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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3SB4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245617**
2.STATE VENDOR OR MEDICAID NO.
(L2) **550012400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CARONDELET VILLAGE CARE CENTER**
(L4) **525 FAIRVIEW AVENUE SOUTH**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 11/13/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 02/07/2014
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/07/2014
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/27/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
12/13/2013
(L32)

32. DETERMINATION OF APPROVAL DATE
12/13/2013
(L33)

DETERMINATION APPROVAL

A standard survey was completed on September 26, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 6, 2013, the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS). The FMS revealed that the facility continued to not be in substantial compliance. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 19, 2013, the Centers for Medicare and Medicaid Services (CMS) informed the facility that the following enforcement remedies were being imposed:

> Mandatory denial of payment for new Medicare and Medicaid admissions effective December 26, 2013. (42 CFR 488.417 (b))

On November 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit by review of the facility's plan of correction and on January 21, 2014, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 26, 2013 and the FMS completed on November 6, 2013. Based on these visits, we determined that the facility has corrected the deficiencies issued pursuant to the standard survey completed on September 26, 2013 and the FMS completed on November 6, 2013 as of December 20, 2013.

As a result of the revisit findings, this Department discontinued the Category 1 remedy of state monitoring effective December 20, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 19, 2013:

> Mandatory denial of payment for new Medicare and Medicaid admissions effective December 26, 2013 be rescinded as of December 20, 2013. (42 CFR 488.417 (b))

Effective December 20, 2013, the facility is certified for 45 skilled nursing facility beds.

Please refer to the CMS 2567B.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5617 February 7, 2014

Ms. Heather Heijerman, Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, Minnesota 55116

Dear Ms. Heijerman:

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

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

Effective December 20, 2013, the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 7, 2014

Ms. Heather Heijerman, Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, Minnesota 55116

RE: Project Number S5617002

Dear Ms. Heijerman:

On October 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 26, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

In addition, on November 6, 2013, the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

In addition, on November 19, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 26, 2013. (42 CFR 488.417 (b))

On November 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit by review of the facility's plan of correction and on January 21, 2014, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 26, 2013 and the FMS completed on November 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2013. We have determined, based on our visits, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 26, 2013 and FMS completed on November 6, 2013 as of December 20, 2013.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 20, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 19, 2013:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 26, 2013 be rescinded as of December 20, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4117
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245617	A. Building B. Wing	11/13/2013

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/04/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/04/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/04/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/04/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/04/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/04/2013**
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** SR/cbl	**Date:** 02/07/2014	**Signature of Surveyor:** 16022	**Date:** 11/13/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/26/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245617	A. Building B. Wing **01 - CARONDELET VILLAGE CARE CENTE**	1/21/2014

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/24/2013**	ID Prefix	Correction Completed **10/24/2013**	ID Prefix	Correction Completed **10/24/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0033		LSC K0038	
ID Prefix	Correction Completed **10/24/2013**	ID Prefix	Correction Completed **10/24/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0052		LSC K0062		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** PS/cbl	**Date:** 02/07/2014	**Signature of Surveyor:** 12424	**Date:** 01/21/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/25/2013

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245617

November 19, 2013
By Certified Mail and Facsimile

Ms. Heather Heijerman, Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Dear Ms. Heijerman:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: September 26, 2013

STATE SURVEY RESULTS
On September 25, 2013, a Life Safety Code Survey and on September 26, 2013, a health survey were completed at Carondelet Village Care Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level F, cited as follows:

- K33 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard.

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567) for each survey.

FEDERAL MONITORING SURVEY
Subsequently, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on November 6, 2013. As the surveyor informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F, cited as follows:

- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K70 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing, to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting

immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is December 26, 2013.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective December 26, 2013

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective December 26, 2013 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on December 26, 2013. We are further notifying the State Medicaid agency that they must also deny payment

for all new Medicaid admissions effective December 26, 2013.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by March 26, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 26, 2013, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Carondelet Village Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 26, 2013. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective December 26, 2013

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Mai Le-Yuen
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245617	A. Building B. Wing **01 - CARONDELET VILLAGE CARE CENTE**	1/21/2014

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013
Reg. # NFPA 101 LSC K0011		Reg. # NFPA 101 LSC K0012		Reg. # NFPA 101 LSC K0018	
ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013
Reg. # NFPA 101 LSC K0025		Reg. # NFPA 101 LSC K0027		Reg. # NFPA 101 LSC K0033	
ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013
Reg. # NFPA 101 LSC K0050		Reg. # NFPA 101 LSC K0051		Reg. # NFPA 101 LSC K0052	
ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed 12/20/2013
Reg. # NFPA 101 LSC K0062		Reg. # NFPA 101 LSC K0064		Reg. # NFPA 101 LSC K0070	
ID Prefix	Correction Completed 12/20/2013	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # NFPA 101 LSC K0144		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	02/07/2014	12424	01/21/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/6/2013

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

FAX to:

Number of Pages: 28

CCN: 245617

Name: Carondelet Village Care Center

City, State: Saint Paul, MN

DPNA Date: 12/26/2013

Termination Date: 03/26/2013

FMS Survey Date: 11/06/2013

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
E	K11	POC 12/20/13
B	K12	POC 12/20/13
B	K18	POC 12/20/13
E	K25	POC 12/20/13
E	K27	POC 12/20/13
E	K33	POC 12/20/13
C	K50	POC 12/20/13
E	K51	POC 12/20/13
F	K52	POC 12/20/13
F	K62	POC 12/20/13
B	K64	POC 12/20/13
A	K69	POC 12/20/13
F	K70	POC 12/20/13
C	K144	POC 12/20/13

Bruce W. Wexelberg

Approved: YES

By: Bruce W. Wexelberg

Date: 01/13/2014

Carondelet VILLAGE

November 25, 2013

651-690-7081 PH
www.carondeletvillage.org

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Re: Enclosed Plan of Correction for the Federal Monitoring Survey Results (CCN 245617)

Dear Mr. Wexelberg,

It is the policy of Carondelet Village to ensure the following plan has been implemented for ongoing compliance. Please see attached copy of the plan of correction with date certain for correction for Federal Monitoring Survey completed November 6, 2013.If you have any questions regarding our response, please let me know.

Heather Heijerman, LNHA
Carondelet Village Care Center
Care Center Administrator
525 Fairview Ave S.
St. Paul MN, 55116

E-mail: hheijerman@preshomes.org
Telephone: 651-695-5003
Fax: 651-695-5059

Sincerely,

Heather Heijerman

Heather Heijerman, LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01 -CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL,MN 55116

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K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring SuNey was conducted by the Centers for Medicare & Medicaid SeNices (CMS) on 11/6/13 following a Minnesota Department of Health suNey on 9/25/13. At this Comparative Federal Monitoring SuNey, Carondelet Village Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Carondelet Village Care Center is located on the first floor of a four story building of Type II (222) construction. The building was constructed in 2011. The building is fully sprinklered and there is supeNised smoke detection in the corridors, spaces open to the corridors and rooms other that resident rooms. The resident rooms have smoke detection that alarms to a nurse call system. The facility has 45 certified beds. All 45 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 44. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	KOOC		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved	K 011	K011 1. The meeting edge of the 90 minute fire rated cross-corridor doors by Wellness Room 6 will be repaired to have no gap by 12/20/2013. The Regional Engineering manager will be responsible for ensuring this repair is properly done.	12/20/13

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

Heather Heijum | Case Center Administrator | 11/25/13

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 suNey 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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K 011	Continued From page 1 self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a two-hour fire rated separation between the skilled nursing unit and the non-long term care hospital facility in accordance with NFPA 101 - 2000 edition, sections 18.1.1.4.4, 18.2.2.2, 8.2.3.1 and 8.2.3.2.3. This deficient practice could affect approximately 20 of the 44 residents. Findings include: 1. On 11/6/13 at 2:19pm, observation revealed that there was a 1/8" gap at the meeting edge of the 90-minute fire rated cross-corridor doors in the two hour rated building separation by Wellness Room 6. 2. On 11/6/13 at 2:21pm, observation revealed that above the ceiling at the cross-corridor doors by Wellness Room 6 there was a 6" by 6" section of the wall above the duct penetration that was filled with mineral wool that was not mechanically secured in place. 3. On 11/6/13 at 2:27pm, observation revealed that above the ceiling in Wellness Room 6 there was an open 10" round duct penetration of the two hour rated building separation wall that was not protected by a fire damper. 4. On 11/6/13 at 2:30pm, observation revealed that above the ceiling at the two hour rated wall in the Human Resources office there was a 1/2" by 2" hole in the wall with penetrations by three	K 011	Continued from page 1. The Environmental Services Director will inspect all doors in the 2 hour separation to ensure that the doors meet the required life safety codes. Will complete monthly audits to ensure ongoing compliance. If any issues arise, work orders will be submitted in electronic work order system. 2. The 6" by 6" section of the wall filled with mineral wool above the duct penetration above the ceiling at the cross corridor doors by Wellness Room 6 will be repaired to meet the required two hour fire rating by 12/20/2013 The Regional Engineering Manager will ensure the repair is properly done using the system specified in UL V438 Gypsum Board Partitions-Steel Framing. (attached) The two hour building separation wall will be inspected and maintained by the Environmental Services Director to preserve the 2 hour rating. Will be inspected as needed to maintain ongoing compliance. 3. The 10" round duct above the ceiling in Wellness Room 6 in the two hour rated building separation wall will have a fire damper installed to preserve the two hour rating of the building separation wall by 12/20/2013. The Regional Engineering Manager will ensure the installation of the fire damper is properly done and meets applicable codes. Will be inspected as needed to maintain ongoing compliance. 4. The ½" by 2" hole penetrated by three cables above the ceiling at the two hour rated wall in the Human Resources office will have proper firestopping installed	

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K 011	Continued From page 2 cables that was not properly firestopped. These deficient practices were confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 011	Continued from page 2. using UL/cUL System No. W-L-3058 (attached) by 12/20/2013. The Regional Engineering Manager will ensure the firestopping is properly done. The two hour building separation wall will be inspected and maintained by the Environmental Services Director to preserve the 2 hour rating. Will be inspected as needed to maintain ongoing compliance.	
K 012 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide the type of construction as required by NFPA 101 - 2000 edition, section 18.1.6.2; as well as, NFPA 220 - 1999 edition, section 3-2 and Table 3-1. This deficient practice could affect approximately 15 of the 44 residents. Findings include: On 11/6/13 at 1:29pm, observation revealed that above the ceiling by the cross-corridor smoke barrier doors by room 195 there was a 6" section of steel beam where the fireproofing was removed and bare steel was exposed. This deficient practice was confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 012	K012 The 6" inch section of steel beam where the fireproofing was removed and bare steel was exposed above the ceiling by the cross-corridor smoke barrier doors by room 195 will be fireproofed to UL system N614 (attached) by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the firestopping is properly done. The Environmental Services Director will be responsible for ensuring the firestopping on the building structural elements is maintained.	
K 018 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are	K 018		

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FORM APPROVED
OMS NO 0938-0391

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

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K 018	Continued From page 3 constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that meet the requirements of NFPA 101 - 2000 edition, Sections 18.3.6.3, 18.3.6.3.1 and 18.3.6.3.3. This deficient practice could affect approximately 15 of the 44 residents. Findings include: On 11/6/13 at 1:17pm, observation revealed that the inactive leaf of the double doors in the corridor wall to the unit C1 TV Lounge closet was not automatically positive latching. The active leaf latched into the inactive leaf. If the inactive leaf were not positively latched the entire door assembly would not be positive latching. This deficient practice was confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 018	K018 The inactive leaf of the double doors in the corridor wall to the unit C1 TV lounge will be made to be automatically positively latching so the entire door assembly is automatically positively latching when the active leaf is closed and latched into the inactive leaf, by 12/20/2013. The Regional Engineering Manager will ensure this repair is correctly done. The Environmental Services Director will ensure that all doors which are required to latch will do so through a monthly inspection task automatically generated by the electronic work order system. Will be reviewed at bi-monthly safety committee.	12/20/13
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD , Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass	K025	K025 1. The 2" by 4" hole which is penetrated by three flexible conduits above the ceiling at the smoke barrier by room 171 will be firestopped using UL/cUL System No. W-L-1249 (attached) by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the	12/20/13

