Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Hayes Residence
1620 Randolph Avenue
St. Paul, MN 55105
Ramsey County

Report #: HE508004

Date: December 17, 2013

Date of Visit: November 25, 2013
Time of Visit: 9:05 a.m. – 1:35 p.m.

By: Stephanie Richard, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: ____________

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect of health care occurred when the facility failed to provide a resident medication, from the date of admission, causing side effects.

An unannounced visit was made at this facility and an investigation was conducted under:

- ☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- ☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- ☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- ☐ Federal Regulations for EMTALA (42 CFR Part 489)
- ☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- ☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- ☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)

- [ ] State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of the evidence, neglect is substantiated. The facility did not ensure the resident received the psychotropic medication clozapine, as ordered by the resident's physician or the lab work to monitor potential negative effects from the medication.

The resident was admitted from a hospital where s/he had been treated for mental health issues. While hospitalized, the resident was stabilized with a series of electroshock treatments and the addition of clozapine to his/her medication regimen. The resident had a history of suicidal thinking and isolating him/herself due to psychosis and depression.

Clozapine requires blood testing for decreased white blood cells, a serious condition with the potential to affect the ability to fight infections. Clozapine requires a "titration" or slow introduction that is ordered by the physician and must be adhered to for safety.

The physician's discharge orders from the hospital, including clozapine, were transcribed onto the medication administration record (MAR). When no medication was available to be given to the resident, staff circled the medication indicating that it was not available. The MAR shows the medication was not given to the resident from the time of admission for 36 days.

Facility staff found the omission 30 days into the residents stay and contacted the inpatient psychiatrist. Because staff did not see the resident as isolating or agitated, the medication was "held" until the resident could be seen at a previously scheduled appointment with outpatient psychiatry. The appointment was scheduled for two weeks after the omission was realized by the facility.

The nurse that completed the resident's admission paperwork was interviewed. That nurse said that s/he received FAX confirmation that the pharmacy had received the orders. The pharmacy that monitors the lab work and dispenses the medication was contacted by the investigator; records showed the resident was not enrolled in the pharmacy program until four weeks after admission to the facility.

The resident's case manager was interviewed and said he took the resident out of the facility to run errands five times. Following the fifth outing with the resident, he reported to staff that the resident was showing symptoms of his/her mental illness. The resident was acting nervous, his/her voice was shaky and the resident raised his/her voice about another patron while at the bank. At that time, the nurse on duty asked the case manager if the resident's increased agitation and nervousness could be related to the omission of the medication clozapine.

Following that conversation, the nurse emergently obtained physician orders for laboratory work and clozapine. The resident received the first dose of clozapine on the 37th day following admission at 8:00 p.m., the medication was initiated according to a titration schedule.

The resident was interviewed and said s/he did not realize that a medication had not been given to him/her but that the care s/he was receiving was good.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility did not have procedures in place to ensure that if a prescribed medication is not available to be administered to a resident that it is investigated and action taken to ensure that the medication is made available.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: ___________
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☐ Facility Incident Reports

☒ Physician Progress Notes

☐ ADL (Activities of Daily Living) Flow Sheets

☒ Laboratory and X-ray Reports

☒ Physician Orders

☐ Social Service Notes

☒ Nurses Notes

☐ Meal Intake Records

☐ Activities Reports

☐ Weight Records

☐ Therapy and/or Ancillary Services Records

☒ Assessments

☐ Skin Assessments

☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: ____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: Clozaril & labwork

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: ____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility report

If unable to contact complainant, attempts were made on:
Date/time: ____ Date/time: ____ Date/time: ____

Interview with family: ○ Yes ◉ No ○ N/A Specify: Resident is responsible party

Did you interview the resident(s) identified in allegation: (•) Yes ( ) No ( ) N/A Specify: ________

Did you interview additional residents: (•) Yes ( ) No

Total number of resident interviews: 9

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: ________

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 4

Physician interviewed: ( ) Yes (•) No

Nurse Practitioner interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): ( ) Yes ( ) No (•) N/A Specify: ________

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ( ) Yes , date subpoena was issued ________ ( ) No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify ________

Observations were conducted related to:

☐ Wound Care	☒ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☒ Call Light	☐ Other: ________	

Was any involved equipment inspected: ( ) Yes ( ) No (•) N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: ________

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Minnesota Board of Pharmacy
St. Paul City Police Department
Ramsey County Attorney
St. Paul City Attorney

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	C 12/17/2013

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 000	INITIAL COMMENTS	F 000		
	An abbreviated standard survey was conducted to investigate complaint #HE508004. The following deficiency is issued:			
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

The facility must ensure that residents are free of any significant medication errors.

