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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: T9BF

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245617**

2.STATE VENDOR OR MEDICAID NO.
(L2) **550012400**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/24/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Capes, HFE NE II — 09/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 09/26/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5617

Electronically Delivered: September 26, 2014

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

Dear Ms. Ballard:

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

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

Effective September 19, 2014, the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 26, 2014

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

RE: Project Number S5617001

Dear Ms. Ballard:

On August 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 26, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2014, effective September 19, 2014 and therefore remedies outlined in our letter to you dated August 18, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245617	A. Building B. Wing	9/24/2014

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/10/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **09/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/10/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/10/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	09/26/2014	22580	09/24/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/7/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
27189	A. Building B. Wing	9/24/2014

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **09/10/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **09/10/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	Correction Completed **09/10/2014**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 AB(** LSC	Correction Completed **09/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	09/26/2014	22580	09/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/7/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245617	A. Building B. Wing 01 - CARONDELET VILLAGE CARE CENTER	9/26/2014

Name of Facility	Street Address, City, State, Zip Code
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0050	Correction Completed **09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **09/19/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 09/26/2014	**Signature of Surveyor:** 12424	**Date:** 09/26/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/12/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 26, 2014

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

Re: Reinspection Results - Project Number S5617001

Dear Ms. Ballard:

On September 24, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T9BF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245617**

2.STATE VENDOR OR MEDICAID NO.
(L2) **550012400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/07/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 09/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/17/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: August 18, 2014

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

RE: Project Number S5617001

Dear Ms. Ballard:

On August 7, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 16, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 7, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic correspondence.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	08/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R8), reviewed for activities of daily living [ADLs], had morning cares completed according to the plan of care. Findings include: Review of R8's most recent Minimum Data Set (MDS), dated 5/21/14 revealed R8 required limited assistance with one staff providing physical assistance for personal hygiene.	F 282	Resident #8 care plan and My Best Day was comprehensively reassessed for activities of daily living (ADL□s) and show to be accurate for current interventions. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon a significant change in status. The care plan policy has been reviewed and is current. Education on care plans completed for	9/10/14

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

Electronically Signed | 08/27/2014

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F 282	Continued From page 1 R8's ADL plan of care, last revised 12/6/13, indicated R8 had an ADL self care performance deficit related to requiring assistance with dressing, grooming, and bathing related to history of a stroke and directed staff, "Please assist me with washing my R [right] hand and drying thoroughly BID [twice a day]" and "Personal Hygiene/Oral Care: I require 1 staff participation with personal hygiene and oral care." During interview on 8/4/14 at 4:50 p.m. a friend of R8's, (F)-A, reported she worried R8 was not getting her hands washed, which particularly concerned her for toilet use, bathing and eating. F-A pointed out the right hand, which was curled after a stroke, was particularly neglected. Observation on 8/6/14 at approximately 9:00 a.m., two nursing assistants, (NA)-A and (NA)-B provided cares for R8. R8's right hand splint was removed. NA-A and NA-B provided assist with toileting and then assisted R8 with setting up a breakfast tray. NA-A did not wash or offer for R8 to have hands, face and/or upper body washed. At approximately 10:20 a.m. NA-A and NA-B returned to R8's room to complete morning cares. R8's hands, face and upper body were not washed. On 8/6/14 at approximately 1:30 p.m., during interview, NA-A reported she did not wash R8's hands as they did not look dirty and R8 is protective of her right hand. NA-A said she did not do so as it was not in R8's "My Best Day" plan of care for nursing assistants. Review of R8's, My Best Day form, last revised 6/2/14 directed staff R8 required assist of one for grooming and "I usually like to sleep in until 8:30 a.m. Then I brush my teeth, comb my hair, wash	F 282	nursing staff on 8-27-14 and is ongoing. Audits regarding care plan interventions being followed by direct observation of cares will be conducted 4x/week for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 9-10-14.	