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K 025	Continued From page 4 panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect approximately 20 of the 44 residents. Findings include: 1. On 11/6/13 at 1:15pm, observation above the ceiling at the smoke barrier by room 171 revealed that there were penetrations of three flexible conduits and a 2" by 4" hole in the drywall that were not properly firestopped. 2. On 11/6/13 at 1:30pm, observation revealed that above the ceiling at the smoke barrier by room 195 there was a penetration of the smoke barrier wall by a fireproof steel beam that was not properly firestopped. 3. On 11/6/13 at 1:53pm, observation revealed that above the ceiling at the smoke barrier by the main nursing station and the Clinical Administrators office there were penetrations of the smoke barrier wall by a plastic pipe and a	K025	Continued from page 4 the firestopping is properly done. The smoke barrier wall will be maintained by the Environmental Services Director to preserve the integrity of the smoke barrier. Will be inspected as needed to maintain ongoing compliance. 2. The penetration of the smoke barrier wall by a steel fireproof beam above the ceiling at the smoke barrier by room 195 will be properly firestopped using UL/cUL System no. W-L-7188 (attached) by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the firestopping is properly done. The smoke barrier wall will be maintained by the Environmental Services Director to preserve the integrity of the smoke barrier. Will be inspected as needed to maintain ongoing compliance. 3. The penetrations of the smoke barrier wall by a plastic pipe and duct above the ceiling at the smoke barrier by the main nursing station and the Clinical Directors office will be properly firestopped using UL/cUL System No. W-L-5225 and UL/cUL System No.W-L-7040 respectively (both attached) by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the firestopping is properly done. The smoke barrier wall will be maintained by the Environmental Services Director to preserve the integrity of the smoke barrier. Will be inspected as needed to maintain ongoing compliance. 4. The penetration of the smoke barrier by a conduit above the ceiling at the smoke barrier by room 195 will be properly	

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K 025	Continued From page 5 duct that were not properly firestopped. 4. On 11/6/13 at 1:59pm, observation revealed that above the ceiling at the smoke barrier in room 195 there was a penetration of a conduit that was not properly firestopped. These deficient practices were confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K025	Continued from page 5 firestopped using UL/cUL System No. W-L-1095 by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the firestopping is properly done. The smoke barrier wall will be maintained by the Environmental Services Director to preserve the integrity of the smoke barrier. Will be inspected as needed to maintain ongoing compliance. K027 1. The door to the C-Wing Household Coordinators office located in the smoke barrier wall will be made to be self closing by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring this door has the proper hardware installed to meet the requirements of the Life Safety Code. The Environmental Services Director will ensure that all doors in smoke barrier walls which are required to be self closing will do so through a monthly inspection task automatically generated by the electronic work order system. Will be reviewed at bi-monthly safety committee. 2. The door to the Clinical Administrators office located in the smoke barrier wall will be made to be self closing by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring this door has the proper hardware installed to meet the requirements of the Life Safety Code. The Environmental Services Director will ensure that all doors in smoke barrier walls which are required to be self closing will do so through a monthly inspection	K027 12/20/13

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K 027	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide doors in smoke barrier walls that met the requirements of NFPA 101 - 2000 edition, sections 18.3.7.1, 18.3.7.5, 18.3.7.6, 8.3 and 8.3.4. This deficient practice could affect approximately 20 of the 44 residents. Findings include: 1. On 11/6/13 at 1:08pm, observation revealed that the door to the C-Wing Household Coordinators office was located in a smoke barrier wall and the door was not self-closing. 2. On 11/6/13 at 1:52pm, observation revealed that the door to the Clinical Administrators office was located in a smoke barrier wall and the door was not self-closing. These deficient practices were confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K027	Continued from page 6 task automatically generated by the electronic work order system. Will be reviewed at bi-monthly safety committee.	
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1	K033	K033 The penetrations of two cables of the fire rated enclosure by room 183 will be properly firestopped using UL/cUL System No. W-L-3058 (attached) by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the firestopping is properly done. The fire rated enclosure will be inspected and maintained by the Environmental Services Director to preserve the integrity of the fire rated enclosure. Will be inspected as needed to maintain ongoing compliance.	12/20/13

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K 033	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire resistance labels on the fire rated doors on the enclosed exit stair in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.1.1, 18.2.2.3, 7.1.3.2, 7.1.3.2.1, 7.2.2, 7.2.2.5.1, 8.2.5 and 8.2.5.4. This deficient practice could affect approximately 10 of the 44 residents. Findings include: On 11/6/13 at 2:05pm. observation revealed that at the fire rated enclosure by room 183 there were penetrations of two cables that were not properly firestopped. This deficient practice was confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 033		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2	KOSO	K050 The monthly fire drill report form will be modified with a line item to require verification that the fire alarm system successfully transmitted the fire alarm signal The fire drill monthly report form will be modified by 12/20/2013. If the fire alarm system does not communicate successfully with the monitoring station, the Environmental Services Director will be responsible for scheduling immediate service for the fire alarm system.	12/20/13

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K 050	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills in accordance with the requirements of NFPA 101 - 2000 edition, Section 18.7.1.2. This deficient practice could affect all 44 residents. Findings included: On 11/6/13 at 10:15am, review of the documents titled "Carondelet Village Fire Drill/Fire Alarm System Test" for the last 12 months revealed that the facility did not document the transmission of the fire alarm signal. This deficient practice was confirmed by the Care Center Administrator at the time of discovery.	KOSC	Continued from page 8 Safety procedures to ensure notification of the fire department in the event of fire alarm activation will be put in place at this time. The monthly routine in the electronic work order system for fire drills will be modified by 12/20/2013 to include language instructing that the fire signal transmission will be verified. The Environmental Services Director will be responsible for ensuring the proper operation of the fire alarm system. The Safety committee reviews fire drill report forms bi-monthly and will ensure the form is completely filled out. Discrepancies will be reported to the Nursing Home Administrator and the Campus Administrator.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6	K051	K051 1. The smoke detector located in the nursing station will be moved to be out of the airflow of the adjacent air supply outlet at least 36" away by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the smoke detector is properly installed. The Environmental Services Director will be responsible for the inspection of smoke detectors to ensure they are properly installed. Installing contractor will audit to ensure code is met on all installed smoke detectors. 2. The smoke detector located in Unit D laundry room will be properly connected to the electrical junction box by 12/20/2013.	12/20/13

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CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL,MN 55116

(X4) ID TAG PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID TAG PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) ATE COMPLETION
K 051	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.4 and 9.6 and NFPA 72- 1999 edition, Sections 1-5.5.6.1 and 2-3.5.1. This deficient practice could affect approximately 10 of the 44 residents. Findings include: 1. On 11/6/13 at 1:11pm, observation revealed that the smoke detector located in the main nursing station was installed within the airflow of the adjacent air supply outlet. 2. On 11/6/13 at 2:02pm, observation revealed that the smoke detector in the Unit D laundry room was not connected to the electrical junction box and was hanging approximately 1" below the ceiling by its wires. 3. On 11/6/13 at 2:09pm, observation revealed that the smoke detector located in kitchen was installed within the airflow of the adjacent air supply outlet. These deficient practices were confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 051	Continued from page 9 The Environmental Services Director will be responsible for ensuring the smoke detector is properly installed and the inspection of the smoke detectors. Monthly audits will be conducted to ensure ongoing compliance and properly installed smoke detectors. 3. The smoke detector located in the kitchen will be moved to be out of the airflow of the adjacent air supply outlet at least 36" away by 12/20/2013. The Regional Engineering Manager will be responsible for ensuring the smoke detector is properly installed. The Environmental Services Director will be responsible for the inspection of smoke detectors to ensure they are properly installed. Installing contractor will audit to ensure code is met on all installed smoke detectors.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance	K052	K052 The off premises transmission equipment will be tested quarterly to ensure proper operation beginning 12/20/2013.	12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01 - CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL,MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICENCIES (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)	(XS) COMPLETION DATE
K 052	Continued From page 10 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3, 7-3.1, 7-3.2, 7-5.2.2 and Figure 7-5.2.2. This deficient practice could affect all 44 residents. Findings include On 11/6/13 at 10:23am, review of the documents titled "Inspection and Testing Form" dated "10/10/13 to 10/11/13" and "System Event Report" dated "10/8/2013 to 10/11/2013" revealed that the fire alarm system was tested annually. There were no quarterly tests of the off premises transmission equipment. This deficient practice was confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K052	Continued from page 10 This test will be performed in conjunction with scheduled fire drills and the fire drill report form will document the testing of the off premises transmission equipment. The Environmental Services Director will be responsible for ensuring the testing of the off premises transmission equipment is done at least quarterly. The safety committee will review fire drills quarterly to ensure the off premises transmission equipment was tested as required.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K062	K062 The quarterly waterflow testing of the sprinkler system will be set up as a task in the electronic work order system by 12/20/2013 that will automatically be generated at least every three months.	12/20/13

PRINTED: 11/19/2013
FORM APPROVED
OMS NO 0938-0391

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
	245617	A. BUILDING 01 - CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL,MN 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
K 062	Continued From page 11 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 -2000 edition, Sections 18.3.5 and 9.7 and NFPA25- 1998 edition, Section 2-3.3 and Table 2-1. This deficient practice could affect all 44 residents. Findings include: On 11/6/13 at 10:30am, review of the documents titled "Olsen Fire Protection, Inc." dated 9/26/13 and "Work Orders - Crondelet Village, CV-CC-SAFE-FLOW-TEST-0" with a hand written date "10/23/13 Done..." revealed that the facility only had documentation showing waterflow tests were only conducted during one quarter of the last 12 months. The facility did not have documentation showing that they conducted waterflow tests on the sprinkler system during each quarter of the the last 12 months. This deficient practice was confirmed by the Regional Engineering Director and the Environmental Services Director at the time of discovery.	K062	Continued from page 11 The Environmental Services Director will be responsible for ensuring the waterflow testing is promptly completed each time the task is generated. The safety committee will review waterflow tests bi-monthly to ensure the test was conducted as required.	
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6	K064	K064 The fire extinguisher in the administrative office area has been replaced with an extinguisher that has been properly tagged and inspected annually. The annual testing of fire extinguishers will be set up as a task in the electronic work order system by 12/20/2013 that will automatically be generated once per year. The Environmental Services Director will be responsible for ensuring the fire extinguisher testing is promptly completed each time the task is generated and that all fire extinguishers are tested.	12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01-CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 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)	(XS) COMPLETION DATE
K 064	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install fire extinguishers in accordance with NFPA 101 - 2000 edition, Sections 18.3.5.6 and 9.7.4.1 as well as NFPA 10- 1998 edition, Section 4-1.2. This deficient practice could affect approximately 10 of the 44. Findings include: On 11/6/13 at 10:30am, observation revealed that the tag on the fire extinguisher in the administrative office area had its last annual service inspection in October of 2012 which was over 12 months ago. This deficient practice was confirmed by the Care Center Administrator at the time of discovery.	K064	Continued from page 12 Monthly inspections will be completed to ensure fire extinguishers are properly tested. The safety committee will review fire extinguisher testing yearly to ensure the inspection was conducted as required.	
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to prohibit the use of portable space heaters in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.7.8. This deficient practice could affect all 44 residents. Findings include:	K070	K070 The document titled "Subject: Space Heaters" dated 1/1/12 will be changed by the Nursing Home Administrator and the Environmental Services Director to prohibit the use of portable space heaters in the facility by 12/20/2013. New policy will be educated to staff by 12/20/2013. The Nursing Home Administrator and the Environmental Services Director will ensure policies are correctly written to meet safety codes. The safety committee will review new policies annually to ensure the policies are correctly written and updated.	12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01 -CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY 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)	(XS) COMPLETION DATE
K 070	Continued From page 13 On 11/6/13 at 10:57am, review of the document titled "Subject: Space Heaters" dated 1/1/12 revealed that the facility does allow the use of portable space heaters in the facility. This deficient practice was confirmed by the Care Center Administrator and the Regional Engineering Director at the time of discovery.	K070		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to inspect and test the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, section 18.5.1 and 9.1.3; NFPA 110 - 1999 edition, Section 3-5.6.1. This deficient practice could affect all 44 residents. Findings include: On 11/6/13 at 2:41pm, observation revealed that the remote annunicator of the emergency generator was located behind a bookshelf type cart containing resident medical charts and was not visible by the staff in the room or area.. This deficient practice was confirmed by the	K 144	K144 The bookshelf type cart that was blocking the staff's visibility of the emergency generator remote enunciator will be removed by 12/20/2013. The Environmental Services Director and the Nursing Home Administrator will ensure required enunciators are not blocked through regular inspections of the enunciator areas.	12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01 -CARONDELET VILLAGE CARE CENTER B. WING	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 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
K 144	Continued From page 14 Regional Engineering Director and the Environmental Services Director at the time of discovery.	K 144		

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245617	MULTIPLE CONSTRUCTION A. BUILDING: 01 - CARONDELET VILLAGE CARE CENTER B. WING	DATE SURVEY COMPLETE: 11/6/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the protection of the cooking facilities in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.2.6 and 9.2.3, as well as, NFPA 96 - 1998 edition, Section 8-2. This deficient practice could affect an indeterminate number of staff. Findings include: On 11/6/13 at 12:37pm, review of the documents titled "Northland Fire & Security" 11/20/12 and 6/20/13 revealed that the kitchen range hood fire protection system was not inspected at least every six months. This deficient practice was confirmed by the Care Center Administrator and the Regional Engineering Director at the time of discovery.

