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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XRD5
Facility ID: 00928

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E508**

2.STATE VENDOR OR MEDICAID NO.
(L2) **314243400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAYES RESIDENCE**
(L4) **1620 RANDOLPH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55105**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/24/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

Posted 04/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/26/2016
(L33)

DETERMINATION APPROVAL

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

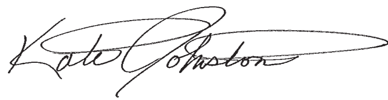
Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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.

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

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

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))

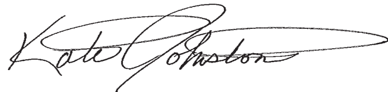
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 30, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 30, 2016, is to be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



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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24E508	A. Building B. Wing	2/17/2016

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).

ID Prefix	Reg. #	LSC	Correction Completed
F0166	483.10(f)(2)		02/05/2016
F0174	483.10(k),(l)		02/05/2016
F0244	483.15(c)(6)		02/05/2016
F0257	483.15(h)(6)		02/05/2016
F0279	483.20(d), 483.20(k)(1)		02/05/2016
F0329	483.25(l)		02/05/2016
F0371	483.35(i)		02/05/2016
F0428	483.60(c)		02/05/2016
F0441	483.65		02/05/2016
F0465	483.70(h)		02/05/2016
F0466	483.70(h)(1)		02/05/2016
F0520	483.75(o)(1)		02/05/2016

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) SR/KJ	DATE 03/23/2016	SIGNATURE OF SURVEYOR 30921	DATE 02/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/30/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00928 (Y1)	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 30630 Reg. # MN Rule 4655.3400 LSC	Correction Completed 02/05/2016	ID Prefix 31095 Reg. # MN Rule 4655.7400 Subp. 1 LSC	Correction Completed 02/05/2016	ID Prefix 31105 Reg. # MN Rule 4655.7810 LSC	Correction Completed 02/05/2016
ID Prefix 31235 Reg. # MN Rule 4655.8520 D LSC	Correction Completed 02/05/2016	ID Prefix 31455 Reg. # MN Rule 4655.9000 Subp. 1 LSC	Correction Completed 02/05/2016	ID Prefix 31880 Reg. # MN Rule 144.651 Subd. 20 LSC	Correction Completed 02/05/2016
ID Prefix 31945 Reg. # MN Rule 144A.13 Subd. 1 LSC	Correction 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

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) SR/KJ	DATE 03/23/2016	SIGNATURE OF SURVEYOR 30921	DATE 02/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/30/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/12/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction 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

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	03/23/2016	36536	03/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/03/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 03/03/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 03/03/2016
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/03/2016	ID Prefix Reg. # NFPA 101 LSC 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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XRD5
Facility ID: 00928

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E508**

2.STATE VENDOR OR MEDICAID NO.
(L2) **314243400**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAYES RESIDENCE**
(L4) **1620 RANDOLPH AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55105**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With
Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 01/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/24/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 02/26/2016 Co.

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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FISCAL YEAR ENDING DATE: (L35) 09/30

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From (a):
To (b):

12. Total Facility Beds 40 (L18)

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And/Or Approved Waivers Of The Following Requirements:
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___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

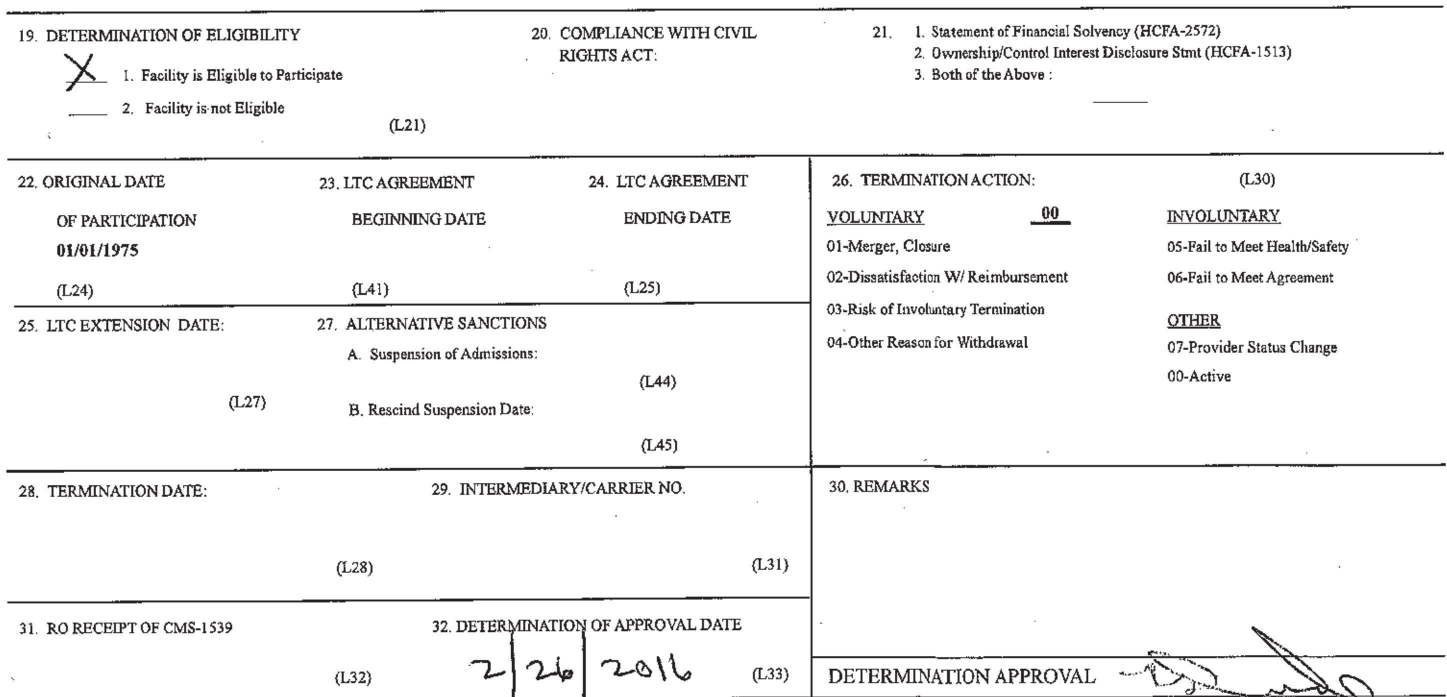
* Code: A1* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		40		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