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F 282	Continued From page 2 up and get dressed." No specific directions on cleaning of right hand were included. Interview, on 8/7/14 at 1:45 p.m. the charge nurse (RN)-A, reported she would expect staff to clean R8's hands during morning and evening cares. Interview, on 8/7/14 at 2:18 p.m. the director of nursing (DON) confirmed R8's hands should be washed as a standard of care during morning cares.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R8) reviewed for activities of daily living [ADLs], received the required assistance with morning cares. Findings include: Review of R8's most recent ADL care area assessment, dated 11/28/13, revealed "Requires staff support for ADLs/Mobility RT [related to] CVA [stroke] and hemiplegia" [Hemiplegia is paralysis of the arm, leg, and trunk on the same side of the body.] Review of R8's most recent Minimum Data Set (MDS), dated 5/21/14, revealed R8 required	F 311	Resident #8 care plan and My Best Day was comprehensively reassessed for activities of daily living (ADL□s) and show to be accurate for current interventions. All care plans are reviewed and updated in conjunction with the RAI process on admission, quarterly, annually and upon a significant change in status. The care plan and resident care policy has been reviewed and is current. Education on care plans has been completed for nursing staff on 8-27-14 as is ongoing. Audits regarding care plan interventions	9/10/14

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F 311	Continued From page 3 limited assistance with one staff providing physical assistance for personal hygiene. R8's activities of daily living [ADL] plan of care, last revised 12/6/13, directed staff "I have an ADL self care performance deficit r/t [related to] I require assitance [sic] with dressing, grooming, and bathing related to hx CVA [stroke]. I have my own natural teeth." with further interventions of "Please assist me with washing my R [right] hand and drying thoroughly BID [twice a day]" and "Personal Hygiene/Oral Care: I require 1 staff participation with personal hygiene and oral care." R8's My Best Day form, last revised 6/2/14 directed staff R8 required assist of one for grooming and "I usually like to sleep in until 8:30 a.m.. Then I brush my teeth, comb my hair, wash up and get dressed." No specific directions on cleaning of right hand were included. During interview on 8/4/14 at 4:50 p.m. a friend of R8's, (F)-A, reported she worried R8 was not getting enough help with grooming, particularly hands washed, which concerned her for toilet use, bathing and eating. F-A pointed out the right hand, which was curled after a stroke, was particularly neglected. Observation on 8/6/14 at approximately 9:00 a.m. revealed two nursing assistants, (NA)-A and (NA)-B removed R8's hand splint, assisted her with removing a soiled brief, cleaned R8's front and then back perineal area. NA-A then assisted with setting up a tray of breakfast food on it, including removing drink covers and buttering toast. R8 was then left to independently eat breakfast in bed. NA-A did not wash or offer R8's	F 311	will be conducted 4x/week for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 9-10-14.	

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F 311	Continued From page 4	F 311		

to be hands, upper body or face after removing her hand splint or prior to serving her breakfast. At approximately 10:20 a.m. NA-A and NA-B returned to R8's room, put on R8's stockings and assisted R8 in sitting up and walking to the bathroom with a cane. R8 was assisted to sit on the toilet. R8 was assisted in cleaning her perineal area and getting her brief and pants on while on the toilet, was transferred to her wheelchair and then assisted with getting her bra and shirt on. NA-A then prepped R8's toothbrush and left her to brush her teeth. R8's hands, upper body and face were not washed after using toilet and prior to brushing her teeth. NA-A then returned and assisted in combing R8'S hair and moved R8 to the living area in her room to watch tv in her wheelchair. R8's hands were not washed at this time. NA-A told R8 she would have lunch in about 20 minutes. On 8/6/14 at approximately 1:30 p.m. NA-A reported she did not wash R8's hands as they did not look dirty and R8 is protective of her right hand. NA-A said she did not do so as it was not in R8's "My Best Day" plan of care for nursing assistants.

Interview, on 8/7/14 at 1:45 p.m. the charge nurse (RN)-A, reported she would expect staff to clean R8's hands during morning and evening cares.

On 8/7/14 at 2:18 p.m. the director of nursing (DON) confirmed R8's hands should be washed as a standard of care during morning cares. R8's hands were observed with DON and no skin breakdown was observed.

Review of the Resident Care policy, last revised 9/3/10, directed staff "Every resident to have A.M [morning] and HS [night] cares done daily." "3. Wash residents face and hands and dry." "4.

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F 311	Continued From page 5 Wash residents back, under arms and breasts, and under abdominal folds and dry."	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide justification for ongoing use of a psychotropic medication based on evaluation of resident's behavior, and failed to provide a minimum effective dosage of a	F 329	Resident #20 non-pharmacological interventions related to psychoactive medication was reviewed. Care plan was updated and is accurate and effective. Resident #20 My Best Day was reviewed	9/10/14

