DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 22, 2026

Administrator
Carondelet Village Care Center
525 FAIRVIEW AVENUE SOUTH
SAINT PAUL, MN 55116

RE: CCN: 245617

Cycle Start Date: November 20, 2025

Dear Administrator:

On January 21, 2206, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 9, 2025

Administrator
Carondelet Village Care Center

525 FAIRVIEW AVENUE SOUTH
SAINT PAUL, MN 55116

RE: CCN:245617

Cycle Start Date: November 20, 2025

Dear Administrator:

On November 20, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by February 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101

Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carondelet Village Care Center	**525 FAIRVIEW AVENUE SOUTH , SAINT PAUL, Minnesota, 55116**

(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
E0000	Initial Comments On 11/17/25, through 11/20/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		12/17/2025
F0000	INITIAL COMMENTS On 11/17/25, through 11/20/25 , a standard recertification survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		12/17/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	01/13/2026

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 reverse for further 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

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F0689 SS = D	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions for 1 of 1 resident (R34) reviewed with a history of falls. Findings include: Findings: R34's Optional State Assessment (OSA) dated 8/8/25, indicated moderate cognitive impairment, did not reject care, required extensive assistance with bed mobility, transfers, and toilet use. R34's quarterly Minimum Data Set (MDS) dated 8/8/25, indicated R34 used a walker and wheelchair, had Parkinsonism (a syndrome characterized by different movement disorders such as walking and balance problems), heart failure, non-Alzheimer's dementia, and an artificial hip joint. Further, R34 fell two or more times with no injury since the prior assessment and fell one time with a non-major injury. R34's care sheet updated 11/17/25, indicated R34 required assist of one with a gait belt and rolling walker to use the bathroom and further indicated R34's walker was to always remain within reach because R34 self-transferred in the room and was at risk for falling. R34's care plan dated 8/19/25, indicated R34 had limited physical mobility due to Parkinsonism, cardiac disease and would self-transfer or self-ambulate often when in the room with or without adaptive equipment and required assist of 1 staff for transfers and ambulation. R34 had impaired cognition and required cueing, reorienting, and supervision as needed, additionally R34 was incontinent. R34 was at risk for falls due to dementia, Parkinsonism, and heart disease and required signage on the walker to remind R34 to take it with wherever she went. R34's Resident Occurrence Report dated 4/29/25, indicated R34 had fallen in her room, sustained a hip fracture and interdisciplinary team (IDT) interventions were deferred until R34 returned from the hospital. A	F0689	Continued from page 1 The Fall prevention and management Program Policy and the Resident Transfer Assessment Policy were reviewed and remain in effect. Carondelet Village continues to adhere to the policies noted to keep our residents, staff, and visitors safe. It remains the expectation for staff to follow these policies to help prevent falls. R34 remains in the facility and did not experience any negative outcomes as a result of the walker not being within reach. The IDT team met to discuss the walker being within reach during the day; the walker should be removed in the evening due to her increasing confusion. The care plan and care sheet were updated to reflect these changes. Nursing staff identified during the survey as not following the Fall policy and Resident Transfer Assessment Policies were coached on the importance of following said policies. Facility completed whole house audits on adherence to the Fall Policy and Resident Transfer Assessment Policies to ensure residents have appropriate interventions in place to help prevent falls. Education on the Fall Prevention and Management Program Policy and Resident Transfer Assessment Policies will be completed with ALL nursing staff and education to ensure staff are following resident plan of care with interventions identified. Random audits have been initiated and will be completed on 10% of residents regarding compliance with the policies and interventions for residents weekly for four weeks. Results will be reported to the QA committee, and the need for ongoing audits and action plans will be initiated as appropriate. The Clinical Administrator, in coordination with the Clinical Coordinators, will be responsible for ongoing compliance. The date for compliance is January 13, 2026.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 2 handwritten note on the form indicated physical therapy (PT) and occupational therapy (OT) was initiated with a review date 5/7/25. R34's Resident Occurrence Report dated 6/22/25, indicated R34 fell while standing and washing her hands and the long-term interventions included R34 being in her wheelchair for all cares. Additionally, staff were educated on the use of a gait belt and use of a walker when completing cares. R34's Resident Occurrence Report and Falls Follow Up Forms dated 7/4/25, indicated R34 was on the floor and had a bump and bruise to the top of her right hand. Further, a long-term intervention included a sign was placed to always keep the walker with R34. R34's Resident Occurrence Report and Falls Follow Up Form dated 8/20/25, indicated R34 did not have her walker and fell going back to bed and sustained an abrasion and laceration. Further, the form indicated R34's walker was not within reach and staff were educated to keep the walker by R34 and follow the care plan. R34's care conference note dated 8/25/25, indicated R34 fell recently and sustained a laceration of her forehead and a skin tear on her wrist. Additionally, staff were re-educated to always have the walker right beside R34. During observation on 11/18/25 at 9:50 a.m., licensed practical nurse (LPN)-A left R34's room and R34's walker was folded up against the wall next to R34's television. A nebulizer was heard running and LPN-A stated she would be back. R34 was not observed to be near the walker. During interview and observation on 11/18/25 at 9:56 a.m., LPN-A verified R34 was receiving a nebulizer in her room. During observation on 11/18/25 at 10:00 a.m., LPN-A went into R34's room and turned off the nebulizer. R34's walker was still folded up by the television. At 10:02 a.m., LPN-A walked out of R34's room and the walker remained folded next to the television and away	F0689		