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



17. SURVEYOR SIGNATURE — Sheryl Reed, HFE NE II — Date: 01/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Kate JohnsTon, Program Specialist — Date: 02/24/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 2/26/2016 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

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 only a suggestion 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

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

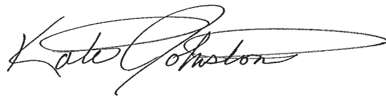
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	12/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unresolved grievances were acted on for 1 of 1 resident (R39) who voiced concerns to facility staff. Findings include: When interviewed on 12/28/15, at 7:00 p.m. in the bedroom, R39 expressed always being warm in the room and unable to spend too much time in the bedroom because it was too warm. The thermostat on the wall was registering the room temperature at 90 degrees Fahrenheit (F). R39	F 166	" R39 was offered an opportunity for a bed change. R39 accepted the bed change and moved rooms on 1/10/16. " Information regarding the updated grievance policy and procedure shall be announced at Resident Council meetings, individual care conferences, and admission. " The Grievance Policy & Procedure has been updated. Grievance Forms are available on the Resident Bulletin Board, as well as in department offices. Staff were educated on the updated policy and	2/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
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.

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F 166	Continued From page 1 said the heat 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." Furthermore R39 expressed not being able to open a window to the outside because her window opened into the resident smoking area so there was no access to fresh air. During an observation of R39's 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 day room and expressed, the room is too warm to stay in. When interviewed on 12/29/15, at 10:00 a.m. licensed practical nurse (LPN)-C verified knowing R39 thought the room was too warm but stated that a resident concern form had not been filled out for R39 and explained that in the 10 years 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 concerns/grievances. 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.	F 166	how to fill out the forms at the all staff meeting on 1/20/16. " Social Services Director or Designee shall maintain grievance logs and follow up results. Social Services Director shall report a summary of concerns to CQI committee for additional direction. Administrator is responsible.	

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F 166	Continued From page 2 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 2015, there was not a system to document and follow through with resident concerns.	F 166		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and 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. Findings include: The facility lacked a system to document reported missing items and a system for following up on the missing items. On 12/28/15, at 2:59 p.m. during interview, R12 explained having reported a pair of missing socks seven days ago and again, two days ago on	F 174	" 3 of 3 residents (R12, R26, R40) were spoken to regarding the missing items, and informed of the updated Missing Items Policy & Procedure. " Information regarding the updated Missing Items Policy & Procedure shall be announced at Resident Council meetings, individual care conferences, and admission. " The Missing Items Policy & Procedure has been updated. Missing Items Forms are available on the Resident Bulletin Board, as well as in department offices. Staff were educated on the updated policy and how to fill out the forms at the all staff	2/5/16

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

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F 174	Continued From page 3 12/26/15. R12 stated the missing socks had been reported to the housekeeper and provided the housekeeper's name. R12 explained that the laundry was done by the facility and the socks had not been returned. On 12/28/15, at 03:46 p.m. R26 stated about 1 to 1 1/2 months ago a computer tablet was stolen from their room. R26 stated this had been reported verbally to staff but couldn't recall who that person was. R26 explained that the missing computer tablet was not written down on the lost and found form, and no one followed up so was unsure whether or not anyone was looking for the tablet. On 12/28/15, at 03:24 p.m. R40 stated someone had taken a charger cord for their cell phone and explained that the charger had been plugged in, in his room. At 3:26 p.m. R40 stated residents were to write any missing items on the lost and found sheet and stated, "I never heard anything back. That's life. I learned my lesson about keeping it plugged in." On 12/29/15, at 1:30 p.m. social service designee (SSD-B) stated she had not heard anything about missing socks for R12, a missing cell phone charger for R40 or a missing computer tablet for R26. At 1:35 p.m. the director of nurses stated not being aware of any of the missing items for R12, R26 or R40. At 2:00 p.m. the administrator and licensed social worker (LSW-A) were interviewed and stated they were not aware of any of the missing items for R12, R26 or R40. The administrator stated the housekeeper who R12 reported to primarily worked weekends.	F 174	meeting on 1/20/16. " Social Services Director or Designee shall maintain grievance logs and follow up results. Social Services Director shall report a summary of concerns to CQI committee for additional direction. Administrator is responsible.	

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F 174

Continued From page 4

F 174

At 2:05 p.m. LSW-A reviewed with the surveyor, R12's team notes dated 12/18/15 to present and verified there was nothing documented about missing socks. LSW-A stated residents were to report to staff if there were any missing items and staff were to document in the nursing notes. LSW-A also stated there was a missing item form on the bulletin board which residents were to complete for any missing items.

On 12/29/15, at 2:10 p.m. licensed practical nurse (LPN)-B stated she had worked the afternoon shift on the weekend and nothing was reported to her about any missing socks for R12. LPN-B stated maybe the missing socks had been reported to the day nurse. LPN-B checked the 24 hour book and stated there was nothing there for 12/26/15 or 12/19/15 about missing socks for R12. The 24 hour book was reviewed back to 10/31/15, and there was nothing documented about R12, R26 or R40's missing items. The Lost and Found form on the bulletin board was reviewed and documentation went back to 4/8/15, however, there was nothing documented about a missing tablet. Only R40's missing cell phone charger cord was documented as being missing on 12/7/15.

At 2:27 p.m. LSW-A stated follow up was done on missing items and information regarding the missing item was to be documented in the Team Notes section of the medical record. A review of R26's Team Notes back to 9/26/15, and R40's Team Notes back to the date of admission 12/4/15, revealed there was no documentation about missing items or that any missing items had been found.

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F 174	Continued From page 5 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 Hayes 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 174		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP 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.	F 244		2/5/16

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F 244	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not have documentation that the facility effectively acted upon grievances voiced by several residents in resident council meetings and for 1 of 30 residents (R14) interviewed in stage one. Findings include: Review of the previous six months of resident council meeting minutes showed that in the August, November, and December 2015 meeting minutes several residents expressed concerns regarding toilet paper availability in resident bathrooms. In the July, August, September, and October 2015 meeting minutes concerns were expressed about some residents smoking near the front entrance of the building, which is a designated non-smoking area of the facility and is near a porch where several residents like to sit. These resident council meeting minutes included reminders to residents that they should not smoke in front of the building and noted that residents who do smoke there have been reminded not to do so. There were no other details of resolution to these concerns listed in the resident council meeting minutes. During stage one interview, on 12/28/15 at 6:12 p.m., R14 stated that there is not always enough toilet paper available in resident bathrooms. On 12/29/2015 at 2:43 p.m. the president of the resident council was interviewed and stated that both of these issues continue to be a problem in the facility.	F 244	" R14 was spoken to regarding the grievance and informed of the updated Grievance Policy & Procedure. A Smoker s Meeting was held on 1/4/16 that specified to resident s the designated areas and times for smoking. " This information shall be shared with Resident Council at the next scheduled meeting. " The Grievance Policy & Procedure has been updated. Grievance Forms are available on the Resident Bulletin Board, as well as in department offices, and shall be available at Resident Council meetings. Staff were educated on the updated policy and how to fill out the forms at the all staff meeting on 1/20/16. " Social Services Director or Designee shall maintain grievance logs and follow up results. Social Services Director shall report a summary of concerns to CQI committee for additional direction. Administrator is responsible.	

