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Mandatory denial of payment for new Medicare and Medicaid admissions, which was imposed effective November 28, 2015, is rescinded effective October 2, 2015.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		

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	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



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 <u>one</u> 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, <u>in writing</u>, 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 <u>not</u> 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 <u>all</u> 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 <u>no later than 60 days</u> 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

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

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION LDING			E SURVEY PLETED	
-	245617		B. WING			08/28/2015		
	PROVIDER OR SUPPLIER PELET VILLAGE CAR	E CENTER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	•		
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	was conducted by t Medicaid Services	ve Federal Monitoring Survey the Centers for Medicare & (CMS) on August 28, 2015 ota Department of Health 2015.						
	Survey Dates: Augu 2015 Survey Census: 45	ust 24, 2015 to August 28,						
	Medicare: 3 Medicaid: 12 Other: 30 Total: 45							
F 279 SS=D	, , , ,	3 k)(1) DEVELOP	F 2	279			10/2/15	
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	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial etified in the comprehensive						
	to be furnished to a highest practicable psychosocial well-k §483.25; and any s	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided	-					
LABORATOR'	L Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

Electronically Signed

09/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		245617	B. WING		08/28/2015	;
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER	5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
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F 279	due to the resident §483.10, including under §483.10(b)(4) This REQUIREME by: Based on interview failed to develop an address syncopal (R12) of 18 residenthe Stage 2 sample Findings include: Review of R12's ac 5/6/15 under "Diag admitted to the face diagnoses that includer malaise and personal history of Review of R12's "C Collection" for adm Neurological Statu next to fainting speweakness. Further indicated "Resider Has orthostatic hy	's exercise of rights under the right to refuse treatment 4). NT is not met as evidenced wand record review the facility in individualized care plan to fainting) episodes for one into reviewed for care plans in e of 26. dmission "Face Sheet" dated noses" indicated R12 was illity on 5/6/15 with admitting uded but were not limited to fatigue, atrial fibrillation and	F 279	·	ing a 15 Ited in pon has Fall ave	
	5/6/15 under "Res check marked nex which indicated re- prior to the admiss	Fall Risk Data Collection" dated ident had falls" revealed a to syncope and dizziness sident had episodes of both ion to the facility.		conjunction with assessments will be conducted weekly for 4 weeks with re reported to Quality Assurance for one compliance and will determine the ne for further auditing. The Clinical Administrator or designer responsible for ongoing compliance.	esults going eed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY MPLETED
		245617	B. WING		08/	/28/2015
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
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F 279	Plan [Initiate with "Problem" indicat was checked but space where fall listed. Review of R12's used by nurse's a residents]" did not episodes before hypotension. Review of R12's dated 5/6/15 und "chronic atrial fibit the arteries where congestive heart	page 2 in 24 hours]" dated 5/6/15 under red, "Fall Risk R/T [related to]" there was no entry in the blank risk factors should have been "My Best Day [a quick guide tool aides on how to care for ot address R12's fainting falls or her orthostatic "Hospital Discharge Summary" er "Active Problems" revealed rillation, diastolic [the pressure in the heart rests between beats] failure, orthostatic , syncope due to othostatic	F 279	Date certain for the purpose compliance is 10/02/15.	es of ongoing	
	5/11/15 at 9:44ar admitted [sic] fro therapy & lasix [corthostatic hypotelight headless [sic] Review of R12's dated 5/13/15 unindicated "She [LBP] low blood properties of R12's care plaindividual care	"Pain Summary Report" dated in revealed "who is a recent im acute hospitalon oxygen diuretic] with daily weights, ension with 2 recent falls with c]." "Hospital Discharge Documents" der "Attending Progress Note" denies pain, ex [sic] except for pressure when she is up." "proximately 2:30pm, RN1 (the dinator) was asked to provide all ans. RN1 provided the initial an that was dated 5/6/15. RN1 the lack of individualized care R12's syncopal episodes present 5/6/15 and re-admission on				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245617	B. WING			08/2	28/2015	
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				5	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 279	would be in there," address R12's synce asked if the care plon 5/17/15 and if R addressed this time to admit that we mit to have that in the control of Nursing facility's initial care verbalized the admit for initiating the interpretable of the initiating the interpretable of the problems then it should be control of Nursing assessment was shown R12's in while looking at the verbalized, "If R12 problems then it should be problems then it should be control of the facility	ended, "In the perfect world it referring to the care plan to copal episodes. RN1 was also an was revised after R12's fall 12's syncopal episodes were e. RN1 stated, "I guess I have ssed that and it was important care plan. Oximately 10:45am, the (DON) was asked about the planning process. The DON itting nurse was responsible erim care plan based on the discharge documents and the nts upon admission. The DON interim care plan under falls, care plan the DON had syncope as one of her hould have been placed here." The to the blank space after the factors R/T (related to). The was important to have put was identified as a problem on ion and re-admission. Ty's "Care Plan and Policy on 8/14 under "Policy" policy of [Name of Facility] to a care plan within 24 hours of the review of the same procedure" revealed, "1. Each ther needed information on the data for the Individual care pecific to the resident needs8. In the world of the land within along with individual care pecific to the resident needs8. In the world of the land within the procedure of the land within the land with the land within the land with the land with the land within the land with the land within the land within the land within the land with the land within						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		OATE SURVEY OMPLETED
		245617	B. WING		8/28/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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 280 SS=D	The resident has incompetent or ot incapacitated und participate in plan	10(k)(2) RIGHT TO ANNING CARE-REVISE CP the right, unless adjudged herwise found to be er the laws of the State, to ning care and treatment or	F 280		10/2/15
	within 7 days after comprehensive as interdisciplinary to physician, a regist for the resident, a disciplines as deteand, to the extent the resident, the relegal representation.	care plan must be developed rethe completion of the ssessment; prepared by an eam, that includes the attending tered nurse with responsibility and other appropriate staff in termined by the resident's needs, practicable, the participation of resident's family or the resident's ve; and periodically reviewed team of qualified persons after			
	by: Based on intervie failed to revise the refusal to perform (R21) of 18 reside the Stage 2 samp Findings include: Review of R21's AR21 had diagnos unspecified cereb	Admission Record indicated that es which included the following: provascular disease, difficulty in ve disorder, muscle weakness		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 Reside #21 including risks and benefits. A new PROM program has been initiated. The assessments and care plan was update to reflect the changes and were communicated to the appropriate staff. Ongoing monitoring for compliance with the new exercise program will be	ed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY PLETED
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	F 280	Review of R21's Ar (MDS) dated 6/10/cognitively intact. FMDS revealed that assistance with bed and personal hygie on staff for bathing under Section G04 Range of Motion (Fupper extremity (sh hand) that indicated in ROM on one side same section of thi lower extremity (high indicated R21 had both sides of lower Review of R21's "lin plan initiated on 8/7 indicated under "Intexercise 1 time dai each leg per hand exercises 1 hr [hour Review of the "Follirelated to R21's paexercises revealed these exercises six In an interview with on 8/27/15 at approverified that R21 m seated exercises. Should have reflect Review of the facility Policy and Procedure.	Inual Minimum Data Set 15, revealed R21 was urther review of R21's Annual R21 required extensive If mobility, dressing, toilet use ne; and, was totally dependent and transfers. The same MDS 00, Functional Limitation in ROM) was coded one for the coulder, elbow, wrist, and If R21 had functional limitation are of the upper extremity. The s MDS was coded two for the or, knee, ankle, and foot) that functional limitation in ROM on	F 28	conducted weekly for 4 we ongoing as needed in conj RAI process. All care plans are reviewed in conjunction with the RAI admission, quarterly, annu significant change in status. The care plan policy has be and is current. Education on care planning initiated and is ongoing. Ongoing Functional Mainter Programs reviewed quarter Residents. Audits regarding care plan conjunction with Functional Programs will be conducted weeks with results reporter Assurance for ongoing conwill determine the need for auditing. The Clinical Administrator responsible for ongoing converse compliance is 10/02/15.	d and updated process on ally and upon s. een reviewed g has been enance and maintenance and maintenance and weekly for 4 d to Quality mpliance and further or designee is empliance.	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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	F PROVIDER OR SUPPLIER NDELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	
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F 28 F 28 SS=	plan is to be change changes for the reschanges occur it was plan in the resident current at all times. According to Long-Assessment Instruversion 3.0, October indicated, "A new of developed after eathe nursing home raplan using the results assessment. Facility appropriateness of including after Qualas needed." 483.20(k)(3)(ii) SEI PERSONS/PER C.	ed and updated as the care sident and as the resident ill be written on the paper care ill be written on the paper care is medical record. It is to be" Term Care Facility Resident ment (RAI) User's Manual er 2014, Chapter 4 page 11 are plan does not need to be chreassessment. Instead, may revise an existing care ilts of the latest comprehensive ties should also evaluate the the care plan at all times reterly assessments, modifying	F 2		10/2/15
	by: Based on observa interview, the facili in accordance with care for one (R7) of accidents; and, (2)	NT is not met as evidenced tion, record review and ty failed to: (1) provide services the resident's written plan of of five residents reviewed for follow physician orders for one onto observed during medication 2 sample of 26.		Resident #7 Care plan and My was comprehensively reassess wandering and adjusted. All car are reviewed and updated in cowith the RAI process on admiss quarterly, annually and upon significations in status. Resident #22 My Best Day and Medications rand are accurate.	eed for re plans onjunction sion, gnificant Care Plan,

