

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B5VG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245617		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: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 550012400		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 10/25/2021 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ____ 1. Acceptable POC ____ 2. Technical Personnel ____ 6. Scope of Services Limit ____ 3. 24 Hour RN ____ 7. Medical Director ____ 4. 7-Day RN (Rural SNF) ____ 8. Patient Room Size ____ 5. Life Safety Code ____ 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12.Total Facility Beds 45 (L18)		13.Total Certified Beds 45 (L17)		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):

17. SURVEYOR SIGNATURE Sarah Grebenc, Unit Supervisor (L19)		Date : 12/17/2021		18. STATE SURVEY AGENCY APPROVAL Melissa Poepping, Enforcement Specialist (L20)		Date: 12/17/2021	
--	--	---------------------------------	--	--	--	--------------------------------	--

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 11/08/2021 (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 26, 2021

CMS Certification Number (CCN): 245617

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Dear Administrator:

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 October 20, 2021 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 26, 2021

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: September 9, 2021

Dear Administrator:

On October 25, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B5VG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245617		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: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 550012400		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 09/09/2021 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u> </u> And/Or Approved Waivers Of The Following Requirements: Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 45 (L18)		13.Total Certified Beds 45 (L17)		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):			
17. SURVEYOR SIGNATURE Brandon Martfeld, HFE NE II (L19)		Date : 10/18/2021		18. STATE SURVEY AGENCY APPROVAL Melissa Poepping, Enforcement Specialist (L20)	
Date:		10/29/2021			

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

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT: <u> </u>		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
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 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 30, 2021

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: September 9, 2021

Dear Administrator:

On September 9, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 9, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 9, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

Carondelet Village Care Center

September 30, 2021

Page 4

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping".

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 9/7/21 through 9/9/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000			
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. On 9/7/21 to 9/9/21, a standard recertification survey was conducted at your facility. In addition, complaint investigations were conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5617015C (MN68702), H5617016C (MN53288) and H5617017C (MN76307). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/08/2021

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 residents (R40) was free from the use of restraints. Findings include:	F 604	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of		10/20/21

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 604	Continued From page 2 R40's diagnoses included Alzheimer's, dementia, depression, a stroke affecting right side of the body, and unsteadiness on her feet obtained from the Admission Record printed on 9/9/21. R40's significant change Minimum Data Set (MDS) dated 8/12/21, indicated R40 had moderate cognitive impairment and required extensive assist of two staff for activities of daily living (ADL). R40's ADL Care Area Assessment (CAA) dated 8/12/21, indicated R40 had left sided impairment and was at risk for falls. R40's care plan dated 9/26/18, indicated R40 had self-care deficit and a history of falls. The care plan further indicated R40 required one to two staff for assistance with bed mobility but at times could assist with bed mobility. R40's care plan dated 10/15/18, indicated R40 did not use physical restraints. On 9/7/21, at 2:21 p.m. R40 was observed laying in bed on her back with a pillow curled the lengthwise under the fitted sheet towards the upper half of R40's body. The pillow was observed on the outside of the bed on R40's right side, while the inside of the bed was placed against the wall. On 9/8/21, at 2:40 p.m. R40 was observed laying in bed on her back with a pillow curled up the lengthwise on top of the fitted sheet, under the chux pad towards the upper half of R40's body on the outside of the mattress. R40's medical record lacked evidence that a	F 604	Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F604: R40 was reassessed for need of pillow for positioning. Facility Restraint policy was reviewed and all nursing staff were educated on the policy as well as options for repositioning while in bed to include use of pillows being utilized as a restraint. A facility audit was completed on all residents to verify plan of care for positioning and restraint use. Audits will be completed by Clinical Coordinator or designee on positioning on 10% of residents weekly for 8 weeks and then monthly until reviewed by the QA committee to ensure ongoing compliance.		