CCN 245617	Provider Name: Carondelet Village Care Center	Survey Date 11/06/2013
Administrator: Heather Heijerman		**Phone Number:** 651-695-5003
Federal Safety Engineer: Bruce Wexelberg 312 353 2859		

(X4) ID PREFIX TAG	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date
K 069	The kitchen range hood inspection schedule will be set up as a task in the electronic work order system by 12/20/2013 that will automatically be generated at least every six months. The Environmental Services Director will be responsible for ensuring the inspection is promptly completed each time the task is generated. The safety committee will review the inspection reports bi-annually.	12/20/2013

Gypsum Board Partitions - Steel Framing (Continued)

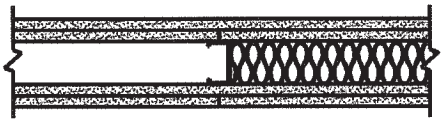
2 Hour FIRE	Design #	GA File #	STC - 56
	UL U411	WP 1548	Sound Test # NGC - 3022

Link to .PDF file
Link to .DWG file
Link to .DWG/Text file

Base layer 5/8" (15.9 mm) Fire-Shield Gypsum Board applied vertically to each side of 2-1/2" steel studs 24" o.c. with 1" type S drywall screws 16" o.c. Face layer 5/8" Fire-Shield Gypsum Board applied vertically with 1-5/8" type S drywall screws 16" o.c. at vertical joints and intermediate studs and 12" o.c. at floor and ceiling runners. Joints staggered 24" on each layer and side.

*Sound test with 3" fiberglass insulation

2 Hour FIRE	Design #	GA File # BASED ON	STC - N/A
	UL V438	WP 1548	Sound Test # N/A



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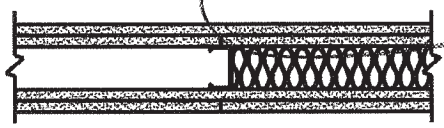
Link to .DWG/Text file

Base layer 5/8" (15.9 mm) Fire-Shield Gypsum Board applied vertically to each side of 2-1/2" steel studs 24" o.c. with 1" type S drywall screws 16" o.c. Face layer 5/8" Fire-Shield Gypsum Board applied vertically or horizontally with 1-5/8" type S drywall screws 16" o.c. Screws offset 8" from base layer. Joints staggered 24" on each layer and side.

2 Hour FIRE	Design #	GA File # BASED ON	STC - N/A
	UL V438	WP 1548	Sound Test # N/A



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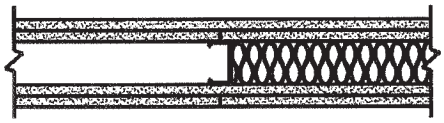
Base layer 5/8" (15.9 mm) Fire-Shield Gypsum Board applied horizontally to each side of 2-1/2" steel studs 24" o.c. with 1" type S drywall screws 24" o.c., with first screw installed 1-1/4" from board edge and to track only spaced 24" o.c. Face layer 5/8" Fire-Shield Gypsum Board applied horizontally with 1-5/8" type S drywall screws 16" o.c. with first and second screws installed 1-1/4" and 8" from the board edge respectively, and to the track only spaced 16" o.c. Vertical joints staggered one stud cavity on each side. Horizontal edge joints need not be staggered on opposite side of stud. Horizontal edge joints must be staggered minimum of 12" from adjacent layers.

2 Hour FIRE	Design #	GA File # BASED ON	STC - 48
	UL U412	WP 1615	Sound Test # NGC-2282



Link to .PDF file
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Link to .DWG/Text file

Base layer 1/2" (12.7 mm) Fire-Shield C Gypsum Board applied vertically to each side of 3-5/8" steel studs 24" o.c. with 1" type S drywall screws 24" o.c. Face layer 1/2" Fire-Shield C Gypsum Board applied vertically or horizontally with 1-5/8" type S drywall screws 12" o.c. Joints staggered 24" on each layer and side.

*Sound test with 3" fiberglass insulation =STC 53 (NGC-2288)

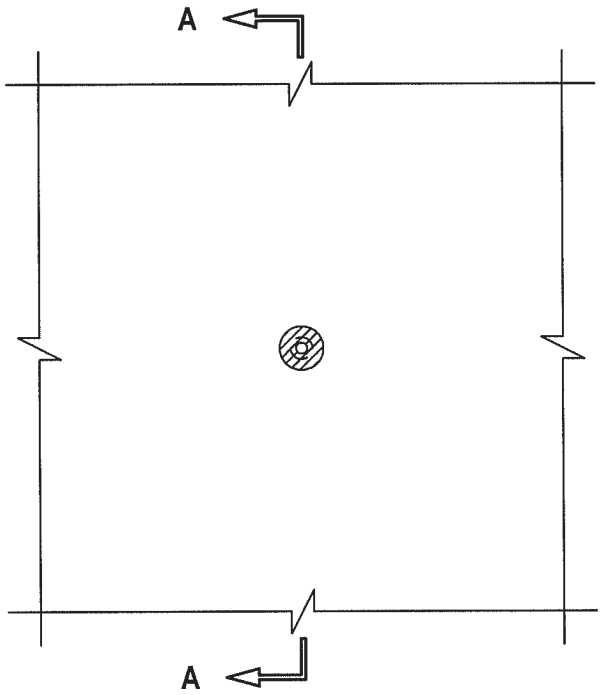
UL/cUL SYSTEM NO. WL3058

CABLE THROUGH GYPSUM WALL ASSEMBLY

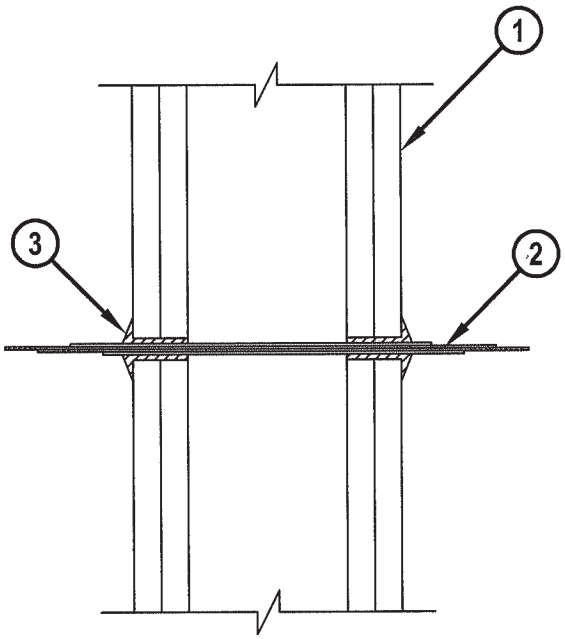
F RATING = 2-HR.
T RATING = 1-1/2-HR.
L RATING AT AMBIENT = LESS THAN 1 CFM/SQ. FT.
L RATING AT 400° F = 4 CFM/SQ. FT.

WL3058c.091699

FRONT VIEW



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL/ULC CLASSIFIED U300 OR U400 SERIES) (2-HR. FIRE-RATING).
2. MAXIMUM 25 PAIR NO. 24 AWG TELEPHONE CABLE.
3. HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT FORCED INTO ANNULAR SPACE TO MAXIMUM EXTENT POSSIBLE, WITH ADDITIONAL 1/4" CROWN AROUND CABLE AS SHOWN.

NOTE : MAXIMUM DIAMETER OF OPENING = 1/2".

HILTI®
FIRESTOP SYSTEMS

HILTI, Inc.
Tulsa, Oklahoma USA (918) 252-6000

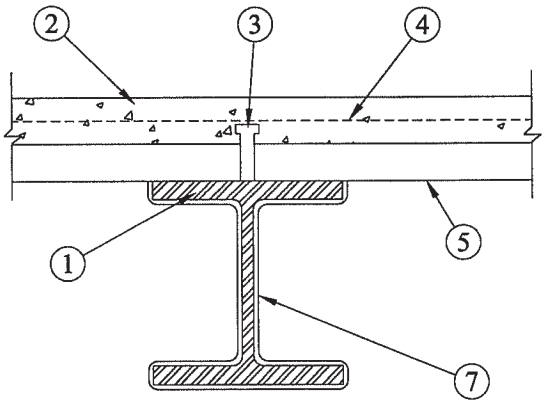
Sheet	1 of 1
Scale	1/4" = 1"
Date	SEPT. 16, 1999

Drawing No.
WL 3058c

Saving Lives through Innovation and Education

Design No. N614

Restrained Beam Ratings - 1, 1-1/2, 2 and 3 Hr. (See Item 7)
Unrestrained Beam Ratings - 1, 1-1/2 and 2 Hr. (See Item 7)
Load Restricted for Canadian Applications — See Guide BXUV7



1. **Steel Beam** — W8x24 or W6x12 or W6x16 or W8x28 min size. Beams shall be free of dirt, loose scale and oil. Beams shall be primed with a phenolic modified alkyd resin primer, a metal alkyd primer, an acrylic primer or an epoxy primer at a nominal thickness of 2 mil.
2. **Normal Weight or Lightweight Concrete** — Compressive strength 3500 psi. For normal weight concrete either carbonate or siliceous aggregate may be used. Unit weight 146 lbs/cu ft. for normal weight concrete and 116 lbs/cu ft. for lightweight concrete. Min concrete thickness, as measured from top plane of steel floor and form units is 2-1/2 in.
3. **Shear Connector** — (Optional) Studs, 3/4 in. diam headed type or equivalent per AISC specifications welded to the top flange of beam through the steel floor units.
4. **Welded Wire Fabric** — 6x6-10/10 SWG
5. **Steel Floor or Form Units** — 1-1/2, 2 or 3 in. deep fluted units, welded to beam.
6. **Mineral Wool Insulation** — (not shown) - For the W6x12, W8x28 and W8x24 beams, min 6 pcf mineral wool insulation cut into pieces and firmly packed into, and completely filling the spaces between the flutes of the steel floor and form units and the top flange of the beam. For the W6x16 beam, min 4 pcf mineral wool insulation cut into pieces and firmly packed into, and completely filling the spaces between the flutes of the steel floor and form units and the top flange of the beam. Mineral wool is not required when the top flange of the beam is protected with intumescent coating at the same thickness shown in the table in Item 7.
7. **Mastic and Intumescent Coatings*** — Coating spray or brush applied in accordance with the manufacturer's instructions at the min dry thickness as shown in the table below. The thickness shown below includes the primer thickness. When mineral wool (Item 6) is used, the top surface of the beam need not be protected with coating.

Beam Size	Beam W/D	Unrestrained Beam Rating, Hr.	Minimum Dry Thickness mils	mm
W6x16	0.58	1	39*	0.99*
W8x28	0.81	1	43	1.10
W8x24	0.70	1	53	1.34
W8x24	0.70	1-1/2	66	1.67
W8x24	0.70	2	115	2.92
W6x12	0.52	1	73	1.83
W6x12	0.52	1-1/2	99	2.50
W6x12	0.52	2	171	4.34

*- NW concrete only (See Item 2).

Beam Size	Beam W/D	Restrained Beam Rating, Hr.	Minimum Dry Thickness mils	mm
W6x16	0.58	1	39*	0.99*
W8x24	0.70	1	53	1.34
W8x28	0.81	1	43	1.10
W8x24	0.70	1-1/2	53	1.34
W8x24	0.70	2	71	1.78
W8x24	0.70	3	158	4.00
W6x12	0.52	1	73	1.83
W6x12	0.52	1-1/2	73	1.83
W6x12	0.52	2	101	2.56

*- NW concrete only (See Item 2).

BERLIN CO LTD —Type WB3, Investigated for Interior General Purpose. Type WB4, Investigated for Interior General Purpose. Type WB4, Investigated for Exterior Use with top coat as described in Item 8.

ISOLATEK INTERNATIONAL —Type SprayFilm-WB 3 and Type WB3, Investigated for Interior General Purpose. Type SprayFilm-WB 4 and Type WB4, Investigated for Interior General Purpose. Type SprayFilm-WB 4 and Type WB4, Investigated for Exterior Use with top coat as described in Item 8.

8. **Top Coat** — Type SprayFilm - TOPSEAL and Type TOPSEAL required for Exterior Use, applied at a minimum dry thickness of 14 mils (0.34 mm) over the intumescent material. See Classification information in the Mastic and Intumescent Coating (CDWZ) category, Isolatek International, for mixing requirements.