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F 244	Continued From page 7 When interviewed on 12/29/2015 at 3:18 p.m., the activities staff member (A)-A who attends the resident council meeting and takes the meeting minutes, was asked if there was documentation of action the facility had taken in response to the repeated concerns of residents smoking in non-smoking areas of the facility and the availability of toilet paper in resident bathrooms. She stated that she made copies of resident council meeting minutes and distributed those copies to all department heads and the administrator of the facility. When she was made aware of any actions taken to respond to these resident concerns, she included that information in the following resident council meeting minutes. The director of nursing was interviewed on 12/30/15 at 9:56 a.m. and asked if she was aware of concerns that residents had recently expressed in resident council meeting. She confirmed that she received a copy of the resident council meeting minutes and that these minutes are discussed in management meetings. She stated that all the documentation of resolution to these issues was listed in resident council meeting minutes and was not documented in any other location. She then explained that completing grievance forms had been part of facility policy but apparently not done in these situations, and she just put a new supply of these blank forms on a facility bulletin board. When asked what had been done to act upon the concerns of residents smoking in non-smoking areas of the facility and toilet paper availability, she stated that some residents who smoke in the non-smoking area had been reminded not to smoke in that location and toilet paper was stacked in the nursing station so that nursing staff could hand out toilet	F 244		

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F 244	Continued From page 8 paper to residents when it was needed. She then added that there was an issue with some residents hoarding toilet paper, so handing it out may not have affected the availability, but there was no documentation of who was hoarding and how that was managed. The facility did not have a specific policy regarding grievances. On 12/29/15, at 2:27 p.m. social worker (SS)-A also provided a copy of a 12/14 revised document titled Hayes Residence Resident Handbook. Page three of the document, under the section titled Grievance Procedure residents were advised to bring up at Resident Council, the care conference, to the social worker or other staff and complaints or concerns. The policy also referenced a "Grievance Resolution" policy, which the facility was not able to provide.	F 244		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain adequate room temperatures for 1 of 2 residents (R39) who expressed the bedroom being too warm. Findings include: Observation of R39 on 12/28/15, from 4:30 p.m. until 7:00 p.m. was in the dining room area. When	F 257	" R39 was offered an opportunity for a bed change. R39 accepted the bed change and moved rooms on 1/10/16 date. " All resident rooms shall be checked for current temperature readings. " Staff was educated on the requirement at the all staff meeting on 1/20/16. The building was initially certified	2/5/16

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F 257	Continued From page 9	F 257		

approached for an interview, R39 said we could go to the bedroom for privacy.

During the initial interview of R39 on 12/28/15, at 7:00 p.m. the bedroom wall mounted thermometer read 90 degrees farenheit (F). R39 expressed always being warm in the room and unable to spend too much time in the bedroom because it was too warm. R39 said the heat 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.

before October 1, 1990.
" Maintenance Supervisor shall conduct random room temperature audits to ensure compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Administrator is responsible.

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	24E508	A. BUILDING ______ B. WING ______	12/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 facility did not develop an initial care plan for wandering and for behaviors and mood for 1 of 1 resident (R44) who was reviewed for accidents and hospitalization. Findings include: The facility failed to develop an initial care plan for wandering and for mood and behavior for newly admitted R44. R44 was rehospitalized within 15 days of admission.	F 279	" R44 has officially discharged from the facility. " Care Plans for residents admitted after 12/30/2015 date have been reviewed for compliance with Initial Care Plan requirement. " Care Planning Policy & Procedure has been updated. Staff have been educated on the updated policy at the all staff meeting on 1/20/16. " Director of Nursing or Designee shall conduct random audits to ensure	2/5/16

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F 279	Continued From page 11	F 279	compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

Continued From page 11

R44 was admitted to the facility on 11/05/15 after being hospitalized (72 hour hold) for behavior outburst due to dementia. Other diagnoses included syncope episodes and falls and history of neuropathic pain. R44 was admitted to the facility with medications that included: amiodipine, aspirin, atorvastin, citalopram (antidepressant) , donepezil, gabapentin and quetiapine (antipsychotic).

The admission minimum data set (MDS) dated 11/11/15, indicated R44 was at risk for wandering. The MDS, indicated R44 had a cognition impairment with a BIMS score of 9 and behaviors that included delusions, and other behaviors not directed at others such as pacing, scratching self.

A review of the medical record's progress note dated 11/8/15 read R44 was alert, disoriented to place-went out east door setting off alarms, found walking around the front of the building with just his socks on with clothes on, was able to be guided back into the building and to the dining room for breakfast.

Progress note dated 11/10/15 revealed resident had wandered off and was found at a bus stop approximately a block away from facility. R44 reported he went for a walk and did not know how to find the facility. Staff encouraged resident to ask for help and would arrange escort for his exercise.

Progress note on 11/11/15 indicated social services had discussed resident's elopement risk with nursing staff and concluded R44 would benefit from being in a secure memory care

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F 279	Continued From page 12 setting. The progress note read: "Also he has already wandered from Hayes at least 2 times since admission on 11/5/15." Progress note on 11/19/15 at 2:00 pm. read "writer spoke wi/ (with) management staff re: option of providing (resident's name) w/ a Wanderguard to provide greater security for him at Hayes. Agreed that this would be sufficient security for his needs at current time. Writer called (technology company name) and ordered transmitter and bands. We will be using Wanderguard w/ (resident's name) to keep him safe at Hayes Residence. At this time any discharge plan has been put on hold." Progress note dated 11/19/15 at 10:43 p.m. read: "Resident was seen fully dressed in his street clothing sitting in the front lobby "blue Room" in a chair closest to the door. He got up and push the release bar which triggered the door alarm as he was exiting the front door. Staff ran and redirected him back into the building." The initial electronic care plan lacked identification of mood or behaviors nor had any interventions regarding mood or behaviors. The care plan lacked evidence of the risk for elopement nor did it indicate R44 had already wandered from the facility. No interventions were identified including the use of a WanderGuard bracelet. On 12/28/15 at 11:00 a.m during the entrance conference, the director of nursing, (DON) indicated the most current care plan for residents would be the electronic care plan. On 12/29/15 at 3:16 p.m., the social services	F 279		

