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

CMS Certification Number (CCN): 245617

November 13, 2015

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

Dear Ms. Ballard:

SUBJECT: DISPOSITION OF REMEDIES
Civil Money Penalty Case Number: 2016-05-LTC-037
Cycle Start Date: August 28, 2015

PRIOR NOTICE

On September 11, 2015, we informed you that we were imposing remedies due to the failure of your facility to be in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs.

SUBSEQUENT VISITS AND SUMMARY OF ENFORCEMENT REMEDIES

The Minnesota Department of Health conducted a revisit of your facility on October 29, 2015. The revisit found your facility to be in substantial compliance with the participation requirements effective October 2, 2015. As a result of the survey findings, and in consideration of the results of the Informal Dispute Resolution you requested, the final status of remedies is as follows:

- Civil Money Penalty was effective August 26, 2015
- Mandatory denial of payment for new Medicare and Medicaid admissions, which was imposed effective November 28, 2015, is rescinded effective October 2, 2015. We are notifying your Medicare Administrative Contractor and the State Medicaid agency of the rescission of the denial of payment remedy
- Mandatory Termination, which was to be effective February 28, 2015, will not be imposed

CIVIL MONEY PENALTY (CMP)

As we informed you on September 11, 2015, a CMP was imposed against your facility for failure to comply with the Federal requirements. This action was taken pursuant to the authority contained in Sections 1819(h) and 1919(h) of the Social Security Act and Federal regulations at 42 CFR Section 488.430. This CMP is as follows:

- Federal Civil Money Penalty of $2,400.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 for the survey ending August 26, 2015

The total CMP amount due is $1,560.00.

This total reflects a thirty-five percent (35%) reduction in the amount of the CMP since you waived your right to a hearing on the noncompliance, as specified at 42 CFR Section 488.436.

CMP PAYMENT
This is to inform you that the CMP as noted is due and payable on December 8, 2015. The CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Do not send your original CMP payment check to the Chicago Regional Office. Otherwise, your payment will be considered late and offset may be initiated and/or interest may be charged. A **copy** of the check and, if applicable, your waiver of your right to a hearing and any other correspondence submitted to either of the above addresses, **must also be sent to this Chicago office,** to the attention of Jan Suzuki to ensure timely and accurate updating of your record.

Please note that, in accordance with the regulations at 42 CFR Section 488.442, CMS will assess interest on any unpaid balance of the penalty beginning on the due date. The rate of interest is 10%.

To pay by electronic transfer of funds to CMS:

Subtype/Type Code:	**10 00**
Amount:	**$1,560.00**
Sending Bank Routing Number:	***(insert the sending bank routing number)***
ABA Number of Receiving Institution:	**021 030 004**
Receiver Name:	**Treasury NYC**
Receiving Institution Name:	**Federal Reserve Bank of New York**
Receiving Institution Address:	**33 Liberty Street, New York, NY 10045**
Beneficiary Account Number:	**875050080000**
Beneficiary Name:	**Centers for Medicare & Medicaid**

	Services (CMS)
Beneficiary Physical Address:	**7500 Security Blvd., Baltimore, MD 21244**
CMS Tax ID Number:	**52-0883104**
Federal Reserve Assistance Number:	**(202) 874-6894**
Remarks:	**Civil Money Penalty; 245617 2016-05-LTC-037**

If CMS does not receive a check or electronic transfer of funds for the full amount by the payment due date, both the CMP and any interest accrued after the payment due date will be deducted from sums owed to you **without any further notification from this office.**

To ensure proper crediting of your payment, you must include the CMP case number and your CMS Certification Number (CCN) on your check and on all correspondence relating to the CMP.

- The CMP case number is: 2016-05-LTC-037
- Your CMS Certification Number (CCN) is 245617.

NURSE AIDE TRAINING PROHIBITION

In our formal notice dated September 11, 2015, we advised you that, in accordance with Section 1819(f)(2)(B)(iii)(I)(b) of the Social Security Act, your facility may be prohibited from conducting a Nurse Aide Training and/or Competency Evaluation Program for two years from November 28, 2015 due to a denial of payment. Since your facility attained substantial compliance on October 2, 2015, the original triggering remedy did not go into effect. Therefore, the NATCEP prohibition is rescinded.

APPEAL RIGHTS

We have received your hearing waiver and, as noted above, the amount of the Civil Money Penalty has been reduced accordingly. There are no other outstanding appeal issues.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact me at (312) 886-5209. Information may also be faxed to (443) 380-6602.

Sincerely,

/s/
Jan Suzuki
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

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

Midwest Division of
Survey & Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CMS Certification Number (CCN): 245617

October 23, 2015

Ms. Rebecca Ballard, Care Center Administrator
Carondolet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Dear Ms. Ballard:

SUBJECT: Informal Dispute Resolution Results
Carondolet Village Care Center

This is in response to your request for Informal Dispute Resolution (IDR) following the August 28, 2015 Federal Monitoring Survey of your facility by the Centers for Medicare & Medicaid Services (CMS). The IDR has been completed by CMS staff and included a full and complete review and consideration of the documentation you submitted for review.

The IDR has determined that you did not successfully dispute the survey findings documented on the CMS-2567 at data tag F323. As a result, there will be no changes to the original findings of this Federal Monitoring Survey.

Thank you for bringing your concerns to our attention. If you have any questions, please contact Jan Suzuki, Principal Program Representative, at (312) 886-5209.

Sincerely,

/s/
Christine Vause
Branch Manager, Survey Branch 2

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

CMS Certification Number (CCN): 245617

September 11, 2015

Andrew M. Luger, United States Attorney
District of Minnesota
600 U.S. Court House, 300 South 4th St.
Minneapolis, MN 55415

Attention: Chief, Civil Division

Dear Mr. Andrew M. Luger, United States Attorney:

This is to notify you of the imposition of a civil money penalty against Carondelet Village Care Center, 525 Fairview Avenue South, Saint Paul, MN 55116 pursuant to sections 1819(h) and 1919(h) of the Social Security Act ("Act"), codified at 42 U.S.C. section 1395i-3(h) and 1396r(h), and the enforcement regulations specified at 42 C.F.R. Part 488. 59 Reg. 56116 et. seq. To participate in the Medicare and Medicaid programs, long-term care facilities must meet Federal participation requirements, as specified in regulations at 42 C.F.R. Part 483, subparts A through C. The Act provides that the Secretary of the Department of Health and Human Services may impose civil money penalties against facilities for noncompliance with program participation requirements. That authority has been delegated to the Centers for Medicare & Medicaid Services (CMS).

Under the Act, CMS may impose a civil money penalty, but only pursuant to an agreement with the Attorney General. See 42 U.S.C. section 1320a-7(c), incorporated by reference in 42 U.S.C. section 1395i-3(h) and 1396r(h). Under the terms of the current agreement between CMS and the Department of Justice, your office has 14 days to review this matter. Therefore, pursuant to the agreement, this letter serves as notice of CMS' imposition of a civil money penalty against Carondelet Village Care Center, pursuant to 42 U.S.C. section 1395i-3(h)(2) and 1396r(h)(3). We are notifying you of our action in the event that such action might adversely affect any pending criminal action or other investigation of the facility, or raise "double jeopardy" issues. If you do not respond within 14 days of receipt of this notice, CMS will be free to collect, or accept payment of, the civil money penalty.

On August 28, 2015, a Federal Monitoring Survey was completed at Carondelet Village Care Center by the Minnesota Department of Health to determine whether the facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. Surveyors found evidence that the facility was not in substantial compliance with participation requirements. As a result of the survey findings, CMS is imposing, among

other remedies, a civil money penalty as follows:

- Federal Civil Money Penalty of $2,400.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 for the survey ending August 26, 2015

The facility will be advised of the imposition of a civil money penalty in a letter from this office.

Thank you very much for your cooperation in this matter. If you have any questions regarding the issues presented in this notice, please contact me at (312) 886-5209. Should you have any legal questions, please contact Marion Wanless, of the Office of General Counsel, at (312) 886-1640. All correspondence should be directed to me in our Chicago office.

Sincerely,

Jan Suzuki
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

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

CMS Certification Number (CCN): 245617

September 11, 2015
By Certified Mail and Facsimile

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

Dear Ms. Ballard:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: August 28, 2015

FEDERAL MONITORING SURVEY
On August 28, 2015, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at Carondelet Village Care Center to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. As the survey team informed you during the exit conference, the FMS has revealed that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level G, cited as follows:

- F323 -- S/S: G -- 483.25(h) -- Free Of Accident Hazards/supervision/devices.

The findings from the FMS will be posted on the EPOC system.

ELECTRONIC PLAN OF CORRECTION (ePOC)
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. 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.

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; and
- An electronic acknowledgement signature and date by an official facility representative.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a civil money penalty 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. To be given such an opportunity, you are required to send your written request to Jan Suzuki, at the Chicago address or by electronic mail to Jan.Suzuki@cms.hhs.gov with an electronic copy of the request sent to CMSQualityAssurance@cms.hhs.gov.

The documents along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute actual harm or immediate jeopardy) should be sent to:

Charlene Beyah, RN, BSN, JD
20871 W. Glen Haven Circle
Northville, MI 48167

Please send a copy of your documents to Jan Suzuki. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Independent IDR in no way is to be construed as a formal evidentiary hearing. They are informal administrative processes to discuss deficiencies. You will be advised verbally of our decision relative to the informal dispute, with written confirmation to follow.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, we are imposing the following remedies:

- Federal Civil Money Penalty of $2,400.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 for the survey ending August 26, 2015
- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective November 28, 2015

The authority for the imposition of remedies is contained in §§1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective November 28, 2015 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at §§1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new

Medicare admissions is effective on November 28, 2015. We will further notify the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective November 28, 2015.

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

CIVIL MONEY PENALTY

In determining the amount of the Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $2,400.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 for the survey ending August 26, 2015

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. **The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, Your CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245617.
- The start date for this cycle is August 28, 2015.

TERMINATION PROVISION

If your facility has not attained substantial compliance by February 28, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

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

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 $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 28, 2015, 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 November 28, 2015. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed:

- Federal Civil Money Penalty of $2,400.00 per instance for the instance of noncompliance at F323 (S/S: G) identified in the CMS-2567 for the survey ending August 26, 2015
- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective November 28, 2015

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a

request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

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

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki. Failure to do so could result in our office proceeding with collection of the CMP.

CONTACT INFORMATION
If you have any questions regarding the Federal Monitoring Survey, please contact Grace Marcelo, RN, State Leader, at (312) 353-6650. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602.