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			E SURVEY IPLETED	
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	NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER					TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
		Continued From paragrams of R7's R7 had diagnoses dementia with behaviors of R7's quare (MDS) with an asset of 6/10/15 under "S Wandering-Presen R7 had behavior of than daily. Review of R7's Ele Progress Notes from had a history of ware was not limited to war on the resident rooms, wandering 3rd floor and wand Review of R7's care under "Focus" inclubed and out of the other resident room but were not limited minute safety check interview with NA1 revealed R7 wand and out of the Care is on half an hour side with the resident room but were not limited minute safety check interview with NA1 revealed R7 wand and out of the Care is on half an hour side with the resident room but were not limited minute safety check interview with NA1 revealed R7 wand and out of the Care is on half an hour side.	age 7 "Admission Record" indicated including, but not limited to, avioral disturbance and osis. arterly Minimum Data Set essment reference date (ARD) Section E0900: ce and Frequency" revealed f this type 4 to 6 days, but less and the section E0900 of the facility. The plan, revised on 06/26/15, and of the Care Center to the ering outside of the facility. The plan, revised on 06/26/15, and of the following: "On 30 oks." The section Record (EHR) of the facility. The plan, revised on 06/26/15, and of the following: "On 30 oks." The section Record of the facility of the following: "On 30 oks." The section Record of the facility of the following: "On 30 oks."	F 2	282	The care plan policy has been reviand is current. Medication pass poreviewed and is current. Education on following care plan a physicians orders has been initiate is ongoing. Audits regarding care plan interverand physicians orders will be concuedly for 4 weeks with results repto Quality Assurance for ongoing compliance and will determine the for further auditing. The Clinical Administrator or design responsible for ongoing compliance Date certain for the purposes of orcompliance is 10-02-15.	and ed and ed and ed and entions lucted corted need need	
		11:04am until 12:0 the doors complete confirmed the resi- of the observations	us observation on 8/26/15 from 3pm, R7 was in R7's room with ely closed. The surveyor had dent location at the conclusion s. No one had entered R7's 9 minutes of observation.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245617					08/	28/2015	
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116			
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F 282	attend other reside On 8/26/15, activity R7's room at 2:33p closed. During a code: 4:15pm, R7 was observed on the observation of the observation other residents on On 8/27/15 at 10:0 leave R7's room. Dobservation until 10 with the doors commursing staff within the observation. NR7's room during the observation of Nursing do safety checks complysically have to what she is doing." In an interview on 8 Director of Nursing do safety checks complysically have to what she is doing. That there is a form the 30 minute check of the facility care plan intervent checks. The DON safety checks are 10 on 8/27/15 at 5:55 Care Director states have a specific polaresident safety checks.	deen to pass medications and ints on the unit. It staff was observed to leave im. The room doors were left ontinuous observation until observed to be inside R7's observed to enter R7's room in and 42 minutes. At the time nursing staff was attending to the unit. It is a visitor was observed to ouring a continuous 0:55am, R7 was in R7's room pletely closed. There was no R7's room vicinity throughout of one was witnessed to enter the 52 minutes of observation. If it is and it is	F 2	282				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
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F 282	the safety check for as requested by the Administrator furth tool and is not part of the "30 Minute (8/23/15-8/26/15 rein a log format, on located on the top under the following Resident", "Observation of the R22 had a Brief In score of 15 (with 1 cognitively intact), following diagnose failure (CHF-unab the body), chronic	orms for the week of 8/23/15, e surveyor on 8/27/15. The er indicated that the form is a cof the medical record. Review Checks" for R7 from vealed the forms, which were ly had the date and R7's name of the page and were blank g segments: "Location of ved doing what?", and "Staff 6/10/15 Quarterly MDS revealed dividual Mental Status (BIMS) 3- 15 indicating R22 was This same MDS revealed the es for R22: congestive heart le to pump blood sufficiently for obstructive pulmonary disease hard for you to breathe), and	F2	282			(2000年) (2000年) (2000年) (2000年) (2000年) (2000年)
	the following informathe potential for all related to COPD. ordered by my phy The Physician's Odated 8/4/15 reveatiskus 100/50 inhated aday," and "to rins inhaled puff." This starting on 1/8/15. Observation on 8/15.	rder Sheet (POS) for R22 aled the following order "Advair aler, give one puff inhaled twice se the mouth after given the order was documented as 26/15 at 9:30am revealed that n Aide 1 (TMA1) gave the					
	breath and release	er, told her to take a deep e the breath, then instructed he inhaler, to take a deep					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		E SURVEY PLETED
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F 282	release the breath. medications with a	ge 10 t for as long as possible then TMA1 then gave other oral oplesauce and water. TMA1 to rinse her mouth after	F 28	32		
	TMA1 revealed that for R22's Advair distrinsed after the puffevelopment of through). She stated	on 8/26/15 at 3:48pm, with t she was aware that the order kus required the mouth to be f was given to help prevent the ush (a fungal infection of the she did not ask R22 to do this red the Advair diskus inhaler.				. 216 79:110 - 2 <u>9:1</u> 2
	Director of Nursing expect the staff to the and administer an inphysician prescribes to rinse the mouth.	on 8/28/15 at 9:48am, the (DON) stated that he would follow the physician's orders inhaler medication as the ed. He stated if the order read after the inhaled puff was the nursing staff to follow the				
	(GlaxoSmithKline) information regardi "Advair can cause fungal infection in y Rinse your mouth y	ufacturer's information revealed the following ng Advair diskus inhaler, serious side effects, including: rour mouth or throat (thrush). with water without swallowing to help reduce your chance of				
F 318 SS=D	Physician's Orders Procedure revealed out as per physicia 483.25(e)(2) INCR	regarding Transcription of created 03/11 under d, "14. All orders will be carried n's orderas indicated" EASE/PREVENT DECREASE TION	F 3 ⁻	18		10/2/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		245617	B. WING		08/28/2015		
	PROVIDER OR SUPPLIER PELET VILLAGE CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
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F 318	resident, the facilit with a limited rang- appropriate treatm	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase ad/or to prevent further	F 318	3			
	by: Based on interview failed to: (1) ensur decline in range of received services a plan of care; and, prevent further decone resident review sample of 26. Findings include: Review of R21's A R21 had diagnose unspecified cerebr	w and record review, the facility e a resident with an identified motion (ROM) consistently and treatment identified in the (2) modify the interventions to cline in ROM for one (R21) of wed for ROM in the Stage 2 dmission Record indicated that is which included the following: rovascular disease, difficulty in e disorder, muscle weakness steoarthrosis.		Resident #21 was comprehensive reassessed for an exercise progra including PROM by an interdisciplinate team including therapy. The recommendations and current participation was discussed with R #21 including risks and benefits. A PROM program has been initiated assessments and care plan was up to reflect the changes and were communicated to the appropriate songoing monitoring for compliance the new exercise program will be conducted weekly for 4 weeks and ongoing as needed in conjunction RAI process.	esident new The odated taff. e with		
	(MDS) dated 3/11/ extensive assistantoilet use, personate was totally dependence as ame MDS under Limitation in Rangindicated R21 had motion on one side	tuarterly Minimum Data Set 15, indicated that R21 required ce with bed mobility, dressing, I hygiene and bathing; and, lent on staff for transfers. The Section G0400, Functional e of Motion was coded one that functional limitation of range of e of upper (shoulder, elbow, and lower extremity (hip, knee,		All residents are assessed upon admission or with a significant cha condition and are reviewed for cha functional ability and need for RON quarterly as part of the RAI proces Interdisciplinary reviews. Care plar Functional Maintenance Programs reviewed and updated in conjunctional the RAI process on admission, quannually and upon significant chan	nges in I s and is and are on with arterly,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER	5	STREET ADDRESS, CITY, STATE, ZIP CODE 125 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE	
F 318	ankle, and foot). Review of R21's Ar (MDS) dated 6/10/extensive assistant toilet use and persedependent on staff same MDS under Stimitation in Range one for the upper ewrist, and hand) the limitation in ROM of The same section the lower extremity that indicated R21 ROM on both sides coding indicated the functional ROM with assessment to the Further review of F6/10/15 revealed A triggered the Care assessment of the and strengths). The R21's CAA for ADL mobility, balance [a [history] of CVA [ce accident/stroke]	nnual Minimum Data Set 15, revealed R21 required ce with bed mobility, dressing, onal hygiene; and, was totally for bathing and transfers. The Section G0400, Functional e of Motion (ROM) was coded extremity (shoulder, elbow, at indicated R21 had functional on one side of upper extremity. of this MDS was coded two for f (hip, knee, ankle, and foot) had functional limitation of s of lower extremities. This at R21 had a decline in thin 90 days from the previous most recent assessment. R21's Annual MDS dated ctivities of Daily Living (ADL) Area Assessment (CAA - resident's problems, needs e "Analysis of Findings" from revealed, "[R21] has impaired and] ROM RT [related to] HX	F 318	status. Therapy evaluations are provided indicated and per physicians; order librations. The review PROM programs for earesident weekly for two months. In addition, PROM programs will be reviewed in conjunction with the RAI process. Ongoing facility measures to include review of a Functional Maintenance Program monthly and in conjunction with RAI process. The care plan policy and Functional Maintenance Plan/ROM policy have be reviewed and are current. Staff are educated on the individual functional maintenance plan through care plan, My Best Day and specific instructions. Education for staff on following the Replan and resident refusals and risks a benefits of FMP; s was initiated and is ongoing. Audits regarding care planning in conjunction with Functional Maintena Programs will be conducted weekly for weeks with results reported to Quality Assurance for ongoing compliance as will determine the need for further auditing. The Clinical Administrator or designer responsible for ongoing compliance.	er. ach IDT with Deen the OM and s nce or 4 / nd	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	, , , , , , , , , , , , , , , , , , , ,	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	considerationsDo problem/need on to rationale for care publication ADLS [activities of mobility [and] imparequires staff support Review of R21's "Inplant initiated on 8/ indicated under "Intexercise 1 time date each leg per hand"	e CAA revealed, "Care Plan escribe impact of this he resident [R21] and your plan decisionWill care plan for daily living], has impaired aired ability to tolerate activities, nort to meet her needs." Imited physical mobility" care 7/12 and revised on 8/27/15 atterventions," "I have seated ily. Do exercise 10 times on out. Tell [me] about my ur] prior to my exercise time."	F3	318	Date certain for the purposes of on compliance is 10/02/15.	going	
	related to R21's parexercises revealed these exercises site. In an interview with (RN1) on 8/27/15 averified that R21 in seated exercises, resident refuses to when seated." Who department was corefusals to get up seated exercises, high back W/C was measures that could be artment would done in bed but I contion exercises of that no further continued the seated exercises of the seated exercises.	low Up Question Report" articipation with the seated if that R21 only participated in a times from 8/1/15 to 8/27/15. In the Clinical Care Coordinator at approximately 10:10am, she nostly refused to perform the RN1 further stated, "The get up and it should be done en asked if the rehabilitation consulted because of R21's and consequently not doing the RN1 stated, "That's why the s started." When asked about all be provided while R21 was id, "Rehab [rehabilitation in not recommend anything to be could write an order [range of order] for nursing." She verified isultation or interventions were ation of the high back					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		245617	B. WING			08/28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAF			STREET ADDRESS, CITY, STATE, ZIF 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE HE APPROPRIA	
F 318	documentation that risks and benefits a seated exercises. In an interview with Charge Nurse (RN 8:45am, RN2 indicassistants (RA) we refusing to do the sabout possible interefusing to get up, refusing, I could tatof pain or assess with the course or [she] just needed to be seated then we have to excare or talk to there	redical record revealed no to R21 was educated about the of refusing to perform the Review of R21's care plan hysical mobility revealed it was ect R21's refusals to do the on the AM (morning) shift (2) on 8/28/15 at approximately ated that the resident ere not reporting that R21 was seated exercises. When asked erventions since R21 has been RN2 further stated, "If she's lik to the resident if it's because why. Maybe it's just personal to don't [sic] want to exercise. If ed and she's refusing to get up raluate and revamp the plan of apy and run it by them.	F3	318		-74-0 -74-0 -73 <u>0-1</u> -73-1
	decline in the ROM RN2 stated, "It's had unavoidable becauted declining but ROM prevent decline. We further stated, "We try to avoid the decline an interview with on 8/28/15 at apprentices."	nterview when asked if the office could have been avoided, and to say that it's avoidable or use some residents are just [exercises] could be done and office could always do better." RN2 is could do whatever we can to cline." In the Physical Therapist (PT1) oximately 9:45am, PT1 was not aware about R21's				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245617	B. WING		1 200	08/	28/2015
	PROVIDER OR SUPPLIER PELET VILLAGE CAR	E CENTER		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	PT1 stated, "Suping avoid decline in RC do the passive ROI can help though no or at least do it duri program." Review of the facility Motion Assessmen	nge 15 nendations she had for R21, e exercises sometimes can by but not all the time, at least of exercises which sometimes always. Better than nothing ng cares even if not part of a ty's policy titled "Range of t Policy" last modified on 9/10 pose, "To maintain resident's	F3	318			
	ability to maintain of prevent further decompleting Range admission, quarterly Further review of the under Procedure, "evaluated at least of indicated8. If any pain or discomfort, program or is unab	urrent range of motion and/or line in range of motion by of Motion Assessment upon y and with significant change." The same policy also revealed6. The program will be quarterly or more frequently as resident is having increased is refusing the range of motion le to complete the program as will be communicated to the					
	483.25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents.	F ACCIDENT EVISION/DEVICES Insure that the resident ns as free of accident hazards each resident receives on and assistance devices to	F	323			10/2/15
	This REQUIREME by:	NT is not met as evidenced					