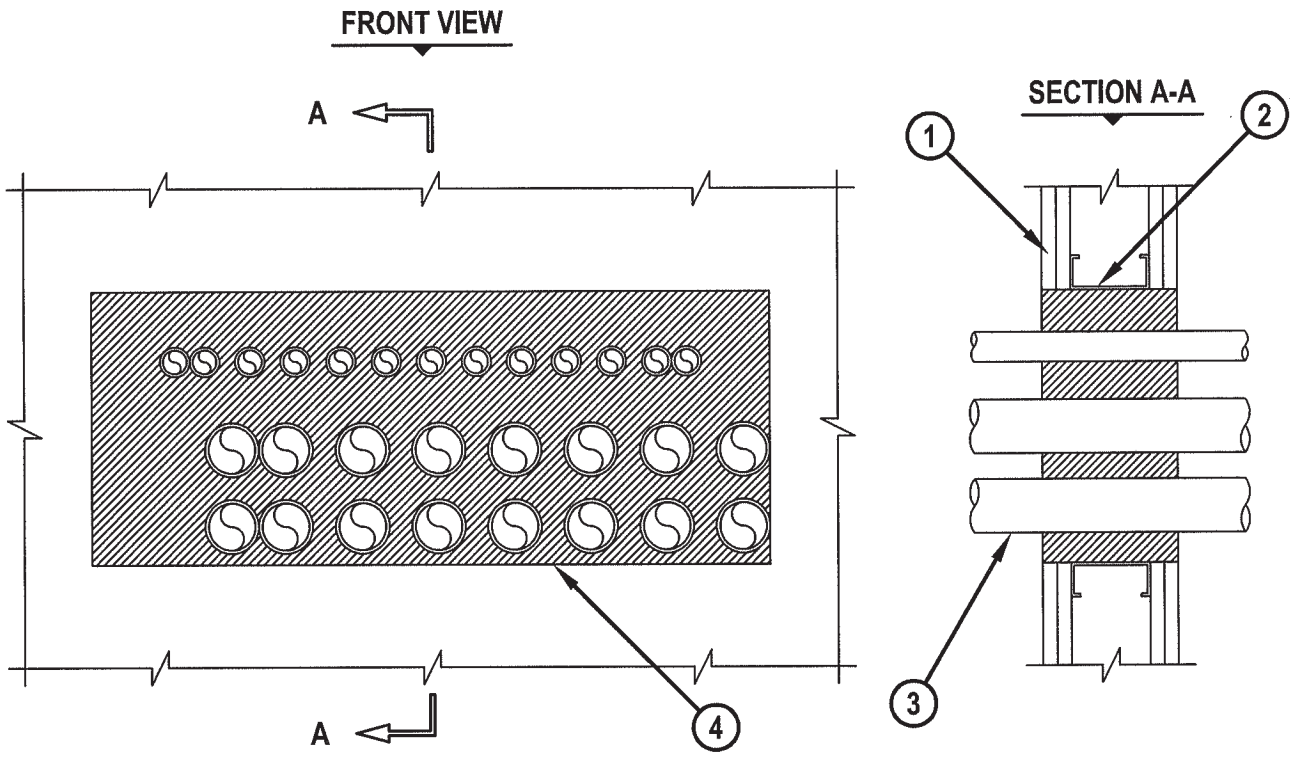
*Bearing the UL Classification Mark

UL/cUL SYSTEM NO. W-L-1249

MULTIPLE METAL PIPES THROUGH 1-HR. OR 2-HR. GYPSUM WALL ASSEMBLY

F-RATING = 1-HR. OR 2-HR.
T-RATING = 1/2-HR.

WL1249a.072401



1. GYPSUM WALL ASSEMBLY (UL/ULC CLASSIFIED U400 SERIES) (1-HR. OR 2-HR. FIRE-RATING) (2-HR. SHOWN).
2. OPENING TO BE "FRAMED OUT" WITH LIGHTGAGE STEEL STUDS (MIN. 3-1/2" WIDE).
3. PENETRATING ITEMS TO BE ONE OR MORE OF THE FOLLOWING :
   - A. MAXIMUM 2" NOMINAL DIAMETER STEEL CONDUIT.
   - B. MAXIMUM 2" NOMINAL DIAMETER EMT.
4. HILTI CP 620 FIRE FOAM INSTALLED FLUSH WITH BOTH SURFACES OF THE WALL :
   - A. MINIMUM 4-3/4" THICKNESS, FOR A 1-HR. FIRE-RATING.
   - B. MINIMUM 6" THICKNESS, FOR A 2-HR. FIRE-RATING.

NOTES : 1. MAXIMUM SIZE OF OPENING = 30" x 12".
2. ANNULAR SPACE BETWEEN PIPES = MINIMUM 0", MAXIMUM 3-3/8".
3. ANNULAR SPACE BETWEEN PIPES AND PERIPHERY OF OPENING = MINIMUM 0", MAXIMUM 3".

HILTI®
FIRESTOP SYSTEMS

HILTI, Inc.
Tulsa, Oklahoma USA (918) 252-6000

Sheet	1 of 1
Scale	1/8" = 1"
Date	July 24, 2001

Drawing No.
WL 1249a

Saving Lives through Innovation and Education

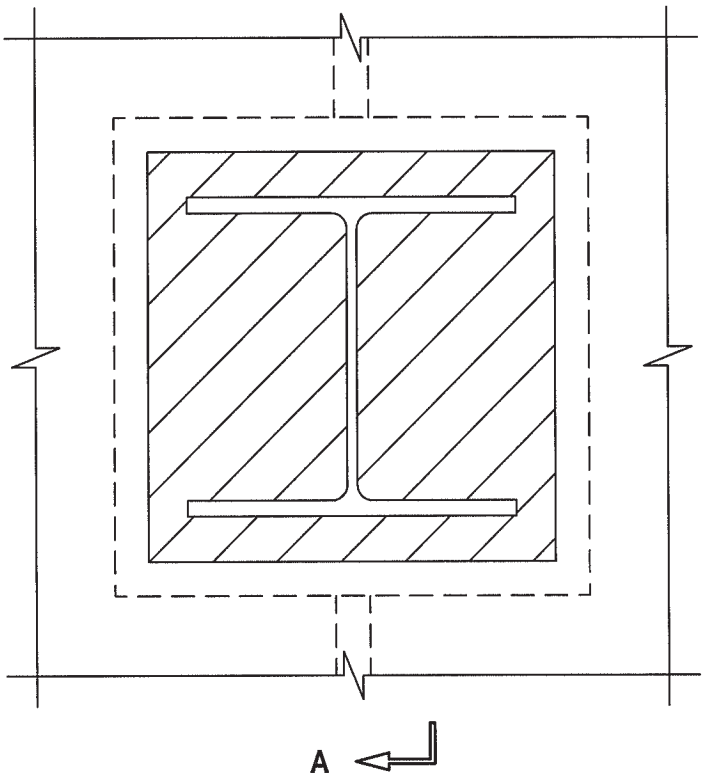
UL/cUL SYSTEM NO. W-L-7188

SUPPORT MEMBER THROUGH GYPSUM WALL ASSEMBLY

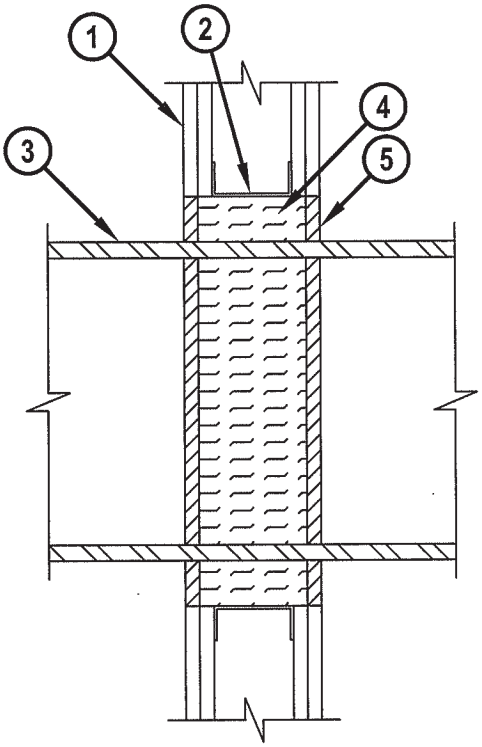
F-RATING = 1-HR. OR 2-HR.
T-RATING = 0-HR.
L-RATING @ AMBIENT = LESS THAN 1 CFM/SQ. FT.
L-RATING @ 400°F = LESS THAN 1 CFM/SQ. FT.

WL7188a.010509

FRONT VIEW



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL/cUL CLASSIFIED U400 OR V400 SERIES) (1-HR. OR 2-HR. FIRE-RATING) (2-HR. SHOWN) TO INCLUDE THE FOLLOWING CONSTRUCTION FEATURES :
   A. STEEL STUDS TO BE MINIMUM 3-1/2" WIDE (SPACED MAXIMUM 24" OC).
   B. NOMINAL 5/8" THICK GYPSUM WALLBOARD. TYPE, NUMBER OF LAYERS, AND SHEET ORIENTATION AS SPECIFIED IN THE INDIVIDUAL UL DESIGN.
2. OPENING TO BE FRAMED OUT WITH ADDITIONAL FRAMING MEMBERS.
3. STEEL I-BEAM SERVICE SUPPORT (MAXIMUM SIZE : W14x90).
4. MINERAL WOOL (MIN. 4 PCF DENSITY) TIGHTLY PACKED, RECESSED TO ACCOMMODATE SEALANT.
5. MINIMUM 5/8" DEPTH HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT.

NOTES : 1. MAXIMUM SIZE OF OPENING = 324 SQ. IN., WITH A MAXIMUM DIMENSION OF 18".
2. ANNULAR SPACE = MINIMUM 1/2", MAXIMUM 3".

Hilti Firestop Systems

HILTI, Inc.
Tulsa, Oklahoma USA (800) 879-8000

Sheet	1 of 1
Scale	1/8" = 1"
Date	Jan. 05, 2009

Drawing No. **WL 7188a**

Saving Lives through Innovation and Education

UL SYSTEM NO. W-L-5225

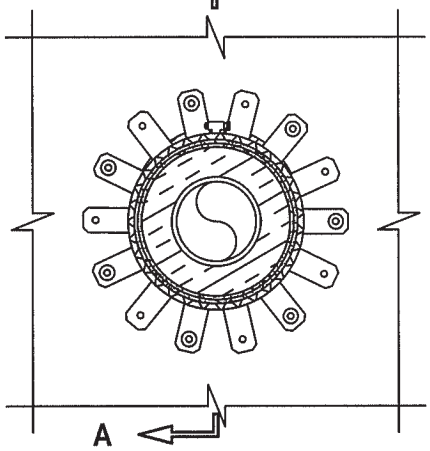
INSULATED PLASTIC PIPE THROUGH GYPSUM WALL ASSEMBLY

F-RATING = 1-HR. OR 2-HR.

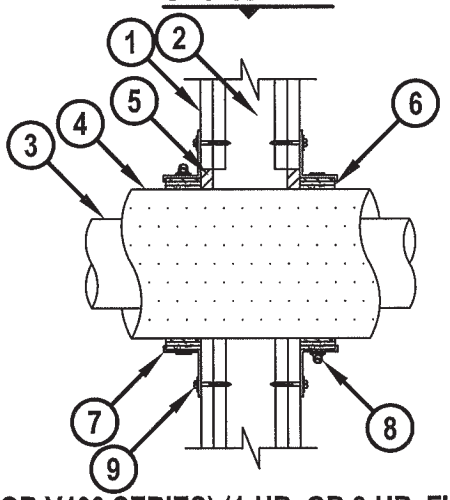
T-RATING = 0-HR., 1-HR., 1 1/2-HR., OR 2-HR.

WL5225e.092209

FRONT VIEW



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL CLASSIFIED U300, U400 OR V400 SERIES) (1-HR. OR 2-HR. FIRE-RATING) (2-HR. SHOWN).
2. [NOT SHOWN] WOOD STUDS TO CONSIST OF NOMINAL 2" x 4" LUMBER. STEEL STUDS TO BE MINIMUM 2-1/2" WIDE.
3. PENETRATING ITEM TO BE ONE OF THE FOLLOWING :
   A. MAXIMUM 4" NOMINAL DIAMETER PVC PLASTIC PIPE (SCHEDULE 40) (CELLULAR OR SOLID CORE) (CLOSED OR VENTED PIPING SYSTEM).
   B. MAXIMUM 4" NOMINAL DIAMETER CPVC PLASTIC PIPE (SDR 13.5) (CLOSED PIPING SYSTEM ONLY).
4. PIPES MAY BE INSULATED WITH NOMINAL 1-1/2" THICK GLASS-FIBER PIPE INSULATION OR 2" AND SMALLER PIPES MAY BE INSULATED WITH MAXIMUM 1" THICK AB/PVC PIPE INSULATION.
5. MINIMUM 5/8" DEPTH HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT.
6. HILTI CP 648E FIRESTOP WRAP STRIPS (NOMINAL 3/16" THICK x 1-3/4" WIDE) CONTINUOUSLY WRAPPED AROUND THE OUTER CIRCUMFERENCE OF THE PIPE, AS SPECIFIED IN TABLE BELOW, WITH ENDS BUTTED AND HELD IN PLACE WITH TAPE.
7. HILTI RETAINING COLLAR WRAPPED OVER WRAP STRIP, OVERLAPPING MINIMUM 1".
8. HILTI COLLAR CLAMP(S) FASTENED AT MID-HEIGHT OF RETAINING COLLAR.
9. EVERY TAB OF RETAINING COLLAR SECURED TO WALL WITH NO. 1-1/4" LONG STEEL LAMINATE SCREWS IN CONJUNCTION WITH 1-1/4" DIAMETER FENDER WASHERS.