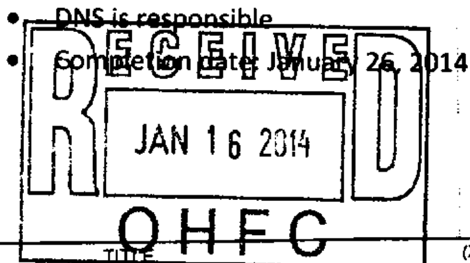
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure that one of three residents (R1) reviewed for medication errors, received all ordered doses of physician prescribed medications.

Findings are as follows:

R1's medical record was reviewed and showed R1 was admitted to the facility on 10/02/2013 from a hospital. R1 received treatment for schizoaffective disorder and suicidal thinking while hospitalized.

Hospital discharge papers dated 10/01/2013 were reviewed, R1 was admitted to the hospital July 22, 2013 for suicidal ideation, underwent 12 electroshock treatments and medication adjustments. Clozapine 200 mg (milligram) at bedtime was added to R1's medication regimen at the hospital. Clozapine is a psychotropic medication used to treat symptoms of schizophrenia. R1 did not have suicidal thinking when discharged from the hospital. Physicians discharge orders show clozapine 200 mg every

- Policies & procedures to ensure medications are made available for administration to residents have been reviewed and revised. Nursing staff have been educated/re-educated on the specific policies/procedures.
- The DNS/designee will conduct random audits to monitor compliance. DNS will report progress of audits to CQI Committee.
- The CQI Committee will provide direction or change when necessary & will dictate the continuation or completion of this monitoring process based on compliance noted.
- DNS is responsible
- Completion date January 26, 2014



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/14/14

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

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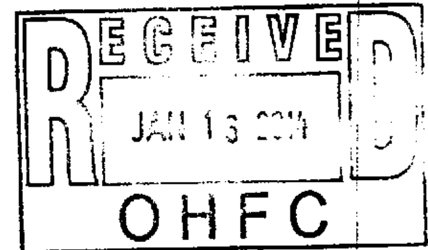
F 333	Continued From page 1	F 333		

night to continue at the facility.

R1's Care Plan was reviewed and revealed that R1 is at risk for impaired decision making, depression and suicidal thinking related to mental illness, interventions include taking medications as prescribed (medications not specified), encouraging R1 to interact with peers, relaxation techniques and staff checking with R1 regarding suicidal thinking.

R1's Medication Administration Record (MAR) dated 10/1/2013 through 10/31/2013 was reviewed and showed R1 was to receive clozapine 200 mg every HS (hour of sleep). The document reveals that R1 did not receive 30 doses of clozapine 200 mg in October 2013.

Review of the MAR dated 11/1/2013 through 11/30/2013 showed R1 received the first dose of clozapine 25 mg at 8:00 p.m. on 11/6/2013. The facility titrated the medication according to a standard titration schedule until the full dose of 200 mg was received by R1 on 11/19/2013 at 8:00 p.m. A total of 35 doses of clozapine were omitted from 10/2/2013 until 11/6/2013.



Documents from the pharmacy that monitors patients blood and dispenses the clozapine show that R1 was not enrolled in their system prior to 10/31/2013 when the facility contacted them to initiate clozapine therapy for R1. R1 should have been enrolled with the pharmacy on 10/2/2013, the day R1 was admitted to the facility.

Nursing Progress notes dated 11/5/2013 through 11/6/2013 reveal that in response to R1's increased symptoms of agitation and irritability, LPN-B obtained an order to have R1's blood

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F 333 Continued From page 2 F 333

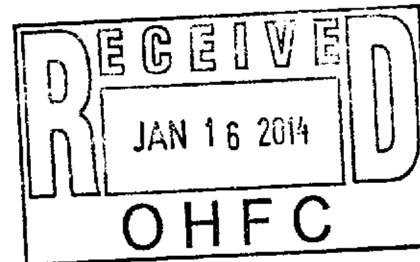
drawn emergently to monitor for agranulocytosis, an acute condition of decreased white blood cells, and the clozapine re-introduced via titration schedule.

The Nursing Drug Handbook, Lippincott, Williams & Wilkins, 2012; directs that the white blood count of patients be monitored due to risk of agranulocytosis, an acute condition of decreased white blood cells. If therapy is reinstated, follow standard guidelines for dosage increases (titration).