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 16 F 323		T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 16 STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) F 323 Continued From page 16 F 323			245617	B. WING		08/	28/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 16 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323			RE CENTER		525 FAIRVIEW AVENUE SOUTH		
. 525	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
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 Particles (Pistel Courted to 1. Whe he are report to survey. 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 interventions have been interventions 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.	F 323	Based on interview facility failed to: (1) initiate individualize to prevent falls; and safety measures as resident's multiple (fainting) episodes reviewed for falls in Findings include: 1. Review of R12's re-admission "Face "Diagnoses" indica facility on 5/6/15 wiincluded but were infatigue, atrial fibrillar rhythm) and person Review of R12's fa Collection" dated 5 Status" revealed a spells, dizziness/vereview of the same reports fainting bef hypotension." Review of R12's fa [EHR] under "Nurs Effective Date 5/11 Position: Clinical Cadmitted from acut failure with hypoxiat thoracentesis, afib valvual [sic] heart clasix with daily weig with 2 recent falls wor for R12 is alert & of R12 i	ws and record reviews the identify individual risk factors, and care plans and interventions of (2) implement and modify is needed to address a falls related to syncopal for one resident (R12) in the Stage 2 sample of 26. facility admission and a Sheet" dated 5/6/15 under ted R12 was admitted to the ith admitting diagnoses that not limited to other malaise and action (abnormal heart rate or nal history of falls. cility "Comprehensive Data 1/6/15 under "J. Neurological check marked next to fainting ertigo and weakness. Further is document indicated "Resident fore falls. Has orthostatic fore falls. Has orthostatic incility Electronic Health Record ing" indicated "ROM Summary 1/15 08:43 Department: Nursing foordinator "who is a recent the hospital RT acute respiratory a & pleura [sic] effusion with on coumdain [sic], CHF & disease- on oxygen therapy & ghts, orthostatic hypotension with light headless[sic]. [Name riented. Is able to express her	F3	Resident #12 could not be comprehensively reviewed closed chart. Resident expiprior to survey. Daily Interdisciplinary Meeting assist in identifying resident change of condition or increase plans and My Best Date updated at that time. All in-house residents ider risk have been reviewed an updated. Care plan interver been initiated for those residiagnosis of syncope as it refalls/safety. All care plans are reviewed in conjunction with the RAI admission, quarterly, annual significant change in status. The care plan policy and the prevention policy have been are current. Comprehensive Data Colle Risk Data Collection assessing been reviewed and is curred. Education on care planning comprehensive assessment assessment, including a for syncope, has been initiated ongoing. Audits regarding care plans.	ings are held to t's with a eased fall risks. ays are ntified as fall ad care plans ntions have dents with a relates to and updated process on ally and upon the fall of the fall of the fall sments have ent.	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
	245617	B. WING _		08/	28/2015
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CE	ENTER		STREET ADDRESS, CITY, STATE, ZIP C 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
with A [Assist] of 1 & wa 4WW[wheeled walker]. has made progress sin Therapist] has starting FMP[Functional Mainted Review of R12's facility indicated "General Noted 14:19 Department: Nur Created by: [Name of Fwas taken out by nepheror a follow up chest xorthat she received a call fall at the clinic and was ER" Review of the hospital of documents that were precords on the facility of the hospital of the series of the	n white board. Transfer alks with A of 1& Is working with Rehab & ce admitted. PT [Physical [sic] walking program per mance Program]. " "S EHR under "Nursing" es Effective Date: 5/12/15 sing Position: RN/LPN RN] "[Name of Resident] ew today to primary clinic ray. Niece, here and stated that [name of R12] had a s being transported to the transfer discharge art of R12's medical evealed the following: 12/15 "Emergency ician Notes" for R12 under of Present Illness]" Patient had a near syncopal admission, patient up to had another near 13/15 "Consult Notes" for Present Illness (HPI)" rought to the hospital pellShe was feeling weak thostatic hypotensionshe	F 33	conducted weekly for 4 wee reported to Quality Assurant compliance and will determit for further auditing. The Clinical Administrator or responsible for ongoing conducted and the purpose compliance is 10/02/15.	ce for ongoing ine the need r designee is npliance.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMI	
		245617	B. WING			08/2	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Review of R12's far "Comprehensive Di "Resident Demogra re-admitted to the further review of th Neurological Status next to fainting spe weakness." Review of R12's "N Record" from 5/1/1 received Coumadin on the following dar R12 also received 5/17/15. Review of "Coumadon 10/11 from Brist of Coumadin) indicated ing" Further under "Medication of have a higher risk of Coumadin and: are trauma such as accomposite right away bleeding problems: headaches, dizzine bruising [bruises the cause or grow in sigumsred or black material that looks Review of R12's far Risk Data Collection "Internal Risk Factor"	cility medical record titled ata Collection" under aphics" revealed R12 was acility on 5/14/15 at 2pm. The same document under "J. "indicated a check marked lls, dizziness/vertigo and ledication Administration 5 to 5/31/15 indicated R12 to 5/31/15 indicated R12 to 5/8/15, 5/11/15, 5/15/15. Coumadin 5mg on 5/16/15 and din's Package Insert" revised of Myer's website (the makers	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245617	B. WING _		08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAF			STREET ADDRESS, CITY, STATE, ZIP COI 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	prior to the re-adm though R12 was an hospital on 5/12/16 Further review of t "Summary of Risk a history of falls, the days ago while out appointment Staff resistive to cares a ambulate with a tramonitor." Review of R12's en Plan [IRCP] [Initiat 5/6/15 under "Proble [related to]" was clin the blank space have been listed. Funder "Intervention monitor for safety, intervention to add syncopal episodes document indicate the only intervention instruct R12 to ask Review of R12's or revealed that there addressed R12's used by nurse's air residents]" for both dates indicated R1 during transfer, an Further review of taddress R12's fair	ent had no episodes of either hission to the facility even dmitted emergently to the 5 due to syncopal episodes. The same document under Factors" indicated, "She has ne most recent being several to a doctors [sic] If noted that resident was and would not allow staff to help ansfer belt. Will continue to the within 24 hours]" dated blem" indicated, "Fall Risk R/T necked but there was no entry where fall risk factors should Review of the same document as" indicated a check next to There was no specific these R12's falls related to her is. Further review of the same and it was revised on 5/18/15 and on that was added was to a for help.	F 32	23		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245617	B. WING		30	3/28/2015
	PROVIDER OR SUPPLIER PELET VILLAGE CAN			STREET ADDRESS, CITY, STATE, ZIP CO 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		ent ent
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	no mention about increased risk of both care coord of R12's care plan individual care plan was asked about IRN1 responded, "RN1 was further a individualized care syncopal episodes admission and rethe perfect world it the care plan to ac episodes. On 8/27/15 at app Director of Nursing facility's admission admitting nurse was IRCP based on the documents and the admission which it collection. The DO under falls. While DON stated, "If R7 problems then it see The DON pointed phrase, "Fall Risk DON confirmed it "syncope" since it main problems on re-admission.	R12's anti-coagulant use and	F3	23		
	was also asked w therapy was not in	hy the use of anti-coagulant included in the risk factors or ned. The DON replied that the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
			245617	B. WING			08/	28/2015
		PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116				
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	F 323	nursing staff were earnd symptoms of the anti-coagulant use hemorrhage. The Ewould the nursing santi-coagulant there one of R12's risk fawas not addressed Best Day." The DO anti-coagulant there would not hurt and importance especial On 8/28/15 at appreasked about the lace R12's use of anti-coagulant there wanti-coagulant there Review of a study the lderly patients with risk for falls." electric from the US National Institute of "Conclusion" reveas should not automational freated with a dictate anticoagular management of fall part of anticoagular should be made to	educated to look for the signs he side effects of like bruising, bleeding and DON was further asked how staff knew if R12 was on apy if it was not identified as actors, not care planned and in the nursing assistants' "My N replied that putting the apy as one of the risk factors that he understood its ally with R12's fall history. Oximately 8:45am, RN1 was ck of care plan to address bagulant therapy. RN1 stated rould develop the apy care plan on day 21. Itled "Use of anticoagulation in a trial fibrillation who are at conically published on 3/11/08 all Library of Medicine and f Health website under led "The risk of falls alone tically disqualify a person from warfarin. While falls should not not choice, assessment and I risk should be an important tion management. Efforts	F3	323			
		"Nursing" indicated Date: 5/17/2015 23 Position: RN/LPN 0 00:49:07 Description hitting her bottom f	"Type: Fall Focus: Effective 1:32:00 Department: Nursing Created Date: 5/18/2015 on: Resident fell backwards irst while exiting the bathroom. bonse: she was in really good					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245617	B. WING		· · · · · · · · · · · · · · · · · · ·	08/	28/2015		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116						
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE		
F 323	spirits and said sh buttock hurt the m first. She denies h Pain level was mo her up to her bed pack and Acetamin 1000mg Acetamin 1000mg Acetamin Curther review of further assessment occured because On 8/26/15 at appalso asked if the cR12's fall on 5/17/episodes were adhave to admit that	e did not feel hurt. She said her lost and that it hit the ground itting her head during the fall. Iderate 4/10. RA and I assisted via mechanical lift. Offered ice nophen - she agreed to take	F3	23					
	Procedure" revise indicated, "It is the to initiate a tempo admission8. Into help meet the goa individualized" F document under "Fall Management the occurence repcontributing to the extrinsic factors and changes to pl fall" B. Review of R12' dated 5/19/15 at 9 [sic] into resident's Assistant] stating	lity's "Care Plan Policy and d on 8/14 under "Policy" e policy of Presbyterian Homes rary care plan within 24 hours of erventions should be written to al. The intervention[s] should be further review of the same Procedure" revealed, "3. Postd.The staff nurse will review fort and will: i. Assess all factors all event including intrinsic and ii. Recommend interventions an of care to prevent a repeat a facility EHR under "Nursing" at 6:08am indicated "Writer calld is room by RA[Resident she found resident on bathroom vation, noted resident lying on							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTRUCTION NG			E SURVEY PLETED
į		245617	B. WING			08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, 525 FAIRVIEW AVENUE SAINT PAUL, MN 55	SOUTH	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	(R) side with blood side of head as well tubing was wrapped her torso. Large he Extremities discolor purple and UTD[un [vital signs]. No per Verified death by not 5/19/15" Review of the "Core facility indicated R1 multiple trauma and On 8/27/15 at approvas asked about R responded that it witubing. When asked	all over her right (R) hand and all as on the floor. Oxygen d around her legs and under matoma on (R) back of head. red and cool to touch. Lips able to determine [sic] VS ripheral pulses or respirations. o AP [apical pulse] at 0415 on oner's Report" provided by the 2's cause of death were from d falls. Oximately 10:45am, the DON as from R12's long oxygen d about R12's syncopal verbalized, "Honestly, I did	F 3	23			

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	ISIT
	B. Wing		Y2	10/29/2015	Y 3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CARONDELET VILLAGE CARE CENTER 525 FAIRVIEW AVENUE SOUTH		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).

ITE Y4		DATE Y5	ITEN Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0279	Correction	n ID Prefix	F0280		Correction	ID Prefix	F0282		Correction
Reg.#	483.20(d), 483.2	Complete	d Reg.#	483.20(d)(3), (2)	483.10(k)	Completed	Reg.#	483.20(k)(3)(ii)	3 163 m m m m	Completed
LSC		10/02/2015	LSC			10/02/2015	LSC			10/02/2015
ID Prefix	F0318	Correction	n ID Prefix	F0323		Correction	ID Prefix			Correction
Reg.#	483.25(e)(2)	Complete	d Reg.#	483.25(h)		Completed	Reg.#			Completed
LSC		10/02/2015	1 -			10/02/2015	LSC			
ID Prefix		Correction	n ID Prefix			Correction	ID Prefix			Correction
Reg. #		Complete	d Reg.#			Completed	Reg.#			Completed
LSC			LSC			***	LSC			
ID Prefix		Correction	ı ID Prefix			Correction	ID Prefix		**************************************	Correction
Reg.#		Complete	d Reg.#			Completed	Reg.#			Completed
LSC			LSC				LSC			
ID Prefix		Correction	n ID Prefix			Correction	ID Prefix	•		Correction
Reg.#		Complete	d Reg.#			Completed	Reg.#			Completed
LSC			LSC				LSC			
REVIEW STATE A		REVIEWED BY (INITIALS)	DATE	SIGN	NATURE OF	SURVEYOR			DATE	
REVIEW CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITL	.E				DATE	
FOLLOW 8/28/201		COMPLETED ON				CTED DEFICIEI ES (CMS-2567)		A SUMMARY OF HE FACILITY?		s 🗆 NO