NOMINAL PIPE DIAMETER	NO. OF LAYERS OF CP 648E
2" (OR SMALLER)	1
4" (OR SMALLER)	3

NOTES : 1. MAXIMUM DIAMETER OF OPENING = 8-1/2".
2. ANNULAR SPACE [GLASS-FIBER INSULATED PIPES] = MINIMUM 0", MAXIMUM 1".
3. ANNULAR SPACE [AB/PVC INSULATED PIPES] = MINIMUM 1/8", MAXIMUM 1/4".

Hilti Firestop Systems

HILTI, Inc.
Tulsa, Oklahoma USA (800) 879-8000

Sheet	1 of 1
Scale	7/64" = 1"
Date	Sep. 22, 2009

Drawing No. WL 5225e

Saving Lives through Innovation and Education

UL/cUL SYSTEM NO. W-L-7040

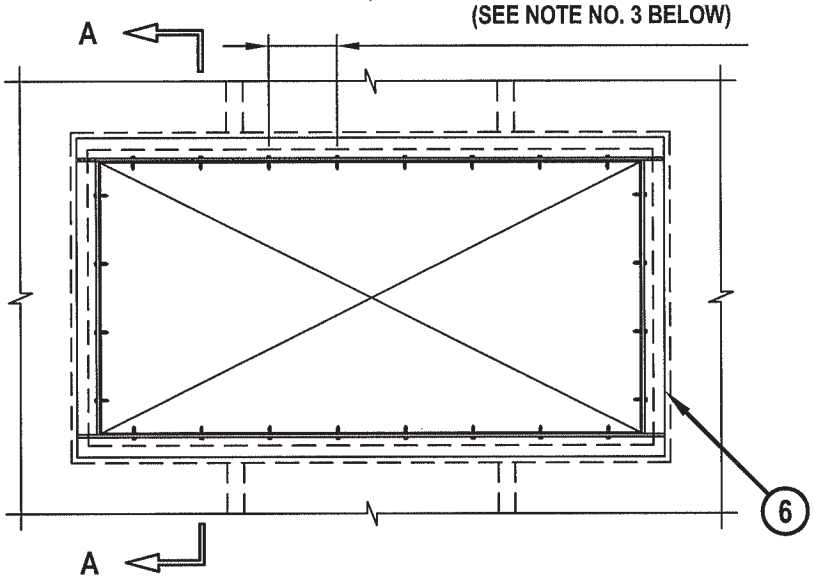
METAL DUCT (WITHOUT DAMPER) THROUGH GYPSUM WALL ASSEMBLY

F-RATING = 1-HR. OR 2-HR.
T-RATING = 0-HR.
L-RATING AT AMBIENT = LESS THAN 1 CFM/SQ. FT.
L-RATING AT 400°F = LESS THAN 1 CFM/SQ. FT.

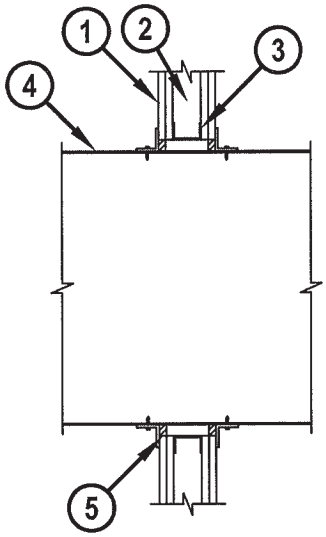
WL7040h.022412

FRONT VIEW

MAX. 6" C/C SPACING
(SEE NOTE NO. 3 BELOW)



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL/cUL CLASSIFIED U300 OR U400 SERIES WALL) (1-HR. OR 2-HR. FIRE-RATING) (2-HR. SHOWN).
2. (NOT SHOWN). WOOD STUDS TO CONSIST OF NOMINAL 2" x 4" LUMBER. STEEL STUDS TO BE MINIMUM 2-1/2" WIDE.
3. OPENING TO BE "FRAMED OUT" WITH LIGHTGAGE METAL FRAMING STUDS.
4. MAXIMUM 48" x 24" RECTANGULAR SHEET METAL DUCT (MIN. 24 GA.) (*NOTE : NOT FOR USE IN DUCT SYSTEMS CONTAINING A FIRE DAMPER*).
5. MINIMUM 5/8" DEPTH HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT, HILTI CP 601S ELASTOMERIC FIRESTOP SEALANT, OR HILTI CP 606 FLEXIBLE FIRESTOP SEALANT.
6. [NOT SHOWN] APPLY MINIMUM 1/2" BEAD HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT, HILTI CP 601S ELASTOMERIC FIRESTOP SEALANT, OR HILTI CP 606 FLEXIBLE FIRESTOP SEALANT AT POINT OF CONTACT PRIOR TO ATTACHING STEEL ANGLE.

NOTES : 1. MAXIMUM AREA OF OPENING = 1300 SQ. IN., WITH A MAXIMUM DIMENSION OF 50".
2. ANNULAR SPACE = MINIMUM 0", MAXIMUM 2".
3. AFTER SEALING SPACE BETWEEN DUCT AND GYPSUM WALL ASSEMBLY WITH HILTI FIRESTOP SEALANT, FASTEN STEEL ANGLE (MIN. 18 GA.) TO DUCT WITH MINIMUM NO. 8 x 3/4" LONG SHEET METAL SCREWS. STEEL ANGLE TO OVERLAP DUCT BY MINIMUM 2" AND GYPSUM WALL ASSEMBLY BY MINIMUM 1". ANGLE DOES NOT HAVE TO BE FASTENED TO GYPSUM WALL ASSEMBLY. WHEN DUCT IS AT POINT OF CONTACT, ANGLES TO BE INSTALLED PRIOR TO FULL MATERIAL CURING.

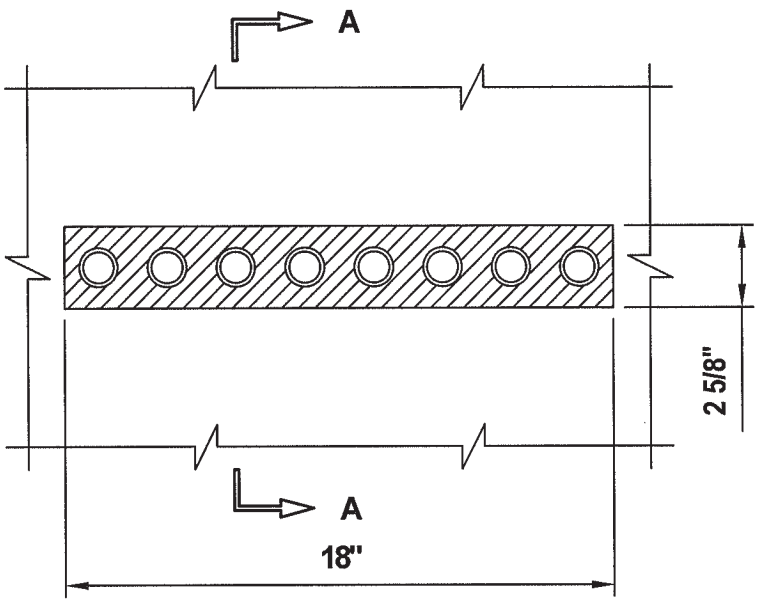
UL/cUL SYSTEM NO. WL1095

METAL PIPE THROUGH GYPSUM WALL ASSEMBLY

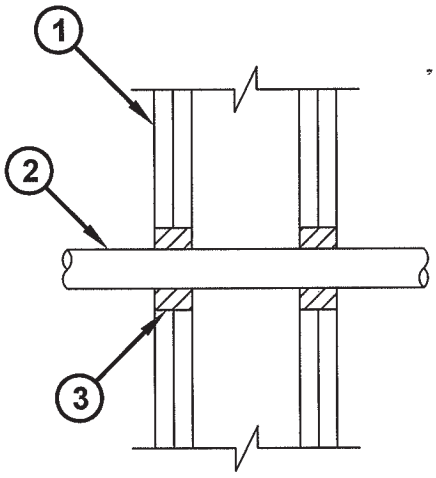
F-RATING = 1 AND 2-HR.
T-RATING = 1 AND 2-HR.
L-RATING AT AMBIENT = LESS THAN 1 CFM/SQ. FT.
L-RATING AT 400° F = 4 CFM/SQ. FT.

WL1095d.091699

FRONT VIEW



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL/ULC CLASSIFIED U300 OR U400 SERIES) (1-HR. OR 2-HR. FIRE-RATING) (2-HR. SHOWN).
2. ONE OR MORE 1" NOMINAL DIAMETER EMT.
3. HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT:
   A. MINIMUM 5/8" DEPTH, FOR A 1-HR. FIRE-RATING.
   B. MINIMUM 1-1/4" DEPTH, FOR A 2-HR. FIRE-RATING.

NOTE : ANNULAR SPACE = MINIMUM 1/2", MAXIMUM 1".

HILTI® FIRESTOP SYSTEMS	HILTI, Inc. Tulsa, Oklahoma USA (918) 252-6000	Sheet 1 of 1 Scale 11/64" = 1" Date SEPT. 16, 1999	Drawing No. WL 1095d

Saving Lives through Innovation and Education

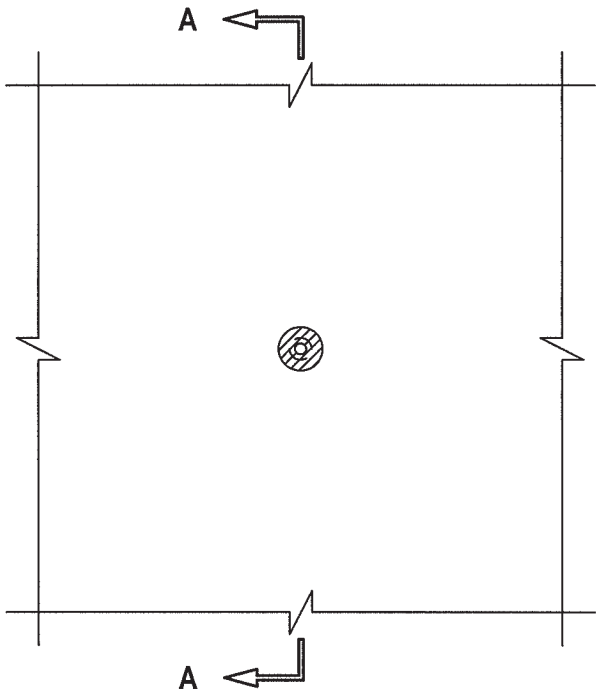
UL/cUL SYSTEM NO. WL3058

CABLE THROUGH GYPSUM WALL ASSEMBLY

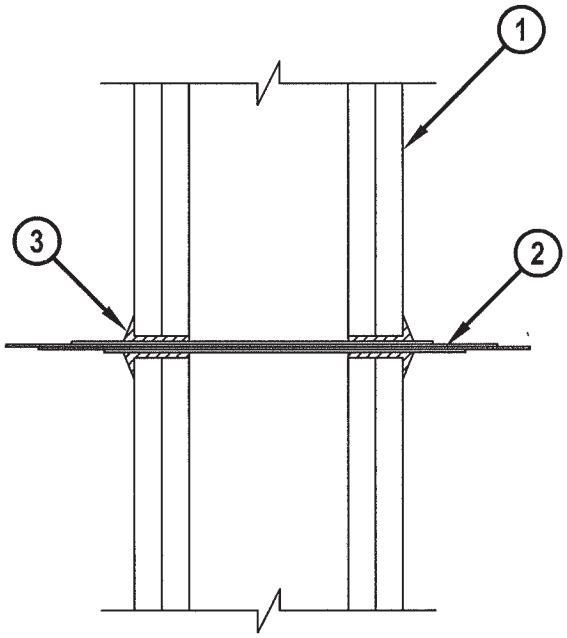
F RATING = 2-HR.
T RATING = 1-1/2-HR.
L RATING AT AMBIENT = LESS THAN 1 CFM/SQ. FT.
L RATING AT 400° F = 4 CFM/SQ. FT.

