONRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE USAL DRAY OF CONRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE USAL DRAY OF CONRECTOR ACTION SHOULD BE (EACH CORRECTOR ACTION SHOULD BE (EAC							
HAVES RESIDENCE 1620 RANDOLPH AVENUE SAINT PAUL, MIN 55105 00410 PHERK REACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG D PRETK (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG D PRETK (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG D PRETK (EACH DEPICIENCY) Open-Provident State (EACH DEPICE) Open-Provide State (EACH DEPICE)			00928	B. WING		12/	30/2015
NAMES SAINT PAUL, MN 55105 (M) ID TAG EVANDARY STATEMENT OF DEFICIENCIES (EAU-INFORMATIVISTIE FRICEDENT ML) (EAU-INFORMATIVISTIE FRICEDENT ML) (EAU-INFORMATIVISTIES FRICEDENT ML) (EAU-INFORMATINSTALION FRICEDENT ML) (EAU-INFORMATIVISTIES FRICE	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PHÉFIX TAG CEACH DEFICIENCY MUST BE PRÉCEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CACIONRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Combine DEFICIENCY 31105 Continued From page 14 31105 31105 31105 3106 Ayear ago. She then stated that she believed that R14's Tylenol order would not be used as a standing order because she thought there had been a specific physician's order for it that included a 4000 mg daily dosage limit and she would ruy to find that original order. The surveyor pointed out that the standing orders in the medication administration record did not contain a daily dosage limit for Tylenol and she replied that she would put the updated copy in the medication administration records immediately. R40 was admitted to the facility on 12/4/15, from the hospital with an order for benztropine (to treat involunary movements) one millingram (mg) 1/2 a tablet at bedtime and 1/2 a tablet every six hours if needed (prn.) There were no parameters identified to determine under what circumstances or for what symptoms the pn benztropine 0.5 mg was to be administred. At the time of the consulting pharmacist's review on 12/14/15, R40 had not used the prn benztropine 0.5 mg. However, a review of the Medication Administration record (MAR) for 12/15, revealed P40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration of the benztropine 0.5 mg every six hours. Description 0.5 mg. The consulting pharmacist failed to address the lack of parameters regarding the pm benztropine 0.5 mg every six hours. Dn 12/30/15, at 12:15 p.m. the consulting	HAYES R	ESIDENCE					
a year ago. She then stated that she believed that R14's Tylenol order would not be used as a standing order because she thought there had been a specific physician's order for it that included a 4000 mg dally dosage limit and she would try to find that original orders. The surveyor pointed out that the standing orders in the medication administration record did not contain a daily dosage limit for Tylenol and she replied that she would put the updated copy in the medication administration record did not contain a daily dosage limit for Tylenol and she replied that she would put the updated copy in the medication administration records immediately. R40 was admitted to the facility on 12/4/15, from the hospital with an order for benztropine (to treat involuntary movements) one milligram (mg) 1/2 a tablet at bedtime and 1/2 a tablet every six hours if needed (prn.) There were no parameters identified to determine under what circumstances or for what symptoms the prn benztropine 0.5 mg was to be administered. At the time of the consulting pharmacist's review on 12/21/15, revealed R40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration meer for resident shakiness or complaints of Extrapyramidal signs (EPS.) It could not be determined if the EPS and/or shakiness were justified reasons for administration of the benztropine 0.5 mg. The consulting pharmacist failed to address the lack of parameters regarding the prn benztropine 0.5 mg every six hours. On 12/30/15, at 12:15 p.m. the consulting	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETE
On 12/30/15, at 12:15 p.m. the consulting		Continued From para a year ago. She that R14's Tylenol of standing order becar been a specific phy included a 4000 mg would try to find that pointed out that the medication administ daily dosage limit for she would put the u administration record. R40 was admitted to the hospital with an involuntary movement tablet at bedtime arr if needed (prn.) The identified to determ or for what symptor was to be administration for 0.5 mg Medication Administ 12/15, revealed R4 0.5 mg on 12/26, 12 reasons for administ shakiness or compl (EPS.) It could not further and/or shakiness w administration of the the consulting phalack of parameters	Ige 14 en stated that she believed order would not be used as a ause she thought there had riscian's order for it that g daily dosage limit and she at original order. The surveyor standing orders in the stration record did not contain a pr Tylenol and she replied that updated copy in the medication rds immediately. to the facility on 12/4/15, from order for benztropine (to treat ents) one milligram (mg) 1/2 a nd 1/2 a tablet every six hours ere were no parameters ine under what circumstances ms the prn benztropine 0.5 mg ered. onsulting pharmacist's review ad not used the prn However, a review of the stration Record (MAR) for 0 had received benztropine 2/27, 12/28, and 12/30/15. The stration were for resident laints of Extrapyramidal signs be determined if the EPS rere justified reasons for e benztropine 0.5 mg. rmacist failed to address the regarding the prn benztropine	31105	DEFICIENCY)		
	innesota De		15 p.m. the consulting				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00		00928	B. WING		12/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	RESIDENCE	1620 RAI		IUE		
IATES I	heoldende	SAINT P	AUL, MN 5510	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31105	Continued From pa	ige 15	31105			
	The pharmacist wa lack of parameters benztropine 0.5 mg pharmacist stated is should be parameter hours benztropine a pharmacist stated to recommendation re- use, if during the re-	their 12/14/15, facility visit. s interviewed regarding the related to the use of every six hours prn. The t made sense that there ers for the use of the every six and "I missed it." The hey usually made a egarding the lack of parameters use of a prn medication.				