R1's case manager (CM) -D was interviewed and said that he drove R1 to the facility 10/2/2013 when R1 was discharged form the hospital. CM-D stated he had seen R1 several times during month of October. On 11/5/2013 while running errands with R1 CM-D observed R1 to be nervous and breathing heavily. Upon return to the facility CM-D told licensed practical nurse (LPN)-B that R1 appeared to be decompensating mentally, LPN-B asked CM-D at that time if he thought R1 needed clozapine.

LPN-B was interviewed on 11/25/2013 at 12:50 p.m. and said as the day charge nurse, she follows up on issues such as the availability of medications and communication with providers but she did not get a note from the evening staff letting her know the medication wasn't being given.

The director of nursing (DON) was interviewed on 11/25/2013 at 11:17 a.m. and said that the error occurred when staff did not question why the medication was on the MAR but not available. The circles indicating the medication was not given should have prompted the staff to question



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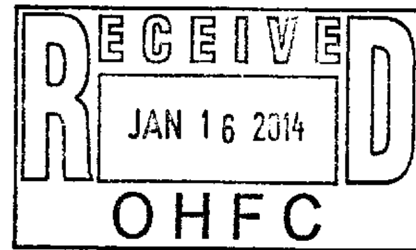
F 333	Continued From page 3 why and look into the matter instead of circling it and not questioning why the medication was not available.	F 333		



Minnesota Department of Health

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3 000	INITIAL COMMENTS	3 000		

*****ATTENTION******

BOARDING CARE HOME
LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

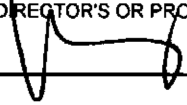
Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance 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:
A complaint investigation was conducted to investigate complaint #HE508004. The following correction order is issued.

RECEIVED
JAN 16 2014
OHFC

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.



TITLE Administrator (X6) DATE 1/14/14

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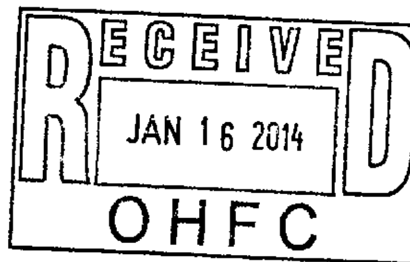
3 000	Continued From page 1	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.	
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.	31105		

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31105 Continued From page 2 31105

This MN Requirement is not met as evidenced by:
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Findings are as follows:

R1's medical record was reviewed and showed R1 was admitted to the facility on 10/02/2013 from a hospital. R1 received treatment for schizoaffective disorder and suicidal thinking while hospitalized.

Hospital discharge papers dated 10/01/2013 were reviewed, R1 was admitted to the hospital July 22, 2013 for suicidal ideation, underwent 12 electroshock treatments and medication adjustments. Clozapine 200 mg (milligram) at bedtime was added to R1's medication regimen at the hospital. Clozapine is a psychotropic medication used to treat symptoms of schizophrenia. R1 did not have suicidal thinking when discharged from the hospital. Physicians discharge orders show clozapine 200 mg every night to continue at the facility.

R1's Care Plan was reviewed and revealed that R1 is at risk for impaired decision making, depression and suicidal thinking related to mental illness, interventions include taking medications as prescribed (medications not specified), encouraging R1 to interact with peers, relaxation techniques and staff checking with R1 regarding suicidal thinking.

R1's Medication Administration Record (MAR) dated 10/1/2013 through 10/31/2013 was

- Policies & procedures to ensure medications are made available for administration to residents have been reviewed and revised. Nursing staff have been educated/re-educated on the specific policies/procedures.
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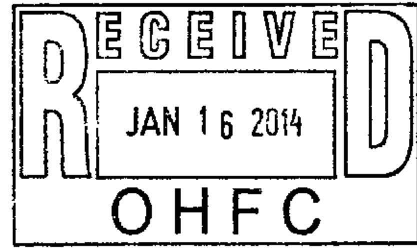

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31105	Continued From page 3	31105		

reviewed and showed R1 was to receive clozapine 200 mg every HS (hour of sleep). The document reveals that R1 did not receive 30 doses of clozapine 200 mg in October 2013.