Sincerely,

Jan Suzuki
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health

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

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 _____	08/28/2015

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 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on August 28, 2015 following a Minnesota Department of Health survey on July 23, 2015. Survey Dates: August 24, 2015 to August 28, 2015 Survey Census: 45 Medicare: 3 Medicaid: 12 Other: 30 Total: 45 Stage 1 Sample: 30 Stage 2 Sample: 26	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		10/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2015

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 _____	08/28/2015

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 279	Continued From page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop an individualized care plan to address syncopal (fainting) episodes for one (R12) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R12's admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation and personal history of falls. Review of R12's "Comprehensive Data Collection" for admision dated 5/6/15 under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension [low blood pressure that happens when you stand up from sitting or lying down]." Review of R12's "Fall Risk Data Collection" dated 5/6/15 under "Resident had falls" revealed a check marked next to syncope and dizziness which indicated resident had episodes of both prior to the admission to the facility. Review of R12's entire "Individual Resident Care	F 279	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired 5-19-15 prior to survey. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and falls policy has been reviewed and is current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and are current. Education on care planning, comprehensive assessment and falls assessment, specific to syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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 _____	08/28/2015

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 279	Continued From page 2 Plan [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" did not address R12's fainting episodes before falls or her orthostatic hypotension. Review of R12's "Hospital Discharge Summary" dated 5/6/15 under "Active Problems" revealed "chronic atrial fibrillation, diastolic [the pressure in the arteries when the heart rests between beats] congestive heart failure, orthostatic hypotension...fall, syncope due to othostatic hypotension..." Review of R12's "Pain Summary Report" dated 5/11/15 at 9:44am revealed "...who is a recent admitted [sic] from acute hospital...on oxygen therapy & lasix [diuretic] with daily weights, orthostatic hypotension with 2 recent falls with light headless [sic]." Review of R12's "Hospital Discharge Documents" dated 5/13/15 under "Attending Progress Note" indicated "...She denies pain, ex [sic] except for [LBP] low blood pressure when she is up." On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about the lack of individualized care plan to address R12's syncopal episodes present on admission on 5/6/15 and re-admission on	F 279	Date certain for the purposes of ongoing compliance is 10/02/15.	

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	245617	A. BUILDING _____ B. WING _____	08/28/2015

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F 279	Continued From page 3 5/14/15. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes. RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed this time. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan. On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's initial care planning process. The DON verbalized the admitting nurse was responsible for initiating the interim care plan based on the hospital's transfer discharge documents and the nursing assessments upon admission. The DON was shown R12's interim care plan under falls, while looking at the care plan the DON verbalized, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to). The DON confirmed it was important to have put "syncope" since it was identified as a problem on both R12's admission and re-admission. Review of the facility's "Care Plan and Policy Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of [Name of Facility] to initiate a temporary care plan within 24 hours of admission..." Further review of the same document under "Procedure" revealed, "1. Each department will gather needed information on admission to provide data for the Individual Resident Care Plan along with individual care plan statements specific to the resident needs...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..."	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the plan of care to reflect the refusal to perform exercises of one resident (R21) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis.	F 280	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be	10/2/15

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F 280	Continued From page 5 Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 was cognitively intact. Further review of R21's Annual MDS revealed that R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of the upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation in ROM on both sides of lower extremities. Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. She further stated that she should have reflected the refusal in the care plan. Review of the facility's policy titled "Care Plan Policy and Procedure" with the last revision on 8/14 revealed under Procedure, "...10. The care	F 280	conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been initiated and is ongoing. Ongoing Functional Maintenance Programs reviewed quarterly for all Residents. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 280	Continued From page 6 plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times..." According to Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, October 2014, Chapter 4 page 11 indicated, "A new care plan does not need to be developed after each...reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to: (1) provide services in accordance with the resident's written plan of care for one (R7) of five residents reviewed for accidents; and, (2) follow physician orders for one (R22) of six residents observed during medication pass in the Stage 2 sample of 26. Findings include:	F 282	Resident #7 Care plan and My Best Day was comprehensively reassessed for wandering and adjusted. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. Resident #22 Care Plan, My Best Day and Medications reviewed and are accurate.	10/2/15

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F 282	Continued From page 7 1. Review of R7's "Admission Record" indicated R7 had diagnoses including, but not limited to, dementia with behavioral disturbance and unspecified psychosis. Review of R7's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/10/15 under "Section E0900: Wandering-Presence and Frequency" revealed R7 had behavior of this type 4 to 6 days, but less than daily. Review of R7's Electronic Health Record (EHR) Progress Notes from 3/9/15-8/26/15 indicated R7 had a history of wandering which included but was not limited to wandering into other resident rooms, wandering out of the Care Center to the 3rd floor and wandering outside of the facility. Review of R7's care plan, revised on 06/26/15, under "Focus" included "I demonstrate wandering behavior (out of the CC [Care Center] & [and] other resident rooms.) "Interventions" included but were not limited to the following: "On 30 minute safety checks." Interview with NA1 on 8/26/15 at 11:04am revealed R7 wanders into other resident rooms and out of the Care Center. NA1 stated "She [R7] is on half an hour safety checks...We have to check on her location..." During a continuous observation on 8/26/15 from 11:04am until 12:03pm, R7 was in R7's room with the doors completely closed. The surveyor had confirmed the resident location at the conclusion of the observations. No one had entered R7's room during the 59 minutes of observation.	F 282	The care plan policy has been reviewed and is current. Medication pass policy reviewed and is current. Education on following care plan and physicians orders has been initiated and is ongoing. Audits regarding care plan interventions and physicians orders will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10-02-15.	

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F 282	Continued From page 8 Nursing staff was seen to pass medications and attend other residents on the unit. On 8/26/15, activity staff was observed to leave R7's room at 2:33pm. The room doors were left closed. During a continuous observation until 4:15pm, R7 was observed to be inside R7's room. No one was observed to enter R7's room during the one hour and 42 minutes. At the time of the observation nursing staff was attending to other residents on the unit. On 8/27/15 at 10:03am, a visitor was observed to leave R7's room. During a continuous observation until 10:55am, R7 was in R7's room with the doors completely closed. There was no nursing staff within R7's room vicinity throughout the observation. No one was witnessed to enter R7's room during the 52 minutes of observation. In an interview on 8/27/15 at 12:38pm, the Director of Nursing (DON) when questioned what do safety checks consist of, replied that staff "physically have to go and see where [R7] is and what she is doing." The DON further indicated that there is a form for staff to complete related to the 30 minute checks. During the interview the DON was made aware of the observations related to the facility's failure to implement R7's care plan interventions of 30 minute safety checks. The DON replied that the 30 minute safety checks are "not always possible." On 8/27/15 at 5:55pm, the Corporate Clinical Care Director stated that the facility does not have a specific policy and procedure related to resident safety checks. On 8/28/15 at 8:40am, the Administrator provided	F 282		

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F 282	Continued From page 9	F 282		

the safety check forms for the week of 8/23/15, as requested by the surveyor on 8/27/15. The Administrator further indicated that the form is a tool and is not part of the medical record. Review of the "30 Minute Checks" for R7 from 8/23/15-8/26/15 revealed the forms, which were in a log format, only had the date and R7's name located on the top of the page and were blank under the following segments: "Location of Resident", "Observed doing what?", and "Staff Initial."

2. Review of the 6/10/15 Quarterly MDS revealed R22 had a Brief Individual Mental Status (BIMS) score of 15 (with 13- 15 indicating R22 was cognitively intact). This same MDS revealed the following diagnoses for R22: congestive heart failure (CHF-unable to pump blood sufficiently for the body), chronic obstructive pulmonary disease (COPD - makes it hard for you to breathe), and generalized muscle weakness.

Review of R22's care plan dated 6/8/15 revealed the following information: "I have an alteration or the potential for alteration in respiratory status related to COPD. Give me my medications as ordered by my physician."

The Physician's Order Sheet (POS) for R22 dated 8/4/15 revealed the following order "Advair diskus 100/50 inhaler, give one puff inhaled twice a day," and "to rinse the mouth after given the inhaled puff." This order was documented as starting on 1/8/15.

Observation on 8/26/15 at 9:30am revealed that Trained Medication Aide 1 (TMA1) gave the resident the inhaler, told her to take a deep breath and release the breath, then instructed R22, while using the inhaler, to take a deep

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F 282	Continued From page 10 breath in and hold it for as long as possible then release the breath. TMA1 then gave other oral medications with applesauce and water. TMA1 did not remind R22 to rinse her mouth after inhaling the puff. During an interview on 8/26/15 at 3:48pm, with TMA1 revealed that she was aware that the order for R22's Advair diskus required the mouth to be rinsed after the puff was given to help prevent the development of thrush (a fungal infection of the mouth). She stated she did not ask R22 to do this after she administered the Advair diskus inhaler. During an interview on 8/28/15 at 9:48am, the Director of Nursing (DON) stated that he would expect the staff to follow the physician's orders and administer an inhaler medication as the physician prescribed. He stated if the order read to rinse the mouth after the inhaled puff was given, he expected the nursing staff to follow the physician's order. Review of the Manufacturer's information (GlaxoSmithKline) revealed the following information regarding Advair diskus inhaler, "Advair can cause serious side effects, including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using ADVAIR to help reduce your chance of getting thrush." The facility's policy regarding Transcription of Physician's Orders created 03/11 under Procedure revealed, "14. All orders will be carried out as per physician's order...as indicated..."	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		10/2/15

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F 318	Continued From page 11 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: (1) ensure a resident with an identified decline in range of motion (ROM) consistently received services and treatment identified in the plan of care; and, (2) modify the interventions to prevent further decline in ROM for one (R21) of one resident reviewed for ROM in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis. Review of R21's Quarterly Minimum Data Set (MDS) dated 3/11/15, indicated that R21 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and bathing; and, was totally dependent on staff for transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion was coded one that indicated R21 had functional limitation of range of motion on one side of upper (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee,	F 318	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All residents are assessed upon admission or with a significant change in condition and are reviewed for changes in functional ability and need for ROM quarterly as part of the RAI process and Interdisciplinary reviews. Care plans and Functional Maintenance Programs are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in	

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F 318	Continued From page 12 ankle, and foot). Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation of ROM on both sides of lower extremities. This coding indicated that R21 had a decline in functional ROM within 90 days from the previous assessment to the most recent assessment. Further review of R21's Annual MDS dated 6/10/15 revealed Activities of Daily Living (ADL) triggered the Care Area Assessment (CAA - assessment of the resident's problems, needs and strengths). The "Analysis of Findings" from R21's CAA for ADL revealed, "[R21] has impaired mobility, balance [and] ROM RT [related to] HX [history] of CVA [cerebrovascular accident/stroke]...Is mainly bed bound. Get up in W/C [wheelchair] 1-2 times per week for beauty shop appointment or PM for activity. Has impaired ability to tolerate W/C activity. Has impaired ROM R [right] UE [upper extremity], BLE [bilateral lower extremities] very weak [and] [R21] was unable to move, has bilateral foot drop..." Review of the same CAA under the "Referral to Other Disciplines" revealed that the question "Is a referral to other disciplines warranted?" had no	F 318	status. Therapy evaluations are provided as indicated and per physicians¿ order. IDT to review PROM programs for each resident weekly for two months. In addition, PROM programs will be reviewed in conjunction with the RAI process. Ongoing facility measures to include IDT review of a Functional Maintenance Program monthly and in conjunction with the RAI process. The care plan policy and Functional Maintenance Plan/ROM policy have been reviewed and are current. Staff are educated on the individual functional maintenance plan through the care plan, My Best Day and specific instructions. Education for staff on following the ROM plan and resident refusals and risks and benefits of FMP¿s was initiated and is ongoing. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 318	Continued From page 13 answer. Review of the same CAA revealed, "Care Plan considerations...Describe impact of this problem/need on the resident [R21] and your rationale for care plan decision...Will care plan for ADLS [activities of daily living], has impaired mobility [and] impaired ability to tolerate activities, requires staff support to meet her needs." Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator (RN1) on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. RN1 further stated, "The resident refuses to get up and it should be done when seated." When asked if the rehabilitation department was consulted because of R21's refusals to get up and consequently not doing the seated exercises, RN1 stated, "That's why the high back W/C was started." When asked about measures that could be provided while R21 was in bed, RN1 stated, "Rehab [rehabilitation department] would not recommend anything to be done in bed but I could write an order [range of motion exercises order] for nursing." She verified that no further consultation or interventions were done after the initiation of the high back	F 318	Date certain for the purposes of ongoing compliance is 10/02/15.	