PRINTED: 05/13/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COMPLETED	
		245617	B. WING _		08	/28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN		F 00	0		
	was conducted by Medicaid Services	ive Federal Monitoring Survey the Centers for Medicare & (CMS) on August 28, 2015 ota Department of Health 2015.				
	Survey Dates: Aug 2015 Survey Census: 45	ust 24, 2015 to August 28,				
	Medicare: 3 Medicaid: 12 Other: 30 Total: 45					
F 279 SS=D	Stage 1 Sample: 30 Stage 2 Sample: 20 483.20(d), 483.20(l COMPREHENSIVE	6 k)(1) DEVELOP	F 27	9		10/2/15
	,	the results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial atified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-k §483.25; and any s	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided				
ABORATOR'	 Y DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

Electronically Signed

09/18/2015

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245617	B. WING		08/2	28/2015
	PROVIDER OR SUPPLIER PELET VILLAGE CAR	E CENTER	5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From padue to the resident §483.10, including under §483.10(b)(4). This REQUIREMED by: Based on interview failed to develop araddress syncopal ((R12) of 18 resider the Stage 2 sample Findings include: Review of R12's ac 5/6/15 under "Diagadmitted to the faci diagnoses that includer malaise and personal history of Review of R12's "Collection" for adm Neurological Status next to fainting speweakness. Further	age 1 Is exercise of rights under the right to refuse treatment It). NT is not met as evidenced It and record review the facility individualized care plan to fainting) episodes for one into reviewed for care plans in e of 26. It is not met as evidenced It is not	F 279	DEFICIENCY)	dated on upon has d Fall have	
	Has orthostatic hyp that happens when lying down]." Review of R12's "F 5/6/15 under "Residue check marked next which indicated residue check marked next	otension [low blood pressure you stand up from sitting or all Risk Data Collection" dated dent had falls" revealed a to syncope and dizziness ident had episodes of both		Audits regarding care planning in conjunction with assessments will be conducted weekly for 4 weeks with reported to Quality Assurance for or compliance and will determine the refor further auditing.	results ngoing need	
	prior to the admissing Review of R12's er	on to the racility.		The Clinical Administrator or design responsible for ongoing compliance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245617	B. WING		08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	"Problem" indicated was checked but the space where fall riselisted. Review of R12's "Mused by nurse's aid residents]" did not a	24 hours]" dated 5/6/15 under d, "Fall Risk R/T [related to]" here was no entry in the blank sk factors should have been by Best Day [a quick guide tool les on how to care for address R12's fainting	F 279	Date certain for the purposes compliance is 10/02/15.	of ongoing	
	hypotension. Review of R12's "H dated 5/6/15 under "chronic atrial fibrill the arteries when th congestive heart fa	Is or her orthostatic Iospital Discharge Summary" "Active Problems" revealed ation, diastolic [the pressure in the heart rests between beats] illure, orthostatic syncope due to othostatic				
	5/11/15 at 9:44am admitted [sic] from therapy & lasix [diu orthostatic hypoten light headless [sic]. Review of R12's "H dated 5/13/15 under indicated "She defined the same admitted the sam	lospital Discharge Documents" er "Attending Progress Note" enies pain, ex [sic] except for				
	On 8/26/15 at approclinical care coordinates of R12's care plans individual care plan was asked about the plan to address R1	essure when she is up." oximately 2:30pm, RN1 (the nator) was asked to provide all is. RN1 provided the initial is that was dated 5/6/15. RN1 ne lack of individualized care 2's syncopal episodes present 6/15 and re-admission on				

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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
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F 279	would be in there," address R12's sync asked if the care plon 5/17/15 and if R addressed this time to admit that we mit to have that in the control of Nursing facility's initial care verbalized the adm for initiating the interpretation of Nursing assessment was shown R12's in while looking at the verbalized, "If R12 problems then it shoon confirmed it whose "Fall Risk for DON confirmed it whose "Syncope" since it where the procedure is admission" Further the initiate a temporary admission" Further department will gat admission to provide Resident Care Plar plan statements spin spin procedure is spin or provided the care plan statements spin on the care plan spin on the care plan statements spin on the care plan	onded, "In the perfect world it referring to the care plan to copal episodes. RN1 was also an was revised after R12's fall 12's syncopal episodes were e. RN1 stated, "I guess I have ssed that and it was important care plan. oximately 10:45am, the (DON) was asked about the planning process. The DON itting nurse was responsible erim care plan based on the discharge documents and the onto upon admission. The DON interim care plan under falls, in care plan the DON had syncope as one of her ould have been placed here." To the blank space after the actors R/T (related to). The was important to have put was identified as a problem on on and re-admission. Ty's "Care Plan and Policy on 8/14 under "Policy" policy of [Name of Facility] to be care plan within 24 hours of the review of the same procedure" revealed, "1. Each ther needed information on the data for the Individual on along with individual care ecific to the resident needs8.	F 27	9			
	plan statements sp	ecific to the resident needs8. d be written to help meet the					

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F 280 SS=D	PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plann changes in care and A comprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident incomprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident put the resident properties and the resident properties and the resident properties are resident properties.	NNING CARE-REVISE CP ne right, unless adjudged erwise found to be rethe laws of the State, to ing care and treatment or	F 280		10/2/15	
	by: Based on interview failed to revise the refusal to perform 6 (R21) of 18 residenthe Stage 2 sample Findings include: Review of R21's Ac R21 had diagnoses unspecified cerebro	Imission Record indicated that s which included the following: ovascular disease, difficulty in e disorder, muscle weakness		Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplin team including therapy. The recommendations and current participation was discussed with Reference #21 including risks and benefits. An PROM program has been initiated, assessments and care plan was up to reflect the changes and were communicated to the appropriate stongoing monitoring for compliance the new exercise program will be	ary sident new The dated aff.	

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F 280	Review of R21's Ar (MDS) dated 6/10/r cognitively intact. F MDS revealed that assistance with beand personal hygie on staff for bathing under Section G04 Range of Motion (Fupper extremity (sh hand) that indicated in ROM on one side same section of thi lower extremity (higindicated R21 had both sides of lower Review of R21's "linglan initiated on 8/7 indicated under "Intexercise 1 time dail each leg per hand exercises 1 hr [hour Review of the "Follor related to R21's parexercises revealed these exercises six In an interview with on 8/27/15 at approverified that R21 m seated exercises. Second have reflect Review of the facility Policy and Procedures.	nnual Minimum Data Set 15, revealed R21 was urther review of R21's Annual R21 required extensive d mobility, dressing, toilet use ne; and, was totally dependent and transfers. The same MDS 00, Functional Limitation in ROM) was coded one for the coulder, elbow, wrist, and d R21 had functional limitation e of the upper extremity. The s MDS was coded two for the o, knee, ankle, and foot) that functional limitation in ROM on	F 2	conducted weekly for 4 week ongoing as needed in conjunction are reviewed in conjunction with the RAI admission, quarterly, annual significant change in status. The care plan policy has be and is current. Education on care planning initiated and is ongoing. Ongoing Functional Mainter Programs reviewed quarter Residents. Audits regarding care planning conjunction with Functional Programs will be conducted weeks with results reported Assurance for ongoing committed will determine the need for auditing. The Clinical Administrator of responsible for ongoing compate certain for the purpose compliance is 10/02/15.	and updated process on ally and upon . een reviewed has been hance ally for all hing in Maintenance deckly for 4 to Quality upliance and further or designee is mpliance.	

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F 280		ge 6 ed and updated as the care	F 2	80		
	changes for the res	ident and as the resident Il be written on the paper care s medical record. It is to be				
F 282	Assessment Instrur Version 3.0, October indicated, "A new can developed after each the nursing home man plan using the result assessment. Facilit appropriateness of including after Quart as needed."	Term Care Facility Resident ment (RAI) User's Manual er 2014, Chapter 4 page 11 are plan does not need to be chreassessment. Instead, nay revise an existing care its of the latest comprehensive ies should also evaluate the the care plan at all times rerly assessments, modifying RVICES BY QUALIFIED	F 2	82		10/2/15
SS=D	PERSONS/PER CA The services provide must be provided by					
	by: Based on observatinterview, the facility in accordance with care for one (R7) of accidents; and, (2)	ion, record review and y failed to: (1) provide services the resident's written plan of five residents reviewed for follow physician orders for one its observed during medication sample of 26.		Resident #7 Care plan and My Be was comprehensively reassessed wandering and adjusted. All care pare reviewed and updated in conju with the RAI process on admission quarterly, annually and upon signif change in status. Resident #22 Ca My Best Day and Medications reviand are accurate.	for plans nction n, icant re Plan,	

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F 282	1. Review of R7's 'R7 had diagnoses idementia with behaunspecified psychology of R7's qual (MDS) with an asset of 6/10/15 under "SWandering-Present R7 had behavior of than daily. Review of R7's Electory of walk was not limited to wrooms, wandering of 3rd floor and wander "Focus" inclubed behavior (out of the other resident room but were not limited minute safety check on her location of the doors complete confirmed the resident resident resident room that the doors complete confirmed the resident resident resident room but were not limited minute safety check on her location of the Care is on half an hour scheck on her location of the observations of the observations.	"Admission Record" indicated including, but not limited to, avioral disturbance and sis. "Interly Minimum Data Set essment reference date (ARD) rection E0900: rece and Frequency" revealed this type 4 to 6 days, but less extronic Health Record (EHR) and 3/9/15-8/26/15 indicated R7 redering which included but wandering into other resident out of the Care Center to the rering outside of the facility. The plan, revised on 06/26/15, reded "I demonstrate wandering e CC [Care Center] & [and] and its the following: "On 30 ks." The plan of the facility on 8/26/15 at 11:04am are into other resident rooms are center. NA1 stated "She [R7] afety checksWe have to	F2	282	The care plan policy has been reviand is current. Medication pass poreviewed and is current. Education on following care plan a physicians orders has been initiate is ongoing. Audits regarding care plan interver and physicians orders will be cond weekly for 4 weeks with results repto Quality Assurance for ongoing compliance and will determine the for further auditing. The Clinical Administrator or design responsible for ongoing compliance Date certain for the purposes of or compliance is 10-02-15.	nd d and ations ucted ported need nee is e.	

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F 282	Nursing staff was sattend other reside On 8/26/15, activity R7's room at 2:33p closed. During a code: 4:15pm, R7 was obroom. No one was during the one hour of the observation of the observation of the residents on the observation until 10 with the doors comnursing staff within the observation. National R7's room during the observation of Nursing do safety checks comphysically have to what she is doing." In an interview on 8 Director of Nursing do safety checks comphysically have to what she is doing." that there is a form the 30 minute check of DON was made awarelated to the facility care plan interventic checks. The DON is safety checks are." On 8/27/15 at 5:55p Care Director state have a specific poli resident safety checks.	een to pass medications and ints on the unit. It staff was observed to leave im. The room doors were left ontinuous observation until observed to be inside R7's observed to enter R7's room in and 42 minutes. At the time nursing staff was attending to the unit. Bam, a visitor was observed to uring a continuous observed to enter in the staff of the properties of the observation. B/27/15 at 12:38pm, the (DON) when questioned what onsist of, replied that staff go and see where [R7] is and The DON further indicated for staff to complete related to ks. During the interview the vare of the observations y's failure to implement R7's ons of 30 minute safety replied that the 30 minute not always possible."	F 28				

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F 282	the safety check for as requested by the Administrator further tool and is not part of the "30 Minute Common to the top of the top of the following Resident", "Observation." 2. Review of the 6/R22 had a Brief Indicated a Brief Indicated to Copport of the body), chronic of (COPD - makes it high generalized muscles the following inform the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical the potential for alterelated to COPD. Cordered by my physical for altere	rms for the week of 8/23/15, as surveyor on 8/27/15. The ser indicated that the form is a of the medical record. Review thecks" for R7 from wealed the forms, which were wealed the forms, which were wealed the date and R7's name of the page and were blank segments: "Location of ed doing what?", and "Staff (10/15 Quarterly MDS revealed dividual Mental Status (BIMS) 3-15 indicating R22 was This same MDS revealed the set for R22: congestive heart to pump blood sufficiently for obstructive pulmonary disease hard for you to breathe), and a weakness. The plan dated 6/8/15 revealed the retain in respiratory status Give me my medications as	F 28			