WL3058c.091699

FRONT VIEW



SECTION A-A



1. GYPSUM WALL ASSEMBLY (UL/ULC CLASSIFIED U300 OR U400 SERIES) (2-HR. FIRE-RATING).
2. MAXIMUM 25 PAIR NO. 24 AWG TELEPHONE CABLE.
3. HILTI FS-ONE INTUMESCENT FIRESTOP SEALANT FORCED INTO ANNULAR SPACE TO MAXIMUM EXTENT POSSIBLE, WITH ADDITIONAL 1/4" CROWN AROUND CABLE AS SHOWN.

NOTE : MAXIMUM DIAMETER OF OPENING = 1/2".

HILTI®
FIRESTOP SYSTEMS

HILTI, Inc.
Tulsa, Oklahoma USA (918) 252-6000

Sheet	1 of 1
Scale	1/4" = 1"
Date	SEPT. 16, 1999

Drawing No.
WL
3058c

Saving Lives through Innovation and Education

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3SB4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245617**

2.STATE VENDOR OR MEDICAID NO.
(L2) **550012400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CARONDELET VILLAGE CARE CENTER**
(L4) **525 FAIRVIEW AVENUE SOUTH**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: B * Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sheryl Reed, HFE NE II — 11/07/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/27/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed September 26, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4530

October 31, 2013

Ms. Heather Heijerman, Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, Minnesota 55116

RE: Project Number S5617002

Dear Ms. Heijerman:

On September 26, 2013, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 4, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 4, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 26, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 26, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL., MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES -- - (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR-REC-TION-- ----- (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(>:.'])- COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification	F 000	RECEIVED NOV - 6 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain tbe_resident's_ highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279 11/4/13 SER	**F279** Resident 34 was comprehensively reassessed by occupational therapy on 9/26/13. Resident 34 care plan and My Best Day was reviewed and revised with new interventions related to wheelchair positioning. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been completed for nursing staff on 10/14/13. FMP process has been reviewed and therapy educated. Therapy discharge summary to match the care plan, My Best Day and FMP.	11/4/13

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Hujima	Care Center Administrator	11/4/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTiFieATION--NtJMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED-
	245617	A. BUILDING _____ B. WING	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION 'DATE
F 279	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to develop a plan of care related to repositioning interventions for 1 of 1 resident (R34) in the sample identified with positioning needs. Findings include: R34's plan of care did not address repositioning interventions to maintain upright positioning and prevent leaning. R34 diagnoses included dementia with lewy bodies, abnormal posture, muscle weakness, and anxiety. During observation on 9/23/13, at 4:20p.m. R34 was sitting in her wheelchair, which was in the upright position, on unit two at an activity table. R34 was leaning to the !efLwithouLany support.. R34 appeared uncomfortable but was unable to reposition herself to an upright position. The wheelchair had a tray table attached on the right side that was in the down position. At 4:30 p.m. nursing assistant (NA)-A approached R34 and asked, "Can I reposition you so you are sitting up straighter." NA-A straightened R34 so her back was supported by the back of the wheelchair. At 4:40p.m. R34 was leaning to the left with no support in place. At 4:58p.m. R34 was sitting in her wheelchair in the dining room. R34 was leaning to her left with no support. At 5:20p.m., R34 was still in the dining room leaning to her left. At 6:20 p.m. R34 was sitting in her wheelchair, which was in the upright position, at a table on unit two. R34 was leaning to her left without any support.	F 279	Continued from page 1 Audits regarding care plan and wheelchair positioning will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLJER/CI.IA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY .COMPLETED
	245617	A. BUILDING _____ B. WING	09/26/2013

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F 279	Continued From page 2 On 9/24, 2013 at 1:30 p.m., R34 was sitting in wheelchair with a right sided half tray table. R34 was leaning to the left with arm, shoulder and neck off the wheelchair. The left arm was hanging down on the side. Resident 34 was not able to reposition self or to pull her shoulder up in alignment. R34 would occasionally raise her head and look up and around and then rest her head down again. At approximately 2:00 p.m. R34 was ambulated by 2-3 staff persons. When R34 was returned to the wheelchair, the right arm rested on the side tray table and the left arm was on the left wheelchair arm. At 2:37 p.m., R34 was taken outside. At 3:10p.m. R34 was back sitting at the table in the lounge area and leaning to the left with the left arm off the wheelchair. The left shoulder was off the wheelchair and R34 was looking down. A staff person obtained a small fleece blanket and rolled it over and placed it over the arm of the chair providing additional padding. R34 appeared to sit up in the wheelchair. On 9/25/13 at 10:00 a.m., R34 was sitting outside the bedroom in the wheelchair eating breakfast. A white fleece material cover was on the left wheelchair arm. R34 was sitting up straight with right arm on the lap tray. Nursing Assistant (NA)-A indicated it should be on the wheelchair at all times unless it is in the wash; then a small blanket should be used. The most recent occupational therapy progress note, dated 5/29/13, indicated the resident was being seen due to decrease posture in wheelchair. The progress note indicated there was improved wheelchair positioning with care giver training for wheelchair positioning and recommended the wheelchair be reclined during the day to improve right posture equality. The	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 Occupational Therapy discharge summary, for services provided from 5/23/13-7/12/13, recommended to staff to recline the wheelchair during the day to rest back for improved upright posture quality. The care plan, undated, identified having limited physical mobility related to Parkinson and scoliosis and read "I require support for bed mobility, transfer and ambulation". Interventions include: I have a wheelchair to reach destinations other than in care center, I request my foot pedals be on my wheelchair when I am being transported, and observe for changes in mobility, contractures forming or worsening, thrombus formation, skin breakdown, fall related injury and update physician as needed. The care plan did not address concerns from occupational therapy. On 9/25/13 at 11:39 a.m, the clinical administrator, (CA) indicated the resident had lewy bodies and tends to reach for the floor, however, everyone knows to redirect the resident to sit up. The CA had not seen the white fleece wrap used before and was unaware of where it came from. The clinical administrator verified the care plan and the "My Best Day" (form used to instruct staff how to care for the resident) did not address how to position the resident in the wheelchair using the side lap tray nor any interventions to prevent leaning.tQaoaside.	F 279		
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.	F 282	**F282** Resident 25 care plan and My Best Day was comprehensively reassessed for falls and adjusted to show current interventions for fall prevention.	11/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING B. WING	09/26/2013

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R25) who were reviewed for accidents. Findings include: R25 was identified as a fall risk, and the facility did not follow the interventions on the care plan to prevent falls. Review of R25's fall care plan, last revised on 8/30/13, directed staff to keep wheelchair at bedside. Resident care guide, "My Best Day"did not have the intervention to keep wheelchair at bedside. On 9/26/13, at 8:30a.m. R25 was observed in bed. Wheelchair was next to wall and out of reach of R25. On 9/26/13, at 9:50a.m., interview with the clinical manager (CM)-A stated R25 fall care plan directed staff to place wheelchair at bedside. CM-A stated staff would be aware of the intervention through facility care guide labeled "My Best Day." CM-A verified the intervention was not on the "My Best Day" form and further explained the "My Best Day" form was a new document the facility introduced within the last 60 to 90 days.	F 282	Continued from page 4 All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been completed for nursing staff on 10/14/13. Audits regarding care plan and fall interventions will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	**F309** Resident 34 was comprehensively	11/4/13

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	245617	A. BUILDING _____ B. WING	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STT«;ET-AODRE88, -OFPf, S-TAT, :Z:ffl-CODE
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F 309	Continued From page 5 Each resident must receive and the facility must provide the necessary care and-services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary services related to repositioning for 1 of 1 resident (R34) identified for positioning needs. Findings include: Record review identified R34 had diagnoses of dementia with lewy bodies, abnormal posture, muscle weakness, anxiety and the facility did not provide services to promote R34 to sit in an upright position. On 9/23/13, at 4:20p.m., during observations, R34 was sitting in a wheelchair, in an upright position, on unit two at an activity table. R34 was leaning to the left without any support. R34 appeared uncomfortable but was unable to reposition herself to an upright position. There was a tray table attached on the right side of the wheelchair in the down position. At 4:30 p.m. nursing assistant (NA)-A approached R34 and asked, "Can I reposition you so you are sitting up straighter." NA-A straightened R34 so her back was supported by the back of the wheelchair. At 4:40p.m. R34 was leaning to the left with no support in place. At 4:58 p.m. R34 was sitting in	F 309	Continued from page 5 reassessed by occupational therapy on 9/26/13. Resident 34 care plan and My Best Day were reviewed and revised with current interventions. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been completed for nursing staff on 10/14/13. FMP process has been reviewed and therapy educated. Therapy discharge summary to match the care plan, My Best Day and FMP. Audits regarding Care Plan will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 6 her wheelchair in the dining room. R34 was leaning to her left with no support. At 5:20 p.m. R34 was still in the dining room leaning to her left. At 6:20p.m. R34 was sitting in her wheelchair, which was in the upright position, at the activity table on unit!>No. R34 was leaning to her left without any support. On 9/24, 2013 at 1:30 p.m., R34 was sitting in wheelchair with a right sided half tray table. R34 was sitting near a table with newspapers and magazine on it. R34 was leaning to the left with arm, shoulder and neck off \he wheelchair. The left arm was hanging down on the side. Resident 34 was not able to reposition self or to pull her shoulder up in alignment. Resident 34 would occasionally raise her head and look up and around and then rest her head down again. At approximately 2:00p.m. R34 was ambulated by 2-3 staff persons. When R34 was returned to the wheelchair, the right arm rested on the side tray table and the left arm was on the left wheelchair arm. At 2:37p.m., R34 was taken outside. At 3:10p.m. R34 was back sitting at the table in the lounge area and leaning to the left with the left arm *off* the wheelchair. A stallperson obtained a small fleece blanket and rolled it over and placed it over the arm of the chair providing additional padding. R34 appeared to sit up in the wheelchair. On 9/25/13 at 10:00 a.m., R34 was sitting outside the bedroom in the wheelchair eating breakfast. A white fleece material cover was on the left wheelchair arm. R34 was sitting up straight with right arm on the lap tray. Nursing Assistant (NA)-A indicated it should be on the wheelchair at all times unless its in the wash; then we should use a small blanket.	F 309		

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F 309	Continued From page 7	F 309		

The quarterly minimum data set (MDS) dated 6/23/13 indicated R34 was cognitively impaired, and required extensive assistance of two staff for bed mobility and transferring. The MDS also indicated the resident did not have a restraint for trunk or side. The
The Care Conference Summary Tool, dated 7/9/13, read "...requires staff support for bed mobility, transfer, and ambulation Needs w/c (wheelchair) propelled. OT(occupational therapy) has started with W/C (wheelchair) pos"1tioning..."

The most recent occupational therapy progress note, dated 5/29/13, indicated the resident was being seen due to decrease posture in wheelchair. The progress note indicated there was improved wheelchair positioning with care giver training for wheelchair positioning and recommended the wheelchair be reclined during the day to improve right posture equality. The Occupational Therapy discharge summary, for services provided from 5/23/13-7/12/13, recommended to staff to recline the wheelchair during the day to rest back for improved upright posture quality.

The care plan, undated, identified having limited physical mobility related to Parkinson and scoliosis and read "I require support for bed mobility, transfer and ambulation". Interventions include: I have a wheelchair to reach destinations other than in care center, I request my foot pedals be on my wheelchair when I am being transported, and observe for changes in mobility, contractors forming or worsening, thrombus formation, skin breakdown, fall related injury and update physician as needed.