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F 279	Continued From page 13 director (SSD) and licensed practical nurse (LPN)-C reviewed the electronic care plan and verified the care plan did not identify the risk for elopement or any interventions. LPN-C indicated R44 should have a paper initial care plan in the medical record, however, it was never located. On 12/30/15 at 10:00 a.m the DON verified the care plan did not identify the risk for elopement or that mood and behaviors and interventions were included in the care plan.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		2/5/16

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications for 2 of 5 residents (R40, R14) were administered safely and/or followed specific parameters for use. Findings include: 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 12/14/15, R40 had not used the prn benztropine 0.5 mg However, a review of the Medication Administration Record (MAR) for 12/15, revealed R40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration were 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. Documentation of a psychiatry visit having been completed on 12/9/15, was found in the consult section of the medical record. Documentation from the visit indicated R40's medications were reviewed, but there was no clarification sought by the facility regarding the lack of parameters for use of prn benztropine.	F 329	" Clarification was immediately requested regarding parameters for use for R40 & R14 PRN medications. " Consulting Pharmacist performed medication regimen review on 1/19/2016. " PRN Medication Policy & Procedure has been updated. Staff have been educated on the updated policy at the all staff meeting on 1/20/16. " Director of Nursing or Designee shall conduct random audits to ensure compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

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F 329	Continued From page 15	F 329		

On 12/30/15, at 10:55 a.m. the director of nurses (DON) stated nursing staff typically contacted the physician and asked for parameters of use for prn medications. When pointed out there were no parameters for use regarding the use of the prn benztropine, the DON had no comment.

R14 had an incomplete order for Tylenol with no frequency and no daily dosage limit.

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

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F 329	Continued From page 16 supplied a copy that contained a Tylenol order that read, "Acetaminiphan [sic] 325 mg or 650 mg 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. .	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		2/5/16

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F 371	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 removal of gloves.	F 371	" Staff member in violation of procedure was immediately re-educated on hand washing technique and procedure. " All dietary staff have been re-educated on hand washing technique and procedure. " The Handwashing and Glove Use Policy was reviewed for accuracy. All staff have been re-educated on the policies at the all staff meeting on 1/20/16. The policies have been integrated into initial department orientation. " Director of Nursing or Designee shall conduct random audits to ensure compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

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F 371	Continued From page 18 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 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT 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 consulting pharmacist failed to identify medication	F 428	" Clarification was immediately requested regarding parameters for use	2/5/16

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F 428	Continued From page 19 irregularities associated with the lack of parameters for safe medication use for 2 of 5 residents (R40, R14) who had orders for, of when necessary (prn), medications. Findings include: 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 12/14/15, R40 had not used the prn benztropine 0.5 mg However, a review of the Medication Administration Record (MAR) for 12/15, revealed R40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration were 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 pharmacist verified their 12/14/15, facility visit. The pharmacist was interviewed regarding the lack of parameters related to the use of benztropine 0.5 mg every six hours prn. The pharmacist stated it made sense that there should be parameters for the use of the every six	F 428	for R40 & R14 PRN medications. " Consulting Pharmacist performed medication regimen review on 1/19/2016. " PRN Medication Policy & Procedure has been updated. Staff have been educated on the updated policy at the all staff meeting on 1/20/16. " Director of Nursing or Designee shall conduct random audits to ensure compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

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F 428	Continued From page 20 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	F 428		

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F 428	Continued From page 21 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 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		2/5/16

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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	12/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure infection control protocols were implemented for glucometer checks and/or insulin administration for 7 of 7 residents (R15, R3, R14, R6, R4, R12, R1) who had glucometer checks and/or administration of insulin observed and failed to ensure that staff were trained on handwashing technique. Findings include: During observation of insulin administration and glucometer checks from 11:40 a.m. to 12:00 p.m. on 12/28/15, the shelf where alcohol packets, individual resident glucometer's, fingerstick pens, new and used cotton balls, was placed without being cleaned/disinfected after each glucometer check. 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	F 441	" A cleanable surface (tray) was obtained to perform insulin administration. Staff were re-educated on the necessity to wash hands for 20 seconds and glove use. Bathrooms have been deep cleaned and the elevated seat has been replaced. " A cleanable surface shelf has been installed to replace old surface for insulin administration. Bathrooms and shower/tub rooms have been deep cleaned. Staff have been re-educated on hand washing and glove use policy. " The Handwashing and Glove Use Policy was reviewed for accuracy. Staff have been re-educated on the policies at the all staff meeting on 1/20/16. The policies have been integrated into initial department orientation. " Director of Nursing or Designee shall conduct random audits to ensure compliance. The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

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

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F 441	Continued From page 24 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 where R15 had placed the bloody cotton ball, and began to pick up an unopened alcohol wipe and clean cotton ball, which had been placed on the uncleaned/undisinfected shelf. R14 proceeded to do their own glucometer check, and was observed to pull out the bloody test strip with their hand and toss it in the sharps container. LPN-A did not have R14 cleanse hands afterwards. LPN-A removed gloves, cleansed hands and then placed a clean cotton ball and unopened alcohol pack on the shelf which had not been cleansed/disinfected after R14's glucometer check. The next resident, R6 picked up and opened the alcohol pack to cleanse his finger, then picked up the cotton ball and used it to dry his finger. LPN-A then proceeded to do R6's glucometer check. LPN-A removed gloves and cleansed hands, but the shelf was not cleansed/disinfected after completion of R6's glucometer check. At 11:55 a.m. LPN-A placed an unopened alcohol pack and a clean cotton ball on the shelf and R4 began do do their glucometer check. After opening and cleansing their finger with the alcohol wipe and placing it on the shelf, R4 picked up the fingerstick pen and stuck their finger. R4 then put the fingerstick pen on the shelf and picked up the used alcohol wipe with soiled fingers to toss it in the sharps container. LPN-A removed gloves and cleansed hands, but	F 441		