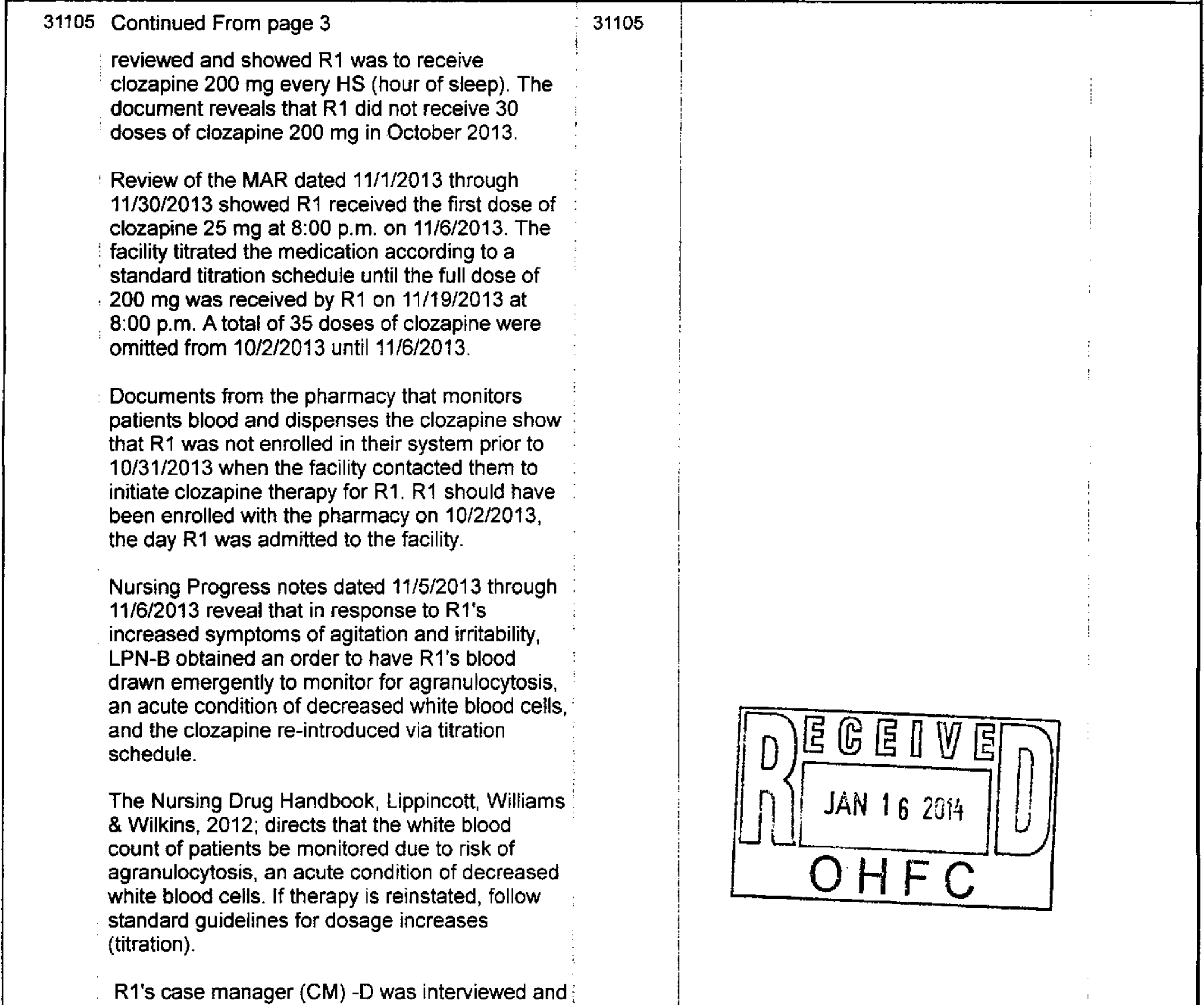
Review of the MAR dated 11/1/2013 through 11/30/2013 showed R1 received the first dose of clozapine 25 mg at 8:00 p.m. on 11/6/2013. The facility titrated the medication according to a standard titration schedule until the full dose of 200 mg was received by R1 on 11/19/2013 at 8:00 p.m. A total of 35 doses of clozapine were omitted from 10/2/2013 until 11/6/2013.

Documents from the pharmacy that monitors patients blood and dispenses the clozapine show that R1 was not enrolled in their system prior to 10/31/2013 when the facility contacted them to initiate clozapine therapy for R1. R1 should have been enrolled with the pharmacy on 10/2/2013, the day R1 was admitted to the facility.

Nursing Progress notes dated 11/5/2013 through 11/6/2013 reveal that in response to R1's increased symptoms of agitation and irritability, LPN-B obtained an order to have R1's blood drawn emergently to monitor for agranulocytosis, an acute condition of decreased white blood cells, and the clozapine re-introduced via titration schedule.

The Nursing Drug Handbook, Lippincott, Williams & Wilkins, 2012; directs that the white blood count of patients be monitored due to risk of agranulocytosis, an acute condition of decreased white blood cells. If therapy is reinstated, follow standard guidelines for dosage increases (titration).