	facility of a Tylenol	rmacist did not advise the order for R14 that did not or daily dosage limits.				
	dated 11/28/14, for mg by mouth as ne medication adminis contained an entry same, with no frequ This medication ad	ealed a physician's order, Tylenol (acetaminophen) 650 reded. The December 2015 stration record for this resident for Tylenol that was listed the uency or daily dosage limit. ministration record also lenol was given to this resident ember 2015.				
	this resident's unit v at 10:17 a.m., and a frequently to give th were any daily dosa She replied that sho standing orders as Tylenol. She was a these standing order showed the survey orders in the medi The order for Tylen	tion aide (TMA)-A working on was interviewed, on 12/30/15 asked how she knew how his medication and if there age limits with this medication. e would use the facility's guidance for administering the asked if there was a copy of ers available to her and she or a copy of the standing ication administration record. ol in these standing orders han [sic] 325 mg or 650 mg PC				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HAYES	RESIDENCE		NDOLPH AVEN NUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
31105	(by mouth) of [sic] F as necessary for dis limit was listed. A c was requested and supplied a copy that that read, "Acetami PO (by mouth) of [s hours as necessary over 3 GMS (grams) The director of nurs 12/30/15 at 11:05 a orders are used for orders in the facility recently updated to daily limit on Tyleno the facility standing the facility contracte a year ago. She that that R14's Tylenol of standing order beca been a specific phy included a 4000 mg would try to find that pointed out that the medication adminis daily dosage limit for she would put the u administration recon The facility's consul interviewed via telep p.m. and was asked Tylenol orders for fr limit. He stated that of a Tylenol order w routine and he was were missed for the stated that he was a	PR (per rectum) every 4 hours scomfort." No daily dosage topy of these standing orders the facility administrator t contained a Tylenol order niphan [sic] 325 mg or 650 mg ic] PR (per rectum) every 4 of or discomfort. Do not giver s) in 24 hours." Sing was interviewed on .m. and stated that standing all the "as needed" Tylenol and the standing orders were include a 3 gram (3,000 mg) I. She went on to explain that orders were updated when ed with a new pharmacy about en stated that she believed order would not be used as a ause she thought there had sician's order for it that g daily dosage limit and she t original order. The surveyor standing orders in the tration record did not contain a or Tylenol and she replied that pdated copy in the medication		DEFIGIENC		

	IT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HAYES F	ESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31105	Continued From pa	ge 17	31105			
	mg daily dosage lin part of that decisior	nit on Tylenol, but he was not n or process.				