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(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 318	Continued From page 14 wheelchair. Review of R21's medical record revealed no documentation that R21 was educated about the risks and benefits of refusing to perform the seated exercises. Review of R21's care plan related to limited physical mobility revealed it was not updated to reflect R21's refusals to do the seated exercises. In an interview with the AM (morning) shift Charge Nurse (RN2) on 8/28/15 at approximately 8:45am, RN2 indicated that the resident assistants (RA) were not reporting that R21 was refusing to do the seated exercises. When asked about possible interventions since R21 has been refusing to get up, RN2 further stated, "If she's refusing, I could talk to the resident if it's because of pain or assess why. Maybe it's just personal choice or [she] just don't [sic] want to exercise. If needed to be seated and she's refusing to get up then we have to evaluate and revamp the plan of care or talk to therapy and run it by them. Therapy could give suggestions and I will inform the nurse practitioner." During the same interview when asked if the decline in the ROM could have been avoided, RN2 stated, "It's hard to say that it's avoidable or unavoidable because some residents are just declining but ROM [exercises] could be done and prevent decline. We could always do better." RN2 further stated, "We could do whatever we can to try to avoid the decline." In an interview with the Physical Therapist (PT1) on 8/28/15 at approximately 9:45am, PT1 indicated that she was not aware about R21's refusal to do the seated exercises. When asked	F 318		

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F 318	Continued From page 15 about what recommendations she had for R21, PT1 stated, "Supine exercises sometimes can avoid decline in ROM but not all the time, at least do the passive ROM exercises which sometimes can help though not always. Better than nothing or at least do it during cares even if not part of a program." Review of the facility's policy titled "Range of Motion Assessment Policy" last modified on 9/10 revealed under Purpose, "To maintain resident's ability to maintain current range of motion and/or prevent further decline in range of motion by completing Range of Motion Assessment upon admission, quarterly and with significant change." Further review of the same policy also revealed under Procedure, "...6. The program will be evaluated at least quarterly or more frequently as indicated...8. If any resident is having increased pain or discomfort, is refusing the range of motion program or is unable to complete the program as recommended, it will be communicated to the interdisciplinary team."	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		10/2/15

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F 323	Continued From page 16 Based on interviews and record reviews the facility failed to: (1) identify individual risk factors, initiate individualized care plans and interventions to prevent falls; and (2) implement and modify safety measures as needed to address a resident's multiple falls related to syncopal (fainting) episodes for one resident (R12) reviewed for falls in the Stage 2 sample of 26. Findings include: 1. Review of R12's facility admission and re-admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation (abnormal heart rate or rhythm) and personal history of falls. Review of R12's facility "Comprehensive Data Collection" dated 5/6/15 under "J. Neurological Status" revealed a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension." Review of R12's facility Electronic Health Record [EHR] under "Nursing" indicated "ROM Summary Effective Date 5/11/15 08:43 Department: Nursing Position: Clinical Coordinator " ...who is a recent admitted from acute hospital RT acute respiratory failure with hypoxia & pleura [sic] effusion with thoracentesis, afib on coumdain [sic], CHF & valvual [sic] heart disease- on oxygen therapy & lasix with daily weights, orthostatic hypotension with 2 recent falls with light headless[sic]. [Name of R12] is alert & oriented. Is able to express her needs, uses call light. Has use of packet [sic]	F 323	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired on 5-19-15 prior to survey. Daily Interdisciplinary Meetings are held to assist in identifying resident's with a change of condition or increased fall risks. Care plans and My Best Days are updated at that time. All in-house residents¿ identified as fall risk have been reviewed and care plans updated. Care plan interventions have been initiated for those residents with a diagnosis of syncope as it relates to falls/safety. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and the fall prevention policy have been reviewed and are current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and is current. Education on care planning, comprehensive assessments and falls assessment, including a focus on syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be	

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F 323	Continued From page 17 talker & written notes on white board. Transfer with A [Assist] of 1 & walks with A of 1& 4WW[wheeled walker]. Is working with Rehab & has made progress since admitted. PT [Physical Therapist] has starting [sic] walking program per FMP[Functional Maintenance Program]. " Review of R12's facility's EHR under "Nursing" indicated "General Notes Effective Date: 5/12/15 14:19 Department: Nursing Position: RN/LPN Created by: [Name of RN] "[Name of Resident] was taken out by nephew today to primary clinic for a follow up chest x ray. Niece, here and stated that she received a call that [name of R12] had a fall at the clinic and was being transported to the ER..." Review of the hospital transfer discharge documents that were part of R12's medical records on the facility revealed the following: A.The hospital's 5/12/15 "Emergency Department Staff/Physician Notes" for R12 under "Relevant HPI[History of Present Illness]" Patient was in clinic today and had a near syncopal event...While awaiting admission, patient up to bathroom with nurse and had another near syncopal event." B.The hospital's 5/13/15 "Consult Notes" for R12 under "History of Present Illness (HPI)" revealed "...who was brought to the hospital because of a fainting spell...She was feeling weak and had issues with orthostatic hypotension...she apparently fainted..." C.Review of R12's hospital "MD [Medical Doctor] Progress Note" dated 5/13/15 under "Principal Problem" indicated "Syncopal episodes	F 323	conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 323	Continued From page 18 A. Hx [History] of OH [orthostatic hypotension]..." Review of R12's facility medical record titled "Comprehensive Data Collection" under "Resident Demographics" revealed R12 was re-admitted to the facility on 5/14/15 at 2pm. Further review of the same document under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness." Review of R12's "Medication Administration Record" from 5/1/15 to 5/31/15 indicated R12 received Coumadin [a blood thinner] tablet 2.5mg on the following dates: 5/8/15, 5/11/15, 5/15/15. R12 also received Coumadin 5mg on 5/16/15 and 5/17/15. Review of "Coumadin's Package Insert" revised on 10/11 from Bristol Myer's website (the makers of Coumadin) indicated "Warning: Bleeding:...Coumadin can cause major or fatal bleeding..." Further review of the same document under "Medication Guide" revealed "...You may have a higher risk of bleeding if you take Coumadin and: are age 65 or older...have had trauma such as accident...Call your healthcare provider right away...signs and symptoms of bleeding problems: pain, swelling, discomfort, headaches, dizziness or weakness, unusual bruising [bruises that develop without known cause or grow in size], nosebleeds, bleeding gums...red or black stools, vomiting blood or material that looks like coffee grounds." Review of R12's facility medical record titled "Fall Risk Data Collection" dated 5/14/15 under "Internal Risk Factors" revealed syncope and vertigo were not marked which incorrectly	F 323		

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F 323	Continued From page 19	F 323		

indicated the resident had no episodes of either prior to the re-admission to the facility even though R12 was admitted emergently to the hospital on 5/12/15 due to syncopal episodes. Further review of the same document under "Summary of Risk Factors" indicated, "...She has a history of falls, the most recent being several days ago while out to a doctors [sic] appointment...Staff noted that resident was resistive to cares and would not allow staff to help ambulate with a transfer belt. Will continue to monitor."

Review of R12's entire "Individual Resident Care Plan [IRCP] [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of the same document under "Interventions" indicated a check next to monitor for safety. There was no specific intervention to address R12's falls related to her syncopal episodes. Further review of the same document indicated it was revised on 5/18/15 and the only intervention that was added was to instruct R12 to ask for help.

Review of R12's only "IRCP" dated 5/6/15 revealed that there was no care plan that addressed R12's use of Coumadin.

Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" for both admission and re-admission dates indicated R12 needed assist of one person during transfer, ambulation and repositioning. Further review of the same document did not address R12's fainting episodes before falls or her orthostatic hypotension. In addition, there was

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F 323	Continued From page 20 no mention about R12's anti-coagulant use and increased risk of bleeding. On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about R12's re-admission care plan. RN1 responded, "This is the only one we have." RN1 was further asked why there was no individualized care plan to address R12's syncopal episodes that were present on admission and re-admission. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes. On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's admission process. The DON stated the admitting nurse was responsible for initiating the IRCP based on the hospital's transfer discharge documents and the nursing assessments upon admission which included the fall risk data collection. The DON was shown R12's IRCP under falls. While looking at the care plan the DON stated, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to)." The DON confirmed it was important to have put "syncope" since it was identified as one of the main problems on both R12's admission and re-admission. On 8/27/15 at approximately 10:45am, the DON was also asked why the use of anti-coagulant therapy was not included in the risk factors or was not care planned. The DON replied that the	F 323		

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nursing staff were educated to look for the signs and symptoms of the side effects of anti-coagulant use like bruising, bleeding and hemorrhage. The DON was further asked how would the nursing staff knew if R12 was on anti-coagulant therapy if it was not identified as one of R12's risk factors, not care planned and was not addressed in the nursing assistants' "My Best Day." The DON replied that putting the anti-coagulant therapy as one of the risk factors would not hurt and that he understood its importance especially with R12's fall history.

On 8/28/15 at approximately 8:45am, RN1 was asked about the lack of care plan to address R12's use of anti-coagulant therapy. RN1 stated that normally she would develop the anti-coagulant therapy care plan on day 21.

Review of a study titled "Use of anticoagulation in elderly patients with atrial fibrillation who are at risk for falls." electronically published on 3/11/08 from the US National Library of Medicine and National Institute of Health website under "Conclusion" revealed "The risk of falls alone should not automatically disqualify a person from being treated with warfarin. While falls should not dictate anticoagulant choice, assessment and management of fall risk should be an important part of anticoagulation management. Efforts should be made to minimize fall risk."