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F 282	release the breath. medications with ap did not remind R22 inhaling the puff. During an interview TMA1 revealed tha for R22's Advair dis rinsed after the puff development of threat mouth). She stated after she administed after she administ	t for as long as possible then TMA1 then gave other oral oplesauce and water. TMA1 to rinse her mouth after on 8/26/15 at 3:48pm, with the she was aware that the order skus required the mouth to be for was given to help prevent the ush (a fungal infection of the she did not ask R22 to do this red the Advair diskus inhaler. on 8/28/15 at 9:48am, the (DON) stated that he would ollow the physician's orders inhaler medication as the did. He stated if the order read after the inhaled puff was the nursing staff to follow the physician's orders inhaler medication as the different inhaled puff was the nursing staff to follow the serious side effects, including our mouth or throat (thrush), with water without swallowing it to help reduce your chance of regarding Transcription of	F 2	32		
F 318 SS=D	Physician's Orders Procedure revealed out as per physician	created 03/11 under d, "14. All orders will be carried n's orderas indicated" EASE/PREVENT DECREASE	F 3	18		10/2/15

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F 318	Based on the com resident, the facility with a limited range appropriate treatm	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase nd/or to prevent further	F 3	18			
	by: Based on interview failed to: (1) ensured decline in range of received services a plan of care; and, prevent further decone resident review sample of 26. Findings include: Review of R21's AR21 had diagnose unspecified cerebrowalking, depressivant generalized of Review of R21's Q (MDS) dated 3/11/extensive assistant toilet use, personal was totally dependent same MDS under Limitation in Range indicated R21 had motion on one side	w and record review, the facility e a resident with an identified motion (ROM) consistently and treatment identified in the (2) modify the interventions to cline in ROM for one (R21) of wed for ROM in the Stage 2 dmission Record indicated that is which included the following: ovascular disease, difficulty in e disorder, muscle weakness steoarthrosis. The transfers of the transfers of the ce with bed mobility, dressing, I hygiene and bathing; and, tent on staff for transfers. The Section G0400, Functional e of Motion was coded one that functional limitation of range of the of upper (shoulder, elbow, and lower extremity (hip, knee,		Resident #21 was compre reassessed for an exercise including PROM by an interest team including therapy. The recommendations and currest participation was discussed #21 including risks and bere PROM program has been it assessments and care plant to reflect the changes and communicated to the approximation of the new exercise program conducted weekly for 4 were ongoing as needed in conjugation of the reviewed and incomplete the same assessed admission or with a significal condition and are reviewed functional ability and need functional ability and need functional Maintenance Previewed and updated in control the RAI process on admission annually and upon significations.	e program rdisciplinary e rent d with Resident nefits. A new initiated. The n was updated were opriate staff. mpliance with will be eks and then unction with the upon ant change in for changes in for ROM I process and are plans and ograms are onjunction with sion, quarterly,		

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F 318	ankle, and foot). Review of R21's A (MDS) dated 6/10/extensive assistant toilet use and persidependent on staff same MDS under Limitation in Rangone for the upper wrist, and hand) the limitation in ROM of The same section the lower extremity that indicated R21 ROM on both side coding indicated the functional ROM with assessment to the Further review of 6/10/15 revealed A triggered the Care assessment of the and strengths). The R21's CAA for ADI mobility, balance [a [history] of CVA [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/s	nnual Minimum Data Set (15, revealed R21 required (16), revealed R21 required (16), revealed R21 required (16), revealed R21 required (16), revealed R21 required (17), revealed R21, was totally (18), for bathing and transfers. The (18), Section G0400, Functional (19), eof Motion (ROM) was coded (19), extremity (shoulder, elbow, (19), at indicated R21 had functional (19), on one side of upper extremity. (19), of this MDS was coded two for (19), knee, ankle, and foot) (19), had functional limitation of (19), so of lower extremities. This (19), had a decline in (19), thin 90 days from the previous (19), and (19), and (19), are assessment (CAA - (19), are assessment (CAA - (19), are aled, "[R21] has impaired (19), and (1	F 31	status. Therapy evaluation as indicated and per physic IDT to review PROM progresident weekly for two monaddition, PROM programs reviewed in conjunction with process. Ongoing facility measures review of a Functional Main Program monthly and in continuous the RAI process. The care plan policy and Functional maintenance Plan/ROM por reviewed and are current. Staff are educated on the infunctional maintenance placare plan, My Best Day and instructions. Education for staff on follow plan and resident refusals benefits of FMP; swas inition ongoing. Audits regarding care plan conjunction with Functional Programs will be conducted weeks with results reported Assurance for ongoing conwill determine the need for auditing. The Clinical Administrator responsible for ongoing conversible for on	rams for each onths. In will be the the RAI to include IDT intenance onjunction with functional olicy have been and wind the dispecific wing the ROM and risks and that and is intended and is intended weekly for 4 dispecific to dispecific the result of th		

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F 318	answer. Review of the same considerationsDe problem/need on the rationale for care plands. [activities of combility [and] impair requires staff supposed for the staff supposed for	ge 13 CAA revealed, "Care Plan scribe impact of this in resident [R21] and your an decisionWill care plan for daily living], has impaired red ability to tolerate activities, out to meet her needs." Inited physical mobility" care 7/12 and revised on 8/27/15 erventions," "I have seated y. Do exercise 10 times on out. Tell [me] about my r] prior to my exercise time." In the Question Report of the clinical Care Coordinator	F3	118	Date certain for the purposes of or compliance is 10/02/15.	going	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	documentation that risks and benefits of seated exercises. Frelated to limited phot updated to refleseated exercises. In an interview with Charge Nurse (RN: 8:45am, RN2 indica assistants (RA) we refusing to do the sabout possible interefusing to get up, refusing, I could tall of pain or assess we choice or [she] just needed to be seated then we have to evecare or talk to there. Therapy could give the nurse practition. During the same in decline in the ROM RN2 stated, "It's had unavoidable becauted declining but ROM prevent decline. We further stated, "We try to avoid the declinal interview with on 8/28/15 at approindicated that she with the residue of the same in the residue of the same in the ROM prevent decline. We further stated, "We try to avoid the declinal interview with on 8/28/15 at approindicated that she with the same in the same in the residue of the same in the same in the residue of the same in the same in the residue of the same in t	edical record revealed no R21 was educated about the of refusing to perform the Review of R21's care plan hysical mobility revealed it was ect R21's refusals to do the the AM (morning) shift 2) on 8/28/15 at approximately ated that the resident re not reporting that R21 was eated exercises. When asked reventions since R21 has been RN2 further stated, "If she's k to the resident if it's because thy. Maybe it's just personal don't [sic] want to exercise. If and she's refusing to get up aluate and revamp the plan of apy and run it by them. suggestions and I will inform ter." terview when asked if the could have been avoided, and to say that it's avoidable or se some residents are just [exercises] could be done and e could always do better." RN2 could do whatever we can to	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245617	B. WING		08/	28/2015
	PROVIDER OR SUPPLIER PELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318 F 323 SS=G	PT1 stated, "Supine avoid decline in RC do the passive RON can help though no or at least do it duri program." Review of the facilit Motion Assessment revealed under Purability to maintain or prevent further decompleting Range admission, quarterly Further review of the under Procedure, "Levaluated at least of indicated8. If any pain or discomfort, program or is unab recommended, it winterdisciplinary tea 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and	nendations she had for R21, a exercises sometimes can be but not all the time, at least of exercises which sometimes it always. Better than nothing ing cares even if not part of a cy's policy titled "Range of it Policy" last modified on 9/10 pose, "To maintain resident's urrent range of motion and/or line in range of motion by of Motion Assessment upon y and with significant change." The same policy also revealed complete the program as ill be communicated to the m." FACCIDENT	F 318			10/2/15
	This REQUIREMENT by:	NT is not met as evidenced				

AND DUAN OF CORDECTION DENTIFICATION NUMBER.		` ′	JLTIPLE CONSTRUCTION .DING		(X3) DATE SURVEY COMPLETED	
		245617	B. WING		08/2	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
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F 323	Based on interview facility failed to: (1) initiate individualize to prevent falls; and safety measures as resident's multiple (fainting) episodes reviewed for falls in Findings include: 1. Review of R12's re-admission "Face "Diagnoses" indica facility on 5/6/15 wi included but were restigue, atrial fibrillar rhythm) and person Review of R12's fa Collection" dated 5 Status" revealed a spells, dizziness/vereview of the same reports fainting bef hypotension." Review of R12's fa [EHR] under "Nursi Effective Date 5/11 Position: Clinical Cadmitted from acut failure with hypoxia thoracentesis, afib valvual [sic] heart clasix with daily weig with 2 recent falls woof R12] is alert & of R12] is alert & of	vs and record reviews the identify individual risk factors, ad care plans and interventions d (2) implement and modify a needed to address a falls related to syncopal for one resident (R12) a the Stage 2 sample of 26. facility admission and a Sheet" dated 5/6/15 under ted R12 was admitted to the th admitting diagnoses that not limited to other malaise and ation (abnormal heart rate or	F 323	Resident #12 could not be comprehensively reviewed due to closed chart. Resident expired on prior to survey. Daily Interdisciplinary Meetings are assist in identifying resident's with change of condition or increased ff Care plans and My Best Days are updated at that time. All in-house residents identified a risk have been reviewed and care updated. Care plan interventions heen initiated for those residents of diagnosis of syncope as it relates falls/safety. All care plans are reviewed and up in conjunction with the RAI process admission, quarterly, annually and significant change in status. The care plan policy and the fall prevention policy have been reviewed are current. Comprehensive Data Collection as Risk Data Collection assessments been reviewed and is current. Education on care planning, comprehensive assessments and assessment, including a focus on syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will	5-19-15 e held to a all risks. as fall plans lave with a to odated s on upon wed and have fall have	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245617	B. WING			08/2	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	, 00/-	0, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	talker & written note with A [Assist] of 1 a 4WW[wheeled walk has made progress Therapist] has start FMP[Functional Markeview of R12's facindicated "General 14:19 Department: Created by: [Name was taken out by note of a follow up chest that she received a fall at the clinic and ER" Review of the hosp documents that we records on the facil Department Staff/P "Relevant HPI[Histowas in clinic today a eventWhile await bathroom with nurs syncopal event." B.The hospital's R12 under "History revealed "who was because of a fainting and had issues with apparently fainted C.Review of R1 Doctor] Progress N	es on white board. Transfer & walks with A of 1& cer]. Is working with Rehab & since admitted. PT [Physical ing [sic] walking program per intenance Program]. " cility's EHR under "Nursing" Notes Effective Date: 5/12/15 Nursing Position: RN/LPN of RN] "[Name of Resident] ephew today to primary clinic at x ray. Niece, here and stated call that [name of R12] had a was being transported to the ital transfer discharge re part of R12's medical ity revealed the following: s 5/12/15 "Emergency hysician Notes" for R12 under ory of Present Illness]" Patient and had a near syncopal ing admission, patient up to e and had another near s 5/13/15 "Consult Notes" for of Present Illness (HPI)" is brought to the hospital ing spellShe was feeling weak in orthostatic hypotensionshe	F3	223	conducted weekly for 4 weeks with reported to Quality Assurance for compliance and will determine the for further auditing. The Clinical Administrator or design responsible for ongoing compliance. Date certain for the purposes of on compliance is 10/02/15.	ngoing need nee is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	` COMPLETE	
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 125 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE
F 323	A. Hx [History] of O Review of R12's fac "Comprehensive Da" "Resident Demogra re-admitted to the factorial forms of the Neurological Status next to fainting spel weakness." Review of R12's "M Record" from 5/1/19 received Coumadin on the following dat R12 also received (5/17/15). Review of "Coumadin on the following dat R12 also received (5/17/15). Review of "Coumadin on 10/11 from Brist of Coumadin) indica Bleeding Coumadin bleeding" Further under "Medication (have a higher risk of Coumadin and: are trauma such as acc provider right away bleeding problems: headaches, dizzine bruising [bruises the cause or grow in siz gumsred or black material that looks Review of R12's fac Risk Data Collectio "Internal Risk Factorial"	H [orthostatic hypotension]" cility medical record titled ata Collection" under aphics" revealed R12 was acility on 5/14/15 at 2pm. e same document under "J." indicated a check marked als, dizziness/vertigo and dedication Administration 5 to 5/31/15 indicated R12 [a blood thinner] tablet 2.5mg ares: 5/8/15, 5/11/15, 5/15/15. Coumadin 5mg on 5/16/15 and din's Package Insert" revised of Myer's website (the makers	F3	323			