R1's case manager (CM) -D was interviewed and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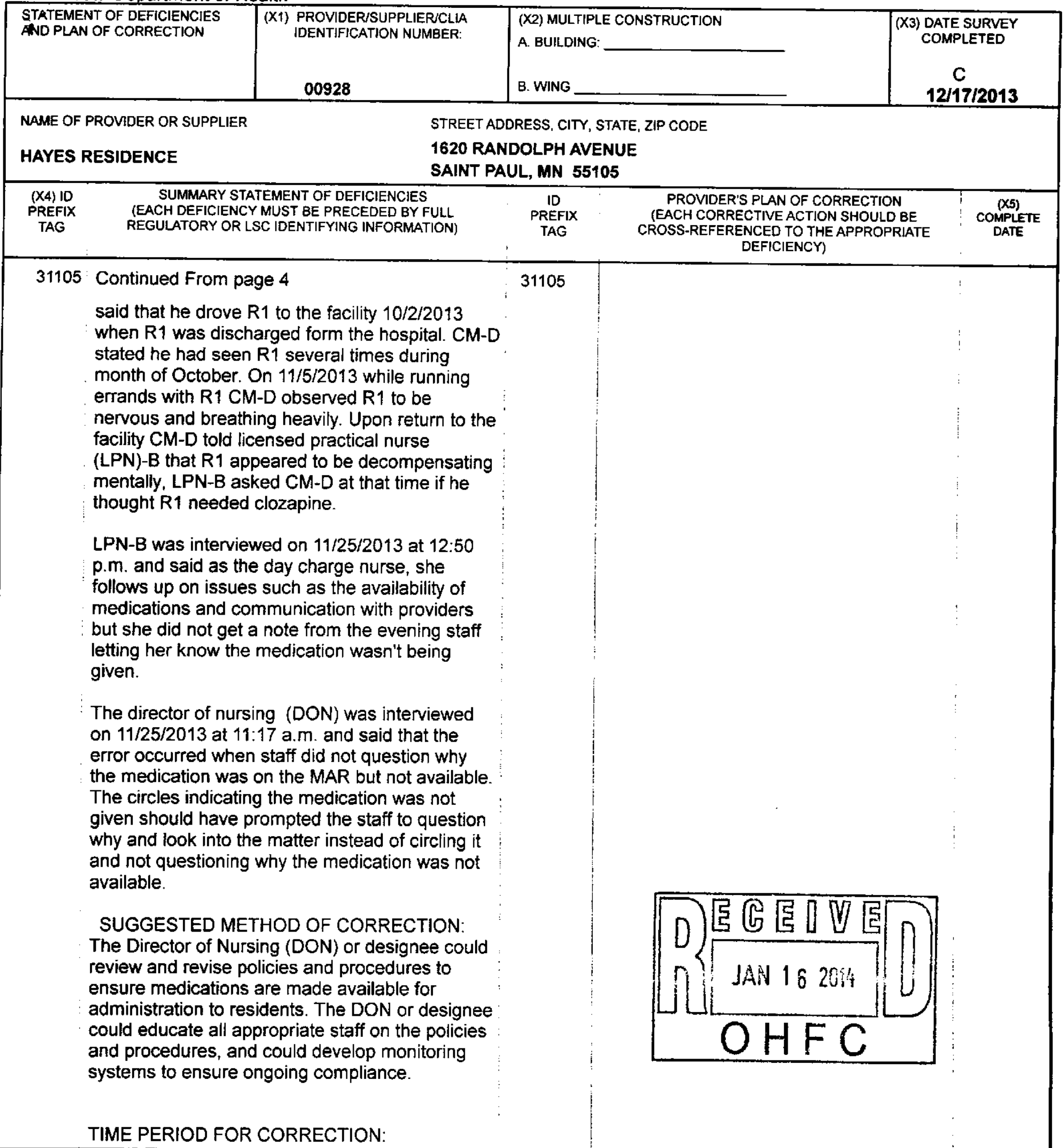

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00928	A. BUILDING: ____ B. WING ____	C 12/17/2013

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
31105	Continued From page 4	31105		

said that he drove R1 to the facility 10/2/2013 when R1 was discharged form the hospital. CM-D stated he had seen R1 several times during month of October. On 11/5/2013 while running errands with R1 CM-D observed R1 to be nervous and breathing heavily. Upon return to the facility CM-D told licensed practical nurse (LPN)-B that R1 appeared to be decompensating mentally, LPN-B asked CM-D at that time if he thought R1 needed clozapine.

LPN-B was interviewed on 11/25/2013 at 12:50 p.m. and said as the day charge nurse, she follows up on issues such as the availability of medications and communication with providers but she did not get a note from the evening staff letting her know the medication wasn't being given.