2. A. Review of R12's facility EHR under "Nursing" indicated "Type: Fall Focus: Effective Date: 5/17/2015 23:32:00 Department: Nursing Position: RN/LPN Created Date : 5/18/2015 00:49:07 Description: Resident fell backwards hitting her bottom first while exiting the bathroom. [Name of R12] response: she was in really good

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spirits and said she did not feel hurt. She said her buttock hurt the most and that it hit the ground first. She denies hitting her head during the fall. Pain level was moderate 4/10. RA and I assisted her up to her bed via mechanical lift. Offered ice pack and Acetaminophen - she agreed to take 1000mg Acetaminophen."

Further review of this same entry revealed no further assessment to determine if R12's fall had occured because R12 had been dizzy or fainted.

On 8/26/15 at approximately 2:30pm, RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan."

Review of the facility's "Care Plan Policy and Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of Presbyterian Homes to initiate a temporary care plan within 24 hours of admission...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..." Further review of the same document under "Procedure" revealed, "...3. Post Fall Management...d.The staff nurse will review the occurence report and will: i. Assess all factors contributing to the fall event including intrinsic and extrinsic factors...ii. Recommend interventions and changes to plan of care to prevent a repeat fall..."

B. Review of R12's facility EHR under "Nursing" dated 5/19/15 at 9:08am indicated "Writer calld [sic] into resident's room by RA[Resident Assistant] stating she found resident on bathroom floor. Upon observation, noted resident lying on

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F 323	Continued From page 23 (R) side with blood all over her right (R) hand and side of head as well as on the floor. Oxygen tubing was wrapped around her legs and under her torso. Large hematoma on (R) back of head. Extremities discolored and cool to touch. Lips purple and UTD[unable to determine [sic] VS [vital signs]. No peripheral pulses or respirations. Verified death by no AP [apical pulse] at 0415 on 5/19/15..." Review of the "Coroner's Report" provided by the facility indicated R12's cause of death were from multiple trauma and falls. On 8/27/15 at approximately 10:45am, the DON was asked about R12's fall on 5/19/15. The DON responded that it was from R12's long oxygen tubing. When asked about R12's syncopal episodes, the DON verbalized, "Honestly, I did not even think about that."	F 323		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245617 Y1	A. Building B. Wing Y2	10/29/2015 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0279	Correction	ID Prefix	F0280	Correction	ID Prefix	F0282	Correction
Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed
LSC		10/02/2015	LSC		10/02/2015	LSC		10/02/2015
ID Prefix	F0318	Correction	ID Prefix	F0323	Correction	ID Prefix		Correction
Reg. #	483.25(e)(2)	Completed	Reg. #	483.25(h)	Completed	Reg. #		Completed
LSC		10/02/2015	LSC		10/02/2015	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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/28/2015	

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F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on August 28, 2015 following a Minnesota Department of Health survey on July 23, 2015. Survey Dates: August 24, 2015 to August 28, 2015 Survey Census: 45 Medicare: 3 Medicaid: 12 Other: 30 Total: 45 Stage 1 Sample: 30 Stage 2 Sample: 26	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		10/2/15

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

Electronically Signed | 09/18/2015

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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F 279	Continued From page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop an individualized care plan to address syncopal (fainting) episodes for one (R12) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R12's admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation and personal history of falls. Review of R12's "Comprehensive Data Collection" for admision dated 5/6/15 under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension [low blood pressure that happens when you stand up from sitting or lying down]." Review of R12's "Fall Risk Data Collection" dated 5/6/15 under "Resident had falls" revealed a check marked next to syncope and dizziness which indicated resident had episodes of both prior to the admission to the facility. Review of R12's entire "Individual Resident Care	F 279	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired 5-19-15 prior to survey. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and falls policy has been reviewed and is current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and are current. Education on care planning, comprehensive assessment and falls assessment, specific to syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 279	Continued From page 2 Plan [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" did not address R12's fainting episodes before falls or her orthostatic hypotension. Review of R12's "Hospital Discharge Summary" dated 5/6/15 under "Active Problems" revealed "chronic atrial fibrillation, diastolic [the pressure in the arteries when the heart rests between beats] congestive heart failure, orthostatic hypotension...fall, syncope due to othostatic hypotension..." Review of R12's "Pain Summary Report" dated 5/11/15 at 9:44am revealed "...who is a recent admitted [sic] from acute hospital...on oxygen therapy & lasix [diuretic] with daily weights, orthostatic hypotension with 2 recent falls with light headless [sic]." Review of R12's "Hospital Discharge Documents" dated 5/13/15 under "Attending Progress Note" indicated "...She denies pain, ex [sic] except for [LBP] low blood pressure when she is up." On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about the lack of individualized care plan to address R12's syncopal episodes present on admission on 5/6/15 and re-admission on	F 279	Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 279	Continued From page 3 5/14/15. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes. RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed this time. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan. On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's initial care planning process. The DON verbalized the admitting nurse was responsible for initiating the interim care plan based on the hospital's transfer discharge documents and the nursing assessments upon admission. The DON was shown R12's interim care plan under falls, while looking at the care plan the DON verbalized, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to). The DON confirmed it was important to have put "syncope" since it was identified as a problem on both R12's admission and re-admission. Review of the facility's "Care Plan and Policy Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of [Name of Facility] to initiate a temporary care plan within 24 hours of admission..." Further review of the same document under "Procedure" revealed, "1. Each department will gather needed information on admission to provide data for the Individual Resident Care Plan along with individual care plan statements specific to the resident needs...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..."	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the plan of care to reflect the refusal to perform exercises of one resident (R21) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis.	F 280	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be	10/2/15

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F 280	Continued From page 5 Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 was cognitively intact. Further review of R21's Annual MDS revealed that R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of the upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation in ROM on both sides of lower extremities. Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. She further stated that she should have reflected the refusal in the care plan. Review of the facility's policy titled "Care Plan Policy and Procedure" with the last revision on 8/14 revealed under Procedure, "...10. The care	F 280	conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been initiated and is ongoing. Ongoing Functional Maintenance Programs reviewed quarterly for all Residents. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 280	Continued From page 6 plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times..." According to Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, October 2014, Chapter 4 page 11 indicated, "A new care plan does not need to be developed after each...reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to: (1) provide services in accordance with the resident's written plan of care for one (R7) of five residents reviewed for accidents; and, (2) follow physician orders for one (R22) of six residents observed during medication pass in the Stage 2 sample of 26. Findings include:	F 282	Resident #7 Care plan and My Best Day was comprehensively reassessed for wandering and adjusted. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. Resident #22 Care Plan, My Best Day and Medications reviewed and are accurate.	10/2/15

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F 282	Continued From page 7 1. Review of R7's "Admission Record" indicated R7 had diagnoses including, but not limited to, dementia with behavioral disturbance and unspecified psychosis. Review of R7's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/10/15 under "Section E0900: Wandering-Presence and Frequency" revealed R7 had behavior of this type 4 to 6 days, but less than daily. Review of R7's Electronic Health Record (EHR) Progress Notes from 3/9/15-8/26/15 indicated R7 had a history of wandering which included but was not limited to wandering into other resident rooms, wandering out of the Care Center to the 3rd floor and wandering outside of the facility. Review of R7's care plan, revised on 06/26/15, under "Focus" included "I demonstrate wandering behavior (out of the CC [Care Center] & [and] other resident rooms.) "Interventions" included but were not limited to the following: "On 30 minute safety checks." Interview with NA1 on 8/26/15 at 11:04am revealed R7 wanders into other resident rooms and out of the Care Center. NA1 stated "She [R7] is on half an hour safety checks...We have to check on her location..." During a continuous observation on 8/26/15 from 11:04am until 12:03pm, R7 was in R7's room with the doors completely closed. The surveyor had confirmed the resident location at the conclusion of the observations. No one had entered R7's room during the 59 minutes of observation.	F 282	The care plan policy has been reviewed and is current. Medication pass policy reviewed and is current. Education on following care plan and physicians orders has been initiated and is ongoing. Audits regarding care plan interventions and physicians orders will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10-02-15.	

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F 282	Continued From page 8	F 282		

Nursing staff was seen to pass medications and attend other residents on the unit.

On 8/26/15, activity staff was observed to leave R7's room at 2:33pm. The room doors were left closed. During a continuous observation until 4:15pm, R7 was observed to be inside R7's room. No one was observed to enter R7's room during the one hour and 42 minutes. At the time of the observation nursing staff was attending to other residents on the unit.

On 8/27/15 at 10:03am, a visitor was observed to leave R7's room. During a continuous observation until 10:55am, R7 was in R7's room with the doors completely closed. There was no nursing staff within R7's room vicinity throughout the observation. No one was witnessed to enter R7's room during the 52 minutes of observation.

In an interview on 8/27/15 at 12:38pm, the Director of Nursing (DON) when questioned what do safety checks consist of, replied that staff "physically have to go and see where [R7] is and what she is doing." The DON further indicated that there is a form for staff to complete related to the 30 minute checks. During the interview the DON was made aware of the observations related to the facility's failure to implement R7's care plan interventions of 30 minute safety checks. The DON replied that the 30 minute safety checks are "not always possible."

On 8/27/15 at 5:55pm, the Corporate Clinical Care Director stated that the facility does not have a specific policy and procedure related to resident safety checks.

On 8/28/15 at 8:40am, the Administrator provided

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F 282	Continued From page 9	F 282		

the safety check forms for the week of 8/23/15, as requested by the surveyor on 8/27/15. The Administrator further indicated that the form is a tool and is not part of the medical record. Review of the "30 Minute Checks" for R7 from 8/23/15-8/26/15 revealed the forms, which were in a log format, only had the date and R7's name located on the top of the page and were blank under the following segments: "Location of Resident", "Observed doing what?", and "Staff Initial."

2. Review of the 6/10/15 Quarterly MDS revealed R22 had a Brief Individual Mental Status (BIMS) score of 15 (with 13- 15 indicating R22 was cognitively intact). This same MDS revealed the following diagnoses for R22: congestive heart failure (CHF-unable to pump blood sufficiently for the body), chronic obstructive pulmonary disease (COPD - makes it hard for you to breathe), and generalized muscle weakness.

Review of R22's care plan dated 6/8/15 revealed the following information: "I have an alteration or the potential for alteration in respiratory status related to COPD. Give me my medications as ordered by my physician."

The Physician's Order Sheet (POS) for R22 dated 8/4/15 revealed the following order "Advair diskus 100/50 inhaler, give one puff inhaled twice a day," and "to rinse the mouth after given the inhaled puff." This order was documented as starting on 1/8/15.

