

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  24E508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Hayes Residence		STREET ADDRESS, CITY, STATE, ZIP CODE  1620 Randolph Avenue Saint Paul, MN 55105	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</b></p> <p>Based on observation, interview, and document review, the facility failed to comprehensively assess, discuss risks and benefits, and attempt alternatives prior to installation of grab bars for 1 of 1 residents (R31) who were observed to have grab bars affixed to their bed.</p> <p>Findings include:</p> <p>R31's admission Minimum Data Set (MDS) dated [DATE], indicated R31 was cognitively intact and had diagnoses of alcohol use and neuropathy. R31 was independent with rolling side to side and moving from lying to sitting in bed.</p> <p>R31's physical device review dated 8/29/24, lacked indication R31 was assessed or had been educated on the risks of grab bars or had attempted alternatives prior to installation of grab bars.</p> <p>R31's care plan dated 9/8/24, indicated R31 was independent in bed mobility. R31's care plan lacked indication R31 used a grab bar for assistance.</p> <p>R31's provider and nursing orders lacked indication R31 required a grab bar.</p> <p>An observation on 9/22/24 at 11:05 a.m., R31 was sitting on their bed. R31's bed was placed close to the wall and on the left side of the bed was a circle grab bar. R31 stated the grab bar was on the bed since they arrived. R31 used the bar sometimes at night when the room was dark.</p> <p>When interviewed on 9/23/24 at 1:34 p.m., registered nurse (RN)-A stated grab bars were used to help residents turn in bed or get up out of bed. If a resident required a grab bars then maintenance was notified to place them. RN-A wasn't sure if there was any other assessment completed other than a mobility assessment. RN-A wasn't aware of R31 having a grab bar and verified with the resident there was one on the bed. RN-A verified R31's care plan did not identify R31 required a grab bar for mobility assistance.</p> <p>When interviewed on 9/24/24 at 11:29 a.m., the Director of Nursing (DON) stated the MDS nurse usually completed the assessments for grab bars or any assistance devices. The assessment would include the resident's mobility and a visual inspection to determine safe use of the bar. DON expected the assessment as well as a provider order to be completed with residents who have grab bars in place.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 24E508
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F 0700  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	A facility policy titled Use of Side Rail, Grab Bar on Resident Beds revised 9/22/23, directed staff to attempt alternatives prior to installation of grab bars and complete an assessment to determine the need for grab bars and risk of entrapment, and educate the resident of the risks and benefits of grab bars.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46885</p> <p>Based on observation, interview, and document review the facility failed to ensure food items were properly labeled and dated and disposed of. Furthermore, the facility failed to maintain clean cooking equipment. This had the potential to affect all residents who ate food from the kitchen.</p> <p>Findings include:</p> <p>During the initial tour with cook (C)-A on 9/22/24 at 10:28 a.m., observed the following:</p> <p>Refrigerator:</p> <p>A tray of juices and milks uncovered in the refrigerator. C-A stated it would be tossed out.</p> <p>Lettuce that had yellowish brown discoloration and was undated. C-A stated it would be tossed out and verified it was undated.</p> <p>A 16 ounce bottle of barbeque sauce with barbeque sauce located around the outside of the lid. C-A took it out of the refrigerator and stated it would get wiped down.</p> <p>Freezers:</p> <p>A package of 10 beef patties in a bag that was twisted shut with no date. C-A stated they were beef patties and verified they were undated.</p> <p>A blue bag of fish that was undated.</p> <p>Equipment:</p> <p>A KitchenAid contained yellow particles along the top where the attachments connect and a powdery substance was located on the handle. C-A stated the KitchenAid was used for icing or for making cakes and further stated she did not use the KitchenAid on 9/22/24, and stated the KitchenAid was supposed to be cleaned after use and did not know what the yellow particles were, and stated there was cake mix on the handle and stated it should have already been cleaned by whoever used it last.</p> <p>During interview on 9/23/24, the certified dietary manager (CDM)-A stated foods should be dated and labeled and further stated she placed the dates on there the morning of 9/23/24.</p> <p>A policy, Dating and Labeling Opened Foods and Juices, dated 10/16/23, indicated all employees will date and label each food and juice item opened with the date in which it was opened and the name of the product. Foods that need to be stored in airtight container will also have date in which it was contained. All perishable items with out expiration date will be discarded after 3 days of opening.</p> <p>(continued on next page)</p>		

