

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered January 20, 2022

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

RE: CCN: 245617 Cycle Start Date: December 7, 2021

Dear Administrator:

On January 13, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

M. Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 20, 2021

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

RE: CCN: 245617 Cycle Start Date: December 7, 2021

Dear Administrator:

On December 7, 2021, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. 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.

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

The state agency may, in lieu of an onsite 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:

Carondelet Village Care Center December 20, 2021 Page 2

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: jamie.perell@state.mn.us Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 7, 2022 (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).

Carondelet Village Care Center December 20, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by June 7, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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. Feel free to contact me if you have questions.

Sincerely,

· Juig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPARTMENT (OF HEALTH	AND HUMAN SERVICES		F		APPROVED
CENTERS FOR	MEDICARE	& MEDICAID SERVICES		C	MB NO.	. 0938-0391
STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245617	B. WING _			C 07/2021
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONDELET VI	LLAGE CAR	E CENTER		525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
PREFIX (EAG	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000 INITIAL	COMMEN	rs	F 00	00		
conduc to be N 42 CFF	ted at your f OT in comp	dard abbreviated survey was facility. Your facility was found liance with the requirements of art B, Requirements for Long s.				
SUBST	ANTIATED: 18C (MN00	plaint was found to be 0078964), with a deficiency				
as your Departr enrolled at the b form. Yo	allegation of nents accept in ePOC, yo ottom of the our electron	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.				
onsite r validate regulati F 689 Free of	evisit of you that substa ons has bee	azards/Supervision/Devices	F 68	39		12/30/21
The fac §483.25						
supervi accider This RE by:	sion and as ts. EQUIREME	resident receives adequate sistance devices to prevent NT is not met as evidenced				
Based	on interviev	v and document review, the		Carondelet Village 2021 Plan of		
LABORATORY DIRECTO		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 12/28/2021

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.

		AND HUMAN SERVICES				FORM	01/04/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED C
		245617	B. WING				07/2021
NAME OF F	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAROND	ELET VILLAGE CAR	E CENTER			25 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	directed by the care reviewed for falls. Findings include: R1's quarterly Minir 11/10/21, indicated impairment and dia Disease, cerebral in hemiparesis (weak one side of the bod required total physic transfers, was not s stabilize with human R1's fall Care Area 8/12/21, indicated F to impaired mobility R1 had difficulty ma R1's care plan date incontinent of bladc assistance with toile directed R1 was no restroom. R1's Nursing Assist 11/19/21, indicated incontinent cares in Task Sheet lacked alone in the bathroo	Inum Data Set (MDS) dated R1 had a moderate cognitive gnoses of Alzheimer's infarction (stroke) and ness or inability to move on y) to the right side. Further, R1 cal assistance of two staff for steady, and only able to in assistance. Assessment (CAA) dated R1 was at risk for falls related y, incontinence, and dementia. aintaining balance while sitting. Id 11/16/21, indicated R! was ler and bowel and needed eting. The care plan also t to be left alone in the tant Task Sheet dated R1 required R1 required i bed. The Nursing Assistant indicated R1 was not to be left om. gress notes revealed: 1 a.m. indicated R1 had a fall	F	\$89	Correction The Credible Allegation of Complia has been prepared and timely sub Submission of the Credible Allegat Compliance is not a legal admission deficiency exists or that the Statem Deficiencies were correctly cited, a also not to be construed as an adma against interest of the Facility, its Administrator, or any employees, a or other individuals who draft or man- discussed in this Credible Allegation Compliance. In addition, preparations submission of this Credible Allegations Compliance does not constitute ar admission or agreement of any kind the facility of the truth of any of the alleged or the correctness of any conclusions set forth in this allegated the survey agency. F689: The Agreement for Clinical Experised contract (effective 10/5/2015) was reviewed and remains current. R1 was reassessed for bowel and to ensure that the care plan remaind appropriate. A facility audit was completed on and current residents to ensure there is continuity between care plans and and and for a plans and and a facility and and helder plans.	mitted. ion of on that a nent of ind is nission agents, ay be on of on and ion of facts ion by ence bladder ns	
	- 11/21/21, at 11: transferred to the b	athroom using a full lift with vo student nurses. R1 was			guides for bowel and bladder plans Training was completed with nursin nursing assistant staff regarding th	ng and	