	The director of nurs and procedures are ensure medications that specific param monitored and addi concerns arise. The designee could ass pharmacist identify	HOD FOR CORRECTION: sing could assure that policies e current and educate staff to are administered safely and eters for use are implemented tional training provided if e director of nursing or ure that the consulting medication irregularities lack of parameters for safe	,			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
31235	MN Rule 4655.852 Requirements; han		31235			2/5/16
	Dietary staff:					
	especially after usin handling soiled dish facilities and shall of hygienic practices i contamination of fo procedure shall als temporary assignm	od. The hand-washing o apply to other staff on ent to the food service and in shall be changed when soiled				
	This MN Requirem by:	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00928	B. WING		12/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
HAYES F	RESIDENCE		NDOLPH AVE AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
31235	Continued From pa	ge 18	31235			
	review, the facility f appropriate hand h preparation proced possibility of food b	on, interview, and document ailed to ensure staff utilized ygiene during meal ures that would minimize the orne illness for 1 resident ts who were served food out		Corrected		
	Findings include:					
	(DC)-A put on glove then proceeded to p to take to work. After preparing the sandwich in a zip-lot took gloves off, put to reach for a pen, y placed the paper back kitchen refrigerator, approached by diet prompted her for ha proceeded to wash An interview condu- with DC-A. verified gloves worn and stathands prior to wear was hurrying but not wearing gloves. During an interview a.m. indicated, her wash hands before removal of gloves. During an interview 12/29/15 at 11:29 a staff should wash home	cted on 12/29/15 at 9:21 a.m. did not wash hands prior to ated, she did not wash her ing the gloves because she ormally will wash hands prior to with DM on 12/29/15 at 11:29 expectation is staff should applying gloves and after with the director of nursing on .m. stated, her expectation is ands before and after glove s between residents and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/	30/2015
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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	(X5) COMPLETE DATE
31235		-	31235			
	thoroughly before a when changing to a Policy and procedu GLOVES-UNIVERS 4/2/2012, indicated immediately after re transfer of microorg environment." Policy and procedu reviewed dated 4/2	SAL PRECAUTIONS, dated , "Wash your hands emoving gloves to avoid				
	The director of nurs that policies and pr educate staff to uti during preparation the possibility of foo	THOD FOR CORRECTION: sing or designee could assure ocedures are current and lize appropriate hand hygiene of meals that would minimize od borne illness. The director nee could monitor to assure g implemented.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
31455	MN Rule 4655.900 General Requireme	0 Subp. 1 Housekeeping; ents	31455			2/5/16
	facility, including wa fixtures, equipment maintained in a clea condition throughou offensive odors, du hazards. Accumula	eral requirements. The entire alls, floors, ceilings, registers, , and furnishings shall be an, sanitary, and orderly ut and shall be kept free from st, rubbish, and safety ation of combustible material ined areas is prohibited.				

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00928	B. WING	12		12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
HAYES F	RESIDENCE		NDOLPH AVE AUL, MN 551	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
31455	Continued From pa	ge 20	31455				
	by: Based on observati failed to ensure res bathing areas were sanitary manner for (R1, R3, R4, R5, R R13, R14, R15, R16 R24, R25, R26, R2	ent is not met as evidenced ion and interview, the facility ident rooms, bathrooms and maintained in a clean and 39 of 39 residents reviewed 6, R8, R9, R10, R11, R12, 6, R17, R19, R20, R22, R23, 7, R28, R29, R30, R31, R32, 6, R37, R38, R39, R40, R41,		Corrected			
	Findings include:						
	on 12/29/15, from 8 during the initial thin observations of res	2:00 p.m. until 7:30 p.m. and 3:00 a.m. until 11:00 a.m. ty resident interviews and ident rooms, toileting areas, here were unsanitary and identified.					
