Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2025

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

RE: CCN: 245617
Cycle Start Date: October 17, 2024

Dear Administrator:

On December 6, 2024, we notified you a remedy was imposed. On January 3, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 2, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 17, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 17, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 2, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 6, 2024

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

RE: CCN: 245617
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 24, 2024, we informed you that we may impose enforcement remedies.

On December 2, 2024, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility 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), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K0291 - Emergency Lighting
K0901- Fundamentals - Building System Categories

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 17, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 17, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 17, 2025.

You should notify all Medicare/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 admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 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 $12,924, 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 January 17, 2025, 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 January 17, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 April 17, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question

cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING **01 - CARONDELET VILLAGE CARE CENTER** B. WING _____	R **12/02/2024**

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 000}	INITIAL COMMENTS Based on an on-site revisit, the facility is not in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 291} SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/16/2024 between 11:00 AM and 1:00 PM, it was revealed during documentation review that the documentation presented for review did not confirm that 90-minute annual emergency light testing was being completed. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	{K 291}	The emergency exit lighting is a part of the normal corridor and stairwell lighting fixtures, there are no battery powered light fixtures. These fixtures will operate in the event of a power failure through the EPSS system and the transfer switch. The generator is tested monthly under load, a task will be entered into the electronic work order system by 12/31/2024 to inspect the emergency exit light fixtures for proper operation of 30 seconds duration during the generator monthly test. This test will be documented monthly Emergency exit lighting will be tested for 90 minutes annually. A test by running the generator for 90 minutes under load or using the emergency lighting circuit breakers will be conducted and documented annually as required by the NFPA 101 (2012) Life Safety Code sections 19.2.9.1, 7.9, and 7.9.3. A recurring annual task will be entered into	12/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2024

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) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING **01 - CARONDELET VILLAGE CARE CENTER** B. WING _____	R **12/02/2024**

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 291}	Continued From page 1	{K 291}	the Electronic Work Order System (EWOS) to ensure this task is scheduled. The Environmental Services Director (ESD) will be responsible for performing, or assigning, and documenting these tasks on a timely basis. The Regional Engineering Manager (REM) will review this task for timely completion during the Annual Facility Review (AFR) documentation review. This task will be entered into the EWOS and performed on or before 12/31/2024	
{K 901} SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility Findings include:	{K 901}	The NFPA 99 Chapter 4 Building Utilities Risk Assessment form was missing from the documentation at the site during the inspection. The form has been updated and placed with the Life Safety Code Documentation at Carondelet Village for inspection. This was done 12/13/2024 The Environmental Services Director will be responsible for ensuring all required	12/13/24

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 _____	R **12/02/2024**

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 901}	Continued From page 2 On 10/16/2024, between 11:00 AM and 1:00 PM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	{K 901}	documentation is available at all times for inspection. The Regional Engineering Manager will inspect all documentation to ensure it is available during the document review portion of the Annual Facilities Review.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 24, 2024

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

RE: CCN: 245617
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 17, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 January 17, 2025 (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 April 17, 2025 (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/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 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 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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 10/17/2024

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
E 000	Initial Comments On 10/14/24 through 10/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/14/24 through 10/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56179307C (MN00107194) 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		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		11/4/24

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

Electronically Signed | 11/01/2024

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) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	C 10/17/2024

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
F 812	Continued From page 1 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ice packs were stored separately from food storage in all three of the unit kitchenette refrigerators. In addition, the facility failed to ensure the proper use of hair restraints during food service. These practices had the potential to affect all 45 residents residing in the care center who received food from the kitchen or snacks from the unit refrigerators/freezers. Findings include: Ice packs During observation on 10/15/24 at 9:55 a.m., freezer in kitchenette of neighborhood one contained two boxed frozen meals, one tub of ice	F 812	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 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	

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	245617	A. BUILDING _____ B. WING _____	C 10/17/2024