Observation on 8/26/15 at 9:30am revealed that Trained Medication Aide 1 (TMA1) gave the resident the inhaler, told her to take a deep breath and release the breath, then instructed R22, while using the inhaler, to take a deep

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F 282	Continued From page 10 breath in and hold it for as long as possible then release the breath. TMA1 then gave other oral medications with applesauce and water. TMA1 did not remind R22 to rinse her mouth after inhaling the puff. During an interview on 8/26/15 at 3:48pm, with TMA1 revealed that she was aware that the order for R22's Advair diskus required the mouth to be rinsed after the puff was given to help prevent the development of thrush (a fungal infection of the mouth). She stated she did not ask R22 to do this after she administered the Advair diskus inhaler. During an interview on 8/28/15 at 9:48am, the Director of Nursing (DON) stated that he would expect the staff to follow the physician's orders and administer an inhaler medication as the physician prescribed. He stated if the order read to rinse the mouth after the inhaled puff was given, he expected the nursing staff to follow the physician's order. Review of the Manufacturer's information (GlaxoSmithKline) revealed the following information regarding Advair diskus inhaler, "Advair can cause serious side effects, including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using ADVAIR to help reduce your chance of getting thrush." The facility's policy regarding Transcription of Physician's Orders created 03/11 under Procedure revealed, "14. All orders will be carried out as per physician's order...as indicated..."	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		10/2/15

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F 318	Continued From page 11 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: (1) ensure a resident with an identified decline in range of motion (ROM) consistently received services and treatment identified in the plan of care; and, (2) modify the interventions to prevent further decline in ROM for one (R21) of one resident reviewed for ROM in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis. Review of R21's Quarterly Minimum Data Set (MDS) dated 3/11/15, indicated that R21 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and bathing; and, was totally dependent on staff for transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion was coded one that indicated R21 had functional limitation of range of motion on one side of upper (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee,	F 318	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All residents are assessed upon admission or with a significant change in condition and are reviewed for changes in functional ability and need for ROM quarterly as part of the RAI process and Interdisciplinary reviews. Care plans and Functional Maintenance Programs are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in	

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F 318	Continued From page 12 ankle, and foot). Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation of ROM on both sides of lower extremities. This coding indicated that R21 had a decline in functional ROM within 90 days from the previous assessment to the most recent assessment. Further review of R21's Annual MDS dated 6/10/15 revealed Activities of Daily Living (ADL) triggered the Care Area Assessment (CAA - assessment of the resident's problems, needs and strengths). The "Analysis of Findings" from R21's CAA for ADL revealed, "[R21] has impaired mobility, balance [and] ROM RT [related to] HX [history] of CVA [cerebrovascular accident/stroke]...Is mainly bed bound. Get up in W/C [wheelchair] 1-2 times per week for beauty shop appointment or PM for activity. Has impaired ability to tolerate W/C activity. Has impaired ROM R [right] UE [upper extremity], BLE [bilateral lower extremities] very weak [and] [R21] was unable to move, has bilateral foot drop..." Review of the same CAA under the "Referral to Other Disciplines" revealed that the question "Is a referral to other disciplines warranted?" had no	F 318	status. Therapy evaluations are provided as indicated and per physicians¿ order. IDT to review PROM programs for each resident weekly for two months. In addition, PROM programs will be reviewed in conjunction with the RAI process. Ongoing facility measures to include IDT review of a Functional Maintenance Program monthly and in conjunction with the RAI process. The care plan policy and Functional Maintenance Plan/ROM policy have been reviewed and are current. Staff are educated on the individual functional maintenance plan through the care plan, My Best Day and specific instructions. Education for staff on following the ROM plan and resident refusals and risks and benefits of FMP¿s was initiated and is ongoing. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 318	Continued From page 13 answer. Review of the same CAA revealed, "Care Plan considerations...Describe impact of this problem/need on the resident [R21] and your rationale for care plan decision...Will care plan for ADLS [activities of daily living], has impaired mobility [and] impaired ability to tolerate activities, requires staff support to meet her needs." Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator (RN1) on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. RN1 further stated, "The resident refuses to get up and it should be done when seated." When asked if the rehabilitation department was consulted because of R21's refusals to get up and consequently not doing the seated exercises, RN1 stated, "That's why the high back W/C was started." When asked about measures that could be provided while R21 was in bed, RN1 stated, "Rehab [rehabilitation department] would not recommend anything to be done in bed but I could write an order [range of motion exercises order] for nursing." She verified that no further consultation or interventions were done after the initiation of the high back	F 318	Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 318	Continued From page 14 wheelchair. Review of R21's medical record revealed no documentation that R21 was educated about the risks and benefits of refusing to perform the seated exercises. Review of R21's care plan related to limited physical mobility revealed it was not updated to reflect R21's refusals to do the seated exercises. In an interview with the AM (morning) shift Charge Nurse (RN2) on 8/28/15 at approximately 8:45am, RN2 indicated that the resident assistants (RA) were not reporting that R21 was refusing to do the seated exercises. When asked about possible interventions since R21 has been refusing to get up, RN2 further stated, "If she's refusing, I could talk to the resident if it's because of pain or assess why. Maybe it's just personal choice or [she] just don't [sic] want to exercise. If needed to be seated and she's refusing to get up then we have to evaluate and revamp the plan of care or talk to therapy and run it by them. Therapy could give suggestions and I will inform the nurse practitioner." During the same interview when asked if the decline in the ROM could have been avoided, RN2 stated, "It's hard to say that it's avoidable or unavoidable because some residents are just declining but ROM [exercises] could be done and prevent decline. We could always do better." RN2 further stated, "We could do whatever we can to try to avoid the decline." In an interview with the Physical Therapist (PT1) on 8/28/15 at approximately 9:45am, PT1 indicated that she was not aware about R21's refusal to do the seated exercises. When asked	F 318		

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F 318	Continued From page 15 about what recommendations she had for R21, PT1 stated, "Supine exercises sometimes can avoid decline in ROM but not all the time, at least do the passive ROM exercises which sometimes can help though not always. Better than nothing or at least do it during cares even if not part of a program." Review of the facility's policy titled "Range of Motion Assessment Policy" last modified on 9/10 revealed under Purpose, "To maintain resident's ability to maintain current range of motion and/or prevent further decline in range of motion by completing Range of Motion Assessment upon admission, quarterly and with significant change." Further review of the same policy also revealed under Procedure, "...6. The program will be evaluated at least quarterly or more frequently as indicated...8. If any resident is having increased pain or discomfort, is refusing the range of motion program or is unable to complete the program as recommended, it will be communicated to the interdisciplinary team."	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		10/2/15

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F 323	Continued From page 16 Based on interviews and record reviews the facility failed to: (1) identify individual risk factors, initiate individualized care plans and interventions to prevent falls; and (2) implement and modify safety measures as needed to address a resident's multiple falls related to syncopal (fainting) episodes for one resident (R12) reviewed for falls in the Stage 2 sample of 26. Findings include: 1. Review of R12's facility admission and re-admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation (abnormal heart rate or rhythm) and personal history of falls. Review of R12's facility "Comprehensive Data Collection" dated 5/6/15 under "J. Neurological Status" revealed a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension." Review of R12's facility Electronic Health Record [EHR] under "Nursing" indicated "ROM Summary Effective Date 5/11/15 08:43 Department: Nursing Position: Clinical Coordinator " ...who is a recent admitted from acute hospital RT acute respiratory failure with hypoxia & pleura [sic] effusion with thoracentesis, afib on coumdain [sic], CHF & valvual [sic] heart disease- on oxygen therapy & lasix with daily weights, orthostatic hypotension with 2 recent falls with light headless[sic]. [Name of R12] is alert & oriented. Is able to express her needs, uses call light. Has use of packet [sic]	F 323	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired on 5-19-15 prior to survey. Daily Interdisciplinary Meetings are held to assist in identifying resident's with a change of condition or increased fall risks. Care plans and My Best Days are updated at that time. All in-house residents¿ identified as fall risk have been reviewed and care plans updated. Care plan interventions have been initiated for those residents with a diagnosis of syncope as it relates to falls/safety. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and the fall prevention policy have been reviewed and are current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and is current. Education on care planning, comprehensive assessments and falls assessment, including a focus on syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be	

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F 323	Continued From page 17 talker & written notes on white board. Transfer with A [Assist] of 1 & walks with A of 1& 4WW[wheeled walker]. Is working with Rehab & has made progress since admitted. PT [Physical Therapist] has starting [sic] walking program per FMP[Functional Maintenance Program]. " Review of R12's facility's EHR under "Nursing" indicated "General Notes Effective Date: 5/12/15 14:19 Department: Nursing Position: RN/LPN Created by: [Name of RN] "[Name of Resident] was taken out by nephew today to primary clinic for a follow up chest x ray. Niece, here and stated that she received a call that [name of R12] had a fall at the clinic and was being transported to the ER..." Review of the hospital transfer discharge documents that were part of R12's medical records on the facility revealed the following: A.The hospital's 5/12/15 "Emergency Department Staff/Physician Notes" for R12 under "Relevant HPI[History of Present Illness]" Patient was in clinic today and had a near syncopal event...While awaiting admission, patient up to bathroom with nurse and had another near syncopal event." B.The hospital's 5/13/15 "Consult Notes" for R12 under "History of Present Illness (HPI)" revealed "...who was brought to the hospital because of a fainting spell...She was feeling weak and had issues with orthostatic hypotension...she apparently fainted..." C.Review of R12's hospital "MD [Medical Doctor] Progress Note" dated 5/13/15 under "Principal Problem" indicated "Syncopal episodes	F 323	conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 323	Continued From page 18 A. Hx [History] of OH [orthostatic hypotension]..." Review of R12's facility medical record titled "Comprehensive Data Collection" under "Resident Demographics" revealed R12 was re-admitted to the facility on 5/14/15 at 2pm. Further review of the same document under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness." Review of R12's "Medication Administration Record" from 5/1/15 to 5/31/15 indicated R12 received Coumadin [a blood thinner] tablet 2.5mg on the following dates: 5/8/15, 5/11/15, 5/15/15. R12 also received Coumadin 5mg on 5/16/15 and 5/17/15. Review of "Coumadin's Package Insert" revised on 10/11 from Bristol Myer's website (the makers of Coumadin) indicated "Warning: Bleeding:...Coumadin can cause major or fatal bleeding..." Further review of the same document under "Medication Guide" revealed "...You may have a higher risk of bleeding if you take Coumadin and: are age 65 or older...have had trauma such as accident...Call your healthcare provider right away...signs and symptoms of bleeding problems: pain, swelling, discomfort, headaches, dizziness or weakness, unusual bruising [bruises that develop without known cause or grow in size], nosebleeds, bleeding gums...red or black stools, vomiting blood or material that looks like coffee grounds." Review of R12's facility medical record titled "Fall Risk Data Collection" dated 5/14/15 under "Internal Risk Factors" revealed syncope and vertigo were not marked which incorrectly	F 323		

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indicated the resident had no episodes of either prior to the re-admission to the facility even though R12 was admitted emergently to the hospital on 5/12/15 due to syncopal episodes. Further review of the same document under "Summary of Risk Factors" indicated, "...She has a history of falls, the most recent being several days ago while out to a doctors [sic] appointment...Staff noted that resident was resistive to cares and would not allow staff to help ambulate with a transfer belt. Will continue to monitor."