	of the bathing areas maintenance super supervisor (HS) and the tour the followin Shower Room M10 brown debris, sand door and along the room M11 and M3, dust on the heat req vertical blinds and f along the floor edgi dried dark substance particles. There was substance on the turing. There were not tan/brown/yellow sub-	0 p.m. the environmental tour s was conducted with the visor (MS), the housekeeping d housekeeper (H)-A. During ng concerns were verified: had a heavy build up of , particles, hair behind the edges of the flooring. Tub had a heavy accumulation of gister, window sill, window floor moldings as well as all ng had an accumulation of ces with sand and hair as an accumulation of white ub water spigots and guard umerous dried splatters of ubstances on the walls. The ring/cords were not a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00928 B. WING		12/	12/30/2015	
	PROVIDER OR SUPPLIER	•	DDRESS, CITY, S	TATE, ZIP CODE	•	
	RESIDENCE					
	RESIDENCE	SAINT P	AUL, MN 5510	95		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From pa	ge 21	31455			
	yellow and brown ir Room M3 had a ch paint and was ruster rust color on the fra areas of duct tape of room M3 was dusty dark substance and dark areas on the u attachments to the The public and resi areas M1, M2, M8 a present and a hear sand, particles, haif the edges of the flo up of dust particles ceiling vents. M1 to portable device tha	and they were discolored dark in areas of the string material. air that had chipped away ed in numerous areas with dark ame of the chair with multiple on the chair pad. The tub lift in y, visibly soiled with a dried on d there were rusty appearing underside of the seat and mechanical lift tub chair. dent shared toilet/ bathroom and M9 had a foul odor vy build up of brown debris, r behind the door and along oring. There was a heavy build on the heat registers and ilet had a raised seat/elevated t was highly permanently and dark brown splatters and	k			
	Employee closet, s foot rests to the wh and there was a he sand, a rubber ban throughout the sma area was observed until 7:30 p.m., on 4:30 p.m. and on 12 1:30 p.m. On 12/30/15, at 1:0 R4, R5, R6, R8, R9 R15,R16, R17, R19	he front door labeled, tored two wheel chairs and the eel chairs were on the floor avy accumulation of dust, hair d, and paper particles all open storage cubicle. This on 12/28/14 at 10:30 a.m. 12/29/15 from 8:00 a.m. until 2/31/15 from 7:00 a.m. until 2/31/15 from 7:00 a.m. until 0 p.m. H-A verified R1, R3, 0, R10, R11, R12, R13, R14, 0, R20, R22, R23, R24, R25, 9, R30, R31. R32, R33, R34,				
	R35, R36, R37, R3 R46 had a heavy a	8, R39, R40, R41, R45, and ccumulation of dust on the rames, window sill, window				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00928	B. WING		12/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	ATE, ZIP CODE		
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From pa	ge 22	31455			
	along the floor edgi each bed and behir	loor moldings as well as all ng especially at the head of nd the bedroom doors had an ed dark substances with sand				
	p.m. expressed livir never having the be the carpet vacuume	with R14 on 12/30/15 at 1:00 ng at the facility for years, and ed frame washed nor having ed behind and under the e years living at the facility.				
	MS verified there w document the clear toileting/bathing are heat registers, vent There was not a po cleaning the facility	on 12/30/15, at 1:30 p.m. the as not a system to monitor or ning of bedrooms, eas, bed frames, window sills, s, or any area of the facility. licy and procedure for and there was not a check off g of the resident rooms in the				
	auditing, deep clear the resident bedroo treatments, vents, h	dures were requested for the ning and general cleaning of ms, bed frames, window neat registers, toileting rooms ms, but were not received at exit.				
	The director of nurs that policies and pro- educate and monito rooms, bathrooms	THOD FOR CORRECTION: sing or designee could assure ocedures are current and or staff to ensure resident and bathing areas are an and sanitary manner				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/30/2015	
		00928	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
HAYES F	RESIDENCE		UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
31880	Continued From pa	ge 23	31880			
31880	MN Rule 144.651 S of HCF Bill of Right	Subd. 20 Patients & Residents s	31880			2/5/16
	shall be encouraged their stay in a facility to understand and e patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fac nursing home ombut Americans Act, sec posted in a conspic					
	residential program 253C.01, every non facility employing m provides outpatient have a written intern at a minimum, sets followed; specifies t limits for facility resp or resident to have advocate; requires grievances; and pro an impartial decisio not otherwise resolv residential program 253C.01 which are treatment programs centers with section	inpatient facility, every as defined in section -acute care facility, and every fore than two people that mental health services shall nal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by ides for a timely decision by n maker if the grievance is ved. Compliance by hospitals, s as defined in section hospital-based primary s, and outpatient surgery 144.691 and compliance by e organizations with section				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00928	B. WING		12/3	2/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	•		
HAYES R	ESIDENCE		NDOLPH AVI AUL, MN 55 ⁻				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE	
31880	Continued From pa	ge 24	31880				
		to be compliance with the rritten internal grievance					
	by: Based on interview facility failed to follo property for 3 of 3 r	ent is not met as evidenced and document review, the w up on reported missing residents (R12, R26, R40) who ey were missing personal		Corrected			
	Findings include:						
		a system to document reported a system for following up on					
	explained having reserven days ago and 12/26/15. R12 state reported to the hour housekeeper's name	9 p.m. during interview, R12 eported a pair of missing socks d again, two days ago on ed the missing socks had been sekeeper and provided the ne. R12 explained that the by the facility and the socks ned.					