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

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F 441	Continued From page 25 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/disinfect the shelf before leaving the room. On 12/28/15, at 4:28 p.m. an announcement was made over the house intercom which instructed residents to come to the nurses station for insulin administration. Residents R15, R3, R12, R14 and R1 were observed one by one, to come into the medication room, to sit in the chair by the 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. During an observation of blood glucose monitoring and insulin administration on 12/28/15, at 4:28 p.m. licensed practical nurse (LPN)-A donned gloves and assisted R15 with setting out the glucometer. R15 did not alcohol gel or wash hands prior to reaching into the container of lancets and with bare fingers retrieved a lancet. R15 was observed with bare fingers touching other lancets in the container. R15 moved a container of insulin syringes on the counter, and took out a packaged syringe. LPN-A with gloved hands removed the blood used lancet from the pen. LPN-A removed gloves, did not sanitize hands and went to the refrigerator for a vial of insulin. Then LPN-A used alcohol gel to sanitize hands and donned a pair of gloves. LPN-A drew up the required amount of insulin and handed the syringe to R15 who self administered the insulin.	F 441		

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F 441	Continued From page 26 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	F 441		

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F 441	Continued From page 27	F 441		

gloves and washed hands for seven seconds. When interviewed about handwashing H-A did not know how long hands were to be washed.

A review of the facility policy dated, 1/11/07, titled, Hand Washing, read, Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers and under your nails. Continue rubbing your hands for at least 20 seconds. Washing hands with soap and water is the best way to reduce the number of germs. If soap and water are not available, use an alcohol-based hand sanitizer.

A review of the facility policy dated 4/2/12, titled, Use of gloves, read, Wash your hands immediately after removing gloves to avoid transfer of microorganisms to others or environment.

During an interview with the director of nursing (DON) on 12/29/15, at 3:00 p.m. verified handwashing is to be for twenty seconds. Furthermore, the DON verified the surface in the nursing station is not a cleanable area and a cleanable surface, such as a tray, would be obtained immediately.

During observation on 12/30/15, at 9:06 a.m. the west common bathroom toilet tank had two rolls of toilet paper stacked on the top of the tank of the toilet.

On 12/29/15, at 1:00 p.m. the environmental tour was conducted with a surveyor, the maintenance supervisor (MS), the housekeeping supervisor (HS) and housekeeper (H)-A.The public and

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F 441	Continued From page 28 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 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. When interviewed on 12/30/15, at 1:30 p.m. the maintenance supervisor verified there was not a system to monitor or document the cleaning of toilet rooms.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident rooms, bathrooms and bathing areas were maintained in a clean and sanitary manner for 39 of 39 residents reviewed (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). Findings include: On 12/28/15, from 2:00 p.m. until 7:30 p.m. and on 12/29/15, from 8:00 a.m. until 11:00 a.m.	F 465	" Thorough cleaning has been initiated for the affected rooms. " A detailed walk through of the building 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 staff meeting on 1/20/16. The policies have been integrated into initial department orientation. " Director of Nursing or Designee shall conduct random audits to ensure compliance. The CQI Committee will	2/5/16

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F 465	Continued From page 29 during the initial thirty resident interviews and observations of resident rooms, toileting areas, and bathing areas there were unsanitary and malodorous areas identified. 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 yellow 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	F 465	provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted. Director of Nursing is responsible.	

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

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F 465	Continued From page 31 toileting/bathing areas, bed frames, window sills, heat registers, vents, or any area of the facility. There was not a policy and procedure for cleaning the facility and there was not a check off list for deep cleaning of the resident rooms in the facility. Policies and procedures were requested for the auditing, deep cleaning and general cleaning of the resident bedrooms, bed frames, window treatments, vents, heat registers, toileting rooms and bathing/tub rooms, but were not received at the time of survey exit.	F 465		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water needs for the facility were estimated and planned for, should loss of normal water supply occur. This had the potential to affect all 39 residents residing in the facility. Findings include: The facility's emergency water supply policy was requested upon entrance. On 12/30/15 an updated policy entitled Emergency Water Supply, dated 12/30/15, was provided. The procedure did	F 466	" 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.	2/5/16

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F 466	Continued From page 32 not specify a method for distributing potable/nonpotable water nor calculations for estimating the gallons of water required daily to meet the needs of the residents and staff should there be a loss of the water supply. On 12/30/15 at approximately 1:30 p.m. the administrator indicated not being aware of any contracts with the city department that would provide a method for distribution of water but had a contract with a local water delivery. No calculations were included. Per the policy provided if the facility had a water shortage, water could be obtained from local stores.	F 466		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		2/5/16

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F 520	Continued From page 33 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure the quality assurance and assessment committee implemented measures to improve upon identified quality concerns in infection control, identified in consecutive surveys. Findings include: The facility failed to develop, implement and maintain a plan for infection control measures during glucose monitoring of residents which included hand washing and glove changing. A review of previous certification surveys, exited 10/23/14, 1/16/14, 3/29/12, identified concerns of non-compliance in infection control. See F441: The facility failed to ensure infection control protocols were implemented for glucometer checks and/or insulin administration for 7 of 7 residents (R15, R3, R14, R6, R4, R12, R1) who had glucometer checks and/or administration of insulin observed and failed to ensure that staff were trained on handwashing technique. During an interview on 12/30/15 at 1:00 p.m., the administraor identified that infection control was discussed at the facility's quality meetings and explained that some changes had been made recently, such as a new ice machine. The administrator stated that education had been	F 520	" Updated Infection Control Policy & Procedure shall be emailed to CQI committee members for committee approval and discussion. " Updated Infection Control Policy & Procedure shall be discussed at next CQI meeting for committee approval and discussion. " Survey results and trends shall be integrated into the quarterly meetings for discussion. " The CQI Committee will provide direction or change to policies when necessary based upon current trending. Administrator is responsible.	