Facility ID: 27189

If continuation sheet Page 2 of 6

TATEMENT	OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	0938-039 E SURVEY PLETED
		245617	B. WING			C 0 7/2021
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONI	DELET VILLAGE CAF	RECENTER		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)	DBE	(X5) COMPLETIC DATE
F 689	given privacy to sit checks. R1 was for hearing a loud ban door. An Occurrence Re a factor regarding I plan of care. During an interview nursing assistant (I on R1's unit on 11/ with nursing studer student nurses we The nursing studer and went into R1's offered to help, but was not sure what complete for R1. T room while their cli was on the comput stated she was sur bathroom as R1 wa and incontinence c was in bed. NA-A w students were able how they were ass During an interview stated on 11/21/21 nurses scheduled a nurses for two of e shadow during thei she spoke with reg utilize the two rema not have a nurse to made to have the t	on the toilet with frequent und on the bathroom floor after g from the students outside the port dated 11/21/21, indicated R1's fall was not following R1's on 12/7/21, at 12:19 p.m. NA)-A stated she was working 21/21. She had not worked the before and believed the re helping with resident cares. Its asked for R1's care sheet room for cares. NA-A had was declined. Further, NA-A cares the students intended to he students went into R1's nical instructor (CI)-A, who ter, sat outside the room. NA-A prised when R1 fell in the as too weak to use the toilet ares were provided when R1 vas not aware of what nursing to do when in the facility or	F 68	9 clinical experience for nursing stu The training illustrated the roles o floor nurse during the clinical exp and prohibits students from using mechanical devices. Training will completed with any student group including the students and instruc- prior to beginning their time on the This is identified in a Student Orie Toolkit provided by the facility. Administrator and Regional Clinic Director met with school faculty to education that will be provided pri students beginning their time lear the facility. Random audits of the clinical experiences will take place staff and students. Audits will be r at the next QA meeting for ongoin compliance and determine need fo ongoing compliance.	f the erience be os, tors, e floor. entation al discuss or to ning in student e with reviewed	

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES				FORM	APPROVED		
		& MEDICAID SERVICES	. <u> </u>				0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY IPLETED		
		045647					С		
		245617	B. WING			12/0	07/2021		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
CAROND	ELET VILLAGE CAR	E CENTER			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 689	Continued From pa	ae 3	F 6	389)	OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE			
		ng students to help with							
		nformed the students she							
		it to assist them. Further, the							
		ere not scheduled to do							
		s date (11/21/21) and had not nt cares. The nursing students							
		port and did not review the							
	residents electronic	medical record prior to							
		stated the students required a							
		erself, in a resident's room resident cares. CI-A stated, "I							
		students some as this was shift							
		them in a position to use their							
	clinical thinking and	their previous experiences on							
		d morning cares completed							
		ent to complete the cares as the room. CI-A stated she							
		dents a few times when							
		R1. CI-A sated she did not							
	think the students w	vould take R1 to the bathroom,							
		she did not provide that							
		udents. Additionally, CI-A							
		not review R1's care plan with ated, "I should not have put							
		and I should have been with							
	them in R1's room a	and reviewed the care plan							
		so verbalized there was not							
		nicals, or detailed list of what							
	facility.	could not do when at the							
	lacinty.								
	During an interview	on 12/7/21, at 2:36 p.m. RN-A							
	stated R1 required	total assistance of two staff for							
		always incontinent. R1 was							
		e toilet as she was too weak.							
		were two nurses scheduled as rsing students, so the							
		ing with cares on R1's unit.							
		sked her opinion regarding							

If continuation sheet Page 4 of 6

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	. <u> </u>				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
						(С
		245617	B. WING			12/0	07/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONE	DELET VILLAGE CAR	E CENTER		-	525 FAIRVIEW AVENUE SOUTH		
			<u>_</u>		SAINT PAUL, MN 55116 PROVIDER'S PLAN OF CORRECTIO		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	689Continued From page 4 nursing students helping with cares. RN-A stated they felt it would be okay as the nursing assistant working on R1's unit was regular staff and knew the residents.F 689						
	they felt it would be working on R1's unit	okay as the nursing assistant					(3) DATE SURVEY COMPLETED C 12/07/2021 E (X5) COMPLETION
	During an interview director of nursing (meeting with CI-A to clinical rotation. The conducted regardin the nursing student year), and types of providing. The colle resident care guide students were able DON stated her und students would be of providing resident of plan to have nursing R1's unit and CI-A h leadership when the DON stated the exp	on 12/7/21, at 3:00 p.m. the (DON) stated there was a o discuss the upcoming e DON stated the meeting was g access students required, s experience (i.e., clinical cares the students would be ege was informed about s, facility policies, and what to do when at the facility. The derstanding was nursing with the instructor when cares and was not aware of the g students help with cares on had not reached out to facility e decision was made. The bectation was for the nursing sent when a student was cares.					
	administrator stated CI-A regarding onsi understanding was mainly observing ar assistants and they cares. The administ was being provided needed more comm of the nursing stude stated there was no nursing students co administrator stated	on 12/7/21, at 4:12 p.m. the d there was a meeting with te clinicals and her nursing students would be nd shadowing nursing were not providing direct trator explained if direct care l by nursing students, staff nunication and understanding ent roles. The administrator of any policies guiding what buld/could not do. The d her expectation was for always be with a staff					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/04/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245617	B. WING			C 0 7/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARONE	DELET VILLAGE CAR	E CENTER		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 689	resident's care plan occur when R1 had Facility policy titled Experience updated will retain responsite will maintain admin supervision of stude	iding direct cares to ensure a was followed, when did not	F 689			