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 604	Continued From page 3 pillow was to be used as a restraint. During an interview on 9/8/21, at 9:47 a.m. R40 stated the pillow was used to keep her in bed and prevent rolling out of bed. R40 further stated she had gotten use to having the pillow there. During an interview on 9/8/21, at 2:56 p.m. nursing assistant (NA)-A stated R40 did not get up on her own, but would "curl" herself out of bed. NA-A further stated the pillow was to keep R40 in bed because she had a history of falling. During an interview on 9/8/21, at 3:00 p.m. registered nurse (RN)-A stated "I believe they [staff] have been doing that [placing the pillow next to R40] historically because she [R40] has been rolling out of bed." RN-A verified the pillow was next to R40's upper body on the outside of the bed and was not being used as a repositioning device and stated "it shouldn't be there." During an interview on 9/9/21, at 8:50 a.m. clinical administrator (director of nursing) (DON) stated RN-A told her about the pillow being next to R40 because there was history of R40 rolling out of bed. The DON stated the pillow should only be used for repositioning and not as a restraint, because they do not use restraints. The DON further stated it had been over a year since R40 last rolled out of bed and that no staff had told her R40 was able to curl or move her legs out of bed. During a follow up interview on 9/9/21, at 8:59 a.m. RN-A stated education with staff had been completed about using the pillow to reposition R40 and how the pillow should not be used to ensure R40 does not roll out of bed. RN-A verified	F 604			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 604	Continued From page 4 the pillow found next to R40 was not being used for repositioning.	F 604			
F 692 SS=D	The facility's Physical Restraint policy dated September 2018, defined physical restraint "as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or normal access to one's body." Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the	F 692		10/20/21	
			F692:		

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 692	Continued From page 5 appropriate fluid consistency according to the physician orders for 1 of 1 resident (R28) reviewed for nutrition and hydration. Findings include: R28's Face Sheet printed 9/9/21, indicated diagnoses that included acute respiratory failure with hypoxia (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide), obstructive sleep apnea (common sleep-related breathing disorder), atelectasis (partial or complete collapse of the lung), pneumonia, chronic obstructive pulmonary disease (refers to a group of diseases that cause airflow blockage and breathing-related problems), acute respiratory failure with hypoxia and acute bronchiolitis (acute inflammatory injury of the bronchioles that is usually caused by a viral infection). R28's significant change Minimum Data Set (MDS) dated 7/22/21, indicated R28 was cognitively intact and required extensive assist of one to eat, was noted to cough and choke during meals in the assessment period and received hospice care. R28's care plan dated 7/22/21, indicated regular diet, regular texture. Honey thick liquid consistency. 1:1 supervision/assist for meals. Cut foods into small pieces. Slow pace of feeding. No hard foods including nuts, chips, caramel candies. May have caramel sauce for difficulty swallowing. R28's Physician Order Summary Report dated 9/2/21, indicated regular texture and honey thick liquids consistency (honey thickened liquids are	F 692	Training was initiated for the resident assistants and nursing staff by the clinical leadership team as well as dietitian to correct the thickened liquid consistency for R28. Facility Thickened Liquid policy was reviewed and up to date and an audit was completed with every resident who is receiving thickened liquids to ensure proper consistencies are identified for staff and being given. Training has been initiated on correct use of thickener used for nectar, honey, and pudding thick liquid diets. Charts have been made for the staff in serving areas to identify the correct number of pumps for thickened liquids based on the size of the cups. Random audits will be completed by the Clinical Administrator or designee on a weekly basis for three months and reviewed by the QA committee for continued compliance.		