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F 812	Continued From page 2 cream, three ice cream bars and one ice cream cone. In addition, there was one ice pack labelled with a current resident name and three additional unlabeled ice packs sitting among the frozen food items. in a plastic bag with J. Fennell listed on it. there are also three additional "ice packs" unlabeled. During observation on 10/15/24 at 10:06 a.m., freezer in kitchenette of neighborhood two contained three ice cream cups, two yogurt cups, and two ice cream cones-one with the wrapper split open and an unlabeled ice pack lying on top of it). In addition, there was one ice pack with another current resident's first name and room number and four additional unlabeled ice packs. During observation on 10/15/24 at 10:11 a.m., refrigerator of neighborhood three contained two unlabeled cold packs and several food items including applesauce, yogurt, prune juice and pudding. In addition, the freezer contained two unlabeled ice packs and food items including a numerous assortment of individual ice cream products. During interview on 10/15/24 at 10:33 a.m., nursing assistant (NA)-A stated the snacks and ice packs stored in the kitchenette refrigerator/freezer were for resident use. During interview on 10/15/24 at 10:43 a.m., NA-B stated the snacks in kitchenettes were for the residents and that nursing would stock and retrieve items from them. NA-B further stated NAs would sanitize and return ice packs to the freezer when removed from a resident's room. During interview on 10/15/24 at 11:32 a.m., care	F 812	conclusions set forth in this allegation by the survey agency. Ice Packs were removed from refrigerator/freezers in all three neighborhoods on 10/15/2024. A freezer was provided in a central location solely for ice packs. Education was initiated on 10/30/2024 for all staff including nursing, culinary and therapy of the proper storage of ice packs and location of freezer. Refrigerator/freezers in the neighborhoods will be audited by the Culinary Director/designee for non-food items twice a week for four weeks, then once a week for four weeks, and once a month until the next QAPI meeting. The Culinary Director removed C-A from the plating/serving line in the kitchen on 10/15/2024. Hair restraints to include hair nets/beard guards were restocked in the care center kitchen area on 10/15/2024. Education was initiated on 10/30/2024 for all culinary and nursing staff regarding the hair/beard net policy. Culinary staff in the Care Center will be audited by the Culinary Director/designee for hair/beard nets twice a week for four weeks, then once a week for four weeks, and once a month until the next QAPI meeting.	

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F 812	Continued From page 3 center food service supervisor (FSS) stated food services was responsible for maintaining the temperature logs for the kitchenette refrigerator/freezers and would look for and remove outdated food items. FSS could not explain why the ice packs were stored in the kitchenettes or what they were used for. During interview on 10/15/24 at 11:47 a.m., culinary director (CD) stated would not expect ice packs for resident use to be stored in the same place as food was stored due to sanitary reasons. CD stated was not aware of that practice and that the ice packs should be removed. During observation and interview on 10/15/24 at 11:58 a.m., CD confirmed the presence of the ice packs in the kitchenette refrigerator/freezers and removed them. During interview on 10/16/24 at 12:36 p.m., director of nursing (DON) stated expectation was that ice packs for resident use would not be stored with food products and that the facility was changing to single use snap-to-chill ice packs. Facility policy Cold Pack, Dry, dated September 2018, indicated, "Re-usable commercially prepared ice packs are to be disinfected after each use following the [organization's] Infection Control manual. These are stored in a dedicated freezer area, and not to be stored with food." Hair restraints During observation and interview on 10/15/24 at 12:00 p.m., the care center main dining area cook (C)-A plated food from inside the kitchen through a window for distribution. C-A had a full	F 812		

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F 812	Continued From page 4	F 812		

beard with approximately ¼ inch growth. C-A was not wearing a facial hair/beard guard while serving food. C-A stated he did not usually wear one.

During interview on 10/15/24 at 12:04 p.m., FSS stated facial hairnets/beard guards were available and that C-A should have been wearing one while in the kitchen serving food.

During observation and interview on 10/15/24 at 12:15 p.m., CD restocked the hair restraint supply bin with beard guards. CD stated expected practice for staff in the kitchen while plating food was to wear hair nets which included facial hair restraints/beard guards.

During interview on 10/16/24 at 12:36 p.m., DON stated expectation for staff to wear hair restraints-including beard guards-while in the kitchen during food service.

Facility policy Hairnet Restraint Policy dated May 2015, indicated, "Beards must be covered with a beard bag, and must be on before entering the kitchens or area where food is being prepared."

