

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HBLD

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245617</b>		3. NAME AND ADDRESS OF FACILITY (L3) <b>CARONDELET VILLAGE CARE CENTER</b> (L4) <b>525 FAIRVIEW AVENUE SOUTH</b> (L5) <b>SAINT PAUL, MN</b> (L6) <b>55116</b>		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) <b>550012400</b>		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>	
6. DATE OF SURVEY <b>05/03/2018</b> (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: <b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>2. Technical Personnel</u> 6. Scope of Services Limit <u>3. 24 Hour RN</u> 7. Medical Director <u>4. 7-Day RN (Rural SNF)</u> 8. Patient Room Size <u>5. Life Safety Code</u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A*</b> (L12)			
12.Total Facility Beds <b>45</b> (L18)		13.Total Certified Beds <b>45</b> (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID <b>45</b> (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  <b>Robyn Woolley, HFE NE II</b>	Date :  <b>05/19/2018</b> (L19)	18. STATE SURVEY AGENCY APPROVAL  <b>Alison Helm, Enforcement Specialist</b>	Date:  <b>05/29/2018</b> (L20)
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## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY  ____ 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION <b>08/27/2012</b> (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) <b>VOLUNTARY 00</b> <b>INVOLUNTARY</b> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <b>OTHER</b> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. <b>03001</b> (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  
May 21, 2018

Mr. Gavin Middleton, Administrator  
Carondelet Village Care Center  
525 Fairview Avenue South  
Saint Paul, MN 55116

RE: Project Number S5617007

Dear Mr. Middleton:

On May 3, 2018, 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

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.

Sincerely,

A handwritten signature in black ink, appearing to read 'Michaelyn Bruer', written in a cursive style.

Michaelyn Bruer, Enforcement Specialist  
Minnesota Department of Health  
Health Regulation Division  
Program Assurance Unit  
phone 651-201-4117 fax 651-215-9697  
email: [michaelyn.bruer@state.mn.us](mailto:michaelyn.bruer@state.mn.us)

cc: Licensing and Certification File

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

PRINTED: 05/30/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245617</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/03/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARONDELET VILLAGE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116</b>		
(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	E 000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted April 30 through May 3, 2018, during a recertification survey. The facility is in compliance with Appendix Z Emergency Preparedness Requirements.				
F 000	INITIAL COMMENTS	F 000			
	A standard survey was conducted 4/30/18-5/3/18. Carondelet Village Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.				
	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 you acknowledge receipt of the electronic documents.				

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

TITLE

(X6) DATE

Electronically Signed

05/22/2018

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: 05/08/2018  
FORM APPROVED  
OMB NO. 0938-0391

F5617007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245617</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - CARONDELET VILLAGE CARE CENTER</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/02/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARONDELET VILLAGE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116</b>		
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>The Facility is a 4 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.</p> <p>The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification.</p> <p>The facility has a capacity of 45 beds and had a census of 43 at the time of the survey.</p>	K 000			

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

TITLE

(X6) DATE

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May 21, 2018

Mr. Gavin Middleton, Administrator  
Carondelet Village Care Center  
525 Fairview Avenue South  
Saint Paul, MN 55116

Re: Project Number S5617007

Dear Mr. Middleton:

The above facility survey was completed on May 3, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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.

Sincerely,

A handwritten signature in black ink, appearing to read 'Michaelyn Bruer', written over a horizontal line.

Michaelyn Bruer, Enforcement Specialist  
Minnesota Department of Health  
Health Regulation Division  
Program Assurance Unit  
phone 651-201-4117 fax 651-215-9697  
email: [michaelyn.bruer@state.mn.us](mailto:michaelyn.bruer@state.mn.us)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>27189</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2018</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: 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 &lt;<a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>&gt; The State licensing orders are delineated on the attached Minnesota</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/22/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>27189</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2018</b>
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2 000	<p>Continued From page 1</p> <p>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>On 4/30/18-5/3/18, surveyors of this Department's staff, visited the above provider and no orders were issued.</p> <p>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.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>27189</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/03/2018</b>
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2 000	Continued From page 2  MINNESOTA STATE STATUTES/RULES.	2 000			