### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	MED	ICARE/MEDICA	AID CERTIFIC	CATION A	ND TRANSMITT	TAL	I	D: C7UC
	PART	I - TO BE COM	PLETED BY T	THE STATI	E SURVEY AGEN	NCY	]	Facility ID: 00763
I. MEDICARE/MEDICAID PROVIDER     (L1) 245524     2.STATE VENDOR OR MEDICAID NO     (L2) 825540700		<ol> <li>NAME AND ADI</li> <li>(L3) LITTLE SIST</li> <li>(L4) 330 EXCHAN</li> <li>(L5) SAINT PAUL</li> </ol>	FERS OF THE F	POOR	(L6) <b>5</b> 5	5102	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>03</u> (L7) 13 PTIP	22 CLIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After Comparison</li> </ol>	9. Other omplaint
6. DATE OF SURVEY 01/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	04/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY X A. In Compliar Program Red Compliance	nce With quirements	:	2. Technic 3. 24 Hour	al Personnel r RN	Following Requirements: 6. Scope of Serv 7. Medical Direct	vices Limit
12.Total Facility Beds 13.Total Certified Beds	<ul><li>73 (L18)</li><li>73 (L17)</li></ul>	B. Not in Com	cceptable POC pliance with Prograr and/or Applied Waiy		4. 7-Day F 5. Life Saf * Code: A	-	8. Patient Room 9. Beds/Room (L12)	Size
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNI 40 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEE 1861 (e) (1) or 186	ETS	(L15)	
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY	Y AGENCY APP	PROVAL	Date:
Thomas Lir	hoff, DSFM		01/04/2016	(L19)	Kate Johns	sTon, Prog	gram Specialist	03/16/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR SIN	NGLE STATI	E AGENCY	
19. DETERMINATION OF ELIGIBILI      1. Facility is Eligible to F      2. Facility is not Eligible	Participate		PLIANCE WITH C ITS ACT:	CIVIL	2. Owr		al Solvency (HCFA-2572) terest Disclosure Stmt (HCF.	A-1513)
2. Tubiny is not 2.1g.ok	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEMI BEGINNING I (L41)		<ol> <li>LTC AGREEMI ENDING DAT (L25)</li> </ol>		26. TERMINATION <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W	00	<u>INVOLUN</u> 05-Fail to M	(L30) <u>FARY</u> leet Health/Safety leet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of		(L44)		03-Risk of Involuntar 04-Other Reason for V		<u>OTHER</u> 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539		DETERMINATION ( 01/11/2016	OF APPROVAL DA		Posted 03/22/20			
	(L32)			(L33)	DETERMINATI	ON APPROV	/AL	



### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245524 March 16, 2016

Sr. Mary Elizabeth Anderson, AdministratorLittle Sisters of the Poor330 Exchange Street SouthSaint Paul, Minnesota 55102

Dear Sr. Anderson:

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

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

Effective December 28, 2015 the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 73 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Little Sisters Of The Poor March 16, 2016 Page 2

Sincerely,

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Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 16, 2016

Sr. Mary Elizabeth Anderson, AdministratorLittle Sisters of the Poor330 Exchange Street SouthSaint Paul, Minnesota 55102

RE: Project Number F5524024

Dear Sr. Anderson:

On December 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C) whereby corrections were required.

On January 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 19, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective December 28, 2015 and therefore remedies outlined in our letter to you dated December 24, 2015, will not be imposed.

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.

Feel free to contact me if you have questions.