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F0689 SS = D	Continued from page 3 from R34. During observation on 11/18/25 at 10:04 a.m., R34 was in her wheelchair in her room with the call light next to her. Signage was located on the walker that indicated to always keep the walker with R34. R34's walker was folded in the corner by the television and out of R34's reach. During interview and observation on 11/18/25 at 10:07 a.m., nursing assistant (NA)-A stated they looked at the care plan to know what cares a resident required. NA-A stated R34 hadn't fallen recently but was at risk for falling and was supposed to have the walker with her at all times in case R34 tried to self-transfer to aide in her balance and further stated R34 even had a sign on her walker as a reminder. NA-A verified R34's walker was in the corner and stated the walker should be by R34. NA-A unfolded the walker and placed it next to R34. During interview on 11/18/25 at 10:12 a.m., LPN-A stated nurses looked at the care plan to know what cares a resident required and the NA's used care sheets. During interview on 11/18/25 at 10:17 a.m., NA-B viewed R34's care sheet dated 11/17/25, and verified the care sheet indicated R34's walker was to be kept within reach at all times. NA-B stated R34 needed the walker because she tried to get out of the chair or bed by herself and was prone to falls. During interview on 11/18/25 at 10:20 a.m., LPN-A stated care sheets were updated with the care plan and added she hadn't worked in R34's neighborhood for approximately four months and stated R34 needed the walker in case R34 got up on her own and if R34 didn't have her walker, her safety would be at risk. LPN-A further stated it was on R34's care plan to be within reach and added R34 could get up on her own and suffer injuries from a fall that possibly could have been prevented. LPN-A acknowledged she was not previously aware it was part of R34's care plan. During interview on 11/18/25 at 1:23 registered nurse (RN)-A stated staff entered the resident room after a fall to determine the cause and document the fall in	F0689		