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F 329	Continued From page 6 psychotropic medication or adequate rationale for declining a dose reduction recommendation for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: Record review for R20, on 8/7/13, revealed physician's orders for trazodone (an antidepressant) 50 mg. every evening, dated 5/23/12; lorazepam (an antianxiety) 1 mg. every six hours as needed for anxiety, dated 12/26/13; mirtazapine (an antidepressant) 15 mg. every evening; and quetiapine (an antipsychotic) 12.5 mg. every morning for acute delirium (a temporary state of confusion and change in consciousness). An order for lorazepam 1 mg. every evening had just been discontinued on 8/6/14. The Psychoactive Medication Informed Consent Form for the quetiapine, dated 7/10/14, did not contain a reason for the use of the quetiapine (Seraquel). The Medication Informed Consent Form for the trazodone, dated 5/31/12, showed restlessness as the reason for use. The Medication Administration Record forms for this resident for July 2014 and August 2014 showed that R20 received all these medications as ordered. The target behavior section of the Medication Administration Record forms for July 2014 and August 2014 for R20 listed the target behavior monitored for quetiapine use as "calling out," and listed the target behaviors for trazodone as "inability to sleep, restless, yelling, cursing at	F 329	and is accurate and effective. Quetiapine for Resident #20 was discontinued on 8-20-14. Request for Trazodone dose reduction sent 8-26-14. All Residents receiving antipsychotics have been reviewed by consulting pharmacist and care planned for non-pharmacological interventions. Temporary care plan to be initiated with any new psychoactive medication order or dose increase. Temporary care plan to include monitoring and documenting effectiveness of non-pharmacological interventions. Policy and procedure regarding psychoactive medication in relation to administering, monitoring and documentation has been reviewed and is accurate. Education on unnecessary medications, monitoring and documentation of effectiveness has been completed for nursing staff on 8-27-14 and is ongoing. Audits regarding monitoring and documentation related to unnecessary medications will be conducted 4x/week for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance.	

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F 329	Continued From page 7 others." The physician provided a letter, dated 8/7/14, that read, "I am asked to justify and give rationale for the use of Seroquel (quetiapine) for [R20] who is in a skilled nursing facility with symptoms of profound depression and previous CVA with hemiparesis. The patient has been extremely agitated, has been crying out and is causing a great deal of disruption due to wailing and crying out. As noted, I elected to begin an extremely low dose of quetiapine and will follow her response closely. I am happy to report that this has been very successful at alleviating symptoms as of this dictation of 8/7/14." Review of the target behavior monitoring section for the quetiapine on the July 2014 Medication Administration Record showed that R20 exhibited no calling out behavior from 7/11/14 to 7/17/14. For the remainder of July 2014 the behavior of calling out increased to one shift a day, except for 7/19/14 and 7/26/14, when calling out was documented on two shifts per day. Target behavior monitoring for the first week of August 2014 was documented in the progress notes of the record and showed 12 entries of the resident calling out from 8/2/14 to 8/7/14. In a Consultant Pharmacist Communication to Physician form, dated 4/29/14, the facility's consultant pharmacist made the recommendation that read, "[R20] is currently receiving lorazepam 1 mg qhs [every evening], and trazodone 50 mg qhs. She has not had concerns with sleep noted in her charting. In an effort to determine a minimum effective dose for [R20] please assess if a trial reduction in her trazodone dose would be appropriate at this time-perhaps to 25mg qhs. If	F 329	Date certain for the purposes of ongoing compliance is 9-10-14.	

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F 329	Continued From page 8 a dose reduction trial would not be appropriate at this time please document for the facility why this would not be in [R20]'s best interest." The facility made several attempts to get a response to this recommendation from the physician, and on 6/17/14 the physician replied, "No change." There was no rationale for this decision provided by the physician, and no further documented attempt of the facility attempting to acquire rationale from the physician. When interviewed on 8/7/14, at 10:00 a.m., the clinical administrator stated that he was unsure as to why the resident was continuing to receive quetiapine for acute delirium. He stated that this resident's physician has a history of not responding to staff at this facility, but the family wants to keep the physician. The clinical administrator also stated that he has spoken with the medical director in the past regarding this physician. When interviewed on 8/11/14, at 10:25 a.m., the facility's consulting pharmacist stated that acute delirium is an appropriate indication for the use of quetiapine. He went on to explain that the question that would need to be answered for this resident is whether or not the delirium had resolved. He then stated that the behavior of calling out would not be an appropriate indication for the use of quetiapine.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		9/10/14