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	A policy, Equipment Cleaning, dated 8/1/22, indicated all equipment shall be cleaned and sanitized after each use or following any interruption of operation during which contamination may have occurred. This begins by removing any physical contaminants from the equipment, then cleaning it with an appropriate solution, then rinsing this solution from the equipment, and then sanitizing the equipment to finish.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44647</p> <p>Based on observation, interview, and document review the facility failed to ensure clean linen was transported and stored in a manner to prevent the spread of infection. This had the potential to impact all 31 residents who reside in the facility.</p> <p>Findings include:</p> <p>An observation on 9/23/24 at 8:25 a.m., housekeeper (HSK)-A had brought up a cart of linens from downstairs. The cart contained fitted sheets, flat sheets, pillowcases, and fabric incontinent protector/pads. The linens were not covered during transport. The cart was transported down past residents and resident rooms and stored on the far end of the east hallway.</p> <p>An observation on 9/23/24 at 12:07 p.m., the same linen cart was now halfway down the west hallway. The cart contained less linens than earlier. The linens remained uncovered. At 12:10 p.m., HSK-B pushed the uncovered linen cart to the middle hallway just outside of the dining room. Residents were coming and going from the dining room for lunch and moving past the uncovered cart.</p> <p>When interviewed on 9/23/24 at 12:12 p.m., HSK-B was not sure if the linen cart needed to be covered when transported or when on the resident hallways.</p> <p>When interviewed on 9/23/24 at 12:17 p.m., HSK-A stated every Monday they changed the sheets and blankets on resident beds and usually it would be completed by now, but it was just taking longer today. HSK-A verified there was a lot of resident traffic on the unit with lunch and stated usually they try to place the cart in a less busy area. HSK-A acknowledged the linen cart should be covered during transport and on the unit.</p> <p>When interviewed on 9/24/24 at 10:46 a.m., the infection preventionist (IP) expected staff to have linens covered when transported or when in the hallways. This was to help prevent infection.</p> <p>A facility policy titled Laundry for Soiled Linens and clothing revised 9/20/23, directed staff to fold linens into piles of like items and stock storage cabinets and bed making cart. The policy lacked direction of how staff were to transport clean linen or if linen was required to be covered when stored on resident units.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</b></p> <p>Based on interview and document review the facility failed to ensure 2 of 5 residents (R31, R1) were accurately assessed and offered the pneumococcal vaccination according to the Centers of Disease Control (CDC).</p> <p>Findings include:</p> <p>R31's admission Minimum Data Set (MDS) dated [DATE], indicated R31 was [AGE] years old, was cognitively intact and had diagnoses of alcohol use and nicotine dependence. Furthermore R31's MDS indicated R31 was not offered the pneumococcal vaccination.</p> <p>R31's Minnesota Information Connection (MIIC) printed 9/24/24, indicated R31 had no prior pneumococcal vaccinations.</p> <p>The CDC identified on the Pneumococcal Vaccine Timing for Adults Chart, dated 3/15/23, directed residents 19-[AGE] years of age who had no history of previous vaccination and a risk factor of smoking to give one dose of pneumococcal 15-valent Conjugate Vaccine (PCV15), pneumococcal 20-valent Conjugate Vaccine (PCV20), or pneumococcal 21-valent Conjugate Vaccine (PCV21).</p> <p>R31's paper and electronic medical record lacked evidence staff had assessed R31's pneumococcal status or offered the pneumococcal vaccination prior to survey entrance on 9/22/24.</p> <p>R1's quarterly MDS dated [DATE], indicated R1 was [AGE] years old, had moderate cognitive impairment and diagnoses of diabetes and lung disease. Furthermore, R31's MDS indicated R31 was up to date for the pneumococcal vaccination.</p> <p>R1's immunization record reviewed 9/23/24, indicated R1 had previously received Prevnar 13 on 9/8/16 and 10/31/18. R1 had received pneumococcal polysaccharide vaccine 23 (PPSV23) on 1/21/13 and on 10/24/17.</p> <p>The CDC identified on the Pneumococcal Vaccine Timing for Adults Chart, dated 3/15/23, directed residents [AGE] years of age who had who had not previously received the PCV15, PCV20, or the PCV21, and had previously received the PCV13 and also the PPSV23 after the age of 65 required shared clinical decision making between the provider and resident on offering the PCV20 or PCV21.</p> <p>R31's paper and electronic medical record lacked evidence staff had accurately assessed R31's pneumococcal status or that shared clinical decision making had taken place to determine if R1 should receive the PCV20 or PCV21 prior to survey entrance on 9/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 9/24/24 at 10:46 a.m., the Infection Preventionist (IP) who was also the Director of Nursing (DON) stated the vaccination status of residents was assessed and determined upon admission. This was by reviewing the hospital paperwork and obtaining a MIIC report. If the need for a pneumococcal vaccine was determined, the resident was educated and either consented or declined. Then usually each year all residents were reassessed to determine if they were not eligible for a vaccination or to education and offer again. The IP stated the assistant DON who reviewed the immunizations was no longer with the facility and it was currently up to the IP or the MDS nurse to complete.</p> <p>A follow up interview on 9/24/24 at 207 p.m., the IP verified R31 had not been assessed and due to the smoking status should have been offered the pneumococcal vaccine. R1 also could receive an additional dose if the resident and provider believed it was necessary. IP stated on R1's MIIC report, it stated the pneumococcal vaccinations were complete and so R1 was not further assessed for the additional dose. IP stated R31 and R1 were being followed up upon.</p> <p>A facility policy titled Influenza, Pneumococcal, COVID-19 vaccinations revised 7/31/24, directed staff to utilize the CDC vaccination guidance and definitions to determine eligibility and up to date status. Furthermore, upon admission staff were directed for pneumococcal vaccines to be given if applicable and all residents will be offered the pneumococcal immunization unless medically contraindicated or the resident had already been immunized during the appropriate time frame.</p>		