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F0689 SS = D	Continued from page 4 the electronic medical record (EMR). A falls form was completed by floor staff. The clinical coordinators conducted the investigation. Falls were discussed at IDT, an intervention was implemented. After a week, the intervention was re-evaluated to determine if the intervention was effective. RN-A stated she expected the care sheet to be followed. During interview on 11/18/25 at 1:47 p.m., physical therapist (PT)-A stated R34 was seen by PT and was on a walking program. PT-A stated R34 was at risk for falls due to Parkinsonism and a history of falling and further stated R34 was probably impulsive; if R34 self-transferred, it would be better to have the walker with her at all times and expected the care sheet to be followed. During interview on 11/18/25 at 2:46 p.m., with the director of nursing (DON) and the regional director of clinical services (RDCS), the DON stated R34 fell during a self-transfer in July and IDT placed a sign to keep the walker with R34 at all times and stated they expected staff to keep the walker with R34 at all times. Further, when R34 fell on 8/20/25, the DON verified R34 did not have her walker within reach and RDCS stated staff were educated to follow the care plan. A policy, Fall Prevention and Management Program Policy, dated 9/2025, indicated the purpose of the policy was to provide a procedure for residents at risk for falls, assess fall risk factors, provide guidelines for fall and repeat fall preventative interventions. Prevention strategies include care plans will indicate the resident specific interventions to prevent falls. All staff are responsible for implementing the intent and directives contained within the policy and creating a safe environment.	F0689		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side	F0883	The Influenza and Pneumococcal Immunizations policies were reviewed and remain in effect. R34 and R38 were both given pneumovax vaccine and are now current and up to date. No negative outcomes occurred because of not receiving the vaccines prior. Infection control nurse was re-educated on ensuring influenza and Pneumococcal Vaccines need to be up to date with consent received, and to help coordinate its administration at the site.	01/13/2026

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F0883 SS = D	Continued from page 5 effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883	Continued from page 5 Facility completed whole house audits on adherence to the Pneumococcal and influenza Policies to ensure all residents have received the appropriate consents who were identified as not current. All residents who consented to vaccines will be administered to the residents by 12/29/2025. Education on the on Pneumococcal and Influenza vaccines will be completed with ALL nursing staff and education to ensure nurses are getting consents and administering vaccines as appropriate. Random audits have been initiated and will be completed on 10% of residents regarding compliance with the policies and interventions for residents weekly for four weeks. Results will be reported to the QA committee, and the need for ongoing audits and action plans will be initiated as appropriate. The Clinical Administrator, in coordination with the Infection Control Nurse, will be responsible for ongoing compliance. The date for compliance is January 13, 2026.	

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F0883 SS = D	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R34, R38) were offered and/or provided updated vaccination for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings: Review of the current, 10/26/24, Centers for Disease Control (CDC) Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old. Additionally, if an adult 50 years or older received PCV13 only, a single dose of PCV21 or PCV20 may be given after one year of receiving the PCV13 dose. R34: R34's quarterly Minimum Data Set (MDS) dated 8/8/25, indicated R34 admitted 12/4/24, and further, R34's pneumococcal vaccine was up to date. R34's Physician's Orders form indicated the following order:· 12/4/24, may receive pneumococcal vaccinations if not already received.R34's Pneumococcal Vaccinations Consent form signed 12/4/24, indicated R34 wanted to receive the pneumococcal vaccinations that were recommended according to ACIP/CDC. R34's Minnesota Immunization Report (MIIC) dated 12/19/24, indicated R34 received PPSV23 on 3/25/2005, and PCV13 on 2/23/15. R34's Care Conference Summary note dated 5/19/25 indicated R34 was due for a pneumococcal vaccination. R34's Immunizations form saved 11/19/25, indicated R34 was 89 years old and received PPSV23 on 3/25/2005, and PCV13 on 2/23/15. The form lacked information R34 received PCV20 or PCV21. R34's medical record was reviewed and lacked evidence a shared clinical decision-making conversation took place or that R34 received PCV20 or PCV21.	F0883		

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Carondelet Village Care Center	525 FAIRVIEW AVENUE SOUTH , SAINT PAUL, Minnesota, 55116