	1 1/2 months ago a from their room. R2 reported verbally to that person was. R2 computer tablet wa and found form, and	46 p.m. R26 stated about 1 to a computer tablet was stolen 26 stated this had been staff but couldn't recall who 26 explained that the missing s not written down on the lost d no one followed up so was not anyone was looking for the					
		24 p.m. R40 stated someone r cord for their cell phone and					

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	•	DDRESS, CITY, ST	TATE, ZIP CODE	<u>_</u>	
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31880	Continued From pa	ige 25	31880			
	in his room. At 3:26 were to write any m found sheet and sta	charger had been plugged in, 5 p.m. R40 stated residents hissing items on the lost and ated, "I never heard anything earned my lesson about in."				
	(SSD-B) stated she missing socks for F charger for R40 or R26. At 1:35 p.m. t	0 p.m. social service designee had not heard anything about 12, a missing cell phone a missing computer tablet for he director of nurses stated any of the missing items for				
	worker (LSW-A) we were not aware of a R12, R26 or R40. T	ministrator and licensed social ere interviewed and stated they any of the missing items for The administrator stated the R12 reported to primarily				
	R12's team notes of verified there was r missing socks. LSV report to staff if the staff were to docum LSW-A also stated	A reviewed with the surveyor, lated 12/18/15 to present and nothing documented about V-A stated residents were to re were any missing items and nent in the nursing notes. there was a missing item form d which residents were to issing items.				
	(LPN)-B stated she shift on the weeker her about any miss stated maybe the m reported to the day hour book and state	0 p.m. licensed practical nurse had worked the afternoon ad and nothing was reported to ing socks for R12. LPN-B nissing socks had been nurse. LPN-B checked the 24 ed there was nothing there for 15 about missing socks for				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00928	B. WING	WING		12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STATE, ZIP CODE				
HAYES I	RESIDENCE		NDOLPH AVEN AUL, MN 5510				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE	
31880	Continued From pa	ge 26	31880				
	10/31/15, and there about R12, R26 or and Found form on reviewed and docu however, there was missing tablet. Only	book was reviewed back to was nothing documented R40's missing items. The Lost the bulletin board was mentation went back to 4/8/15 nothing documented about a v R40's missing cell phone ocumented as being missing					
	missing items and i missing item was to Notes section of the R26's Team Notes Team Notes back to 12/4/15, revealed th	A stated follow up was done or nformation regarding the b be documented in the Team e medical record. A review of back to 9/26/15, and R40's the date of admission here was no documentation s or that any missing items					
	three of an undated indicated residents safeguarding their of was not reponsible itmes including, but dentures, rings and provided a copy of titled Hayes Reside which indicated the board to report any as something was n was to write a desc along with their nan the item missing. T staff and other resid find what was miss locate any other po missing items and l	SW-A provided a copy of page Admission Agreement, which were responsible for own property and the facility for replacing lost or missing not limited to glasses, watches. LSW-A also a 12/14 revised document ince Resident Handbook, re was a sheet on the bulletin lost or missing items. As soon noticed as missing the residen ription of the item on the list, ne and the date they noticed he resident was also to notify dents so everyone could help ing. LSW-A was unable to licy and procedure regarding now the facility was to respond re to be taken by the facility to	t				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00928	B. WING		12/	12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
HAYES F	RESIDENCE		NDOLPH AVEN AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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	
31880	Continued From pa	ge 27	31880				
	find the missing iter	ns.					
	supervisor (MS), wh laundry was asked missing socks MS s	0 a.m. maintenance no also was in charge of the if R12 had reported any stated, "there might have been d top socks, but I don't know if g."					