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F 520	Continued From page 34 conducted and that infection control has been a concern with the facility and apparently more education and retraining would be necessary.	F 520		

FE 508025

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	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/08/2016**

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

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPTS OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Hayes Residence was found not in substantial compliance with the requirements for participation in Medicaid at 42 CFR, Subpart 483.470 (j), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

HEALTHCARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145

Or by email to:
Marian.Whitney@state.mn.us

EPOC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 or Angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Hayes Residence is a 1-story building with a full basement. The building was constructed in 1958 and was determined to be of Type II(111) construction. The building is divided into 3 smoke zones. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The alarm is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are connected to the fire alarm system in accordance with the Minnesota State Fire Code. The building is fully sprinkled per NFPA 13. The facility has a capacity of 40 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.470(j), is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA	K 052		2/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 052	Continued From page 2 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:00 am to 12:30 pm on 01/08/2016, the following deficient conditions were found affecting the facility's fire alarm system, The records did not reflect any current sensitivity tests for the smoke alarms. This deficient practice was verified by the Maintenance Supervisor. (SS)	K 052	1. Sensitivity Test was conducted by Nardini on 1/15/2016. During the test Nardini□s equipment failed. A subsequent test will be conducted no later than 2/5/2016. 2. A copy of the completed test will be submitted to the State Fire Marshal no later than 2/12/2016. 3. Steve Smieja, Maintenance Supervisor and Colin Faulkner, Assistant Administrator.	
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		2/5/16

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K 067 SS=F	Continued From page 3 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 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.. 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 practice was verified by the Maintenance Supervisor. (SS) An annual waiver has been previously granted.	K 067	1. A waiver will be requested from the state fire marshal and CMS. The last waiver request was approved by the fire marshal and granted by CMS in 2015. 2. The request for waiver will be mailed to the State Fire Marshal no later than 2/5/2016. 3. Colin Faulkner, Assistant Administrator	

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 only a suggestion 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

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

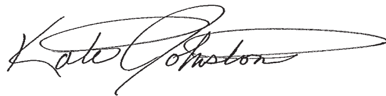
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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	(X3) DATE SURVEY COMPLETED
	00928	A. BUILDING: ______ B. WING ______	12/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. On December 28, 29, and 30, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	3 000		

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3 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 630	MN Rule 4655.3400 Medical Record The medical record shall be initiated for each patient or resident within 72 hours in accordance with part 4655.4700. This MN Requirement is not met as evidenced by: Based on document review and interview the facility did not develop an initial care plan for wandering and for behaviors and mood for 1 of 1 resident (R44) who was reviewed for accidents and hospitalization. Findings include: The facility failed to develop an initial care plan for wandering and for mood and behavior for newly admitted R44. R44 was rehospitalized within 15 days of admission. R44 was admitted to the facility on 11/05/15 after being hospitalized (72 hour hold) for behavior outburst due to dementia. Other diagnoses included syncope episodes and falls and history of neuropathic pain. R44 was admitted to the facility with medications that included: amiodipine, aspirin, atorvastin, citalopram (antidepressant) , donepezil, gabapentin and quetiapine (antipsychotic). The admission minimum data set (MDS) dated	3 630	Corrected	2/5/16

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3 630	Continued From page 3	3 630		

Continued From page 3

11/11/15, indicated R44 was at risk for wandering. The MDS, indicated R44 had a cognition impairment with a BIMS score of 9 and behaviors that included delusions, and other behaviors not directed at others such as pacing, scratching self.

A review of the medical record's progress note dated 11/8/15 read R44 was alert, disoriented to place-went out east door setting off alarms, found walking around the front of the building with just his socks on with clothes on, was able to be guided back into the building and to the dining room for breakfast.

Progress note dated 11/10/15 revealed resident had wandered off and was found at a bus stop approximately a block away from facility. R44 reported he went for a walk and did not know how to find the facility. Staff encouraged resident to ask for help and would arrange escort for his exercise.

Progress note on 11/11/15 indicated social services had discussed resident's elopement risk with nursing staff and concluded R44 would benefit from being in a secure memory care setting. The progress note read: "Also he has already wandered from Hayes at least 2 times since admission on 11/5/15."

Progress note on 11/19/15 at 2:00 pm. read "writer spoke wi/ (with) management staff re: option of providing (resident's name) w/ a Wanderguard to provide greater security for him at Hayes. Agreed that this would be sufficient security for his needs at current time. Writer called (technology company name) and ordered transmitter and bands. We will be using Wanderguard w/ (resident's name) to keep him

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3 630	Continued From page 4 safe at Hayes Residence. At this time any discharge plan has been put on hold." Progress note dated 11/19/15 at 10:43 p.m. read: "Resident was seen fully dressed in his street clothing sitting in the front lobby "blue Room" in a chair closest to the door. He got up and push the release bar which triggered the door alarm as he was exiting the front door. Staff ran and redirected him back into the building." The initial electronic care plan lacked identification of mood or behaviors nor had any interventions regarding mood or behaviors. The care plan lacked evidence of the risk for elopement nor did it indicate R44 had already wandered from the facility. No interventions were identified including the use of a WanderGuard bracelet. On 12/28/15 at 11:00 a.m during the entrance conference, the director of nursing, (DON) indicated the most current care plan for residents would be the electronic care plan. On 12/29/15 at 3:16 p.m., the social services director (SSD) and licensed practical nurse (LPN)-C reviewed the electronic care plan and verified the care plan did not identify the risk for elopement or any interventions. LPN-C indicated R44 should have a paper initial care plan in the medical record, however, it was never located. On 12/30/15 at 10:00 a.m the DON verified the care plan did not identify the risk for elopement or that mood and behaviors and interventions were included in the care plan.	3 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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3 630	Continued From page 5 SUGGESTED METHOD FOR CORRECTION: The director of nursing could assure that policies and procedures are current and educate staff to assure that temporary care plans for all newly admitted residents are initiated within 72 hours. The director of nursing or designee could review temporary care plans for appropriateness and monitor to assure pertinent information has been included. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 630		
31095	MN Rule 4655.7400 Subp. 1 Storage; Equipment/Supplies in General Subpart 1. Equipment and supplies in general. Cabinets and other suitable space shall be provided and identified for the safe storage of equipment and supplies in a sanitary, convenient, and orderly manner. Supplies shall be identified. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure infection control protocols were implemented for glucometer checks and/or insulin administration for 7 of 7 residents (R15, R3, R14, R6, R4, R12, R1) who had glucometer checks and/or administration of insulin observed and failed to ensure that staff were trained on handwashing technique. Findings include: During observation of insulin administration and	31095	Corrected	2/5/16

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31095	Continued From page 6	31095		

glucometer checks from 11:40 a.m. to 12:00 p.m. on 12/28/15, the shelf where alcohol packets, individual resident glucometer's, fingerstick pens, new and used cotton balls, was placed without being cleaned/disinfected after each glucometer check.

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 where R15 had placed the bloody cotton ball, and began to pick up an unopened alcohol wipe and clean cotton ball, which had been placed on the uncleaned/undisinfected shelf. R14 proceeded to do their own glucometer check, and was observed to pull out the bloody test strip with their hand and toss it in the sharps container. LPN-A did not have R14 cleanse hands afterwards.