(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
F0883 SS = D	Continued from page 7 R38: R38's comprehensive MDS dated 10/22/25, indicated R38 admitted to the facility 10/16/25, and R34's pneumococcal vaccinations were up to date. R38's Physician's Orders form indicated R38 was 88 years old and had an order dated 10/16/25, to receive pneumococcal vaccinations if not already received. R38's medication administration record (MAR) and treatment administration record (TAR) dated October 2025 and November 2025 were reviewed and lacked information R38 received pneumococcal vaccinations. R38's Pneumococcal Vaccinations Consent form dated 10/16/25, indicated R38's pneumococcal vaccination status was up to date. R38's Immunizations form indicated R38 received PCV13 on 9/15/2015. No other pneumococcal vaccinations were documented as administered. The form lacked information PCV20 or PCV21 was administered at least 1 year after PCV13 was given. During interview on 11/19/25 at 1:32 p.m., with the infection preventionist (IP) and regional director of clinical services (RDCS), the IP stated on admission, the health unit coordinator accesses the MIIC, and the facility provides information on the pneumococcal vaccine and obtain consents. IP stated they used the CDC PneumoRecs Advisor application for use in determining residents eligible for vaccination and stated R34 was due for additional vaccination and would check to see if a conversation took place. Further, RDCS would check the MIIC for R38 and verified R38 was also due for another pneumococcal vaccination. During interview on 11/19/25 at 3:12 p.m., IP stated she would ask for an order for the pneumococcal vaccination for R38 and would update R38's family and would investigate whether a conversation took place for R34. During interview on 11/20/25 at 11:04 a.m., with RDCS and the director of nursing, the RDCS verified information in R34's and R38's medical record was correct. The DON stated they had vaccination plans and RDCS stated when a resident admitted to the facility, pneumococcal vaccinations were administered and further stated R34 and R38, "missed them," and should have gotten the vaccinations. During interview on 11/20/25 at 11:21 a.m., IP stated	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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F0883 SS = D	Continued from page 8 it was their responsibility to see if pneumococcal vaccinations were up to date and offer the vaccinations to help elderly residents build an immunity to pneumonia and further stated it was important for vaccinations to be as up to date as possible. A policy, Pneumococcal Vaccination Policy, dated November 2024, indicated each resident was offered the pneumococcal immunization unless the immunization was contraindicated, declined, or the resident has already been immunized, and the purpose of pneumococcal vaccinations was to reduce the incidence of pneumococcal disease and the morbidity and mortality attributed to this infection. All residents who have never received a pneumococcal vaccination will be offered the vaccine upon admission and as needed in accordance with current ACIP/CDC recommendations. Each resident’s pneumococcal immunization status will be determined upon admission or soon thereafter and if vaccination has occurred, the vaccination date will be documented in the resident’s medical record. Complete shared clinical decision making if applicable.	F0883		

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20000	Initial Comments *****ATTENTION****** NH 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: On 11/17/25 through 11/20/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		12/17/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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20000	Continued from page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin The State licensing orders are 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.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions for 1 of 1 resident (R34) reviewed with a history of falls. Findings: R34's Optional State Assessment (OSA) dated 8/8/25, indicated moderate cognitive impairment, did not reject	20830	The Fall prevention and management Program Policy and the Resident Transfer Assessment Policy were reviewed and remain in effect. Carondelet Village continues to adhere to the policies noted to keep our residents, staff, and visitors safe. It remains the expectation for staff to follow these policies to help prevent falls. R34 remains in the facility and did not experience any negative outcomes as a result of the walker not being within reach. The IDT team met to discuss the walker being within reach during the day; the walker should be removed in the evening due to her increasing confusion. The care plan and care sheet were updated to reflect these changes. Nursing staff identified during the survey as not following the Fall policy and Resident Transfer Assessment Policies were coached on the importance of following said policies. Facility completed whole house audits on adherence to the Fall Policy and Resident Transfer Assessment Policies to ensure residents have appropriate interventions in place to help prevent falls.	01/13/2026