Facility ID: 27189

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 20, 2021

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders Event ID: DKU711

Dear Administrator:

The above facility was surveyed on December 7, 2021 through December 7, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 <u>only a suggestion</u> 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 order 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

Carondelet Village Care Center December 20, 2021 Page 2

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:

Jamie Perell, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: jamie.perell@state.mn.us Office: (651) 245-8094

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.

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		27189	B. WING		(12/0) 7/ 2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARONI	DELET VILLAGE CAR	E CENTER	/IEW AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	your facility by surv Department of Hea found NOT in comp Licensure. Please i of correction you ha identify the date wh	TS: blaint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was blance with the MN State ndicate in your electronic plan ave reviewed these orders and en they will be completed.				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 12/28/21

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		27189	B. WING			C 07/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
CARONE	DELET VILLAGE CAR	E CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	The following complaint was found to be SUBSTANTIATED: H5617018C (MN00078964) with a licensing order issued at 830. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulatio n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically.					
	State Statutes/Rule "CORRECTED" in must then indicate licensure process,	f correction is necessary for es, please enter the word the box available for text. You in the electronic State under the heading completion orders will be corrected prior				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		0
		IDENTIFICATION NUMBER.	· · ·			SURVEY LETED
		27189	B. WING		(12/0) 7/2021
NAME OF	PROVIDER OR SUPPLIER	1	1	STATE, ZIP CODE	, •	
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	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			12/30/21
	receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.				
	by: Based on interview facility failed to imp	ent is not met as evidenced and document review, the lement fall interventions as e plan for 1 of 3 residents (R1)		Corrected.		
	Findings include:					
	11/10/21, indicated impairment and dia Disease, cerebral i	mum Data Set (MDS) dated R1 had a moderate cognitive ignoses of Alzheimer's nfarction (stroke) and ness or inability to move on				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	COM	E SURVEY PLETED
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2 830	Continued From pa	ige 3	2 830			
	required total physi	y) to the right side. Further, R1 cal assistance of two staff for steady, and only able to n assistance.				
	R1's fall Care Area Assessment (Care Area Assessment) (Care Area Assessment) (Care Area Assessment) (Care Area Assessment) (Care Area Area Assessment) (Care Area Area Assessment) (Care Area Area Area Assessment) (Care Area Area Assessment) (Care Area Area Area Assessment) (Care Area Area Area Area Area Area Area A	R1 was at risk for falls related , incontinence, and dementia.				
	incontinent of blade assistance with toil	ed 11/16/21, indicated R! was der and bowel and needed eting. The care plan also t to be left alone in the				
	11/19/21, indicated incontinent cares in	ant Task Sheet dated R1 required R1 required bed. The Nursing Assistant indicated R1 was not to be left om.				
	- 11/21/21, at 9:11 a the bathroom while - 11/21/21, at 11:00 transferred to the b the assistance of tv given privacy to sit checks. R1 was fou	gress notes revealed: a.m. indicated R1 had a fall in being toileted. a.m. indicated R1 was athroom using a full lift with vo student nurses. R1 was on the toilet with frequent and on the bathroom floor after g from the students outside the				
		port dated 11/21/21, indicated R1's fall was not following R1's				
	nursing assistant (N	on 12/7/21, at 12:19 p.m. NA)-A stated she was working 21/21. She had not worked				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		27189	B. WING		12/	07/2021
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CARONE	DELET VILLAGE CAR	(ENTER	RVIEW AVENUI AUL, MN 5511			
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2 830	Continued From pa	age 4	2 830			
	student nurses wer The nursing studer and went into R1's offered to help, but was not sure what complete for R1. T room while their cli was on the comput stated she was sur bathroom as R1 wa and incontinence c was in bed. NA-A w	nts before and believed the re helping with resident cares. Its asked for R1's care sheet room for cares. NA-A had was declined. Further, NA-A cares the students intended to he students went into R1's nical instructor (CI)-A, who er, sat outside the room. NA-A prised when R1 fell in the as too weak to use the toilet ares were provided when R1 vas not aware of what nursing to do when in the facility or igned.				
	stated on 11/21/21, nurses scheduled a nurses for two of ei- shadow during thei- she spoke with reg utilize the two rema- not have a nurse to made to have the tr cares on R1's neigh one nursing assista instructed the nursi resident care and in would be on the un nursing students w resident care on the prepared for reside had not received re- residents electronic resident care. CI-A staff member, or he	y on 12/7/21, at 2:08 p.m. CI-A , the care center had two and there were not enough ight nursing students to r clinical rotation. CI-A stated istered nurse (RN)-A on how to aining student nurses, who did o follow, and a decision was wo nursing students help with hborhood as there was only ant scheduled. CI-A then ing students to help with nformed the students she it to assist them. Further, the ere not scheduled to do is date (11/21/21) and had not ent cares. The nursing students eport and did not review the c medical record prior to stated the students required a erself, in a resident's room	5			
	pushed these two	resident cares. CI-A stated, "I students some as this was shif them in a position to use their	t			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		SURVEY
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		27189	B. WING			C 07/2021
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2 830	Continued From pa	age 5	2 830			
	2 830 Continued From page 5 clinical thinking and their previous experiences on the unit." R1 needed morning cares completed and the students went to complete the cares as she waited outside the room. CI-A stated she checked on the students a few times when providing cares to R1. CI-A sated she did not think the students would take R1 to the bathroom, but also confirmed she did not provide that instruction to the students. Additionally, CI-A confirmed she did not review R1's care plan with the students and stated, "I should not have put them on that unit, and I should have been with them in R1's room and reviewed the care plan with them." CI-A also verbalized there was not meeting prior to clinicals, or detailed list of what students could and could not do when at the facility.					
	stated R1 required transfers and was a never placed on the On 11/21/21, there there were eight nu students were help RN-A stated CI-A a nursing students he they felt it would be	on 12/7/21, at 2:36 p.m. RN-A total assistance of two staff for always incontinent. R1 was toilet as she was too weak. were two nurses scheduled as ursing students, so the ing with cares on R1's unit. sked her opinion regarding elping with cares. RN-A stated to okay as the nursing assistant it was regular staff and knew				
	director of nursing meeting with CI-A t clinical rotation. The conducted regardin the nursing student year), and types of providing. The colle	on 12/7/21, at 3:00 p.m. the (DON) stated there was a o discuss the upcoming e DON stated the meeting was ng access students required, ts experience (i.e., clinical cares the students would be ege was informed about es, facility policies, and what				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27189		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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2 830	Continued From page 6		2 830				
	DON stated her un students would be providing resident of plan to have nursin R1's unit and CI-A leadership when th DON stated the ex- instructor to be pre- providing resident of During an interview administrator state CI-A regarding ons understanding was mainly observing a assistants and they cares. The adminis was being provided needed more comr of the nursing students co administrator state nursing students to member when prov- resident's care plar occur when R1 had Facility policy titled Experience update will retain responsil will maintain admin supervision of stud	y on 12/7/21, at 4:12 p.m. the d there was a meeting with ite clinicals and her a nursing students would be nd shadowing nursing y were not providing direct strator explained if direct care d by nursing students, staff munication and understanding ent roles. The administrator of any policies guiding what build/could not do. The d her expectation was for o always be with a staff viding direct cares to ensure a n was followed, when did not					
	The director of nurs	THODS OF CORRECTION: sing (DON), or designee, could d/or revise policies and	1				