The director of nursing (DON) was interviewed on 11/25/2013 at 11:17 a.m. and said that the error occurred when staff did not question why the medication was on the MAR but not available. The circles indicating the medication was not given should have prompted the staff to question why and look into the matter instead of circling it and not questioning why the medication was not available.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could review and revise policies and procedures to ensure medications are made available for administration to residents. The DON or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	R 03/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An abbreviated standard survey was conducted to investigate complaint #HE508004.	{F 000}		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the care plan addressing smoking interventions were followed for 1 of 1 (R35) in the sample reviewed for accidents. Finding include: R 35 was found smoking in the bedroom, and the facility failed to follow smoking interventions for the resident.	F 282		

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

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

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F 282	Continued From page 1	F 282		

The medical record was reviewed on 3/6/14 at approximately 11:00 a.m. Progress note, dated 3/5/14 at 3:45 p.m. read: "Resident was seen smoking in room. approached by nurse and she {resident} said "you go out there, it is cold, I am not going out there". The progress continues to explain the nurse told the resident she needed to smoke out on the back patio. The note indicated there was some physical altercation between the resident and the nurse.
Another progress note, dated 3/5/14 with no time indicated, read "2nd nurse had to intervene during this time. Will monitor."

Progress note 3/5/14 At 4:15 p.m., "resident has continued to be verbally aggressive/abusive to roommate saying "You don't belong here, you don't pay rent, you need to get out of here etc. and I wont stop. Writer told reside her behavior was inappropriate and if she continues the police will be called or she will be sent out to crisis. RN here and writer asked her to talk to resident after explaining what has happened since the start. She has refused accucheck and insulin at 4:45 p.m."

Progress note dated: 2/?/14 (unable to read date), indicated resident was caught smoking in room, when asked where she got it from, she pointed to roommate who said she stole it from {resident's name}.

Review of the current care plan, dated 2/14/14, indicated R35 would be compliant with smoking rules of the facility. The care plan directed staff to store all cigarettes with nursing staff, the resident was to ask for one cigarette at a time when smoking during allowed smoking hours and the

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F 282	Continued From page 2	F 282		

resident does not smoke anywhere inside the facility. The resident would smoke only in approved areas of the facility.

On 3/6/14 at 11:40 a.m., licensed practical nurse (LPN-B) indicated R35 had been smoking in her room the previous afternoon. When R35 tried to dispose of the cigarettes in the trash bag (plastic bag), LPN-B tried to grab them. R35 grabbed at her arm and shirt. LPN-B was wearing a Band-Aid on her hand and indicated her underclothing had been ripped by R35. LPN-B indicated R35 had own cigarettes in her room. When asked LPN-B about what the current care plan indicated regarding staff storing the cigarettes, LPN-B indicated she was not aware R35 could not have cigarettes and stated that stopped awhile ago. LPN-B directed further questions to the social worker.

On 3/6/14 approximately 2:00 p.m., the social worker was asked about the smoking incident and how did R35 have access to cigarettes. The social worker indicated nursing staff were to store the cigarettes and give one cigarette at a time to R35. R35 was directed to smoke in the back patio right off the main dining room. The social worker was not aware R35 had access to own cigarettes. The social worker clarified with LPN-B the cigarettes of R35 were to be stored in the office and R35 should not have access to the cigarettes.

On 3/6/14 at approximately 3:50 p.m. the social worker confirmed the staff were not storing the cigarettes for R35 and therefore, not following the care plan for smoking.

F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 3 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the care plan addressing smoking interventions were followed for 1 of 1 (R35) in the sample reviewed for accidents. Finding include: R 35 was found smoking in the bedroom, and the facility failed to follow smoking interventions for the resident. The medical record was reviewed on 3/6/14 at approximately 11:00 a.m. Progress note, dated 3/5/14 at 3:45 p.m. read: "Resident was seen smoking in room. approached by nurse and she {resident} said "you go out there, it is cold, I am not going out there". The progress note continued to explain the nurse told the resident she needed to smoke out on the back patio. The note indicated there was some physical altercation between the resident and the nurse. Another progress note, dated 3/5/14 with no time indicated, read "2nd nurse had to intervene during this time. Will monitor."	F 323		

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F 323	Continued From page 4	F 323		

Progress note 3/5/14 At 4:15 p.m., "resident has continued to be verbally aggressive/abusive to roommate saying "You don't belong here, you don't pay rent, you need to get out of here etc. and I wont stop. Writer told reside her behavior was inappropriate and if she continues the police will be called or she will be sent out to crisis. RN here and writer asked her to talk to resident after explaining what has happened since the start. She has refused accucheck and insulin at 4:45 p.m."