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20830	Continued from page 2 care, required extensive assistance with bed mobility, transfers, and toilet use. R34's quarterly Minimum Data Set (MDS) dated 8/8/25, indicated R34 used a walker and wheelchair, had Parkinsonism (a syndrome characterized by different movement disorders such as walking and balance problems), heart failure, non-Alzheimer's dementia, and an artificial hip joint. Further, R34 fell two or more times with no injury since the prior assessment and fell one time with a non-major injury. R34's care sheet updated 11/17/25, indicated R34 required assist of one with a gait belt and rolling walker to use the bathroom and further indicated R34's walker was to always remain within reach because R34 self-transferred in the room and was at risk for falling. R34's care plan dated 8/19/25, indicated R34 had limited physical mobility due to Parkinsonism, cardiac disease and would self-transfer or self-ambulate often when in the room with or without adaptive equipment and required assist of 1 staff for transfers and ambulation. R34 had impaired cognition and required cueing, reorienting, and supervision as needed, additionally R34 was incontinent. R34 was at risk for falls due to dementia, Parkinsonism, and heart disease and required signage on the walker to remind R34 to take it with wherever she went. R34's Resident Occurrence Report dated 4/29/25, indicated R34 had fallen in her room, sustained a hip fracture and interdisciplinary team (IDT) interventions were deferred until R34 returned from the hospital. A handwritten note on the form indicated physical therapy (PT) and occupational therapy (OT) was initiated with a review date 5/7/25. R34's Resident Occurrence Report dated 6/22/25, indicated R34 fell while standing and washing her hands and the long-term interventions included R34 being in her wheelchair for all cares. Additionally, staff were educated on the use of a gait belt and use of a walker when completing cares. R34's Resident Occurrence Report and Falls Follow Up Forms dated 7/4/25, indicated R34 was on the floor and had a bump and bruise to the top of her right hand. Further, a long-term intervention included a sign was placed to always keep the walker with R34.	20830	Continued from page 2 Education on the Fall Prevention and Management Program Policy and Resident Transfer Assessment Policies will be completed with ALL nursing staff and education to ensure staff are following resident plan of care with interventions identified. Random audits have been initiated and will be completed on 10% of residents regarding compliance with the policies and interventions for residents weekly for four weeks. Results will be reported to the QA committee, and the need for ongoing audits and action plans will be initiated as appropriate. The Clinical Administrator, in coordination with the Clinical Coordinators, will be responsible for ongoing compliance. The date for compliance is January 13, 2026.	

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20830	Continued from page 3 R34's Resident Occurrence Report and Falls Follow Up Form dated 8/20/25, indicated R34 did not have her walker and fell going back to bed and sustained an abrasion and laceration. Further, the form indicated R34's walker was not within reach and staff were educated to keep the walker by R34 and follow the care plan. R34's care conference note dated 8/25/25, indicated R34 fell recently and sustained a laceration of her forehead and a skin tear on her wrist. Additionally, staff were re-educated to always have the walker right beside R34. During observation on 11/18/25 at 9:50 a.m., licensed practical nurse (LPN)-A left R34's room and R34's walker was folded up against the wall next to R34's television. A nebulizer was heard running and LPN-A stated she would be back. R34 was not observed to be near the walker. During interview and observation on 11/18/25 at 9:56 a.m., LPN-A verified R34 was receiving a nebulizer in her room. During observation on 11/18/25 at 10:00 a.m., LPN-A went into R34's room and turned off the nebulizer. R34's walker was still folded up by the television. At 10:02 a.m., LPN-A walked out of R34's room and the walker remained folded next to the television and away from R34. During observation on 11/18/25 at 10:04 a.m., R34 was in her wheelchair in her room with the call light next to her. Signage was located on the walker that indicated to always keep the walker with R34. R34's walker was folded in the corner by the television and out of R34's reach. During interview and observation on 11/18/25 at 10:07 a.m., nursing assistant (NA)-A stated they looked at the care plan to know what cares a resident required. NA-A stated R34 hadn't fallen recently but was at risk for falling and was supposed to have the walker with her at all times in case R34 tried to self-transfer to aide in her balance and further stated R34 even had a	20830		