		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245617	B. WING		08/	28/2015	
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F 323	indicated the reside prior to the re-admithough R12 was achospital on 5/12/15 Further review of th "Summary of Risk a history of falls, the days ago while out appointmentStaff resistive to cares a ambulate with a tramonitor." Review of R12's er Plan [IRCP] [Initiate 5/6/15 under "Prob [related to]" was chin the blank space have been listed. Funder "Intervention monitor for safety. intervention to addisyncopal episodes. document indicated the only interventio instruct R12 to ask Review of R12's or revealed that there addressed R12's under "R12's under "R	ent had no episodes of either ission to the facility even dmitted emergently to the due to syncopal episodes. The same document under factors" indicated, "She has emost recent being several to a doctors [sic] in noted that resident was not would not allow staff to help insfer belt. Will continue to the within 24 hours]" dated lem" indicated, "Fall Risk R/T lecked but there was no entry where fall risk factors should deview of the same document s" indicated a check next to There was no specific ress R12's falls related to her. Further review of the same dit was revised on 5/18/15 and in that was added was to for help.	F 323	3			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	no mention about Fincreased risk of bloom 10 mention about Fincreased risk of bloom 10 mention 10 m	R12's anti-coagulant use and	F3	23			
	therapy was not inc	luded in the risk factors or ed. The DON replied that the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245617	B. WING _		08/	28/2015	
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	OB/28/2019 ODE RRECTION (X5 COMPLE C		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	nursing staff were and symptoms of the anti-coagulant use hemorrhage. The Ewould the nursing anti-coagulant there one of R12's risk far was not addressed Best Day." The DO anti-coagulant there would not hurt and importance especial On 8/28/15 at appreasked about the lace R12's use of anti-coagulant there was anti-coagulant there anti-coagulant there anti-coagulant there are leading to the lace of th	educated to look for the signs he side effects of like bruising, bleeding and DON was further asked how staff knew if R12 was on apy if it was not identified as actors, not care planned and in the nursing assistants' "My N replied that putting the apy as one of the risk factors that he understood its ally with R12's fall history. Oximately 8:45am, RN1 was ck of care plan to address bagulant therapy. RN1 stated yould develop the apy care plan on day 21. Itiled "Use of anticoagulation in a trial fibrillation who are at conically published on 3/11/08 and Library of Medicine and f Health website under led "The risk of falls alone tically disqualify a person from warfarin. While falls should not ant choice, assessment and I risk should be an important tion management. Efforts	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245617	B. WING _		08/	28/2015	
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	, 50,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	spirits and said she buttock hurt the mofirst. She denies hit Pain level was mocher up to her bed vpack and Acetamin 1000mg Acetamino Further review of the further assessment occured because FON 8/26/15 at appralso asked if the care R12's fall on 5/17/1 episodes were add have to admit that vimportant to have to initiate a tempora admission8. Interhelp meet the goal individualized" Further the procedure of the faciliary revised indicated, "It is the to initiate a tempora admission8. Interhelp meet the goal individualized" Further the occurrence reports occurred the factorsii. and changes to pla fall" B. Review of R12's dated 5/19/15 at 9: [sic] into resident's Assistant] stating services and said stating services and said stating services and said stating services and said said said said said said said sai	e did not feel hurt. She said her est and that it hit the ground ting her head during the fall. derate 4/10. RA and I assisted ia mechanical lift. Offered ice ophen - she agreed to take	F 32	3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245617	B. WING		08	/28/2015		
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP (525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 323	(R) side with blood side of head as wel tubing was wrapped her torso. Large he Extremities discolor purple and UTD[un [vital signs]. No per Verified death by no 5/19/15" Review of the "Cord facility indicated R1 multiple trauma and On 8/27/15 at approwas asked about R responded that it we tubing. When asked	all over her right (R) hand and I as on the floor. Oxygen d around her legs and under matoma on (R) back of head. red and cool to touch. Lips able to determine [sic] VS ipheral pulses or respirations. AP [apical pulse] at 0415 on oner's Report" provided by the 2's cause of death were from d falls. Description of the polygen of the po	F3	23				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 000	INITIAL COMMENT	ΓS	F (000			
	Survey was conduct Medicare & Medica	ve Federal Monitoring cted by the Centers for id Services (CMS) on August a Minnesota Department of uly 23, 2015.					
	Survey Dates: Augu 2015 Survey Census: 45	ust 24, 2015 to August 28,					
	Medicare: 3 Medicaid: 12 Other: 30 Total: 45						
F 279 SS=D	(//	S x)(1) DEVELOP	F2	279			10/2/15
	,	the results of the assessment and revise the resident's n of care.					
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable stables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From padue to the resident §483.10, including under §483.10(b)(4). This REQUIREMED by: Based on interview failed to develop araddress syncopal ((R12) of 18 resider the Stage 2 sample Findings include: Review of R12's ac 5/6/15 under "Diagadmitted to the faci diagnoses that includer malaise and personal history of Review of R12's "Collection" for adm Neurological Status next to fainting speweakness. Further	age 1 Is exercise of rights under the right to refuse treatment It). NT is not met as evidenced It and record review the facility individualized care plan to fainting) episodes for one into reviewed for care plans in e of 26. It is not met as evidenced It is not	F 279	DEFICIENCY)	dated on upon has d Fall have	
	Has orthostatic hyp that happens when lying down]." Review of R12's "F 5/6/15 under "Residue check marked next which indicated residue check marked next	otension [low blood pressure you stand up from sitting or all Risk Data Collection" dated dent had falls" revealed a to syncope and dizziness ident had episodes of both		Audits regarding care planning in conjunction with assessments will be conducted weekly for 4 weeks with reported to Quality Assurance for or compliance and will determine the refor further auditing.	results ngoing need	
	prior to the admissing Review of R12's er	on to the racility.		The Clinical Administrator or design responsible for ongoing compliance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	"Problem" indicated was checked but the space where fall riselisted. Review of R12's "Mused by nurse's aid residents]" did not a	24 hours]" dated 5/6/15 under d, "Fall Risk R/T [related to]" here was no entry in the blank sk factors should have been by Best Day [a quick guide tool les on how to care for address R12's fainting	F 279	Date certain for the purposes compliance is 10/02/15.	of ongoing	
	hypotension. Review of R12's "H dated 5/6/15 under "chronic atrial fibrill the arteries when th congestive heart fa	Is or her orthostatic Iospital Discharge Summary" "Active Problems" revealed ation, diastolic [the pressure in the heart rests between beats] illure, orthostatic syncope due to othostatic				
	5/11/15 at 9:44am admitted [sic] from therapy & lasix [diu orthostatic hypoten light headless [sic]. Review of R12's "H dated 5/13/15 under indicated "She defined the same admitted the sam	lospital Discharge Documents" er "Attending Progress Note" enies pain, ex [sic] except for				
	On 8/26/15 at approclinical care coordinates of R12's care plans individual care plan was asked about the plan to address R1	essure when she is up." oximately 2:30pm, RN1 (the nator) was asked to provide all is. RN1 provided the initial is that was dated 5/6/15. RN1 ne lack of individualized care 2's syncopal episodes present 6/15 and re-admission on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 279	would be in there," address R12's sync asked if the care plon 5/17/15 and if R addressed this time to admit that we mit to have that in the control of Nursing facility's initial care verbalized the adm for initiating the interpretation of Nursing assessment was shown R12's in while looking at the verbalized, "If R12 problems then it shoon confirmed it whose "Fall Risk for DON confirmed it whose "Syncope" since it where the procedure is admission" Further the initiate a temporary admission" Further department will gat admission to provide Resident Care Plar plan statements spin spin procedure is spin or provided the care plan statements spin on the care plan spin on the care plan statements spin on the care plan	onded, "In the perfect world it referring to the care plan to copal episodes. RN1 was also an was revised after R12's fall 12's syncopal episodes were e. RN1 stated, "I guess I have ssed that and it was important care plan. oximately 10:45am, the (DON) was asked about the planning process. The DON itting nurse was responsible erim care plan based on the discharge documents and the onto upon admission. The DON interim care plan under falls, in care plan the DON had syncope as one of her ould have been placed here." To the blank space after the actors R/T (related to). The was important to have put was identified as a problem on on and re-admission. Ty's "Care Plan and Policy on 8/14 under "Policy" policy of [Name of Facility] to be care plan within 24 hours of the review of the same procedure" revealed, "1. Each ther needed information on the data for the Individual on along with individual care ecific to the resident needs8.	F 27	9		
	plan statements sp	ecific to the resident needs8. d be written to help meet the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTI	ON	
F 280 SS=D	PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plann changes in care and A comprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident incomprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident put the resident properties and the resident properties and the resident properties are resident properties.	NNING CARE-REVISE CP ne right, unless adjudged erwise found to be rethe laws of the State, to ing care and treatment or	F 280		10/2/15		
	by: Based on interview failed to revise the refusal to perform 6 (R21) of 18 residenthe Stage 2 sample Findings include: Review of R21's Ac R21 had diagnoses unspecified cerebro	Imission Record indicated that s which included the following: ovascular disease, difficulty in e disorder, muscle weakness		Resident #21 was comprehensively reassessed for an exercise program including PROM by an interdisciplin team including therapy. The recommendations and current participation was discussed with Reference #21 including risks and benefits. An PROM program has been initiated, assessments and care plan was up to reflect the changes and were communicated to the appropriate stongoing monitoring for compliance the new exercise program will be	ary sident new The dated aff.		