Little Sisters Of The Poor March 16, 2016 Page 2

Sincerely,

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Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
245524 <sub>Y1</sub>	Building 01 - MAIN BUILDING 01		1/4/2016	Y3		
IDENTIFICATION NUMBER     A. Building     01 - MAIN BUILDING 01     1/4/2016       245524     Y1     B. Wing     1/4/2016       NAME OF FACILITY     STREET ADDRESS, CITY, STATE, ZIP CODE       LITTLE SISTERS OF THE POOR     330 EXCHANGE STREET SOUTH						
LITTLE SISTERS OF THE POOR		330 EXCHANGE STREET SOUTH				
		SAINT PAUL MN 55102				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM DATE		DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0050	12/28/2015	LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix _	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
REVIEWE STATE AG	/	REVIEWED BY (INITIALS) SR/KJ	date 03/16/2016	SIGNATURE OF SURVEYOR	424	date 01/04/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/11/2015		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL FE SURVEY AGENCY	ID: C7UC Facility ID: 00763
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245524           2.STATE VENDOR OR MEDICAID NO.           (L2)         825540700	ΙΟ.	3. NAME AND ADI (L3) LITTLE SIST (L4) 330 EXCHAN (L5) SAINT PAUL	FERS OF THE PONGE STREET SO	OOR	(L6) <b>55102</b>	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 12/10 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	0/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 73 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	B. Not in Comp Requireme ICF (L42)	ce With quirements Based On: cceptable POC bliance with Program nts and/or Applied W IID (L43)	'aivers:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Robyn Woo			12/28/2015	(L19)	<u>Kate JohnsTon, Pr</u>	(L20)
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Par        2. Facility is not Eligible	7	20. COM	<b>D BY HCFA RE</b> PLIANCE WITH CI ITS ACT:		LOFFICE OR SINGLE STAT         21.       1. Statement of Financ         2. Ownership/Control         3. Both of the Above :	
22. ORIGINAL DATE OF PARTICIPATION <b>02/01/1988</b>	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMEN		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susj	of Admissions:	(L25) (L44)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	nt 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539		DETERMINATION C	DF APPROVAL DAT		Posted 01/11/2016 Co.	
	(L32)			(L33)	DETERMINATION APPRO	VAL



Electronically delivered December 24, 2015

Sr. Mary Elizabeth Anderson, Administrator Little Sisters Of The Poor 330 Exchange Street South Saint Paul, Minnesota 55102

RE: Project Number S5524025

Dear Sr.. Anderson:

On December 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567 whereby corrections are required. Copies of the Statement of Deficiencies (CMS-2567) and Form A are enclosed.

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

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

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

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

Little Sisters Of The Poor December 24, 2015 Page 2

### DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793 Fax: 651-215-9697

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the

Little Sisters Of The Poor December 24, 2015 Page 3

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePOC, a revisit of a facility may be conducted to verify that compliance with the regulations has been attained. If a revisit is conducted, it will occur after the date you identified that compliance was achieved in your plan of correction.

## **INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

Little Sisters Of The Poor December 24, 2015 Page 4

period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Tomoton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245524	B. WING			12/	10/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITTLE SI	STERS OF THE POOR				30 EXCHANGE STREET SOUTH AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	7, 8, 9, 10, 2015. Litt compliance with 42 C	as conducted on December le Sisters of the Poor is in FR Part 483, subpart B, g Term Care Facilities.					
	signature is not requir page of the CMS-256 correction is required	I in ePOC and therefore a red at the bottom of the first 7 form. Although no plan of , it is required that you of the electronic documents.					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

PRINTED: 12/24/2015

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS <sup>®</sup> NG 01 - MAI	IN BUILDING 01		ATE SURVEY OMPLETED
		245524	B. WING			1	2/11/2015
NAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP	CODE	
LITTLE	SISTERS OF THE PO	OR			ANGE STREET SOUTH		
				SAINT P	AUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
K 000	INITIAL COMMEN	rs	ко	00			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.	,				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.					
5	THE POOR was fou compliance with the in Medicare/Medica 483.70(a), Life Safe	urvey, LITTLE SISTERS OF and not in substantial requirements for participation id, 42 CFR, Subpart ty from Fire, and National Fire on (NFPA) Standard 101 -					
	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY					
	HEALTHCARE FIRE STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510	HAL DIVISION TREET, SUITE 145		2 - -	EP(	C	
	Or by email to: Angela.Kappenman Marian.Whitney@st					-	e.