Progress note dated: 2/?/14 (unable to read date), indicated resident was caught smoking in room, when asked where she got it from, she pointed to roommate who said she stole it from {resident's name}.

Review of the current care plan, dated 2/14/14, indicated R35 would be compliant with smoking rules of the facility. The care plan directed staff to store all cigarettes with nursing staff, the resident was to ask for one cigarette at a time when smoking during allowed smoking hours and the resident does not smoke anywhere inside the facility. The resident would smoke only in approved areas of the facility.

On 1/6/14 a self administration of smoking assessment was completed for R35. The Assessment indicated the resident was evaluated as independent for a smoking plan, and wanted to reduce from 4 to 3 cigarettes a day.

On 3/6/14 at 11:40 a.m., licensed practical nurse (LPN-B) indicated R35 had been smoking in her room the previous afternoon. When R35 tried to dispose of the cigarettes in the trash bag (plastic bag), LPN-B tried to grab them. R35 grabbed at

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F 323	Continued From page 5	F 323		

her arm and shirt. LPN-B was wearing a Band-Aid on her hand and indicated her underclothing had been ripped by R35. LPN-B indicated R35 had own cigarettes in her room. When mentioned to LPN-B about the current care plan indicated regarding staff storing the cigarettes, LPN-B indicated she was not aware R35 could not have cigarettes and stated that stopped awhile ago. LPN-B directed further questions to the social worker.

On 3/6/14 approximately 2:00 p.m., the social worker was asked about the smoking incident and how did R35 have access to cigarettes. The social worker indicated nursing staff were to store the cigarettes and give one cigarette at a time to R35. R35 was directed to smoke in the back patio right off the main dining room. The social worker was not aware R35 had access to own cigarettes. The social worker clarified with LPN-B the cigarettes of R35 were to be stored in the office and R35 should not have access to the cigarettes. At 3:30 p.m., after the change of shift for the nursing staff, the social worker informed LPN-C that R35 should not have cigarettes in the private room and that staff should be handing out one cigarette and lighter at a time.

On 3/6/14 at approximately 3:50 p.m. the social worker confirmed the staff were not storing the cigarettes for R35, not giving R35 one cigarette at a time and therefore, not following the care plan for smoking.

The Smoking Policy, last revised on 5/9/13 with additional updates made by the social worker on 3/6/14, indicated that smoking was not permitted in any part of the building but was permitted on the south side of the screen porch or patio from

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

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{F 431}	Continued From page 7 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to ensure medications were labeled properly and discarded from use when discontinued for 2 of 2 residents. (R21 and R36). Findings include: During observation of the medication storage refrigerator, 10 bisacodyl suppositories were stored in a clear small plastic bag. The bag had a partial label on the exterior of the bag. Four letters of resident's name were noted as well as partial instructions were noted on the label. When LPN-B was asked about them, LPN-B identified what patient they were for and stated" he has not used them for awhile". During observation of the medication cart 1, two tubes of erythromycin ointment were found for R36. The order had been stopped on 11/08/13, however, the ointment tubes remained in the cart for dispensing. The trained medication assistant (TMA-B) wasn't sure why they remained in the cart. The items were removed from the refrigerator	{F 431}		

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{F 431}	Continued From page 8 and the medication cart. No audits, part of the correction plan, were available during the post certification survey. The director of nursing was not available during survey. On 3/5/14 at approximately 5:00 p.m., a registered nurse (RN-A) was called in to the facility to answer questions. On 3/5/14 at 5:00 p.m., the registered nurse (RN-A) was interviewed. RN-A was responsible for completing the minimum data sets for residents and completing all admissions and discharges for the facility. At this time, RN-A verified the suppositories and the eye ointment should have been disposed of earlier. RN-A would look for additional information regarding policy and procedures and correction steps and leave for further review. The Pharmacy Services policy, dated 1/16/2014, indicated the facility in coordination with Licensed Pharmacist, will ensure that medications and biological's are labeled with expiration date and expired medications are discarded per procedure. Review of R21 record revealed a diagnoses of constipation and a physician order for bisacodyl (ducal) 10 mg suppository for as needed basis. Review of R36's medical record revealed a physician order for erythromycin eye ointment and direct staff to instill a thin ribbon to each eye at bedtime for 90 days. The start date for the order was 8/13/13 and was discontinued 11/12/13.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	{F 441}		

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{F 441}	Continued From page 9	{F 441}		

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.