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
CARONI	DELET VILLAGE CAR	E CENTER		525 FAIRVIEW AVENUE SOUTH		
				SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 280	Review of R21's Ar (MDS) dated 6/10/r cognitively intact. F MDS revealed that assistance with beand personal hygie on staff for bathing under Section G04 Range of Motion (Fupper extremity (sh hand) that indicated in ROM on one side same section of thi lower extremity (higindicated R21 had both sides of lower Review of R21's "linglan initiated on 8/7 indicated under "Intexercise 1 time dail each leg per hand exercises 1 hr [hour Review of the "Follor related to R21's parexercises revealed these exercises six In an interview with on 8/27/15 at approverified that R21 m seated exercises. Second have reflect Review of the facility Policy and Procedures.	nnual Minimum Data Set 15, revealed R21 was urther review of R21's Annual R21 required extensive d mobility, dressing, toilet use ne; and, was totally dependent and transfers. The same MDS 00, Functional Limitation in ROM) was coded one for the coulder, elbow, wrist, and d R21 had functional limitation e of the upper extremity. The s MDS was coded two for the o, knee, ankle, and foot) that functional limitation in ROM on	F 2	conducted weekly for 4 week ongoing as needed in conjunction are reviewed in conjunction with the RAI admission, quarterly, annual significant change in status. The care plan policy has be and is current. Education on care planning initiated and is ongoing. Ongoing Functional Mainter Programs reviewed quarter Residents. Audits regarding care planning conjunction with Functional Programs will be conducted weeks with results reported Assurance for ongoing committed will determine the need for auditing. The Clinical Administrator of responsible for ongoing compate certain for the purpose compliance is 10/02/15.	and updated process on ally and upon . een reviewed has been hance ally for all hing in Maintenance deckly for 4 to Quality upliance and further or designee is mpliance.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	RIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280		ge 6 ed and updated as the care	F 2	80		
	changes for the res	ident and as the resident Il be written on the paper care s medical record. It is to be				
F 282	Assessment Instrur Version 3.0, October indicated, "A new can developed after each the nursing home man plan using the result assessment. Facilit appropriateness of including after Quart as needed."	Term Care Facility Resident ment (RAI) User's Manual er 2014, Chapter 4 page 11 are plan does not need to be chreassessment. Instead, nay revise an existing care its of the latest comprehensive ies should also evaluate the the care plan at all times rerly assessments, modifying RVICES BY QUALIFIED	F 2	82		10/2/15
SS=D	PERSONS/PER CA The services provide must be provided by					
	by: Based on observatinterview, the facility in accordance with care for one (R7) of accidents; and, (2)	ion, record review and y failed to: (1) provide services the resident's written plan of five residents reviewed for follow physician orders for one its observed during medication sample of 26.		Resident #7 Care plan and My Be was comprehensively reassessed wandering and adjusted. All care pare reviewed and updated in conju with the RAI process on admission quarterly, annually and upon signif change in status. Resident #22 Ca My Best Day and Medications reviand are accurate.	for plans nction n, icant re Plan,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245617	B. WING			08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	1. Review of R7's 'R7 had diagnoses idementia with behaunspecified psychology of R7's qual (MDS) with an asset of 6/10/15 under "SWandering-Present R7 had behavior of than daily. Review of R7's Electory of walk was not limited to wrooms, wandering of 3rd floor and wander "Focus" inclubed behavior (out of the other resident room but were not limited minute safety check on her location of the doors complete confirmed the resident resident resident room that the doors complete confirmed the resident resident resident room but were not limited minute safety check on her location of the Care is on half an hour scheck on her location of the observations of the observations.	"Admission Record" indicated including, but not limited to, avioral disturbance and sis. "Interly Minimum Data Set essment reference date (ARD) rection E0900: rece and Frequency" revealed this type 4 to 6 days, but less extronic Health Record (EHR) and 3/9/15-8/26/15 indicated R7 redering which included but wandering into other resident out of the Care Center to the rering outside of the facility. The plan, revised on 06/26/15, reded "I demonstrate wandering e CC [Care Center] & [and] and its the following: "On 30 ks." The plan of the facility on 8/26/15 at 11:04am are into other resident rooms are center. NA1 stated "She [R7] afety checksWe have to	F2	282	The care plan policy has been reviand is current. Medication pass poreviewed and is current. Education on following care plan a physicians orders has been initiate is ongoing. Audits regarding care plan interver and physicians orders will be cond weekly for 4 weeks with results repto Quality Assurance for ongoing compliance and will determine the for further auditing. The Clinical Administrator or design responsible for ongoing compliance Date certain for the purposes of or compliance is 10-02-15.	nd d and ations ucted ported need nee is e.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	Nursing staff was s attend other resider On 8/26/15, activity R7's room at 2:33p closed. During a code:15pm, R7 was obroom. No one was during the one hour of the observation of the observation of the residents on the observation until 10 with the doors compursing staff within the observation. No R7's room during the observation of Nursing do safety checks complysically have to what she is doing." That there is a form the 30 minute check DON was made awarelated to the facility care plan interventic checks. The DON resident safety checks are." On 8/27/15 at 5:55p Care Director state have a specific poli resident safety checks.	een to pass medications and hts on the unit. staff was observed to leave m. The room doors were left ntinuous observation until served to be inside R7's observed to enter R7's room and 42 minutes. At the time nursing staff was attending to he unit. Bam, a visitor was observed to uring a continuous c:55am, R7 was in R7's room oletely closed. There was no R7's room vicinity throughout to one was witnessed to enter he 52 minutes of observation. S/27/15 at 12:38pm, the (DON) when questioned what onsist of, replied that staff go and see where [R7] is and The DON further indicated for staff to complete related to ks. During the interview the eare of the observations y's failure to implement R7's ons of 30 minute safety eplied that the 30 minute not always possible."	F 2	82				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	, 50,	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 282	the safety check fo as requested by the Administrator further tool and is not part of the "30 Minute Comment of the top of under the following Resident", "Observation." 2. Review of the 66 Regan and a Brief Incomment of the following diagnoses failure (CHF-unable the body), chronic of (COPD - makes it higher of the following inform the potential for alterelated to COPD. Condered by my physometric ordered by my physometric or the potential for altered to COPD. Condered by my physometric ordered by my physom	rms for the week of 8/23/15, a surveyor on 8/27/15. The er indicated that the form is a of the medical record. Review hecks" for R7 from realed the forms, which were had the date and R7's name of the page and were blank segments: "Location of ed doing what?", and "Staff (10/15 Quarterly MDS revealed lividual Mental Status (BIMS) 3-15 indicating R22 was This same MDS revealed the for R22: congestive heart to pump blood sufficiently for obstructive pulmonary disease hard for you to breathe), and weakness. The plan dated 6/8/15 revealed lation: "I have an alteration or eration in respiratory status Give me my medications as	F 28			

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F 282	release the breath. medications with ap did not remind R22 inhaling the puff. During an interview TMA1 revealed tha for R22's Advair dis rinsed after the puff development of threat mouth). She stated after she administed after she administ	t for as long as possible then TMA1 then gave other oral oplesauce and water. TMA1 to rinse her mouth after on 8/26/15 at 3:48pm, with the she was aware that the order of the was given to help prevent the she did not ask R22 to do this red the Advair diskus inhaler. on 8/28/15 at 9:48am, the (DON) stated that he would ollow the physician's orders inhaler medication as the did. He stated if the order read after the inhaled puff was the nursing staff to follow the physician's orders inhaler medication as the different inhaled puff was the nursing staff to follow the current information revealed the following ing Advair diskus inhaler, serious side effects, including: your mouth or throat (thrush), with water without swallowing it to help reduce your chance of regarding Transcription of	F 2	32		
F 318 SS=D	Physician's Orders Procedure revealed out as per physician	created 03/11 under d, "14. All orders will be carried n's orderas indicated" EASE/PREVENT DECREASE	F 3	18		10/2/15

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	PROVIDER OR SUPPLIER DELET VILLAGE CAF			STREET ADDRESS, CITY, STATE, ZIP (525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
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F 318	Based on the com resident, the facility with a limited range appropriate treatm	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase nd/or to prevent further	F 3	18			
	by: Based on interview failed to: (1) ensured decline in range of received services a plan of care; and, prevent further decone resident review sample of 26. Findings include: Review of R21's AR21 had diagnose unspecified cerebrowalking, depressivant generalized of Review of R21's Q (MDS) dated 3/11/extensive assistant toilet use, personal was totally dependent same MDS under Limitation in Range indicated R21 had motion on one side	w and record review, the facility e a resident with an identified motion (ROM) consistently and treatment identified in the (2) modify the interventions to cline in ROM for one (R21) of wed for ROM in the Stage 2 dmission Record indicated that is which included the following: ovascular disease, difficulty in e disorder, muscle weakness steoarthrosis. The transfers of the transfers of the ce with bed mobility, dressing, I hygiene and bathing; and, tent on staff for transfers. The Section G0400, Functional e of Motion was coded one that functional limitation of range of the of upper (shoulder, elbow, and lower extremity (hip, knee,		Resident #21 was compre reassessed for an exercise including PROM by an interest team including therapy. The recommendations and curricular participation was discussed #21 including risks and ber PROM program has been it assessments and care plarest to reflect the changes and communicated to the approximation of the new exercise program conducted weekly for 4 were ongoing as needed in conjugation and are reviewed functional ability and need functional ability and need functional Maintenance Programs of the RAI interdisciplinary reviews. Concept Functional Maintenance Programs of the RAI process on admission and updated in contents of the RAI process on admission and upon significations.	e program rdisciplinary e rent d with Resident nefits. A new initiated. The n was updated were opriate staff. mpliance with will be eks and then unction with the upon ant change in for changes in for ROM I process and are plans and ograms are onjunction with sion, quarterly,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 318	ankle, and foot). Review of R21's A (MDS) dated 6/10/extensive assistant toilet use and persidependent on staff same MDS under Limitation in Rangone for the upper wrist, and hand) the limitation in ROM of The same section the lower extremity that indicated R21 ROM on both side coding indicated the functional ROM with assessment to the Further review of 6/10/15 revealed A triggered the Care assessment of the and strengths). The R21's CAA for ADI mobility, balance [a [history] of CVA [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/stroke]I W/C [wheelchair] shop appointment impaired ability to impaired ROM R [ca accident/s	nnual Minimum Data Set (15, revealed R21 required (16), revealed R21 required (16), revealed R21 required (16), revealed R21 required (16), revealed R21 required (17), revealed R21, was totally (18), for bathing and transfers. The (18), Section G0400, Functional (19), eof Motion (ROM) was coded (19), extremity (shoulder, elbow, (19), at indicated R21 had functional (19), on one side of upper extremity. (19), of this MDS was coded two for (19), knee, ankle, and foot) (19), had functional limitation of (19), so of lower extremities. This (19), had a decline in (19), thin 90 days from the previous (19), and (19), and (19), are assessment (CAA - (19), are assessment (CAA - (19), are aled, "[R21] has impaired (19), and (1	F 31	status. Therapy evaluation as indicated and per physic IDT to review PROM progresident weekly for two monaddition, PROM programs reviewed in conjunction with process. Ongoing facility measures review of a Functional Main Program monthly and in continuous the RAI process. The care plan policy and Functional maintenance Plan/ROM por reviewed and are current. Staff are educated on the infunctional maintenance placare plan, My Best Day and instructions. Education for staff on follow plan and resident refusals benefits of FMP; swas inition ongoing. Audits regarding care plan conjunction with Functional Programs will be conducted weeks with results reported Assurance for ongoing conwill determine the need for auditing. The Clinical Administrator responsible for ongoing conversible for on	rams for each onths. In will be the the RAI to include IDT intenance onjunction with functional olicy have been and wind the dispecific wing the ROM and risks and the		

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F 318	answer. Review of the same considerationsDe problem/need on the rationale for care plands. [activities of combility [and] impair requires staff supposed for the staff supposed for	ge 13 CAA revealed, "Care Plan scribe impact of this in resident [R21] and your an decisionWill care plan for daily living], has impaired red ability to tolerate activities, out to meet her needs." Inited physical mobility" care 7/12 and revised on 8/27/15 erventions," "I have seated y. Do exercise 10 times on out. Tell [me] about my r] prior to my exercise time." In the Question Report of the clinical Care Coordinator	F3	118	Date certain for the purposes of or compliance is 10/02/15.	going	

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F 318	documentation that risks and benefits of seated exercises. Frelated to limited phot updated to refleseated exercises. In an interview with Charge Nurse (RN: 8:45am, RN2 indica assistants (RA) we refusing to do the sabout possible interefusing to get up, refusing, I could tall of pain or assess we choice or [she] just needed to be seated then we have to evecare or talk to there. Therapy could give the nurse practition. During the same in decline in the ROM RN2 stated, "It's had unavoidable becauted declining but ROM prevent decline. We further stated, "We try to avoid the decline in the result of the same in the result of the same in the ROM RN2 stated, "It's had unavoidable becauted lining but ROM prevent decline. We further stated, "We try to avoid the decline in the result of the same in the result of the same in the result of the same in the ROM prevent decline. We further stated, "We try to avoid the decline in the same in the result of the same in	edical record revealed no R21 was educated about the of refusing to perform the Review of R21's care plan hysical mobility revealed it was ect R21's refusals to do the the AM (morning) shift 2) on 8/28/15 at approximately ated that the resident re not reporting that R21 was eated exercises. When asked reventions since R21 has been RN2 further stated, "If she's k to the resident if it's because thy. Maybe it's just personal don't [sic] want to exercise. If and she's refusing to get up aluate and revamp the plan of apy and run it by them. suggestions and I will inform ter." terview when asked if the could have been avoided, and to say that it's avoidable or se some residents are just [exercises] could be done and e could always do better." RN2 could do whatever we can to	F 318			