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on October 16, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Carondelet Village Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/01/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. CARONDELET VILLAGE CARE CENTER is a 4-story building with a basement, with the skilled nursing facility being located on the 1st floor only. CARONDELET VILLAGE CARE CENTER was constructed in 2012 and determined to be Type II (222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to	K 000		

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K 000	Continued From page 2 the corridors that are monitored for automatic fire department notification. Resident rooms have hard-wired smoke alarms. The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/16/2024 between 11:00 AM and 1:00 PM, it was revealed during documentation review that the documentation presented for review did not confirm that 90-minute annual emergency light testing was being completed. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 291	A test and inspection of the battery-powered emergency lighting will be conducted and documented annually as required by the NFPA 101 (2012) Life Safety Code sections 19.2.9.1, 7.9, and 7.9.3. A recurring annual task will be entered into the Electronic Work Order System (EWOS) to ensure this task is scheduled. The Environmental Services Director (ESD) will be responsible for performing, or assigning, and closing this task on a timely basis. The Regional Engineering Manager (REM) will review this task for timely completion during the Annual Facility Review (AFR) documentation review. This task will be entered into the EWOS and performed on or before 11/27/2024.	11/27/24

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K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1, 7.10.1.8 and 19.2.10 These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 10/16/2024, between 11:00 AM and 1:00 PM, it was revealed by observation that there were 3 doors located on each of the neighborhoods that did not have proper signage on the door to indicate that it is not an exit. Signs must read "Not and Exit" in code compliant font. 2. On 10/16/2024, between 11:00 AM and 1:00 PM, it was revealed by observation that at the intersection of Stair K, there were no exit signs visible to direct person in the event of an emergency. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 293	1.To meet the requirements of the NFPA 101 (2012) sections 7.10.1.5.1, and 7.10.1.8, and 19.2.10, Proper signage will be affixed to the glass area of the door as directed by the fire code. The signage will state Not an exit in code compliant font. The ESD will be responsible for obtaining this signage and installing it as required. The REM will confirm that the listed doors and any others that require this signage are compliant on or before 11//27/2024. 2. To meet the requirements of the NFPA 101 (2012) sections 7.10.1.5.1, and 7.10.1.8, and 19.2.10, Exit signage will be installed to be visible as required, at least two signs visible from all areas. The ESD and the REM will be responsible for procuring these signs, determining required locations, and ensuring the signs are installed. These signs will be installed on or before 11/27/2024.	11/27/24
K 511	Utilities - Gas and Electric	K 511		11/27/24

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K 511 SS=F	Continued From page 4 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/16/2024 between 11:00 AM and 1:00 PM, it was revealed by observation that in the housekeeping closet, there were combustibles being stored in front of and directly below the electric panel. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	In accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C), the housekeeping closets will be inspected for improper storage of flammable items in front of and directly below the electrical panels. The storage in the housekeeping closets will made to comply with fire codes. The ESD will train the housekeepers and maintenance staff on the proper means of storage, and the ESD will conduct semi-annual audits for one year to ensure compliance. A semi-annual task will be entered into the EWOS to ensure the audit is completed. The above items will be completed on or before 11/27/2024. The REM will review the task log during the document review portion of the AFR.	

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K 712	Continued From page 5	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/16/2024 between 11:00 AM and 1:00 PM, it was revealed by a review of available documentation at the time of the survey, the facility had not performed fire drills at the following times. a. On the 2nd shift of the 4th quarter of 2023 b. On the 2nd and 3rd shift of the 2nd quarter in 2024 c. On the 2nd and 3rd shift of the 3rd quarter in 2024 An interview with the Maintenance Director	K 712	To meet the fire drill requirements of the NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6, the facility will annually develop a fire drill schedule meeting the requirements of shift timing, monthly drills, and varying times and locations as required. Fire drill report forms will be filled out and filed in the Life Safety documentation. The scheduled drills will be entered as tasks in the EWOS. The ESD will be responsible for developing the fire drill schedule and entering it into the EWOS task list with help from the REM as required. The REM will review the fire drill reports during the document review portion of the AFR. The above items will be completed on or before 11/27/2024.	11/27/24

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K 712	Continued From page 6 verified this deficient finding at the time of discovery.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 10/16/2024, between 11:00 AM and 1:00 PM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	A facility risk assessment document for building systems will be developed to meet Category 1 through 4 requirements in accordance with NFPA 99 (2012 edition), Chapter 4. This document will be developed by the Campus Administrator (CA), ESD, and the REM. This risk assessment document will be completed on or before 11/27/2024. The document will be annually reviewed by the safety committee and by the REM during the document review portion of the AFR.	11/27/24

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