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F 428	Continued From page 9 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not thoroughly act upon the recommendation of the consulting pharmacist and the consulting pharmacist did not advise the facility of irregularities in the medication regimen of 1 of 5 residents (R20) reviewed for unnecessary medication. Findings include: Record review for R20, on 8/7/13 revealed physician's orders for trazodone (an antidepressant) 50 mg. every evening, dated 5/23/12; lorazepam (an antianxiety) 1 mg. every six hours as needed for anxiety, dated 12/26/13; mirtazapine (an antidepressant) 15 mg. every evening; and quetiapine (an antipsychotic) 12.5 mg. every morning for acute delirium (a temporary state of confusion and change in consciousness). An order for lorazepam 1 mg. every evening had just been discontinued on 8/6/14. The Psychoactive Medication Informed Consent Form for the quetiapine, dated 7/10/14, did not contain a reason for the use of the quetiapine. The Medication Informed Consent Form for the trazodone, dated 5/31/12, showed restlessness as the reason for use.	F 428	The facilities consulting pharmacist was notified on 8-8-14 regarding Resident #20 in terms of the lack of monitoring and documentation of effectiveness of non-pharmacological interventions related to the use of psychoactive medications. Pharmacist consultant will monitor the facilities documentation for effectiveness of non-pharmacological measures in relation to psychoactive medications monthly. Resident #20 non-pharmacological interventions related to psychoactive medication were updated and are accurate and effective. Resident #20 care plan and My Best Day were reviewed and are accurate. All Residents receiving antipsychotics have been reviewed by consulting pharmacist and care planned for non-pharmacological interventions. Temporary care plan to be initiated with any new psychoactive medication order or dose increase. Temporary care plan to include monitoring and documenting effectiveness of non-pharmacological interventions.	

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F 428	Continued From page 10 The Medication Administration Record forms for this resident for July 2014 and August 2014 showed that R20 received all these medications as ordered. The target behavior section of the Medication Administration Record forms for July 2014 and August 2014 for R20 listed the target behavior monitored for quetiapine use as "calling out," and listed the target behaviors for trazodone as "inability to sleep, restless, yelling, cursing at others." The physician provided a letter, dated 8/7/14, that read, "I am asked to justify and give rationale for the use of Seroquel (quetiapine) for [R20] who is in a skilled nursing facility with symptoms of profound depression and previous CVA with hemiparesis. The patient has been extremely agitated, has been crying out and is causing a great deal of disruption due to wailing and crying out. As noted, I elected to begin an extremely low dose of quetiapine and will follow her response closely. I am happy to report that this has been very successful at alleviating symptoms as of this dictation of 8/7/14." Review of the target behavior monitoring section for the quetiapine on the July 2014 Medication Administration Record showed that R20 exhibited no calling out behavior from 7/11/14 to 7/17/14. For the remainder of July 2014 the behavior of calling out increased to one shift a day, except for 7/19/14 and 7/26/14, when calling out was documented on two shifts per day. Target behavior monitoring for the first week of August 2014 was documented in the progress notes of the record and showed 12 entries of the resident	F 428	Policy and procedure regarding psychoactive medication in relation to administering, monitoring and documentation has been reviewed and is accurate. Education on unnecessary medications, monitoring and documentation of effectiveness has been completed for nursing staff on 8-27-14 and is ongoing. Audits regarding monitoring and documentation related to unnecessary medications will be conducted 4x/week for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 9-10-14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	08/07/2014

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

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F 428	Continued From page 11 calling out from 8/2/14 to 8/7/14. In a Consultant Pharmacist Communication to Physician form, dated 4/29/14, the facility's consultant pharmacist made the recommendation that read, "[R20] is currently receiving lorazepam 1 mg qhs [every evening], and trazodone 50 mg qhs. She has not had concerns with sleep noted in her charting. In an effort to determine a minimum effective dose for [R20] please assess if a trial reduction in her trazodone dose would be appropriate at this time-perhaps to 25mg qhs. If a dose reduction trial would not be appropriate at this time please document for the facility why this would not be in [R20]'s best interest." The facility made several attempts to get a response to this recommendation from the physician, and on 6/17/14 the physician replied, "No change." There was no rationale for this decision provided by the physician, and no further documented attempt of the facility attempting to acquire rationale from the physician. The consulting pharmacist's Record of Medication Regimen Review form showed that the consulting pharmacist had visited the facility and completed a medication regimen review for this resident on 7/28/14. The pharmacist made note of the new quetiapine order of 7/10/14, but there was no recommendation in the record regarding the use of the quetiapine for calling out behavior. When interviewed on 8/7/14, at 10 a.m. the clinical administrator stated that he was unsure as to why the resident was continuing to receive quetiapine for acute delirium. He stated that this resident's physician has a history of not responding to staff at this facility, but the family	F 428		