	The director of nurs that policies and pro educate and monito	THOD FOR CORRECTION: sing or designee could assure ocedures are current and or to assure all appropriate t upon and follow up on roperty of residents.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One					
31945	MN Rule 144A.13 S Resident's Rights	Subd. 1 Complaints;	31945			2/5/16	
	relating to the opera are the subject of a resident and which person or employed delivered to the fact evaluation and action administrator within resolve the complain of the administrator days after its receip stating that the com- valid objection to th shall be a violation complaint directly in nursing home admi	Processing. All matters ation of a nursing home which written complaint from a are received by a controlling of the nursing home shall be ility's administrator for on. Failure of the seven days of its receipt to int, or alternatively, the failure to make a reply within seven of to the complaining resident inplaint did not constitute a e nursing home 's operations, of section 144A.10. If a nvolves the activities of a nistrator, the complaint shall ordance with this section by a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00928	B. WING		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
HAYES F	RESIDENCE		NDOLPH AVI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETI DATE
31945	Continued From pa	ge 28	31945			
	authorized by the n	the administrator, duly ursing home to investigate the ement any necessary s.				
	by: Based on observati review, the facility fa grievances were ac	ent is not met as evidenced on, interview and document ailed to ensure unresolved ted on for 1 of 1 resident oncerns to facility staff.		Corrected		
	Findings include:					
	bedroom, R39 expr the room and unable the bedroom becau thermostat on the w temperature at 90 c said the heat conce times to the facility resolution to the co always so tired feel do anything." Furthe being able to open because her window	on 12/28/15, at 7:00 p.m. in the ressed always being warm in le to spend too much time in use it was too warm. The vall was registering the room degrees Fahrenheit (F). R39 ern was reported numerous staff, but there wasn't any ncern. R39 stated, "I am ing because it is too warm to ermore R39 expressed not a window to the outside w opened into the resident ere was no access to fresh air				
	12/29/15, at 10:30 a registered at 86 deg	ion of R39's room temp on a.m. the wall thermometer grees F. R39 was sitting out in expressed, the room is too				
	licensed practical n R39 thought the roo that a resident cond	on 12/29/15, at 10:00 a.m. urse (LPN)-C verified knowing om was too warm but stated cern form had not been filled blained that in the 10 years				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 31945 Continued From page 29 31945 31945 Service Action of the concern form for any resident. LPN-C said if a resident had a concern it would be in the chart notes. LPN-C did not know if there was a system to follow up with residents about concerns and did not know if there was a policy for concerns/grievances. 31945 When interviewed on 12/29/15, at 11:30 p.m. social service designee (SSD)-B, who worked part time and had been at the facility for 6 months, was not aware of a resident grievance or concern form, and had not filled out any forms. When asked how a resident concern was reported, SS-B said would verbally pass on a concern but did not know what the outcome would be. SS-B verified not knowing about a concern/grievance procedure. When interviewed on 12/29/15, at 2:46 p.m. the director of social services (DSS) verified being at the facility two years and in that time did not log resident concerns/grievances and currently for	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/30/2015	
AME OF PROVIDER OR SUPPLIER 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 PRECOED DE VF ULL REQUATORY OR LSC IDENTIFYING INFORMATION) 31945 Continued From page 29 31945 Continued From page 29 31945 Working at the facility had never filled out a concern form for any resident. LPN-C said if a resident had a concern it would be in the chart notes. LPN-C did not know if there was a system to follow up with residents about concerns and did not know if there was a policy for concern form, and had been at the facility for 6 months, was not aware of a resident grievance or concern form, and had not filled out any forms. When interviewed on 12/29/15, at 11:30 p.m. social service designee (SSD)-B, who worked part time and had been at the facility for 6 months, was not aware of a resident grievance or concern form, and had not filled out any forms. When asked how a resident concern was reported, SS-B said would verbally pass on a concern/grievance procedure. When interviewed on 12/29/15, at 2:46 p.m. the director of social services (DSS) verified being at the facility two years and in that time did not log resident concerns/grievances and currently for		00928				
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	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
		OF CORRECTION PROVIDER OR SUPPLIER ESIDENCE SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From pa working at the facili concern form for ar resident had a conc notes. LPN-C did n to follow up with res did not know if then concerns/grievance When interviewed of social service design part time and had b months, was not av concern form, and l When asked how a reported, SS-B said concern/grievance When interviewed of director of social set the facility two year resident concerns/g 2015, there was no follow through with SUGGESTED MET The director of nurse that policies and pro- educate and monito grievances are acter TIME PERIOD FOR	OF CORRECTION IDENTIFICATION NUMBER: 00928 00928 PROVIDER OR SUPPLIER STREET AL RESIDENCE 1620 RAI SAINT PZ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 working at the facility had never filled out a concern form for any resident. 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