Review of R12's entire "Individual Resident Care Plan [IRCP] [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of the same document under "Interventions" indicated a check next to monitor for safety. There was no specific intervention to address R12's falls related to her syncopal episodes. Further review of the same document indicated it was revised on 5/18/15 and the only intervention that was added was to instruct R12 to ask for help.

Review of R12's only "IRCP" dated 5/6/15 revealed that there was no care plan that addressed R12's use of Coumadin.

Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" for both admission and re-admission dates indicated R12 needed assist of one person during transfer, ambulation and repositioning. Further review of the same document did not address R12's fainting episodes before falls or her orthostatic hypotension. In addition, there was

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no mention about R12's anti-coagulant use and increased risk of bleeding.

On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about R12's re-admission care plan. RN1 responded, "This is the only one we have." RN1 was further asked why there was no individualized care plan to address R12's syncopal episodes that were present on admission and re-admission. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes.

On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's admission process. The DON stated the admitting nurse was responsible for initiating the IRCP based on the hospital's transfer discharge documents and the nursing assessments upon admission which included the fall risk data collection. The DON was shown R12's IRCP under falls. While looking at the care plan the DON stated, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to)." The DON confirmed it was important to have put "syncope" since it was identified as one of the main problems on both R12's admission and re-admission.

On 8/27/15 at approximately 10:45am, the DON was also asked why the use of anti-coagulant therapy was not included in the risk factors or was not care planned. The DON replied that the

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nursing staff were educated to look for the signs and symptoms of the side effects of anti-coagulant use like bruising, bleeding and hemorrhage. The DON was further asked how would the nursing staff knew if R12 was on anti-coagulant therapy if it was not identified as one of R12's risk factors, not care planned and was not addressed in the nursing assistants' "My Best Day." The DON replied that putting the anti-coagulant therapy as one of the risk factors would not hurt and that he understood its importance especially with R12's fall history.

On 8/28/15 at approximately 8:45am, RN1 was asked about the lack of care plan to address R12's use of anti-coagulant therapy. RN1 stated that normally she would develop the anti-coagulant therapy care plan on day 21.

Review of a study titled "Use of anticoagulation in elderly patients with atrial fibrillation who are at risk for falls." electronically published on 3/11/08 from the US National Library of Medicine and National Institute of Health website under "Conclusion" revealed "The risk of falls alone should not automatically disqualify a person from being treated with warfarin. While falls should not dictate anticoagulant choice, assessment and management of fall risk should be an important part of anticoagulation management. Efforts should be made to minimize fall risk."

2. A. Review of R12's facility EHR under "Nursing" indicated "Type: Fall Focus: Effective Date: 5/17/2015 23:32:00 Department: Nursing Position: RN/LPN Created Date : 5/18/2015 00:49:07 Description: Resident fell backwards hitting her bottom first while exiting the bathroom. [Name of R12] response: she was in really good

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spirits and said she did not feel hurt. She said her buttock hurt the most and that it hit the ground first. She denies hitting her head during the fall. Pain level was moderate 4/10. RA and I assisted her up to her bed via mechanical lift. Offered ice pack and Acetaminophen - she agreed to take 1000mg Acetaminophen."

Further review of this same entry revealed no further assessment to determine if R12's fall had occured because R12 had been dizzy or fainted.

On 8/26/15 at approximately 2:30pm, RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan."

Review of the facility's "Care Plan Policy and Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of Presbyterian Homes to initiate a temporary care plan within 24 hours of admission...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..." Further review of the same document under "Procedure" revealed, "...3. Post Fall Management...d.The staff nurse will review the occurence report and will: i. Assess all factors contributing to the fall event including intrinsic and extrinsic factors...ii. Recommend interventions and changes to plan of care to prevent a repeat fall..."

B. Review of R12's facility EHR under "Nursing" dated 5/19/15 at 9:08am indicated "Writer calld [sic] into resident's room by RA[Resident Assistant] stating she found resident on bathroom floor. Upon observation, noted resident lying on

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F 323	Continued From page 23 (R) side with blood all over her right (R) hand and side of head as well as on the floor. Oxygen tubing was wrapped around her legs and under her torso. Large hematoma on (R) back of head. Extremities discolored and cool to touch. Lips purple and UTD[unable to determine [sic] VS [vital signs]. No peripheral pulses or respirations. Verified death by no AP [apical pulse] at 0415 on 5/19/15..." Review of the "Coroner's Report" provided by the facility indicated R12's cause of death were from multiple trauma and falls. On 8/27/15 at approximately 10:45am, the DON was asked about R12's fall on 5/19/15. The DON responded that it was from R12's long oxygen tubing. When asked about R12's syncopal episodes, the DON verbalized, "Honestly, I did not even think about that."	F 323		

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F 000	INITIAL COMMENTS A health comparative **Federal Monitoring Survey** was conducted by the Centers for Medicare & Medicaid Services (CMS) on August 28, 2015 following a Minnesota Department of Health survey on July 23, 2015. Survey Dates: August 24, 2015 to August 28, 2015 Survey Census: 45 Medicare: 3 Medicaid: 12 Other: 30 Total: 45 Stage 1 Sample: 30 Stage 2 Sample: 26	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		10/2/15

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

Electronically Signed | 09/18/2015

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 _____	08/28/2015

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 279	Continued From page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop an individualized care plan to address syncopal (fainting) episodes for one (R12) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R12's admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation and personal history of falls. Review of R12's "Comprehensive Data Collection" for admision dated 5/6/15 under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension [low blood pressure that happens when you stand up from sitting or lying down]." Review of R12's "Fall Risk Data Collection" dated 5/6/15 under "Resident had falls" revealed a check marked next to syncope and dizziness which indicated resident had episodes of both prior to the admission to the facility. Review of R12's entire "Individual Resident Care	F 279	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired 5-19-15 prior to survey. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and falls policy has been reviewed and is current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and are current. Education on care planning, comprehensive assessment and falls assessment, specific to syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 279	Continued From page 2 Plan [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" did not address R12's fainting episodes before falls or her orthostatic hypotension. Review of R12's "Hospital Discharge Summary" dated 5/6/15 under "Active Problems" revealed "chronic atrial fibrillation, diastolic [the pressure in the arteries when the heart rests between beats] congestive heart failure, orthostatic hypotension...fall, syncope due to othostatic hypotension..." Review of R12's "Pain Summary Report" dated 5/11/15 at 9:44am revealed "...who is a recent admitted [sic] from acute hospital...on oxygen therapy & lasix [diuretic] with daily weights, orthostatic hypotension with 2 recent falls with light headless [sic]." Review of R12's "Hospital Discharge Documents" dated 5/13/15 under "Attending Progress Note" indicated "...She denies pain, ex [sic] except for [LBP] low blood pressure when she is up." On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about the lack of individualized care plan to address R12's syncopal episodes present on admission on 5/6/15 and re-admission on	F 279	Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 279	Continued From page 3 5/14/15. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes. RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed this time. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan. On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's initial care planning process. The DON verbalized the admitting nurse was responsible for initiating the interim care plan based on the hospital's transfer discharge documents and the nursing assessments upon admission. The DON was shown R12's interim care plan under falls, while looking at the care plan the DON verbalized, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to). The DON confirmed it was important to have put "syncope" since it was identified as a problem on both R12's admission and re-admission. Review of the facility's "Care Plan and Policy Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of [Name of Facility] to initiate a temporary care plan within 24 hours of admission..." Further review of the same document under "Procedure" revealed, "1. Each department will gather needed information on admission to provide data for the Individual Resident Care Plan along with individual care plan statements specific to the resident needs...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..."	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the plan of care to reflect the refusal to perform exercises of one resident (R21) of 18 residents reviewed for care plans in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis.	F 280	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be	10/2/15

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F 280	Continued From page 5 Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 was cognitively intact. Further review of R21's Annual MDS revealed that R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of the upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation in ROM on both sides of lower extremities. Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. She further stated that she should have reflected the refusal in the care plan. Review of the facility's policy titled "Care Plan Policy and Procedure" with the last revision on 8/14 revealed under Procedure, "...10. The care	F 280	conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy has been reviewed and is current. Education on care planning has been initiated and is ongoing. Ongoing Functional Maintenance Programs reviewed quarterly for all Residents. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 280	Continued From page 6 plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times..." According to Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, October 2014, Chapter 4 page 11 indicated, "A new care plan does not need to be developed after each...reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to: (1) provide services in accordance with the resident's written plan of care for one (R7) of five residents reviewed for accidents; and, (2) follow physician orders for one (R22) of six residents observed during medication pass in the Stage 2 sample of 26. Findings include:	F 282	Resident #7 Care plan and My Best Day was comprehensively reassessed for wandering and adjusted. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. Resident #22 Care Plan, My Best Day and Medications reviewed and are accurate.	10/2/15

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F 282	Continued From page 7 1. Review of R7's "Admission Record" indicated R7 had diagnoses including, but not limited to, dementia with behavioral disturbance and unspecified psychosis. Review of R7's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/10/15 under "Section E0900: Wandering-Presence and Frequency" revealed R7 had behavior of this type 4 to 6 days, but less than daily. Review of R7's Electronic Health Record (EHR) Progress Notes from 3/9/15-8/26/15 indicated R7 had a history of wandering which included but was not limited to wandering into other resident rooms, wandering out of the Care Center to the 3rd floor and wandering outside of the facility. Review of R7's care plan, revised on 06/26/15, under "Focus" included "I demonstrate wandering behavior (out of the CC [Care Center] & [and] other resident rooms.) "Interventions" included but were not limited to the following: "On 30 minute safety checks." Interview with NA1 on 8/26/15 at 11:04am revealed R7 wanders into other resident rooms and out of the Care Center. NA1 stated "She [R7] is on half an hour safety checks...We have to check on her location..." During a continuous observation on 8/26/15 from 11:04am until 12:03pm, R7 was in R7's room with the doors completely closed. The surveyor had confirmed the resident location at the conclusion of the observations. No one had entered R7's room during the 59 minutes of observation.	F 282	The care plan policy has been reviewed and is current. Medication pass policy reviewed and is current. Education on following care plan and physicians orders has been initiated and is ongoing. Audits regarding care plan interventions and physicians orders will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10-02-15.	

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F 282	Continued From page 8	F 282		

Nursing staff was seen to pass medications and attend other residents on the unit.

On 8/26/15, activity staff was observed to leave R7's room at 2:33pm. The room doors were left closed. During a continuous observation until 4:15pm, R7 was observed to be inside R7's room. No one was observed to enter R7's room during the one hour and 42 minutes. At the time of the observation nursing staff was attending to other residents on the unit.

On 8/27/15 at 10:03am, a visitor was observed to leave R7's room. During a continuous observation until 10:55am, R7 was in R7's room with the doors completely closed. There was no nursing staff within R7's room vicinity throughout the observation. No one was witnessed to enter R7's room during the 52 minutes of observation.