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20830	Continued from page 4 sign on her walker as a reminder. NA-A verified R34's walker was in the corner and stated the walker should be by R34. NA-A unfolded the walker and placed it next to R34. During interview on 11/18/25 at 10:12 a.m., LPN-A stated nurses looked at the care plan to know what cares a resident required and the NA's used care sheets. During interview on 11/18/25 at 10:17 a.m., NA-B viewed R34's care sheet dated 11/17/25, and verified the care sheet indicated R34's walker was to be kept within reach at all times. NA-B stated R34 needed the walker because she tried to get out of the chair or bed by herself and was prone to falls. During interview on 11/18/25 at 10:20 a.m., LPN-A stated care sheets were updated with the care plan and added she hadn't worked in R34's neighborhood for approximately four months and stated R34 needed the walker in case R34 got up on her own and if R34 didn't have her walker, her safety would be at risk. LPN-A further stated it was on R34's care plan to be within reach and added R34 could get up on her own and suffer injuries from a fall that possibly could have been prevented. LPN-A acknowledged she was not previously aware it was part of R34's care plan. During interview on 11/18/25 at 1:23 registered nurse (RN)-A stated staff entered the resident room after a fall to determine the cause and document the fall in the electronic medical record (EMR). A falls form was completed by floor staff. The clinical coordinators conducted the investigation. Falls were discussed at IDT, an intervention was implemented. After a week, the intervention was re-evaluated to determine if the intervention was effective. RN-A stated she expected the care sheet to be followed. During interview on 11/18/25 at 1:47 p.m., physical therapist (PT)-A stated R34 was seen by PT and was on a walking program. PT-A stated R34 was at risk for falls due to Parkinsonism and a history of falling and further stated R34 was probably impulsive; if R34 self-transferred, it would be better to have the walker with her at all times and expected the care sheet to be followed.	20830		

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20830	Continued from page 5 During interview on 11/18/25 at 2:46 p.m., with the director of nursing (DON) and the regional director of clinical services (RDCS), the DON stated R34 fell during a self-transfer in July and IDT placed a sign to keep the walker with R34 at all times and stated they expected staff to keep the walker with R34 at all times. Further, when R34 fell on 8/20/25, the DON verified R34 did not have her walker within reach and RDCS stated staff were educated to follow the care plan. A policy, Fall Prevention and Management Program Policy, dated 9/2025, indicated the purpose of the policy was to provide a procedure for residents at risk for falls, assess fall risk factors, provide guidelines for fall and repeat fall preventative interventions. Prevention strategies include care plans will indicate the resident specific interventions to prevent falls. All staff are responsible for implementing the intent and directives contained within the policy and creating a safe environment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		

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K0000	INITIAL COMMENTS Initial Comments Section FIRE SAFETY An annual Life Safety Code survey was conducted on November 18, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Carondelet Village Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		12/17/2025

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 reverse for further 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

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K0000	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: CARONDELET VILLAGE CARE CENTER is a 4-story building with a basement, with the skilled nursing facility being located on the 1st floor only. CARONDELET VILLAGE CARE CENTER was constructed in 2012 and determined to be Type II (222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. Resident rooms have hard-wired smoke alarms. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey.	K0000		

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K0000	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0521 SS = F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/18/2025, at 9:40 AM, it was revealed by a review of available documentation that the facility could not provide the required 4 year fire damper test/inspection report. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K0521	Fire Dampers will be properly maintained in accordance with NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. Total Mechanical has been hired to identify all fire dampers using mechanical drawings, develop a master inventory, and inspect each fire damper. Each fire damper added to this master list will be assigned a damper ID, location, and type of fire damper. Total Mechanical will manually test each fire damper enclosure, whether it employs a spring-loaded mechanism or a fusible link, to ensure proper functionality. Any fire dampers requiring repairs will be addressed immediately through repair or replacement. The Environmental Service Director will be responsible for tracking these repairs and monitoring their completion on the master list. Fire dampers in the Care Center that need repair or replacement will be prioritized. The Environmental Service Director has created a Life Safety “Task” within the TELS equipment management system that includes fire damper inspections every four years. The Environmental Service Director will train staff to conduct fire damper testing for future inspections. These fire damper inspections will be completed on or before 12/12/25. Identified repairs will be completed on or before 12/31/2025.	12/31/2025
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K0712	Carondelet Village recognizes the requirements outlined in NFPA 101, Life Safety Code Sections 19.7.1.4 through 19.7.1.7, and will promptly implement a comprehensive fire drill program in line with these standards. Fire drills will be performed across all shifts to ensure staff preparedness and patient safety. Each drill will include activation or simulation of the fire alarm system, staff response following the RACE and PASS protocols, and assessment of horizontal and vertical evacuation procedures. All drills will be documented with details such as the date, time, participating individuals, observed outcomes, and confirmation that the fire alarm monitoring vendor receives the alarm signal within six seconds of activation. Corrective actions will be identified and addressed swiftly, with results reported to the Safety Committee for review. The Director of Environmental Services has developed a fire drill matrix that schedules drills by month,	12/31/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carondelet Village Care Center	525 FAIRVIEW AVENUE SOUTH , SAINT PAUL, Minnesota, 55116