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{F 441}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure glove changing and hand washing were completed during used during blood glucose monitoring to prevent the spread of infection for 5 of 6 residents(R3, R35, R2, R18, R10) and the facility failed to provide documentation of tuberculin skin tests (TST) for new employees per Center for Disease Control and Prevention (CDC) guidelines. Findings include: Five residents had their glucose monitoring and received insulin with assistance from the licensed practical nurse (LPN)and LPN-D did not provide consistent glove wearing or hand washing. On 3/4/14 at 4:45 p.m., LPN-D set out blood glucose supplies for R3 that included a glucometer, alcohol pad, lancet, cotton ball and monitoring slip. R3 does own stick but needs assistance with the monitoring slip from the LPN-D. LPN-D administers the medication, and removes gloves. LPN-D then wipes down the glucometer with an alcohol pad, puts it back in the case and then plastic bag. LPN-D then washes her hands. R35 comes into the nursing station to have blood sugar monitored. Again LPN-D set up equipment needed for monitoring the blood. After administering insulin to R35, LPN-D removed the gloves. LPN-D picked up the glucometer and wipes off with a alcohol pad without wearing gloves. The glucometer was then placed into a plastic zip lock bag.	{F 441}		

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HAYES RESIDENCE	1620 RANDOLPH AVENUE SAINT PAUL, MN 55105

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	R 03/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 12 individual glucometer, the LPN indicated gloves should be worn when picking things up, and while cleaning the glucometers. On 3/5/14 at 4:30 p.m., the registered nurse for MDS, (RN) was called in to assist with survey. After reviewing the procedure of obtaining blood sugars and dispensing insulin, picking up soiled items and cleansing the glucometers with alcohol, the RN verified the nurse conducting the finger sticks should have worn gloves while cleaning up soiled items, and should have worn gloves while cleaning the individual glucometers with a alcohol pad. At this time the RN was asked about policies regarding hand washing and glucometer cleansing. The RN indicated she would see what she could find and leave all policy/procedures that were developed for corrections. On 3/6/14 at 09:00 a.m. the Blood Glucose Monitoring Policy and Procedure , written 1/13/14, was reviewed. the policy statement indicated the facility will prevent cross contamination using transmission based precautions in addition to standard precautions. and Procedure statement indicated that each resident with a diagnosis of diabetes and wherein diabetic blood glucose monitoring is warranted, s/he will have their own blood glucose monitoring kit for blood glucose testing. The facility failed to provide documented results of a tuberculin skin test (TST) for new hires per Centers for Disease Control and Prevention (CDC) recommendations. On entrance on 3/4/14 at approximately 12:00 noon, the office manager was questioned regarding potential recent new hires. The office	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. BUILDING ______ B. WING ______	R 03/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 13 manager indicated there had been at least one new hire of a housekeeper however, there was no access to the employee record. The office manager indicated the employee files were maintained in the Assistant Administrator ' s office. The Assistant Administrator was on annual leave, and the office was locked. No one working had access to the office. On 3/5/14 at 4:30 p.m., the registered nurse (RN), was interviewed about new and rewritten policies for infection control. It was agreed that she would look for additional policies and make them available for review the next day. When information provided by the RN was reviewed on 3/6/14 at 9:30 a.m., there was no policy identified for tuberculin skin test. The RN was not available for further interview at the facility. The Director of Nursing was not available during the three days of survey at the facility.	{F 441}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

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

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	03/19/2014	22581	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
1/16/2014

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

AH Form Approved
3/19/2014

State Form: Revisit Report

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

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 31455 Reg. # MN Rule 4655.9000 Subp. LSC	Correction Completed 02/20/2014	ID Prefix 31810 Reg. # MN Rule 144.651 Subd. 6 LSC	Correction Completed 02/20/2014	ID Prefix 32000 Reg. # MN Rule 626.557 Subd. 14 LSC	Correction Completed 02/20/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	03/19/2014	22581	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/16/2014

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

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Hayes Residence
1620 Randolph Avenue
St. Paul, MN 55105
Ramsey County

Report #: HE508004

Date: March 18, 2014

Date of Visit: March 4-7, 2014

By: Sheryl Reed, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one federal deficiency and one state licensing order which were issued on January 6, 2014, as the result of an investigation which had been completed on December 17, 2013.

The status of the order is as follow:
1 MN Rule 4655.7810 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

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

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

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0333 Reg. # 483.25(m)(2) LSC	Correction Completed 03/07/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/AK	03/19/2014	22581	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/17/2013

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

AH Form Approved
3/19/2014

State Form: Revisit Report

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

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

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 31105 Reg. # MN Rule 4655.7810 LSC	Correction Completed 03/07/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/AK	03/19/2014	22581	03/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/17/2013				