In an interview on 8/27/15 at 12:38pm, the Director of Nursing (DON) when questioned what do safety checks consist of, replied that staff "physically have to go and see where [R7] is and what she is doing." The DON further indicated that there is a form for staff to complete related to the 30 minute checks. During the interview the DON was made aware of the observations related to the facility's failure to implement R7's care plan interventions of 30 minute safety checks. The DON replied that the 30 minute safety checks are "not always possible."

On 8/27/15 at 5:55pm, the Corporate Clinical Care Director stated that the facility does not have a specific policy and procedure related to resident safety checks.

On 8/28/15 at 8:40am, the Administrator provided

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F 282	Continued From page 9	F 282		

the safety check forms for the week of 8/23/15, as requested by the surveyor on 8/27/15. The Administrator further indicated that the form is a tool and is not part of the medical record. Review of the "30 Minute Checks" for R7 from 8/23/15-8/26/15 revealed the forms, which were in a log format, only had the date and R7's name located on the top of the page and were blank under the following segments: "Location of Resident", "Observed doing what?", and "Staff Initial."

2. Review of the 6/10/15 Quarterly MDS revealed R22 had a Brief Individual Mental Status (BIMS) score of 15 (with 13- 15 indicating R22 was cognitively intact). This same MDS revealed the following diagnoses for R22: congestive heart failure (CHF-unable to pump blood sufficiently for the body), chronic obstructive pulmonary disease (COPD - makes it hard for you to breathe), and generalized muscle weakness.

Review of R22's care plan dated 6/8/15 revealed the following information: "I have an alteration or the potential for alteration in respiratory status related to COPD. Give me my medications as ordered by my physician."

The Physician's Order Sheet (POS) for R22 dated 8/4/15 revealed the following order "Advair diskus 100/50 inhaler, give one puff inhaled twice a day," and "to rinse the mouth after given the inhaled puff." This order was documented as starting on 1/8/15.

Observation on 8/26/15 at 9:30am revealed that Trained Medication Aide 1 (TMA1) gave the resident the inhaler, told her to take a deep breath and release the breath, then instructed R22, while using the inhaler, to take a deep

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F 282	Continued From page 10 breath in and hold it for as long as possible then release the breath. TMA1 then gave other oral medications with applesauce and water. TMA1 did not remind R22 to rinse her mouth after inhaling the puff. During an interview on 8/26/15 at 3:48pm, with TMA1 revealed that she was aware that the order for R22's Advair diskus required the mouth to be rinsed after the puff was given to help prevent the development of thrush (a fungal infection of the mouth). She stated she did not ask R22 to do this after she administered the Advair diskus inhaler. During an interview on 8/28/15 at 9:48am, the Director of Nursing (DON) stated that he would expect the staff to follow the physician's orders and administer an inhaler medication as the physician prescribed. He stated if the order read to rinse the mouth after the inhaled puff was given, he expected the nursing staff to follow the physician's order. Review of the Manufacturer's information (GlaxoSmithKline) revealed the following information regarding Advair diskus inhaler, "Advair can cause serious side effects, including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using ADVAIR to help reduce your chance of getting thrush." The facility's policy regarding Transcription of Physician's Orders created 03/11 under Procedure revealed, "14. All orders will be carried out as per physician's order...as indicated..."	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		10/2/15

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F 318	Continued From page 11 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: (1) ensure a resident with an identified decline in range of motion (ROM) consistently received services and treatment identified in the plan of care; and, (2) modify the interventions to prevent further decline in ROM for one (R21) of one resident reviewed for ROM in the Stage 2 sample of 26. Findings include: Review of R21's Admission Record indicated that R21 had diagnoses which included the following: unspecified cerebrovascular disease, difficulty in walking, depressive disorder, muscle weakness and generalized osteoarthrosis. Review of R21's Quarterly Minimum Data Set (MDS) dated 3/11/15, indicated that R21 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and bathing; and, was totally dependent on staff for transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion was coded one that indicated R21 had functional limitation of range of motion on one side of upper (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee,	F 318	Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplinary team including therapy. The recommendations and current participation was discussed with Resident #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was updated to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be conducted weekly for 4 weeks and then ongoing as needed in conjunction with the RAI process. All residents are assessed upon admission or with a significant change in condition and are reviewed for changes in functional ability and need for ROM quarterly as part of the RAI process and Interdisciplinary reviews. Care plans and Functional Maintenance Programs are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in	

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F 318	Continued From page 12 ankle, and foot). Review of R21's Annual Minimum Data Set (MDS) dated 6/10/15, revealed R21 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene; and, was totally dependent on staff for bathing and transfers. The same MDS under Section G0400, Functional Limitation in Range of Motion (ROM) was coded one for the upper extremity (shoulder, elbow, wrist, and hand) that indicated R21 had functional limitation in ROM on one side of upper extremity. The same section of this MDS was coded two for the lower extremity (hip, knee, ankle, and foot) that indicated R21 had functional limitation of ROM on both sides of lower extremities. This coding indicated that R21 had a decline in functional ROM within 90 days from the previous assessment to the most recent assessment. Further review of R21's Annual MDS dated 6/10/15 revealed Activities of Daily Living (ADL) triggered the Care Area Assessment (CAA - assessment of the resident's problems, needs and strengths). The "Analysis of Findings" from R21's CAA for ADL revealed, "[R21] has impaired mobility, balance [and] ROM RT [related to] HX [history] of CVA [cerebrovascular accident/stroke]...Is mainly bed bound. Get up in W/C [wheelchair] 1-2 times per week for beauty shop appointment or PM for activity. Has impaired ability to tolerate W/C activity. Has impaired ROM R [right] UE [upper extremity], BLE [bilateral lower extremities] very weak [and] [R21] was unable to move, has bilateral foot drop..." Review of the same CAA under the "Referral to Other Disciplines" revealed that the question "Is a referral to other disciplines warranted?" had no	F 318	status. Therapy evaluations are provided as indicated and per physicians¿ order. IDT to review PROM programs for each resident weekly for two months. In addition, PROM programs will be reviewed in conjunction with the RAI process. Ongoing facility measures to include IDT review of a Functional Maintenance Program monthly and in conjunction with the RAI process. The care plan policy and Functional Maintenance Plan/ROM policy have been reviewed and are current. Staff are educated on the individual functional maintenance plan through the care plan, My Best Day and specific instructions. Education for staff on following the ROM plan and resident refusals and risks and benefits of FMP¿s was initiated and is ongoing. Audits regarding care planning in conjunction with Functional Maintenance Programs will be conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 318	Continued From page 13 answer. Review of the same CAA revealed, "Care Plan considerations...Describe impact of this problem/need on the resident [R21] and your rationale for care plan decision...Will care plan for ADLS [activities of daily living], has impaired mobility [and] impaired ability to tolerate activities, requires staff support to meet her needs." Review of R21's "limited physical mobility" care plan initiated on 8/7/12 and revised on 8/27/15 indicated under "Interventions," "I have seated exercise 1 time daily. Do exercise 10 times on each leg per hand out. Tell [me] about my exercises 1 hr [hour] prior to my exercise time." Review of the "Follow Up Question Report" related to R21's participation with the seated exercises revealed that R21 only participated in these exercises six times from 8/1/15 to 8/27/15. In an interview with the Clinical Care Coordinator (RN1) on 8/27/15 at approximately 10:10am, she verified that R21 mostly refused to perform the seated exercises. RN1 further stated, "The resident refuses to get up and it should be done when seated." When asked if the rehabilitation department was consulted because of R21's refusals to get up and consequently not doing the seated exercises, RN1 stated, "That's why the high back W/C was started." When asked about measures that could be provided while R21 was in bed, RN1 stated, "Rehab [rehabilitation department] would not recommend anything to be done in bed but I could write an order [range of motion exercises order] for nursing." She verified that no further consultation or interventions were done after the initiation of the high back	F 318	Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 318	Continued From page 14 wheelchair. Review of R21's medical record revealed no documentation that R21 was educated about the risks and benefits of refusing to perform the seated exercises. Review of R21's care plan related to limited physical mobility revealed it was not updated to reflect R21's refusals to do the seated exercises. In an interview with the AM (morning) shift Charge Nurse (RN2) on 8/28/15 at approximately 8:45am, RN2 indicated that the resident assistants (RA) were not reporting that R21 was refusing to do the seated exercises. When asked about possible interventions since R21 has been refusing to get up, RN2 further stated, "If she's refusing, I could talk to the resident if it's because of pain or assess why. Maybe it's just personal choice or [she] just don't [sic] want to exercise. If needed to be seated and she's refusing to get up then we have to evaluate and revamp the plan of care or talk to therapy and run it by them. Therapy could give suggestions and I will inform the nurse practitioner." During the same interview when asked if the decline in the ROM could have been avoided, RN2 stated, "It's hard to say that it's avoidable or unavoidable because some residents are just declining but ROM [exercises] could be done and prevent decline. We could always do better." RN2 further stated, "We could do whatever we can to try to avoid the decline." In an interview with the Physical Therapist (PT1) on 8/28/15 at approximately 9:45am, PT1 indicated that she was not aware about R21's refusal to do the seated exercises. When asked	F 318		

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F 318	Continued From page 15 about what recommendations she had for R21, PT1 stated, "Supine exercises sometimes can avoid decline in ROM but not all the time, at least do the passive ROM exercises which sometimes can help though not always. Better than nothing or at least do it during cares even if not part of a program." Review of the facility's policy titled "Range of Motion Assessment Policy" last modified on 9/10 revealed under Purpose, "To maintain resident's ability to maintain current range of motion and/or prevent further decline in range of motion by completing Range of Motion Assessment upon admission, quarterly and with significant change." Further review of the same policy also revealed under Procedure, "...6. The program will be evaluated at least quarterly or more frequently as indicated...8. If any resident is having increased pain or discomfort, is refusing the range of motion program or is unable to complete the program as recommended, it will be communicated to the interdisciplinary team."	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		10/2/15