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F 309	Continued From page 8 On 9/25/13 at 11:00 a.m , the rehabilitation supervisor indicated she was aware of the resident and ongoing concerns with positioning and verified the recommendations made by the occupational therapist. On 9/25/13 at 11:39 a.m., the clinical administrator indicated the resident had lewy bodies and tends to reach for the floor, however, everyone knows to redirect her to sit up. The clinical administrator verified the care plan and the "My Best Day" (form used to instruct staff how to care for the resident) did not address how to position the resident in the wheelchair using the side lap tray nor any interventions to prevent leaning to one side. The clinical administrator also identified that nursing does not review the occupational progress notes. The procedure to communicate with nursing is to fill out a functional maintenance program (FMP) and indicate recommendations. The occupational therapist sending the progress notes, did not fill out a FMP to communicate with the nursing staff and the recommendations did not get identified. The Policy and Procedure for Therapy Recommendations/FMP, dated 3/29/11, indicated after a comprehensive evaluation of patient status is completed the "Therapy recommendations/FMP form to communicate carryover recommendations to the IDT (interdisciplinary team)." and "Caregiver education will be conducted for needs identified in each functional area." On 9/25/13 at 1:00 p.m. the rehabilitation supervisor reviewed their records and agreed the Therapy Recommendations/FMP for R34 had not been completed and/or forwarded to the IDT.	F 309		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT 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 observation, interview, and document review, the facility failed to ensure consistent fall safety measures were in place to minimize the risk of falls for 1 of 3 residents (R25) who were reviewed for accidents. Findings include: R25's wheelchair was not placed at bedside as directed by facility plan of care last revised on 8/30/13. On 9/25/13, at 9:58a.m. R25 was observed to be sleeping in bed. The wheelchair was next to bed, breaks were locked and call light was within reach. On 9/26/13, at 8:30 a.m. R25 was in bed. The wheelchair was next to the wall and out of reach of R25. Breaks were locked, and the call light was within reach. Minimum Data Set (MDS) dated 8/14/13, identified R25 as a fall risk with an extensive fall history, and required extensive assist with transfers. BIMS (Brief Interview Mental Status) cognitive assessment indicated R25 was moderately impaired as evidenced by score 9 of	F 323	**F323** Resident 25 care plan and My Best Day was comprehensively reviewed for falls and adjusted to show current interventions for fall prevention. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and the fall prevention policy have been reviewed and is current. Education on care planning has been completed for nursing staff on 10/14/13. Audits regarding Care Plan and fall interventions will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	11/4/13

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F 323	Continued From page 10 15. The care plan last revised on 8/30/13, indicated R25 was a fall risk, and unaware of safety needs. Diagnoses included dementia with confusion, depression, insomnia and psychosis. Fall interventions initiated on 6/12113, indicated "place wheelchair next to bed." The resident/visitor fall report dated 9/6/13, at 11:10 p.m. R25 was standing outside of doorway and lowered self to ground and began to crawl when staff called R25's name. On 9/25/13, at 10:15 a.m. the charge nurse (RN-A) stated R25 had a history of falls due to self-transfers, crawling out of bed and insomnia. The facility interventions in place were to decrease falls. On 9/26/13, at 9:45a.m. nursing assistant (NAR-A) stated the wheelchair should be at bedside when R25 was sleeping because R25 often gets out of bed when she can't sleep. NAR-A stated she was directed to place the wheelchair at bedside by the "My Best Day" form. On 9/26/13, at 9:50 a.m. the clinical manager (CM)-A stated staff would be aware of the safety intervention to put wheelchair at bedside when occupied, by the "My Best Day" form. CM-A verified the information was not on R25's record. CM-A further stated the documentation form had been changed in the past 60 to 90 days, however the intervention to put wheelchair nex1to bed had not been transcribed to "My Best Day" form for R25.	F 323		
F 329	483.25(1) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 11 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an *effort* to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to monitor and document effectiveness of dose increases and of non-pharmacological interventions related to the use of psychoactive medication for 2 of 5 residents (R7, R52) reviewed for unnecessary medications. Findings include:	F 329	**F329** Resident 7 and Resident 52 non-pharmacological interventions related to psychoactive medication were reviewed. Care plan was updated and is accurate and effective. Resident 7 and Resident 52 My Best Day were reviewed and are accurate. PHQ9's were completed on 10/15/13 for Resident 7 and Resident 52 and are favorable to previous PHQ9. All Residents receiving antidepressants have been reviewed by consulting pharmacist and care planned for non-pharmacological interventions. Temporary care plan to be initiated with any new psychoactive medication order or dose increase. Temporary care plan to include monitoring and documenting effectiveness of non-pharmacological interventions. Policy and procedure regarding psychoactive medication in relation to administering, monitoring and documentation has been reviewed and is accurate. Education on unnecessary medications, monitoring and documentation of effectiveness has been completed for nursing staff on 10/14/13. Audits regarding monitoring and documentation related to unnecessary	11/4/13

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY 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 329	Continued From page 12 R7 did not have identification of target behaviors, accurate monitoring of depression, an individualized plan of care related to depression, and non-pharmacological interventions for depression incorporated into the plan of care. R7's current physician orders dated 2/28/13, included an order for mirtazapine (Remeron, an anti-depressant) 3 75 milligrams (mg) at bedtime for depression. The Medication Informed Consent Form dated 3/18/13, listed Remeron 3.75 mg at bedtime, but the line on the form for the "reasons and benefits" for using this medication was blank. The September 2013, medication administration record (MAR) showed R7 received the medication daily, and contained monitoring for side effects of the medication, but contained no documentation of behavior monitoring or non-pharmacological interventions related to the medication. R7's current care plan dated 2/5/13, read, "I use an antidepressant medication r/t [related to) Depression (sic]." Interventions included, "Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness...Observe and update my physician to MD prn (as needed) ongoing s/sx [signs/symptoms] of RAsst [sic] depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations..." No non-pharmacological interventions were listed on the care plan for depression. R7's care plan dated 5/21113, "I have adjustment issues to *rlt* anxiety and i still look for my father (sic]." The interventions related to anxiety did not include the use of anti-depressant medication.	F 329	Continued from page 12 medications will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(, 1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	{X3}-B/\TE--8URVE¥ COMPLETED
	245617	A. BUILDING _____ B. WING	09/26/2013

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F 329	Continued From page 13 R? scored 6 on the 7/31113, PHQ-9 (Patient Health Questionnaire) section of the Minimum Data Set, and 5 on the 4/30/13, PHQ-9 (a score of 5-9 being mild depression). When interviewed on 9/26/16, at 9:15a.m. clinical manager (CM)-A was asked where the target behaviors for the Remeron were listed in the record. CM-A stated target behaviors were generally listed on the resident's MAR, but could not locate them on R?'s MAR. The CM·A was asked if the list of possible behaviors related to depression listed on R?'s care plan were a specific, individualized list for R7, or a generic listed generated by the care plan software. CM-A stated she believed they were a generic list generated by the care plan software. CM-A then stated R7's problems were mainly related to anxiety and confusion. During interview on 9/26/13, at 9:30a.m. the clinical administrator (CA) was asked if there were target behaviors documented for Remeron that R7 was receiving. TheCA stated the facility does not develop target behaviors for monitoring depression. When asked how the facility monitors the depression and where the facility gets the data to analyze the effectiveness of the psychoactive medication, the CA stated the facility used the PHQcS form resos andihe household coordinator documented a quarterly analysis note in the record The household coordinator was interviewed 9/26/13, at 9:35a.m. The household coordinator stated received the data to write a quarterly analysis note for R7's depression from interdisciplinary meetings and progress notes in	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) P. ID	PPLIERICLIA N NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 14		F 329		

the resident's record. The analysis dated 8/27113, and 5/21/1 esident has adjusted significantly more t care conferences. There are s t times of confusion and asking to s er (she really means her son Steve). R MS [Brief Interview for Mental Statu sseverely impaired cognition with 06 dent is extremely forgetful, and o her oxygen off/states she doesn't nee is has happened a lot less since CC [care conference] as well [sic]. asking for her father, needing to call him needs still indicate care center place sident enjoys her time here and has bee a lot more activities since last cc."

R7's progress notes were for 7/31/13 through 9/26/13. Only nine the progress notes were found detailing issues for R7, and did not support th nt in the quarterly analysis, "Const for her father, needing to call him

R52 received sertraline (Z lepression and the medical record lac oring of the effectiveness of a dose inc he medication. The care plan entify comprehensive individual or non-pharmacological inter or depression. R52 was adn e facility on 4/8/13, with diagnoses tha congestive heart failure, depression a ar degeneration. R52 had tr from out of state to Minnesota.

The admission order for s Zoloft) was 50 milligrams (mg) daily. On e Zoloft was increased to 75 mg daily. practitioner

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F 329	Continued From page 15 note, dated 5/8/13 read: "likely depressed, keeps eyes closed and pleasant but withdrawn." A nurse practitioner note dated 6/11113, read, "No noted SE (side effects) of increase dose Zoloft-watch and if she has issues then decrease or de (discontinue) it. The medical record lacked any monitoring of symptoms of depression or side effects of the medication. On 7117113, the primary physician wrote, "has good days and bad days, Sometimes quite lethargic..." and depression stable." The progress notes documentation revealed only one entry had been made regarding follow up monitoring on the symptoms of depression or the side effects of the medication for R52. The progress note dated 7/14/13, indicated the resident was lethargic and refused to eat. No additional information was provided, when requested. The resident scored 3 on the PHQ-9 (Patient Health Questionaire) on the admission Minimum Data Set (MDS) and on the 7/10/13, quarterly MOS. Scores indicated no signs or symptoms of depression. The care conference summary tool dated 7/30/13, indicated R52 "has adjusted adequately to the the care center...Wandering was a one time issue." R52 had transferred from living out of state however, the summary did not address how that may have impacted the resident. R52's current care plan dated 4/18/13, identified the use of an antidepressant medication related to depression. The care plan read, "Observe and	F 329		

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F 329	Continued From page 16 update my physician to MD pm (as needed) s/sx (signs symptoms) of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance." Other interventions on the care plan directed staff to inform resident and family of side effects and risks and benefits of the medications. There was no indication on the care plan identifying what symptoms R52 displayed. On 9/26/13 at 9:20a.m., the clinical coordinator indicated the care plan for depression was generic and not specific for any one individual resident. The care plan lacked specific non-pharmalogical interventions for depression symptoms. On 9/26/13 at 9:30a.m. the clinical administrator (CA) indicated the nursing staff would not have reviewed the nurse practitioner notes regarding the ongoing use of medications. The CA indicated R52 had been the same for a long time, since he had known her, and there had been no change. However, the CA was not aware of the . medication dose increase.-'fheGAadded-target-behaviors were not identified for monitoring depression. The CA verified there was no documentation justifying the increase nor any staff documentation regarding monitoring the effectiveness of the increased dose or of any side effects. The CA added the significant changes were discussed at the daily meeting.	F 329		

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F 329	Continued From page 17 On 9/26/13, at 10:13 a.m. the house hold coordinator indicated the PHQ-9 score for the quarterly assessment showed an improvement going from a 5 to a 3 since the increase of the antidepressant. The documented MDS records indicated the scores remained at a score of 3, showing no depression. On 9/30/13 at approximately 10:30 a.m. 1trE CA- clarified the care plan verses the "My Best Day" form. The CA indicated the "My Best Day" form was a tool used to assist staff to care for residents, but it was not part of the care plan. The facility's Psychotropic Medication Use policy dated November 2011, read, "Facility staff (such as licensed nurses, certified nursing assistants, activity therapists, social workers, and other staff members) will monitor the resident's medical symptoms, condition, circumstances and environment in order to evaluate the appropriateness of the psychoactive medication being used." "Designated facility staff will document episodes of behavior, the impact of the medication on behavior and the presence or absence of side effects."	F 329		
F 428 SS=D	483.6D(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**F428** The facilities consulting pharmacist was notified on 10/1/13 regarding Resident 7 and Resident 52 in terms of the lack of monitoring and documentation of effectiveness of non-pharmacological interventions related to the use of psychoactive medications.	11/4/13

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F 428	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility's consulting pharmacist did not advise the facility regarding the lack of monitoring and documentation of the effectiveness of non-pharmacological interventions related to the use of psychoactive medications for 2 of 5 residents (R7, R52) reviewed for unnecessary medications. Findings include: R7's current physician orders dated 2/28/13, included an order for mirtazapine (Remeron, an anti-depressant) 3.75 milligrams (mg) at bedtime for depression. The Medication Informed Consent Form dated 3/18/13, listed Remeron 3.75 mg at bedtime, but the line on the form for the "reasons and benefits" for using this medication was blank. The September 2013, medication administration record {MAR) showed R7 received the medication daily, and contained monitoring for side effects of the medication, but contained no documentation of behavior monitoring or non-pharmacological interventions related to the medication. R7's current care plan dated 2/5/13, read, "I use an antidepressant medication r/t [related to] Depression [sic]." Interventions included, "Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness...Observe and update my physician to MD prn [as needed] ongoing slsx	F 428	Continued from page 18 Pharmacist consultant will monitor the facilities documentation for effectiveness of non-pharmacological measures in relation to psychoactive medications monthly. Resident 7 and Resident 52 non-pharmacological interventions related to psychoactive medication were updated and are accurate and effective. Resident 7 and Resident 52 care plan and My Best Day were reviewed and are accurate. PHQ9's were completed on 10/15/13 for Resident 7 and Resident 52 and are favorable to previous PHQ9. All Residents receiving antidepressants have been reviewed by consulting pharmacist and care planned for non-pharmacological interventions. Temporary care plan to be initiated with any new psychoactive medication order or dose increase. Temporary care plan to include monitoring and documenting effectiveness of non-pharmacological interventions. Policy and procedure regarding psychoactive medication in relation to administering, monitoring and documentation has been reviewed and is accurate. Education on unnecessary medications has been completed for nursing staff on	

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F 428	Continued From page 19 [signs/symptoms] of RAsst [sic] depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations..." No non-pharmacological interventions were listed on the care plan for depression. R7's care plan dated 5/21113, "I have adjustment issues to r/t anxiety and i still look for my father [sic]." The interventions related to anxiety did not include the use of anti-depressant medication. R7 scored 6 on the 7/31113, PHQ-9 (Patient Health Questionnaire) section of the Minimum Data Set, and 5 on the 4/30/13, PHQ-9 (a score of 5-9 being mild depression). When interviewed on 9/26/16, at 9:15a.m. clinical manager (CM)-A was asked where the target behaviors for the Remeron were listed in the record. CM-A stated target behaviors were generally listed on the resident's MAR, but could not locate them on R7's MAR. The CM-A was asked if the list of possible behaviors related to depression listed on R7's care plan were a specific, individualized list for R7, or a generic list generated by the care plan software. CM-A stated she believed they were a generic list generated by the care plan software. CM-A then stated R7's problems were mainly related to anxiety and confusion. During interview on 9/26/13, at 9:30a.m. the clinical administrator (CA) was asked if there were target behaviors documented for Remeron that R7 was receiving. TheCA stated the facility does not develop target behaviors for monitoring depression. When asked how the facility monitors the depression and where the facility gets the data to analyze the effectiveness of the	F 428	Continued from page 19 10/14/13. Audits regarding monitoring and documentation related to unnecessary medications will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 11/4/13.	