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 processing for the facility. program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES		FOF	ED: 12/29/2015 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY
		245524	B. WING _		2/11/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	SISTERS OF THE POO	DR		330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC 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 K 050 SS=C	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficient 2. The actual, or pro 3. The name and/or responsible for correprevent a reoccurrent This 5-story building determined to be of has no basement and throughout. The fact At the time of surve The requirement at NOT MET as evident NFPA 101 LIFE SAM Fire drills are held and varying conditions, and The staff is familiar that drills are part of Responsibility for pla assigned only to corr qualified to exercise conducted between announcement may alarms. 19.7.1.2	RRECTION FOR EACH TINCLUDE ALL OF THE RMATION: what has been, or will be, done ency. oposed, completion date. title of the person ection and monitoring to nce of the deficiency. constructed in 1977 was Type II(222) construction. It nd is fully fire sprinklered ility has a capacity of 73 beds. y the census was 73. 42 CFR Subpart 483.70(a) is need by: FETY CODE STANDARD t unexpected times under at least quarterly on each shift. with procedures and is aware established routine. anning and conducting drills is npetent persons who are leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible	K 00	0	12/28/15
		not met as evidenced by: reports and interview, it was		Maintenance Director and Safety Office	r

FORM CMS-2567(02-99) Previous Versions Obsolete

La de la companya de

Facility ID: 00763

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORM A	12/29/2015 PPROVED 938-0391
STATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245524	B. WING			12/1	1/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 30 EXCHANGE STREET SOUTH		
LITTLE S	SISTERS OF THE POO	DR		-	AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	determined that the on fire drills in accordance with	e facility failed to vary the times NFPA 101 LSC (00) Section tient practice could affect how	K	050	to devise a schedule that will vary th times of the drill to include all shifts.		
	1:00 PM on 12/11/2 available documen facility has not varie during the evening 4 drills were condu 4:00pm.	our between 09:00 AM and 2015, based on review of tation it was reveled that the ed the times for fire drills shift for the last 12 months. all cted between 3:15pm and					
		e Director (KS) at the time of				64	2
	2						
#2 							
8 10							
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: C7UC2	21	Fa	cility ID: 00763 If continu	ation shee	et Page 3 of 3

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245524	B. WING		12/	11/2015
	PROVIDER OR SUPPLIER	DR		STREET ADDRESS, CITY, STATE, ZIP CODE 330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.	,			
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	THE POOR was fo compliance with the in Medicare/Medica 483.70(a), Life Safe	urvey, LITTLE SISTERS OF und not in substantial e requirements for participation id, 42 CFR, Subpart ety from Fire, and National Fire ion (NFPA) Standard 101 -				
15	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY	54			
	HEALTHCARE FIR STATE FIRE MARS 445 MINNESOTA ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145		EPO	С	
	Or by email to: Angela.Kappenmar Marian.Whitney@s	n@state.mn.us and tate.mn.us				÷

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.