(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
K0712 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per 42 CFR 483.470(i). These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/18/2025, at 9:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility was missing evidence of 8 fire drills for the last quarter of 2024 and all 4 quarters of 2005. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K0712	Continued from page 3 quarter, shift, and location, confirming compliance. Additionally, the Environmental Services Director has created a Life Safety “Task” within the TELS equipment management system to meet the standard of one fire drill per shift per quarter. The Environmental Services Director will be responsible for evaluating the fire drills and reporting findings to the Safety Committee. Initial fire drill will be documented and filed for review on or before 12/18/25.	
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K0918	Carondelet Village recognizes the requirements outlined Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.7 and will promptly implement a comprehensive Electrical Systems - Essential Electric System Maintenance and Testing program. This program will include the following: At least monthly, the facility tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature. If the facility does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours At least monthly, the facilty tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented At least annually, the facility tests the fuel quality	12/31/2025

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K0918 SS = F	Continued from page 4 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/18/2025, at 9:50 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing the following:Weekly generator inspections from 9/26/2025 through 11/18/2025.Monthly Generator run from 9/26/2025 through 11/18/2025.Annual fuel test for the GeneratorThe required 36 month 4 hour load bank test.An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K0918	Continued from page 4 to ASTM standards. The test results and completion dates are documented. At least once every 36 months, facility with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers' exhaust gas temperature. At least weekly, the facility inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented. The Environmental Services Director has created a Life Safety “Task” within the TELS equipment management system to schedule Electrical Systems - Essential Electric System Maintenance and Testing program. The Environmental Service Director will set a Task for the following: Weekly generator inspections Monthly 30 Minutes Load Bank Testing Annual Load Bank Monthly ATS Testing Annual Fuel Analysis 3-year 4-hour Load Bank Testing HM Cragg, the Carondelet Village generator service provider, has been hired to conduct 3-year, 4-hour load-bank testing on both generators. The testing is scheduled for completion by December 19, 2025. Annual diesel fuel samples will be collected on December 17, 2025, and expedited to a local laboratory for analysis. Results will be available by 12/31/25. Regional engineering is responsible for training CV engineering personnel in both monthly load bank testing and weekly generator inspections. The training will align with the initial execution of these inspections and will be completed by 12/19/25. CV engineering personnel are responsible for conducting future load bank testing and weekly generator inspections. The Environmental Services Director will oversee the review of inspection	

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K0918 SS = F		K0918	Continued from page 5 forms to ensure compliance with established standards.	
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly store oxygen cylinders in accordance with NFPA 99, 2012 Edition,	K0923	Carondelet Village removed the oxygen concentrator on 11/18/2025 to adhere to the requirements specified in NFPA 99, 2012 Edition, sections 5.1.3.3.2 and 5.1.3.3.3, and will start weekly audits. Audits will be done weekly for 4 weeks, and then twice monthly for 2 months by the ESD/LNHA or designee, and report to the Safety Committee. Staff education will be provided and ESD is responsible for ongoing compliance.	12/31/2025

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K0923 SS = F Bldg. 01	Continued from page 6 5.1.3.3.2 and 5.1.3.3.3 . This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/18/2025, at 10:30 AM, it was revealed by observation and staff interview that an oxygen concentrator was being stored within the corridor by room 187. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K0923		