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F 428	Continued From page 20 psychoactive medication, the CA stated the facility used the PHQ-9 form results and the household coordinator documented a quarterly analysis note in the record. The household coordinator was interviewed 9/26/13, at 9:35a.m. The household coordinator stated received the data to write a quarterly analysis note for R7's depression from interdisciplinary meetings and progress notes in the resident's record. The quarterly analysis dated 8/27/13, and 5/21113, read, "Resident has adjusted significantly more since last care conferences. There are still frequent times of confusion and asking to see her father (she really means her son). Resident BIMS [Brief Interview for Mental Status] indicates severely impaired cognition with 06/15. Resident is extremely forgetful, and often takes her oxygen off/states she doesn't need it, but this has happened a lot less since previous CC [care conference] as well [sic]. Constant asking for her father, needing to call him. Clinical needs still indicate care center placement. Resident enjoys her time here and has been out for a lot more activities since last cc." R7's progress notes were reviewed for 7/31/13 through 9/26/13. Only nine entries in the progress notes were found detailing behavior issues for R7, and did not support the statement in the quarterly analysis, "Constant asking for her father, needing to call him." The consulting pharmacist's medicaticm regimen reviews from 2/5/13 until 8/20/13, indicated the consulting pharmacist documented resident record reviews monthly, but there was no documentation of irregularities related to the	F 428		

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLE1EO
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F 428	Continued From page 21 issues detailed above for R7. Surveyo;: Reed,·Sheryl R52 received sertraline (Zoloft) for depression and the medical record lacked monitoring of the effectiveness of a dose increase of the medication. The care plan did not identify comprehensive individual symptoms or non-pharmacological interventions for depression. R52 was admitted to the facility on 4/8/13, with diagnoses that included congestive heart failure, depression and macular degeneration. R52 had transferred from out of state to Minnesota. A nurse practitioner note dated 6/11113, read, "No noted SE (side effects) of increase dose Zoloft-watch and if she has issues then decrease or de (discontinue) it. The primary physician The medical record lacked any monitoring of symptoms of depression or side effects of the medication. The medical record was reviewed. The admission order for sertraline (Zoloft) was 50 mg daily. On 5/08/13, the antidepressant sertraline was increased to 75 mg daily. The nurse practitioner note, dated 5/8/13, read, "likely depressed, keeps eyes closed, and pleasant but withdrawn." On 7/17113, the primary physician wrote "has good days and bad days, Sometimes quite lethargic..." and depression stable." R52's progress notes indicated no entries made related to follow up monitoring on the symptoms	F 428		

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F 428	Continued From page 22 of depression or the side effects of the medication. The care conference summary tool dated 7/30/13, indicated R52, "has adjusted adequately to the the care center." There was no reference to transferring from a southern state. R52's current care plan dated 4/18/13, identified the use of an antidepressant medication related to depression. The care plan read, "Observe and update rny physician to MD prn (as needed) s/sx (signs symptoms) of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, sharne, worthlessness, guilt, suicidal ideations, neg. rnood/comrnents, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance." There was no indication on the care plan identifying what symptoms R52 displayed. Other interventions on the care plan directed staff to inform resident and family of side effects and risks and benills of the medications On 9/26/13, at 9:20 a.rn. the clinical coordinator indicated the care plan for depression was generic and not specific for the individual resident. On 9/26/13, at 9:30 a.rn. the clinical administrator (CA) indicated nursing staff would not have reviewed the nurse practitioner notes regarding the ongoing use of medications. The CA ndicated R52 had been the same for a long time, since he had known her, and there had been no change. However, the CA was not aware of the	F 428		

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F. 428	Continued From page 23 medication dose increase. The CA verified there was no documentation justifying the increase nor any staff documentation regarding monitoring the effectiveness of the increased dose or of any side effects. The CA stated the interventions for depression would be added to the "My Best Day" tool and that significant changes are discussed at the daily meeting. The facility's pharmacist reviewed the resident's physician orders monthly however, no irregularities were noted. On 9/26/13, at 10:30 a.m. the pharmacist indicated that non-pharmacy interventions were not the best for a resident with depression.	F 428		

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

F 561 7002

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING 01 -CARONDELET VILLAGE CARE CENTER B. WING	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFCIENCY 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)	(XS) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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 YOU. VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, CARONDELET VILLAGE CARE CENTER was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	RECEIVED NOV 4 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok FS 11-7-13	

DC: 11.05.2013

EXIT: 09.26.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Heather Hagen

TITLE

Care Center Administrator

11/4/2013

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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
	245617	A. BUILDING 01 -CARONDELET VILLAGE CARE CENTER B. WING	09/25/2013

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Carondelet Village Care Center is located on the first floor of a 4-story building with a full basement. The building was constructed in 2011, and was determined to be of Type 11(222) construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029	1. The trash chute room door to the corridor on the 1st floor by the front desk will be repaired to fully close and latch as required by October 24th. Monthly testing of the trash chute room door for the trash chute room on 1st floor	10/24/13

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K 029	Continued From page 2 This STANDARD is not met as evidenced by Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 18.3.6.2. This deficient practice could affect staff patients anad visitors within these smoke compartments. Findings include: On facility tour between 09:00AM and 02:00PM on 09/25/2013, it was observed that: 1) The trash Chute Room door to the corridor on the 1st. floor near the front desk did not fully close and latch when tested. 2) 1st. floor Soiled Linen Room door to the corridor by room 151 did not fully close and latch when tested. These deficiencies were verified by Environmental Service Director (NS).	K 029	Continued from page 2 near the front desk to ensure the doors close and latch properly will be added to the electronic work order system preventative maintenance routines by October 24th 2013. Any deficiencies found during monthly testing will result in a work order being entered into the electronic work order system. Monthly testing of all trash chute room doors for proper operation will be added to the electronic work order system preventative maintenance routines by October 24th, 2013. Any deficiencies found during monthly testing will result in a work order being entered into the electronic work order system. The Environmental Services Director will be responsible for overseeing the timely completion of any work orders generated by deficiencies found during the monthly testing of the trash chute room doors. The safety committee will review work orders quarterly for doors found to be deficient.	
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1		2. The 1st floor soiled linen room door to the corridor by room 151 will be repaired to fully close and latch as required by October 24th. Monthly testing of the 1st floor soiled linen room door to the corridor by room 151 to ensure it closes and latches properly will be added to the electronic work order system preventative maintenance routines by October 24th. Any deficiencies found during monthly testing will result in a work order being entered into the electronic work order system.	10/24/13 10/24/13

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-K 033	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation the stairway was not properly enclosed between 2 floors as required by LSC(00) Section 18.3.1.1. This deficient practice could effect all residents, staff, and visitors. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/25/2013, it was observed that the 2nd floor drop down fire door on the East side of the main stairway was blocked by furniture when testing the doors. The furniture was stopping the doors from fully closing. Furniture was placed against the stairway rail a second time when reviewing the this stairway. This deficiency was verified by Environmental Service Director (NS).	K 033	Continued from page 3 Monthly testing of all soiled linen room doors will be added to the electronic work order system preventative maintenance routines by October 24th 2013. Any deficiencies found during monthly testing will result in a work order being entered into the electronic work order system. The Environmental Services Director will be responsible for overseeing the timely completion of any work orders generated by the monthly testing of the soiled linen room doors. The safety committee will review work orders quarterly for doors found to be deficient. A barrier will be constructed by November 5th,2013 to ensure that furniture cannot be placed in the path of travel of the drop down fire door on 2nd floor east side of the of the lobby.	11/4/13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observations, the facility has failed to provide proper exit hardware on exit doors to the stairwells These deficient practice's could affect	K 038	All drop down fire doors in the facility will be evaluated to ensure furniture is not placed in the path of travel of the drop down fire door by October 24th, 2013. Monthly inspections will be placed in the electronic work order system preventative maintenance routines by 10/24/2013 to check all drop down fire doors for blockage in the path of the door travel. The safety committee will quarterly review any incidents of blockages found in the path of travel of the drop down fire doors. A sign will be placed as required at the locked exit by room 151 by October 24th, 2013 which will instruct cognitively aware people how to exit the area.	10/24/13 10/24/13

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K 038	Continued From page 4 the safe and rapid evacuation of residents, visitors and staff in the event of an emergency that may require quick evacuation. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/25/2013, it was observed that the Locked Exit Door by room 161 did not have instructions on how to open the door restricting multiple means of egress from smoke the compartment. This area is not in a memory loss unit. This deficiency was verified by Environmental Service Director (NS).	K 038	Continued from page 4 A routine will be added to the current monthly check of all exit doors in the preventative maintenance section of the electronic work order system by October 24th, 2013 to ensure the required signs are present, correct, and readable. If a sign is found to be missing, covered, or otherwise unreadable, a work order will be entered into the electronic work order system to correct the deficiency. The Environmental Services Director will be responsible to ensure any deficiencies regarding these signs are corrected in a timely manner. The safety committee will quarterly review any deficiencies found.	10/24/13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on review, the facility has failed to properly maintain the fire alarm system in accordance with NFPA 72, 1999 Edition. Section 9.6.1.4. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: On facility tour between 09:00AM and 12:00 PM	K 052	1. An entry into the electronic work order system preventative maintenance routines will be made by October 24th, 2013 to prompt scheduling of the annual inspection of the fire alarm system to ensure the system is inspected as required. The Environmental Services Director will be responsible for ensuring the fire alarm system inspection is scheduled and completed within the required timeframe. The Nursing Home Administrator and Campus Administrator will enter a recurring notice in their respective electronic calendars by October 24th, 2013 of the annual requirement for scheduling the annual fire alarm system inspection. The NHA and CA will receive copies of the inspection report from the ESD and will verify the inspection was completed within the required timeframe.	10/24/13

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K 052	Continued From page 5 on 09/21/10, it was revealed during review of available fire alarm documentation that 1) The fire alarm system has not been inspected d on 10/24/11.. on an annual basis. The system was last inspecte 2) The DACT has not been tested on a monthly basis. These deficiencies were verified by Environmental Service Director (NS).	K 052	Continued from page 5 2. The monthly fire drill report form will be modified to require verification that the DACT successfully communicated with the central station after each monthly fire drill. The fire drill monthly report form will be modified by October 24th, 2013	10/24/13
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6i 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to properly maintain the fire sprinkler system NFPA 101 Section 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 09:00AM and 02:00 PM on 09/25/2013, it was discovered, during review of available documentation, that the fire sprinkler system was not tested and inspected by a licensed sprinkler contractor on an annual basis. last inspection was 10/21/11.. These deficiencies were verified by Environmental Service Director (NS).	K 052	If the DACT does not communicate successfully with the monitoring station, the ESD will be responsible for scheduling immediate service for the DACT. Safety procedures to ensure notification of the fire department in the event of fire alarm activation will be activated at this time. The monthly routine in the electronic work order system for fire drills will be modified by 10/21/2013 to include language instructing that the DACT operation will be checked. The Environmental Services Director will be responsible for ensuring the proper operation of the DACT. The safety committee reviews fire drill report forms quarterly and will ensure the form is completely filled out. Discrepancies will be reported to the Nursing Home Administrator, and the Campus Administrator. K062 An entry into the electronic work order system preventative maintenance routines will be made by October 24th, 2013 to prompt scheduling of the annual inspection of the fire sprinkler system to ensure the system is inspected as required.	10/24/13 10/24/13

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			Continued from page 6 The Environmental Services Director will be responsible for ensuring the fire sprinkler system inspection is scheduled and completed within the required timeframe. The Nursing Home Administrator and Campus Administrator will enter a recurring notice in their respective electronic calendars by October 24th, 2013 of the annual requirement for scheduling the annual fire sprinkler system inspection. The NHA and CA will receive copies of the inspection report from the ESD and will verify the inspection was completed within the required timeframe.	