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F 428	Continued From page 12 wants to keep the physician. The clinical administrator also stated that he has spoken with the medical director in the past regarding this physician, but did not know if any action was taken by the medical director. When interviewed on 8/11/14, at 10:25 a.m., the facility's consulting pharmacist stated that acute delirium is an appropriate indication for the use of quetiapine. He went on to explain that the question that would need to be answered for this resident is whether or not the delirium had resolved. He then stated that the behavior of calling out would not be an appropriate indication for the use of quetiapine and he will advise the facility of this irregularity.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		9/10/14

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F 441	Continued From page 13 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff hand hygiene was completed during morning cares for 1 of 2 residents (R8) observed for cares. Findings include: The facility failed to ensure staff hand hygiene was completed during morning cares for R8. Observation on 8/6/14 at approximately 9:00 a.m. revealed two nursing assistants, (NA)-A and (NA)-B removed R8's hand splint, assisted her with removing a soiled brief, cleaned R8's front and then back perineal area. NA-A then removed her gloves, but did not wash her hands. NA-A then assisted with setting up a tray of breakfast food on it, including removing drink covers and buttering toast. NA-A put on gloves after taking	F 441	Staff member caring for resident #8 was immediately re-educated on hand washing and glove use upon notification. The infection control policy and procedures, including hand hygiene has been reviewed and I current. Education on hand hygiene has been completed for nursing staff on 8-27-14 and is ongoing. Audits regarding resident care observations will be conducted 4x/week for 4 weeks with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing.	

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F 441	Continued From page 14 covers off drinks but before buttering toast. R8 was then left to independently eat breakfast in bed. NA-A did not wash or offer R8's hands to be cleaned after removing her hand splint or prior to serving her breakfast. Following cares, NA-A, confirmed she did not perform hand hygiene following perineal cares and before setting up R8's breakfast tray. During interview, on 8/7/14 at 9:30 a.m. the director of nursing [DON] reported he would expect staff to perform hand hygiene after performing perineal care and prior to setting up a breakfast tray. Review of the facility Hand Hygiene Policy, dated 8/8/14, directed staff "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are work; immediately after gloves are removed and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment." "Specific examples of situations in which hand washing must be used include but are not limited to: "3. Before touching medication or food to be given to a resident." and "Before and after providing personal cares to a resident (e.g. peri-care, bathing, oral cares)."	F 441	The Clinical Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 9-10-14.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. 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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2014

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		9/19/14

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K 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire Findings include: During the facility tour between 09:00 AM and 1:00 PM on 08/12/2014, based on review of available documentation it was reveled that fire drills have not been conducted on a one per shift per quarter basis. No night shift fire drills were conducted during the 1st quarter of 2014. This deficient practice was confirmed by the facility Maintenance Director at the time of discovery.	K 050	The facility will conduct fire drills with frequencies and timings as required by NFPA 101 LSC (2000) including at least once per shift per quarter at varying times and conditions. These fire drills will be conducted by the Environmental Services Director or his proxy. The fire drill schedule will be entered into the electronic work order scheduling system to ensure completion. The fire drill schedule will also be entered into the care center administrators and the campus administrators electronic calendars. The care center administrator and the campus administrator will verify that the fire drills were conducted as required. The safety committee will review fire drill reports quarterly for accuracy and timeliness. Date certain for the purposes of ongoing compliance is 9-19-14.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		9/19/14

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on a review and interview of available documentation, the emergency generator is not being properly load tested on annual basis. Findings include: During the facility tour between 09:00 AM and 1:00 PM on 08/12/2014, based on interview, and review of documentation with the facility Administrator (RB) and Director of Facility Maintenance (PM), there was no documentation that the emergency generator is being tested to ensure that the normal operating temperature of the engine is being reached, of that 30% of the name plate rating is being reached as required by LSC(00) and NFPA 99 (99). This deficient practice was confirmed by the facility Maintenance Director at the time of discovery.	K 144	The generator will be tested as required by the NFPA 101 LSC (2000) whereas once per year the generator will be connected to a sufficient load to meet or exceed 30% of the nameplate rating to ensure the operating temperature requirements are met for load bank testing. This testing will be arranged by the Environmental Services Director or his proxy. The schedule for this testing will be entered into the electronic work order scheduling system to ensure completion. The schedule for load testing the generator will be entered into the care center administrators□ and campus administrators□ electronic calendar. The care center administrator and campus administrator will verify that the load testing of the generator was completed as required. The safety committee will review the results of the load testing for accuracy and timeliness. Date certain for the purposes of ongoing compliance is 9-19-14.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: August 18, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5617001

Dear Ms. Ballard:

The above facility was surveyed on August 4, 2014 through August 7, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697