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 692	Continued From page 6 those that stick to the sides of a cup like honey and pour very slowly). 1:1 supervision/assist for meals. Cut foods into small pieces. Slow pace of feeding. No hard foods including nuts, chips, caramel candies. May have caramel sauce for difficulty swallowing. The facility Neighborhood 2 Communication Sheet for nursing assistants updated 9/9/21, indicated R28 was on regular diet and honey thick liquids and required one-to-one assistance for meals. During dining observation on 9/7/21, between 5:25 p.m. and 6:05 p.m. R28 sat in a Broda chair in the main dining room and was assisted to eat by nursing assistant (NA)-B. One clear cup with lid sat on table next to R28, with cranberry juice in the clear cup. NA-B gave R28 several drinks of the liquid and R28 was noted to cough during the meal. Cranberry juice was observed to be of nectar thickened consistency (Nectar thick liquids are thicker than water, fall slowly from a spoon, and are sipped through a straw or from a cup). Staff brought in another cup of cranberry juice to the table after R28 had drank most of the cranberry juice in the first cup. The second cup was also observed to be nectar thickened consistency. During interview with NA-B on 9/7/21, at 6:12 p.m. NA-B stated R28 had recently been started on honey thickened liquids. NA-B stated 3 pumps of the Simply Thick EasyMix was required to make honey thickened consistency. The facility's Simply Thick EasyMix printed label dated 1/2020, indicated for 8 ounces (oz) of liquid, staff were required to add four pumps of Simply Thick EasyMix required for honey thickened	F 692			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 692	Continued From page 7 consistency. During observation on 9/8/21, at 7:59 a.m. R28 was asleep in a Broda chair with two clear cups with lids next to him on the table in the common area. After shaking the cups of cranberry juice and milk, the fluids were observed to be nectar thickened consistency vs. honey consistency. NA-C was interviewed on 9/8/21, at 8:00 a.m. and indicated R28 needed honey consistency for his beverages but NA-C was unclear with the number of pumps needed for nectar thickened or honey thickened. NA-C did not think there were directions on the thickener container but staff had the general knowledge to know. During observation and interview on 9/8/21, at 9:39 a.m. R28 sat in Broda chair with two clear cups with lids next to him on the table in the common area. Occupational therapist (OTR)-D verified after shaking the milk and the cranberry juices in R28's cups that she would not gave the consistency that currently was in the cups to a resident who was on honey thickened liquid. During observation and interview on 9/8/21, at 9:47 a.m. R28 sat in Broda chair with clear cups next to him on the table in the common area. OTR-D removed the milk from R28's table to the kitchenette area. Registered nurse (RN)-B came into the kitchenette area, shook the cup of milk to verify the consistency. RN-B verified the milk in R28's cup was more like nectar thickened consistency and not honey thickened per the physician order. During observation and interview on 9/8/21, at 12:31 p.m. R28 was in the main dining room and staff assisted R28 to eat. RN-A went to the dining	F 692			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 692	Continued From page 8 table and verified the milk and cranberry juice offered to R28 was not at the honey thickened consistency. RN-A asked the staff who assisted R28 to add more thickener for the accurate consistency. During interview on 9/9/21, at 9:29 a.m. director of nursing (DON) stated, it was the expectation that staff provided the ordered diet and liquid consistency according to physician orders. During interview on 9/9/21, at 1:25 p.m. speech language pathologist (SLP)-E stated if R28 was not offered the physician ordered honey thickened consistency it could cause penetration into the airway and could cause pneumonia. SLP-E also stated gravity can cause the thinner liquid consistency to enter the lungs and lead to aspiration. Facility Thickened Liquids policy undated indicated thickened liquids are recommended for patient safety. Failure to comply with the Speech Language Pathologist recommendations may result in aspiration, choking, aspiration, pneumonia, or other medical complications that may be life threatening.	F 692			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758			10/20/21

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 758	Continued From page 9 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 758	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to evaluate the continued use of an as needed psychotropic medication every 14 days for 1 of 5 residents (R29) reviewed for unnecessary medication. Findings include: R29's diagnoses included dementia, anxiety, and weakness obtained from the Admission Record dated 9/9/21. R29's care plan dated 7/29/21, indicated R29 used anti-anxiety medication Lorazepam. Furthermore, R29's care plan also indicated R29 used anti-psychotic medication Seroquel. R29's physician order dated 7/13/21, revealed an order to obtain renewal for Seroquel as order only for 14 days and would expire on 10/7/21. The order was to start on 10/1/21. R29's physician order dated 7/8/21, revealed an order for Seroquel tablet 25 milligrams (mg), give 12.5 mg by mouth as needed for agitation/anxiety for three months twice a day. The order had an end date of 10/8/21. In addition, R29's physician orders revealed R29 had an order for lorazepam solutab, give 0.5 mg sublingually (under the tongue) every 6 hours as needed for anxiety with an order date of 7/17/21. R29's care plan dated 7/29/21, identified R29 had the potential for psychotropic drug adverse drug reactions related to use of psychotropic medication and received anti-anxiety medication lorazepam. Furthermore R40's care plan dated 7/29/21, identified R29 had the potential for	F 758	F758: R29 passed away in the facility on 9/12/2021. A facility audit on Antipsychotic medications was completed to ensure they have been stopped or a new order has been obtained after 14 days. Psychotropic and Unnecessary Medication Use policy was reviewed and education was given to MD/NP providers, RN's, LPN's, and TMA's of the PRN use of psychotropic medications and the required 14 day stop date. Audits will be completed biweekly for 8 weeks by Clinical Administrator or Clinical Coordinator on all pharmacy orders for PRN antipsychotics and then monthly until reviewed by the QA committee to ensure continued compliance.		