The summer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIENCUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245524       B. WING       12/11/2015         ITTLE SISTERS OF THE POOR       STREET ADDRESS, CITY, STATE, ZIP CODE       330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102       12/11/2015         (X3) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WILST INFOLUDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY WILST INCLUDE ALL OF THE FOLLOWING INFORMATION:       (X6) 00         K 000       Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY       K 000       K 000         1. A description of what has been, or will be, done to correct the deficiency.       K 000       K 000         2. The actual, or proposed, completion date.       3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.       K 000         This 5-story building constructed in 1977 was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a capacity of 73 beds. At the time of survey the census was 73.       In the requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       LITTLE SISTERS OF THE POOR     330 EXCHANGE STREET SOTH       MILD     SUMMARY STATEMENT OF DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCIES       Image: Summary Statement of DEFICIENCIES     Image: Summary Statement of DEFICIENCY       Image: Summary Statement of DEFICIENCY     Image: Summary Statement of DEFICIENCY       Image: Summary Statement of DEFICIENCY     Image: Summary Statement of DEFICIENCY       Image: Summary Statement of DEFICIENCY     Image: Summary Statement of DEFICIENCY       Image: Summary Statement of DEFICIENCY     Image: Summary Statement of DEFICIENCY       Image: Summary Statement of DEFICIENCY	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
INTERS OF THE POOR         INTERS OF THE POOR         SUMMARY STATEMENT OF DEFICIENCIES PARTY         CONTRESTING INFORMATION         TAG         SUMMARY STATEMENT OF DEFICIENCIES PARTY         CONTRESTING INFORMATION         TAG         CONTRESTING INFORMATION         TAG         CONTRESTING INFORMATION         K 000         CONTRESTING INFORMATION         K 000         CONTRESTING INFORMATION         K 000         CONTRESTING INFORMATION         K 000         CONTRESTING INFORMATION:         1.1         CONTRE			245524	B. WING		12/	11/2015
LITTLE SISTERS OF THE POOR     SAINT PAUL, MN 55102       (M) D PREFIX TAG     Summary statement of Deficiencies reconductor wust be received by the reconductor wust be reconductor wust be reconductor percent a record the deficiency.     000       1. A description of what has been, or will be, done to correct the deficiency.     K 000     K 000       2. The actual, or proposed, completion date.     3. The name and/or title of the person responsible for correction and monitoring to prevent a recocurrence of the deficiency.     K 050       This 5-story building constructed in 1977 was determined to be of Type II(222) construction. It has no beament and is fully fire sprinklered throughout. The facility has a capacity of 73 beds. At the time of survey the census was 73.     K 050       Sec     Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with proceares and is avare that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadershift. The STANDARD is not met as evidenced by:     K 050	NAME OF 1	PROVIDER OR SUPPLIER					
(A) U       (EACH DEPICENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       CRACE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:       K 000         K 000       Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:       K 000         1. A description of what has been, or will be, done to correct the deficiency.       K 000         2. The actual, or proposed, completion date.       3. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.         This 5-story building constructed in 1977 was determined to be of Type II(22) construction. It has no basement and is fully fire sprinklered throughout. The facility has a capacity of 73 beds. At the time of survey the census was 73.       K 050         SS=C       Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to excess leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2       12/28/		SISTERS OF THE POO	DR				
THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:         1. A description of what has been, or will be, done to correct the deficiency.         2. The actual, or proposed, completion date.         3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.         This 5-story building constructed in 1977 was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a capacity of 73 beds. At the time of survey the census was 73.         The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:         K 050         SS=C         Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to completent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2         This STANDARD is not met as evidenced by:	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
This STANDARD is not met as evidenced by:	K 050	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr prevent a reoccurre This 5-story buildin determined to be o has no basement at throughout. The fac At the time of surve The requirement at NOT MET as evide NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercis conducted betweer announcement ma	RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. g constructed in 1977 was f Type II(222) construction. It and is fully fire sprinklered cility has a capacity of 73 beds. by the census was 73. c 42 CFR Subpart 483.70(a) is enced by: FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is ompetent persons who are e leadership. Where drills are n 9 PM and 6 AM a coded y be used instead of audible				12/28/15
		This STANDARD	s not met as evidenced by:		Maintenance Director and Safe	ety Officer	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00763

If continuation sheet Page 2 of 3

PRINTED: 12/29/2015

		AND HUMAN SERVICES				FORM A	12/29/2015 PPROVED 938-0391
STATEMENT	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245524	B. WING			12/1	1/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 30 EXCHANGE STREET SOUTH		
LITTLE S	SISTERS OF THE POO	DR		-	AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	determined that the on fire drills in accordance with	e facility failed to vary the times NFPA 101 LSC (00) Section tient practice could affect how	K	050	to devise a schedule that will vary th times of the drill to include all shifts.		
	1:00 PM on 12/11/2 available documen facility has not varie during the evening 4 drills were condu 4:00pm.	our between 09:00 AM and 2015, based on review of tation it was reveled that the ed the times for fire drills shift for the last 12 months. all cted between 3:15pm and					
		e Director (KS) at the time of				64	2
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FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: C7UC2	21	Fa	cility ID: 00763 If continu	ation shee	et Page 3 of 3