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31095	Continued From page 7	31095		

LPN-A removed gloves, cleansed hands and then placed a clean cotton ball and unopened alcohol pack on the shelf which had not been cleansed/disinfected after R14's glucometer check. The next resident, R6 picked up and opened the alcohol pack to cleanse his finger, then picked up the cotton ball and used it to dry his finger. LPN-A then proceeded to do R6's glucometer check. LPN-A removed gloves and cleansed hands, but the shelf was not cleansed/disinfected after completion of R6's glucometer check.

At 11:55 a.m. LPN-A placed an unopened alcohol pack and a clean cotton ball on the shelf and R4 began do do their glucometer check. After opening and cleansing their finger with the alcohol wipe and placing it on the shelf, R4 picked up the fingerstick pen and stuck their finger. R4 then put the fingerstick pen on the shelf and picked up the used alcohol wipe with soiled fingers to toss it in the sharps container. LPN-A removed gloves and cleansed hands, but 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/disinfect the shelf before leaving the room.

On 12/28/15, at 4:28 p.m. an announcement was made over the house intercom which instructed residents to come to the nurses station for insulin administration. Residents R15, R3, R12, R14 and R1 were observed one by one, to come into the medication room, to sit in the chair by the

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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.

During an observation of blood glucose monitoring and insulin administration on 12/28/15, at 4:28 p.m. licensed practical nurse (LPN)-A donned gloves and assisted R15 with setting out the glucometer. R15 did not alcohol gel or wash hands prior to reaching into the container of lancets and with bare fingers retrieved a lancet. R15 was observed with bare fingers touching other lancets in the container. R15 moved a container of insulin syringes on the counter, and took out a packaged syringe. LPN-A with gloved hands removed the blood used lancet from the pen. LPN-A removed gloves, did not sanitize hands and went to the refrigerator for a vial of insulin. Then LPN-A used alcohol gel to sanitize hands and donned a pair of gloves. LPN-A drew up the required amount of insulin and handed the syringe to R15 who self administered the insulin. 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

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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 gloves and washed hands for seven seconds. When interviewed about handwashing H-A did not know how long hands were to be washed.

A review of the facility policy dated, 1/11/07, titled, Hand Washing, read, Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers and under your nails. Continue rubbing your hands for at least 20 seconds. Washing hands with soap and water is the best way to reduce the number of germs. If soap and water are not available, use an alcohol-based hand sanitizer.

A review of the facility policy dated 4/2/12, titled, Use of gloves, read, Wash your hands immediately after removing gloves to avoid

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31095	Continued From page 10 transfer of microorganisms to others or environment. During an interview with the director of nursing (DON) on 12/29/15, at 3:00 p.m. verified handwashing is to be for twenty seconds. Furthermore, the DON verified the surface in the nursing station is not a cleanable area and a cleanable surface, such as a tray, would be obtained immediately. During observation on 12/30/15, at 9:06 a.m. the west common bathroom toilet tank had two rolls of toilet paper stacked on the top of the tank of the toilet. On 12/29/15, at 1:00 p.m. the environmental tour was conducted with a surveyor, the maintenance supervisor (MS), the housekeeping supervisor (HS) and housekeeper (H)-A.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 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. When interviewed on 12/30/15, at 1:30 p.m. the maintenance supervisor verified there was not a system to monitor or document the cleaning of toilet rooms. SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate use and cleaning of the	31095		

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31095	Continued From page 11 glucometer/equipment and shelving, then audit this service to ensure that it is being implemented as directed and take action as needed. The director of nursing or designee could monitor to assure policy and procedures are current, implemented and monitored. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31095		
31105	MN Rule 4655.7810 Distribution of Medications A system shall be developed in each boarding care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the resident's personal care record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications for 2 of 5 residents (R40, R14) were administered safely and/or followed specific parameters for use. In addition, the consulting pharmacist failed to identify medication irregularities associated with the lack of parameters for safe medication use for 2 of 5 residents (R40, R14) who had orders for, of when necessary (prn), medications. Findings include: R40 was admitted to the facility on 12/4/15, from the hospital with an order for benztropine (to treat	31105	Corrected	2/5/16

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31105	Continued From page 12 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 12/14/15, R40 had not used the prn benztropine 0.5 mg However, a review of the Medication Administration Record (MAR) for 12/15, revealed R40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration were 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. Documentation of a psychiatry visit having been completed on 12/9/15, was found in the consult section of the medical record. Documentation from the visit indicated R40's medications were reviewed, but there was no clarification sought by the facility regarding the lack of parameters for use of prn benztropine. On 12/30/15, at 10:55 a.m. the director of nurses (DON) stated nursing staff typically contacted the physician and asked for parameters of use for prn medications. When pointed out there were no parameters for use regarding the use of the prn benztropine, the DON had no comment. R14 had an incomplete order for Tylenol with no frequency and no daily dosage limit. Record review revealed a physician's order,	31105		

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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 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

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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.

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 12/14/15, R40 had not used the prn benztropine 0.5 mg However, a review of the Medication Administration Record (MAR) for 12/15, revealed R40 had received benztropine 0.5 mg on 12/26, 12/27, 12/28, and 12/30/15. The reasons for administration were 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

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pharmacist verified their 12/14/15, facility visit. The pharmacist was interviewed regarding the lack of parameters related to the use of benztropine 0.5 mg every six hours prn. The pharmacist stated it made sense that there should be parameters for the use of the every six 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

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(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 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

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31105	Continued From page 17 mg daily dosage limit on Tylenol, but he was not part of that decision or process. SUGGESTED METHOD FOR CORRECTION: The director of nursing could assure that policies and procedures are current and educate staff to ensure medications are administered safely and that specific parameters for use are implemented, monitored and additional training provided if concerns arise. The director of nursing or designee could assure that the consulting pharmacist identify medication irregularities associated with the lack of parameters for safe medication use. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31105		
31235	MN Rule 4655.8520 D Dietary Staff Requirements; handwashing Dietary staff: D. They shall wash their hands frequently, especially after using handkerchief or tissue, after handling soiled dishes, and after using toilet facilities and shall observe all other accepted hygienic practices in the prevention of contamination of food. The hand-washing procedure shall also apply to other staff on temporary assignment to the food service and in addition, uniforms shall be changed when soiled activities are involved. This MN Requirement is not met as evidenced by:	31235		2/5/16

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31235	Continued From page 18 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 removal of gloves. 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,	31235	Corrected	