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 758	Continued From page 11 psychotropic drug adverse drug reactions related to use of psychotropic medication and received anti-psychotic medication Seroquel. R29's July medication administration record (MAR) revealed R29 received one dose of lorazepam on 7/19/21. R29's August MAR revealed R40 received two doses of lorazepam on 8/24/21 and 8/26/21, and had received three doses of Seroquel in August on 8/18/21, 8/24/21 and 8/26/21. R29's September MAR revealed R29 received three doses of lorazepam on 9/2/21, 9/3/21 and 9/7/21, in addition, R29 had received a dose of as needed Seroquel on 9/7/21. R29's visit summary from nurse practitioner (NP) dated 7/8/21, indicated R29 was started on a low dose of Seroquel for sundowning (a state of confusion occurring in the late afternoon and spanning into the night) behaviors and the next visit was to occur in two months. R29's visit summary from NP dated 8/16/21, revealed R29 took Seroquel 12.5 mg by mouth twice daily as needed for anxiety/agitation and lorazepam 0.5 mg solutab sublingually every 6 hours as needed for anxiety. R29's pharmacy consultation report dated 7/20/21, indicated R29 had an as needed order for lorazepam without a stop date. The pharmacy consultation report further indicated that CMS (Centers for Medicare & Medicaid Services) allows 14 days for as needed anti-anxiety medication unless a longer end date and rationale are given. The pharmacy consultation report further indicated the rationale for recommendation was CMS required that as	F 758			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 758	Continued From page 12 needed orders for non-anti-psychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the as needed order. The pharmacy consultation report did not acknowledge the as needed order for Seroquel and the report was not addressed by the NP. R29's pharmacy consultation report dated 8/13/21, indicated a repeated recommendation from 7/20/21, pharmacy consultation report. Again the pharmacy consultation report dated 8/13/21, did not acknowledge R29's as needed Seroquel order and the report was not addressed by the NP. During an interview on 9/8/21, at 2:00 p.m. registered nurse (RN)-A indicated R29's as needed Seroquel was prescribed for his sundowning behaviors. RN-A further stated the last visit from the nurse practitioner was on 8/16/21, and any communication from the pharmacy goes to the clinical administrator (director of nursing (DON) first then gets distributed out to me. During an interview on 9/8/21, at 2:08 p.m. DON indicated psychotropic medication needed to have a 14 day end date, unless the physician had a rationale for further use. The clinical administrator indicated R29 had recently started hospice and hospice managed R29's medications. During an interview on 9/8/21, at 2:15 p.m. pharmacist consultant indicated being aware of the 14 day as needed psychotropic medication	F 758			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 758	Continued From page 13 regulation. The pharmacist consultant indicated he would not approve an as needed antipsychotic and that R29 would have needed to be evaluated every 14 days by a physician or NP. During an interview on 9/8/21, at 2:23 p.m. NP indicated a pharmacist had recommended a 90 day order for Seroquel, so R29's medication did not need to be reviewed every 14 days. The NP further acknowledged that R29's hospice team order the lorazepam for agitation. The NP then stated she would go back to the every 14 day evaluation for as needed psychotropic medication. During an interview on 9/9/21, at 8:46 a.m. DON indicated there was no documentation of a physician or NP evaluation every 14 days for R29. The facility's Psychotropic and Unnecessary Medication Use policy dated September 2017, directed as needed "orders for psychotropic must have a specific condition and indication for use." As needed "medications are limited to 14 days." Except as provided below: a. Psychotropic's (excluding anti-psychotic) may only be used for 14 days, unless the prescribing practitioner documents the rationale for an extended period of time and indicate a specific duration. b. anti-psychotics: may only be used for 14 days. If the prescribing practitioner wishes to write a new order for the as needed anti-psychotic the resident must first be evaluated using these guidelines: i. the prescribing practitioner must directly examine the resident and assess the residents current condition and document in the medical record: 1. why the anti-psychotic is still needed on an as needed basis? 2. what is the benefit of the medication to the resident? 3. has	F 758			

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

PRINTED: 10/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 758	Continued From page 14 the resident's expression or indication of distress improved as a result of the as needed medication.	F 758			

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

F5617011

Printed: 09/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245617		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CARONDELET VILLAGE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2021	
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/08/2021. At the time of this survey, Carondelet Village Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The facility is a four-story building with a basement. The facility was constructed in 2012 and was determined to be of Type II (222) construction. The skill living is located on the 1st floor only. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. Resident rooms have hard-wired smoke alarms tied into the nurse call system. The facility has a capacity of 45 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.			K 000			

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

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 30, 2021

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: B5VG11

Dear Administrator:

The above facility was surveyed on September 7, 2021 through September 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Carondelet Village Care Center