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F 323	Continued From page 16 Based on interviews and record reviews the facility failed to: (1) identify individual risk factors, initiate individualized care plans and interventions to prevent falls; and (2) implement and modify safety measures as needed to address a resident's multiple falls related to syncopal (fainting) episodes for one resident (R12) reviewed for falls in the Stage 2 sample of 26. Findings include: 1. Review of R12's facility admission and re-admission "Face Sheet" dated 5/6/15 under "Diagnoses" indicated R12 was admitted to the facility on 5/6/15 with admitting diagnoses that included but were not limited to other malaise and fatigue, atrial fibrillation (abnormal heart rate or rhythm) and personal history of falls. Review of R12's facility "Comprehensive Data Collection" dated 5/6/15 under "J. Neurological Status" revealed a check marked next to fainting spells, dizziness/vertigo and weakness. Further review of the same document indicated "Resident reports fainting before falls. Has orthostatic hypotension." Review of R12's facility Electronic Health Record [EHR] under "Nursing" indicated "ROM Summary Effective Date 5/11/15 08:43 Department: Nursing Position: Clinical Coordinator " ...who is a recent admitted from acute hospital RT acute respiratory failure with hypoxia & pleura [sic] effusion with thoracentesis, afib on coumdain [sic], CHF & valvual [sic] heart disease- on oxygen therapy & lasix with daily weights, orthostatic hypotension with 2 recent falls with light headless[sic]. [Name of R12] is alert & oriented. Is able to express her needs, uses call light. Has use of packet [sic]	F 323	Resident #12 could not be comprehensively reviewed due to being a closed chart. Resident expired on 5-19-15 prior to survey. Daily Interdisciplinary Meetings are held to assist in identifying resident's with a change of condition or increased fall risks. Care plans and My Best Days are updated at that time. All in-house residents¿ identified as fall risk have been reviewed and care plans updated. Care plan interventions have been initiated for those residents with a diagnosis of syncope as it relates to falls/safety. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon significant change in status. The care plan policy and the fall prevention policy have been reviewed and are current. Comprehensive Data Collection and Fall Risk Data Collection assessments have been reviewed and is current. Education on care planning, comprehensive assessments and falls assessment, including a focus on syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will be	

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F 323	Continued From page 17 talker & written notes on white board. Transfer with A [Assist] of 1 & walks with A of 1& 4WW[wheeled walker]. Is working with Rehab & has made progress since admitted. PT [Physical Therapist] has starting [sic] walking program per FMP[Functional Maintenance Program]. " Review of R12's facility's EHR under "Nursing" indicated "General Notes Effective Date: 5/12/15 14:19 Department: Nursing Position: RN/LPN Created by: [Name of RN] "[Name of Resident] was taken out by nephew today to primary clinic for a follow up chest x ray. Niece, here and stated that she received a call that [name of R12] had a fall at the clinic and was being transported to the ER..." Review of the hospital transfer discharge documents that were part of R12's medical records on the facility revealed the following: A.The hospital's 5/12/15 "Emergency Department Staff/Physician Notes" for R12 under "Relevant HPI[History of Present Illness]" Patient was in clinic today and had a near syncopal event...While awaiting admission, patient up to bathroom with nurse and had another near syncopal event." B.The hospital's 5/13/15 "Consult Notes" for R12 under "History of Present Illness (HPI)" revealed "...who was brought to the hospital because of a fainting spell...She was feeling weak and had issues with orthostatic hypotension...she apparently fainted..." C.Review of R12's hospital "MD [Medical Doctor] Progress Note" dated 5/13/15 under "Principal Problem" indicated "Syncopal episodes	F 323	conducted weekly for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/02/15.	

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F 323	Continued From page 18 A. Hx [History] of OH [orthostatic hypotension]..." Review of R12's facility medical record titled "Comprehensive Data Collection" under "Resident Demographics" revealed R12 was re-admitted to the facility on 5/14/15 at 2pm. Further review of the same document under "...J. Neurological Status" indicated a check marked next to fainting spells, dizziness/vertigo and weakness." Review of R12's "Medication Administration Record" from 5/1/15 to 5/31/15 indicated R12 received Coumadin [a blood thinner] tablet 2.5mg on the following dates: 5/8/15, 5/11/15, 5/15/15. R12 also received Coumadin 5mg on 5/16/15 and 5/17/15. Review of "Coumadin's Package Insert" revised on 10/11 from Bristol Myer's website (the makers of Coumadin) indicated "Warning: Bleeding:...Coumadin can cause major or fatal bleeding..." Further review of the same document under "Medication Guide" revealed "...You may have a higher risk of bleeding if you take Coumadin and: are age 65 or older...have had trauma such as accident...Call your healthcare provider right away...signs and symptoms of bleeding problems: pain, swelling, discomfort, headaches, dizziness or weakness, unusual bruising [bruises that develop without known cause or grow in size], nosebleeds, bleeding gums...red or black stools, vomiting blood or material that looks like coffee grounds." Review of R12's facility medical record titled "Fall Risk Data Collection" dated 5/14/15 under "Internal Risk Factors" revealed syncope and vertigo were not marked which incorrectly	F 323		

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indicated the resident had no episodes of either prior to the re-admission to the facility even though R12 was admitted emergently to the hospital on 5/12/15 due to syncopal episodes. Further review of the same document under "Summary of Risk Factors" indicated, "...She has a history of falls, the most recent being several days ago while out to a doctors [sic] appointment...Staff noted that resident was resistive to cares and would not allow staff to help ambulate with a transfer belt. Will continue to monitor."

Review of R12's entire "Individual Resident Care Plan [IRCP] [Initiate within 24 hours]" dated 5/6/15 under "Problem" indicated, "Fall Risk R/T [related to]" was checked but there was no entry in the blank space where fall risk factors should have been listed. Review of the same document under "Interventions" indicated a check next to monitor for safety. There was no specific intervention to address R12's falls related to her syncopal episodes. Further review of the same document indicated it was revised on 5/18/15 and the only intervention that was added was to instruct R12 to ask for help.

Review of R12's only "IRCP" dated 5/6/15 revealed that there was no care plan that addressed R12's use of Coumadin.

Review of R12's "My Best Day [a quick guide tool used by nurse's aides on how to care for residents]" for both admission and re-admission dates indicated R12 needed assist of one person during transfer, ambulation and repositioning. Further review of the same document did not address R12's fainting episodes before falls or her orthostatic hypotension. In addition, there was

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no mention about R12's anti-coagulant use and increased risk of bleeding.

On 8/26/15 at approximately 2:30pm, RN1 (the clinical care coordinator) was asked to provide all of R12's care plans. RN1 provided the initial individual care plan that was dated 5/6/15. RN1 was asked about R12's re-admission care plan. RN1 responded, "This is the only one we have." RN1 was further asked why there was no individualized care plan to address R12's syncopal episodes that were present on admission and re-admission. RN1 responded, "In the perfect world it would be in there," referring to the care plan to address R12's syncopal episodes.

On 8/27/15 at approximately 10:45am, the Director of Nursing (DON) was asked about the facility's admission process. The DON stated the admitting nurse was responsible for initiating the IRCP based on the hospital's transfer discharge documents and the nursing assessments upon admission which included the fall risk data collection. The DON was shown R12's IRCP under falls. While looking at the care plan the DON stated, "If R12 had syncope as one of her problems then it should have been placed here." The DON pointed to the blank space after the phrase, "Fall Risk factors R/T (related to)." The DON confirmed it was important to have put "syncope" since it was identified as one of the main problems on both R12's admission and re-admission.

On 8/27/15 at approximately 10:45am, the DON was also asked why the use of anti-coagulant therapy was not included in the risk factors or was not care planned. The DON replied that the

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nursing staff were educated to look for the signs and symptoms of the side effects of anti-coagulant use like bruising, bleeding and hemorrhage. The DON was further asked how would the nursing staff knew if R12 was on anti-coagulant therapy if it was not identified as one of R12's risk factors, not care planned and was not addressed in the nursing assistants' "My Best Day." The DON replied that putting the anti-coagulant therapy as one of the risk factors would not hurt and that he understood its importance especially with R12's fall history.

On 8/28/15 at approximately 8:45am, RN1 was asked about the lack of care plan to address R12's use of anti-coagulant therapy. RN1 stated that normally she would develop the anti-coagulant therapy care plan on day 21.

Review of a study titled "Use of anticoagulation in elderly patients with atrial fibrillation who are at risk for falls." electronically published on 3/11/08 from the US National Library of Medicine and National Institute of Health website under "Conclusion" revealed "The risk of falls alone should not automatically disqualify a person from being treated with warfarin. While falls should not dictate anticoagulant choice, assessment and management of fall risk should be an important part of anticoagulation management. Efforts should be made to minimize fall risk."

2. A. Review of R12's facility EHR under "Nursing" indicated "Type: Fall Focus: Effective Date: 5/17/2015 23:32:00 Department: Nursing Position: RN/LPN Created Date : 5/18/2015 00:49:07 Description: Resident fell backwards hitting her bottom first while exiting the bathroom. [Name of R12] response: she was in really good

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spirits and said she did not feel hurt. She said her buttock hurt the most and that it hit the ground first. She denies hitting her head during the fall. Pain level was moderate 4/10. RA and I assisted her up to her bed via mechanical lift. Offered ice pack and Acetaminophen - she agreed to take 1000mg Acetaminophen."

Further review of this same entry revealed no further assessment to determine if R12's fall had occured because R12 had been dizzy or fainted.

On 8/26/15 at approximately 2:30pm, RN1 was also asked if the care plan was revised after R12's fall on 5/17/15 and if R12's syncopal episodes were addressed. RN1 stated, "I guess I have to admit that we missed that and it was important to have that in the care plan."

Review of the facility's "Care Plan Policy and Procedure" revised on 8/14 under "Policy" indicated, "It is the policy of Presbyterian Homes to initiate a temporary care plan within 24 hours of admission...8. Interventions should be written to help meet the goal. The intervention[s] should be individualized..." Further review of the same document under "Procedure" revealed, "...3. Post Fall Management...d.The staff nurse will review the occurence report and will: i. Assess all factors contributing to the fall event including intrinsic and extrinsic factors...ii. Recommend interventions and changes to plan of care to prevent a repeat fall..."

B. Review of R12's facility EHR under "Nursing" dated 5/19/15 at 9:08am indicated "Writer calld [sic] into resident's room by RA[Resident Assistant] stating she found resident on bathroom floor. Upon observation, noted resident lying on

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F 323	Continued From page 23 (R) side with blood all over her right (R) hand and side of head as well as on the floor. Oxygen tubing was wrapped around her legs and under her torso. Large hematoma on (R) back of head. Extremities discolored and cool to touch. Lips purple and UTD[unable to determine [sic] VS [vital signs]. No peripheral pulses or respirations. Verified death by no AP [apical pulse] at 0415 on 5/19/15..." Review of the "Coroner's Report" provided by the facility indicated R12's cause of death were from multiple trauma and falls. On 8/27/15 at approximately 10:45am, the DON was asked about R12's fall on 5/19/15. The DON responded that it was from R12's long oxygen tubing. When asked about R12's syncopal episodes, the DON verbalized, "Honestly, I did not even think about that."	F 323		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P1O8

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds 45 (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Robyn Wolley, HFE NE II — 08/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/01/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 5, 2015

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

RE: Project Number S5617003

Dear Ms. Ballard:

On July 23, 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.

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	07/23/2015

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 000	INITIAL COMMENTS A standard survey was conducted on July 20, 21, 22, 23, 2015. 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.	F 000		

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

Electronically Signed

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 _____	**07/22/2015**

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 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, CARONDELET VILLAGE CARE CENTER was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care. Carondelet Village Care Center is located on the first floor of a 4-story building with a full basement. The building was constructed in 2011, and was determined to be of Type II(222) construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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