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31235	Continued From page 19 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." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could assure that policies and procedures are current and educate staff to utilize appropriate hand hygiene during preparation of meals that would minimize the possibility of food borne illness. The director of nursing or designee could monitor to assure the process is being implemented. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31235		
31455	MN Rule 4655.9000 Subp. 1 Housekeeping; General Requirements Subpart 1. General requirements. The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited.	31455		2/5/16

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31455	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident rooms, bathrooms and bathing areas were maintained in a clean and sanitary manner for 39 of 39 residents reviewed (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). Findings include: On 12/28/15, from 2:00 p.m. until 7:30 p.m. and on 12/29/15, from 8:00 a.m. until 11:00 a.m. during the initial thirty resident interviews and observations of resident rooms, toileting areas, and bathing areas there were unsanitary and malodorous areas identified. 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	31455	Corrected	

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	00928	A. BUILDING: ______ B. WING ______	12/30/2015

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

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31455	Continued From page 21 cleanable surface and they were discolored dark yellow 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 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	31455		

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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, toileting/bathing areas, bed frames, window sills, heat registers, vents, or any area of the facility. There was not a policy and procedure for cleaning the facility and there was not a check off list for deep cleaning of the resident rooms in the facility.

Policies and procedures were requested for the auditing, deep cleaning and general cleaning of the resident bedrooms, bed frames, window treatments, vents, heat registers, toileting rooms and bathing/tub rooms, but were not received at the time of survey exit.

SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could assure that policies and procedures are current and educate and monitor staff to ensure resident rooms, bathrooms and bathing areas are maintained in a clean and sanitary manner

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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31880	Continued From page 23	31880		
31880	MN Rule 144.651 Subd. 20 Patients & Residents of HCF Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every non-acute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	31880		2/5/16

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31880	Continued From page 24 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN 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. Findings include: The facility lacked a system to document reported missing items and a system for following up on the missing items. On 12/28/15, at 2:59 p.m. during interview, R12 explained having reported a pair of missing socks seven days ago and again, two days ago on 12/26/15. R12 stated the missing socks had been reported to the housekeeper and provided the housekeeper's name. R12 explained that the laundry was done by the facility and the socks had not been returned. On 12/28/15, at 03:46 p.m. R26 stated about 1 to 1 1/2 months ago a computer tablet was stolen from their room. R26 stated this had been reported verbally to staff but couldn't recall who that person was. R26 explained that the missing computer tablet was not written down on the lost and found form, and no one followed up so was unsure whether or not anyone was looking for the tablet. On 12/28/15, at 03:24 p.m. R40 stated someone had taken a charger cord for their cell phone and	31880	Corrected	

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explained that the charger had been plugged in, in his room. At 3:26 p.m. R40 stated residents were to write any missing items on the lost and found sheet and stated, "I never heard anything back. That's life. I learned my lesson about keeping it plugged in."

On 12/29/15, at 1:30 p.m. social service designee (SSD-B) stated she had not heard anything about missing socks for R12, a missing cell phone charger for R40 or a missing computer tablet for R26. At 1:35 p.m. the director of nurses stated not being aware of any of the missing items for R12, R26 or R40.

At 2:00 p.m. the administrator and licensed social worker (LSW-A) were interviewed and stated they were not aware of any of the missing items for R12, R26 or R40. The administrator stated the housekeeper who R12 reported to primarily worked weekends.

At 2:05 p.m. LSW-A reviewed with the surveyor, R12's team notes dated 12/18/15 to present and verified there was nothing documented about missing socks. LSW-A stated residents were to report to staff if there were any missing items and staff were to document in the nursing notes. LSW-A also stated there was a missing item form on the bulletin board which residents were to complete for any missing items.

On 12/29/15, at 2:10 p.m. licensed practical nurse (LPN)-B stated she had worked the afternoon shift on the weekend and nothing was reported to her about any missing socks for R12. LPN-B stated maybe the missing socks had been reported to the day nurse. LPN-B checked the 24 hour book and stated there was nothing there for 12/26/15 or 12/19/15 about missing socks for

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31880	Continued From page 26 R12. The 24 hour book was reviewed back to 10/31/15, and there was nothing documented about R12, R26 or R40's missing items. The Lost and Found form on the bulletin board was reviewed and documentation went back to 4/8/15, however, there was nothing documented about a missing tablet. Only R40's missing cell phone charger cord was documented as being missing on 12/7/15. At 2:27 p.m. LSW-A stated follow up was done on missing items and information regarding the missing item was to be documented in the Team Notes section of the medical record. A review of R26's Team Notes back to 9/26/15, and R40's Team Notes back to the date of admission 12/4/15, revealed there was no documentation about missing items or that any missing items had been found. 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 Hayes 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	31880		

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31880	Continued From page 27 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." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could assure that policies and procedures are current and educate and monitor to assure all appropriate staff investigate, act upon and follow up on reported missing property of residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31880		
31945	MN Rule 144A.13 Subd. 1 Complaints; Resident's Rights Subdivision 1. Processing. All matters relating to the operation of a nursing home which are the subject of a written complaint from a resident and which are received by a controlling person or employee of the nursing home shall be delivered to the facility's administrator for evaluation and action. Failure of the administrator within seven days of its receipt to resolve the complaint, or alternatively, the failure of the administrator to make a reply within seven days after its receipt to the complaining resident stating that the complaint did not constitute a valid objection to the nursing home ' s operations, shall be a violation of section 144A.10. If a complaint directly involves the activities of a nursing home administrator, the complaint shall be resolved in accordance with this section by a	31945		2/5/16

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31945	Continued From page 28 person, other than the administrator, duly authorized by the nursing home to investigate the complaint and implement any necessary corrective measures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unresolved grievances were acted on for 1 of 1 resident (R39) who voiced concerns to facility staff. Findings include: When interviewed on 12/28/15, at 7:00 p.m. in the bedroom, R39 expressed always being warm in the room and unable to spend too much time in the bedroom because it was too warm. The thermostat on the wall was registering the room temperature at 90 degrees Fahrenheit (F). R39 said the heat 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." Furthermore R39 expressed not being able to open a window to the outside because her window opened into the resident smoking area so there was no access to fresh air. During an observation of R39's 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 day room and expressed, the room is too warm to stay in. When interviewed on 12/29/15, at 10:00 a.m. licensed practical nurse (LPN)-C verified knowing R39 thought the room was too warm but stated that a resident concern form had not been filled out for R39 and explained that in the 10 years	31945	Corrected	

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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 concerns/grievances.

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 2015, there was not a system to document and follow through with resident concerns.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing or designee could assure that policies and procedures are current and educate and monitor staff to ensure unresolved grievances are acted on.

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