September 30, 2021

Page 2

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/7/21 through 9/9/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	*****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/08/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H5617015C (MN68702), H5617016C (MN53288) and H5617017C (MN76307).	2 000	been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	
21933	MN St. Statute 144651 Subd. 33 Patients & Residents of HC Fac.Bill of Rights Subd. 33. Restraints. (a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians,	21933		10/20/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21933	Continued From page 2 and health care agents as defined under section 145C.01 have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident. (b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use. The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used. (c) A nursing home providing a restraint under paragraph (b) must: (1) document that the procedures outlined in that paragraph have been followed; (2) monitor the use of the restraint by the resident; and (3) periodically, in consultation with the resident, the family, and the attending physician, reevaluate the resident's need for the restraint. (d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the commissioner from taking action to protect the	21933		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21933	Continued From page 3 health and safety of a resident if: (1) the use of the restraint has jeopardized the health and safety of the resident; and (2) the nursing home failed to take reasonable measures to protect the health and safety of the resident. (e) For purposes of this subdivision, "medical symptoms" include: (1) a concern for the physical safety of the resident; and (2) physical or psychological needs expressed by a resident. A resident's fear of falling may be the basis of a medical symptom. A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint. (f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C.01 that the facility provide a physical restraint in order to enhance the physical safety of the resident.	21933			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21933	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 residents (R40) was free from the use of restraints. Findings include: R40's diagnoses included Alzheimer's, dementia, depression, a stroke affecting right side of the body, and unsteadiness on her feet obtained from the Admission Record printed on 9/9/21. R40's significant change Minimum Data Set (MDS) dated 8/12/21, indicated R40 had moderate cognitive impairment and required extensive assist of two staff for activities of daily living (ADL). R40's ADL Care Area Assessment (CAA) dated 8/12/21, indicated R40 had left sided impairment and was at risk for falls. R40's care plan dated 9/26/18, indicated R40 had self-care deficit and a history of falls. The care plan further indicated R40 required one to two staff for assistance with bed mobility but at times could assist with bed mobility. R40's care plan dated 10/15/18, indicated R40 did not use physical restraints. On 9/7/21, at 2:21 p.m. R40 was observed laying in bed on her back with a pillow curled the lengthwise under the fitted sheet towards the upper half of R40's body. The pillow was observed on the outside of the bed on R40's right side, while the inside of the bed was placed against the wall.	21933	This has been corrected.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21933	Continued From page 5 On 9/8/21, at 2:40 p.m. R40 was observed laying in bed on her back with a pillow curled up the lengthwise on top of the fitted sheet, under the chux pad towards the upper half of R40's body on the outside of the mattress. R40's medical record lacked evidence that a pillow was to be used as a restraint. During an interview on 9/8/21, at 9:47 a.m. R40 stated the pillow was used to keep her in bed and prevent rolling out of bed. R40 further stated she had gotten use to having the pillow there. During an interview on 9/8/21, at 2:56 p.m. nursing assistant (NA)-A stated R40 did not get up on her own, but would "curl" herself out of bed. NA-A further stated the pillow was to keep R40 in bed because she had a history of falling. During an interview on 9/8/21, at 3:00 p.m. registered nurse (RN)-A stated "I believe they [staff] have been doing that [placing the pillow next to R40] historically because she [R40] has been rolling out of bed." RN-A verified the pillow was next to R40's upper body on the outside of the bed and was not being used as a repositioning device and stated "it shouldn't be there." During an interview on 9/9/21, at 8:50 a.m. clinical administrator (director of nursing) (DON) stated RN-A told her about the pillow being next to R40 because there was history of R40 rolling out of bed. The DON stated the pillow should only be used for repositioning and not as a restraint, because they do not use restraints. The DON further stated it had been over a year since R40 last rolled out of bed and that no staff had told her R40 was able to curl or move her legs out of bed.	21933			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21933	Continued From page 6 During a follow up interview on 9/9/21, at 8:59 a.m. RN-A stated education with staff had been completed about using the pillow to reposition R40 and how the pillow should not be used to ensure R40 does not roll out of bed. RN-A verified the pillow found next to R40 was not being used for repositioning. The facility's Physical Restraint policy dated September 2018, defined physical restraint "as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or normal access to one's body." SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure assessments were performed on all residents that require pillows or such aids for repositioning are not being used as a restraint. Those assessments should occur upon admission, quarterly, yearly, with a significant change and periodically thereafter as needed to accurately reflect in-use by residents. The facility could create policies and procedures, educate staff on these changes, and perform environmental rounds/audits periodically to ensure resident safety from having a device that is intended to be used as a repositioning aide is not being used as a restraint is appropriately monitored. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21933		