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F 318 F 323 SS=G	PT1 stated, "Supine avoid decline in RC do the passive RON can help though no or at least do it duri program." Review of the facilit Motion Assessment revealed under Purability to maintain correvent further decompleting Range admission, quarterly Further review of the under Procedure, "Levaluated at least coindicated8. If any pain or discomfort, program or is unab recommended, it winterdisciplinary tea 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and	nendations she had for R21, a exercises sometimes can be but not all the time, at least of exercises which sometimes it always. Better than nothing ing cares even if not part of a cy's policy titled "Range of it Policy" last modified on 9/10 pose, "To maintain resident's urrent range of motion and/or line in range of motion by of Motion Assessment upon y and with significant change." The same policy also revealed complete the program as ill be communicated to the m." FACCIDENT	F 318			10/2/15
	This REQUIREMENT by:	NT is not met as evidenced				

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	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)) BE	(X5) COMPLETION DATE
F 323	Based on interview facility failed to: (1) initiate individualize to prevent falls; and safety measures as resident's multiple (fainting) episodes reviewed for falls in Findings include: 1. Review of R12's re-admission "Face "Diagnoses" indica facility on 5/6/15 wi included but were restigue, atrial fibrillar rhythm) and person Review of R12's fa Collection" dated 5 Status" revealed a spells, dizziness/vereview of the same reports fainting bef hypotension." Review of R12's fa [EHR] under "Nursi Effective Date 5/11 Position: Clinical Cadmitted from acut failure with hypoxia thoracentesis, afib valvual [sic] heart clasix with daily weig with 2 recent falls woof R12] is alert & of R12] is alert & of	vs and record reviews the identify individual risk factors, ad care plans and interventions d (2) implement and modify is needed to address a falls related to syncopal for one resident (R12) in the Stage 2 sample of 26. facility admission and a Sheet" dated 5/6/15 under ted R12 was admitted to the th admitting diagnoses that not limited to other malaise and ation (abnormal heart rate or	F 323	Resident #12 could not be comprehensively reviewed due to closed chart. Resident expired on prior to survey. Daily Interdisciplinary Meetings are assist in identifying resident's with change of condition or increased ff Care plans and My Best Days are updated at that time. All in-house residents identified a risk have been reviewed and care updated. Care plan interventions heen initiated for those residents of diagnosis of syncope as it relates falls/safety. All care plans are reviewed and up in conjunction with the RAI process admission, quarterly, annually and significant change in status. The care plan policy and the fall prevention policy have been reviewed are current. Comprehensive Data Collection as Risk Data Collection assessments been reviewed and is current. Education on care planning, comprehensive assessments and assessment, including a focus on syncope, has been initiated and is ongoing. Audits regarding care planning in conjunction with assessments will	5-19-15 e held to a all risks. as fall plans lave with a to odated s on upon wed and have fall have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245617	B. WING			08/2	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	, 00/-	0, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	talker & written note with A [Assist] of 1 a 4WW[wheeled walk has made progress Therapist] has start FMP[Functional Markeview of R12's facindicated "General 14:19 Department: Created by: [Name was taken out by note of a follow up chest that she received a fall at the clinic and ER" Review of the hosp documents that we records on the facil Department Staff/P "Relevant HPI[Histowas in clinic today a eventWhile await bathroom with nurs syncopal event." B.The hospital's R12 under "History revealed "who was because of a fainting and had issues with apparently fainted C.Review of R1 Doctor] Progress N	es on white board. Transfer & walks with A of 1& cer]. Is working with Rehab & since admitted. PT [Physical ing [sic] walking program per intenance Program]. " cility's EHR under "Nursing" Notes Effective Date: 5/12/15 Nursing Position: RN/LPN of RN] "[Name of Resident] ephew today to primary clinic at x ray. Niece, here and stated call that [name of R12] had a was being transported to the ital transfer discharge re part of R12's medical ity revealed the following: s 5/12/15 "Emergency hysician Notes" for R12 under ory of Present Illness]" Patient and had a near syncopal ing admission, patient up to e and had another near s 5/13/15 "Consult Notes" for of Present Illness (HPI)" is brought to the hospital ing spellShe was feeling weak in orthostatic hypotensionshe	F3	223	conducted weekly for 4 weeks with reported to Quality Assurance for compliance and will determine the for further auditing. The Clinical Administrator or design responsible for ongoing compliance. Date certain for the purposes of on compliance is 10/02/15.	ngoing need nee is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		E SURVEY IPLETED
		245617	B. WING			08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 125 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE
F 323	A. Hx [History] of O Review of R12's fac "Comprehensive Da" "Resident Demogra re-admitted to the factorial forms of the Neurological Status next to fainting spel weakness." Review of R12's "M Record" from 5/1/19 received Coumadin on the following dat R12 also received C 5/17/15. Review of "Coumac on 10/11 from Brist of Coumadin) indicated ing" Further under "Medication Chave a higher risk of Coumadin and: are trauma such as accomprovider right away bleeding problems: headaches, dizzine bruising [bruises the cause or grow in siz gumsred or black material that looks of Review of R12's fact Risk Data Collectio "Internal Risk Factorial forms of the comprehension of R12's factorial first page 12.5 factorial	H [orthostatic hypotension]" cility medical record titled ata Collection" under aphics" revealed R12 was acility on 5/14/15 at 2pm. e same document under "J." indicated a check marked als, dizziness/vertigo and dedication Administration 5 to 5/31/15 indicated R12 [a blood thinner] tablet 2.5mg ares: 5/8/15, 5/11/15, 5/15/15. Coumadin 5mg on 5/16/15 and din's Package Insert" revised of Myer's website (the makers	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245617	B. WING		08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	indicated the reside prior to the re-admithough R12 was achospital on 5/12/15 Further review of th "Summary of Risk a history of falls, the days ago while out appointmentStaff resistive to cares a ambulate with a tramonitor." Review of R12's er Plan [IRCP] [Initiate 5/6/15 under "Prob [related to]" was chin the blank space have been listed. Funder "Intervention monitor for safety. intervention to addisyncopal episodes. document indicated the only interventio instruct R12 to ask Review of R12's or revealed that there addressed R12's under "R12's under "R	ent had no episodes of either ission to the facility even dmitted emergently to the due to syncopal episodes. The same document under factors" indicated, "She has emost recent being several to a doctors [sic] in noted that resident was not would not allow staff to help insfer belt. Will continue to the within 24 hours]" dated lem" indicated, "Fall Risk R/T lecked but there was no entry where fall risk factors should deview of the same document s" indicated a check next to There was no specific ress R12's falls related to her. Further review of the same dit was revised on 5/18/15 and in that was added was to for help.	F 323	3		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		COMPLETED			
		245617	B. WING			08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	no mention about Fincreased risk of bloom 10 mention about Fincreased risk of bloom 10 mention 10 m	R12's anti-coagulant use and	F3	23			
	therapy was not inc	luded in the risk factors or ed. The DON replied that the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245617	B. WING _		08/	28/2015
	PROVIDER OR SUPPLIER DELET VILLAGE CAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	nursing staff were and symptoms of the anti-coagulant use hemorrhage. The Ewould the nursing anti-coagulant there one of R12's risk far was not addressed Best Day." The DO anti-coagulant there would not hurt and importance especial On 8/28/15 at appreasked about the lace R12's use of anti-coagulant there was anti-coagulant there anti-coagulant there are leading to the lace R12's use of anti-coagulant there was for falls." electrom the US Nation National Institute of "Conclusion" reveas should not automatic being treated with a dictate anticoagular management of fall part of anticoagular should be made to 2. A. Review of R12" Nursing" indicated Date: 5/17/2015 23 Position: RN/LPN 00:49:07 Description hitting her bottom for the part of anticoagular should be made to 2. A. Review of R12" Nursing" indicated Date: 5/17/2015 23 Position: RN/LPN 00:49:07 Description hitting her bottom for the part of	educated to look for the signs he side effects of like bruising, bleeding and DON was further asked how staff knew if R12 was on apy if it was not identified as actors, not care planned and in the nursing assistants' "My N replied that putting the apy as one of the risk factors that he understood its ally with R12's fall history. Oximately 8:45am, RN1 was ck of care plan to address bagulant therapy. RN1 stated yould develop the apy care plan on day 21. Itiled "Use of anticoagulation in a trial fibrillation who are at conically published on 3/11/08 and Library of Medicine and f Health website under led "The risk of falls alone tically disqualify a person from warfarin. While falls should not ant choice, assessment and I risk should be an important tion management. Efforts	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245617	B. WING _		08/	28/2015	
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	spirits and said she buttock hurt the mofirst. She denies hit Pain level was mocher up to her bed vpack and Acetamin 1000mg Acetamino Further review of the further assessment occured because FON 8/26/15 at appralso asked if the care R12's fall on 5/17/1 episodes were add have to admit that vimportant to have to initiate a tempora admission8. Interhelp meet the goal individualized" Further the procedure of the faciliary revised indicated, "It is the to initiate a tempora admission8. Interhelp meet the goal individualized" Further the occurrence reports occurred the factorsii. and changes to pla fall" B. Review of R12's dated 5/19/15 at 9: [sic] into resident's Assistant] stating services and said stating services and said stating services and said stating services and said said said said said said said sai	e did not feel hurt. She said her est and that it hit the ground ting her head during the fall. derate 4/10. RA and I assisted ia mechanical lift. Offered ice ophen - she agreed to take	F 32	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245617				08	08/28/2015		
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 323	(R) side with blood side of head as wel tubing was wrapped her torso. Large he Extremities discolor purple and UTD[un [vital signs]. No per Verified death by no 5/19/15" Review of the "Cord facility indicated R1 multiple trauma and On 8/27/15 at approwas asked about R responded that it we tubing. When asked	all over her right (R) hand and I as on the floor. Oxygen d around her legs and under matoma on (R) back of head. red and cool to touch. Lips able to determine [sic] VS ipheral pulses or respirations. AP [apical pulse] at 0415 on oner's Report" provided by the 2's cause of death were from d falls. Description of the DON 12's fall on 5/19/15. The DON as from R12's long oxygen d about R12's syncopal verbalized, "Honestly, I did	F3	23				

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P108

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I - TO BE COMPLETED BY THE STATE						TE 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 CENT (L4) 525 FAIRVIEW AVENUE SOUTH (L5) SAINT PAUL, MN		(L6) 55116		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWN (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 07/23/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	45 (L18) 45 ^(L17)	B. Not in Comp	ce With quirements	m	2. Tech 3. 24 H 4. 7-Da	nnical Personnel		ector	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY M	EETS			
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE Date :					18. STATE SUR	EVEY AGENCY APPROVAL Date:			
Robyn Wolley,	HFE NE II		08/05/2015	(L19)	Kate JohnsTon, Program Specialist 08/26/2015 (L20)				
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part		20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE 23. LTC AGREEME OF PARTICIPATION BEGINNING I 08/27/2012				26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure		(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety			
(L24)	(L24) (L25)					n W/ Reimbursemen	nt 06-Fail to M	Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44)					03-Risk of Involu	•	OTHER 07-Provide 00-Active	er Status Change	
(L27) B. Rescind Suspension Date:									
			(L45)						
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.					30. REMARKS				
03001 (L28) (L31)									
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE					Posted 09/01/2015 Co.				
(L32) (L33)					DETERMINATION APPROVAL				



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

PRINTED: 09/22/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245617		B. WING			07/23/2015	
NAME OF PROVIDER OR SUPPLIER CARONDELET VILLAGE CARE CENTER				52	REET ADDRESS, CITY, STATE, ZIP CODE 5 FAIRVIEW AVENUE SOUTH AINT PAUL, MN 55116	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	000			
	22, 23, 2015. Caror compliance with 42	was conducted on July 20, 21, ndelet Village Care Center is in CFR Part 483, subpart B, ong Term Care Facilities.					
	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that you of the electronic documents.					

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.

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

TITLE

(X6) DATE

1-5617004

Printed: 07/24/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - CARONDELET VILLAGE CARE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED CENTER 245617 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 SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLÉTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 **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.

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.