STATEMENT OF DEPICIPNOIES (N) PROVIDERSUPPLIERQLIA IDENTIFICATION NUMBERSUPPLIERQLIA A BULDING: (O2) MULTIFIC CONSTRUCTION A BULDING: (V3) DATE SUPPLY C NAME OF PROVIDER ON SUPPLIER CARONDELET VILLAGE CARE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE SAINT PAUL, MN 55116 STREET ADDRESS, CITY, STATE, 2IP CODE SAINT PAUL, MN 55116 (V4) ID PHOLONER OF SUPPLIER TAG SUMMARY STREET CORECORDERSY SAINT PAUL, MN 55116 PROVIDERS MAY CORECTION SAINT PAUL, MN 55116 (V4) ID PHOLONER OF SUPPLIER TAG SUMMARY STREET SUPPLIER SUMMARY STREET SUPPLIER SUPPLIER SUMMARY STREET SUPPLIER SUMMARY STREET SUPLIE	Minnesota Department of Health												
27189 IN.WING 12/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S25 FAINTY END KES SOTTH CARONDELET VILLAGE CARE CENTER S25 FAINTY END KES SOTTH S25 FAINTY END KES SOTTH SAMT PAUL, MN 55115 PREVIDENTIAL INFORMATION OF INFORMATION PREVIDENTIAL INFORMATION OF CORRECTION CORRECTION PREVIDENTIAL PREVIDENTIAL INFORMATION PREVIDENTIAL INFORMATION PREVIDENTIAL INFORMATION CORRECTION 2830 Continued From page 7 2 830 PREVIDENTIAL INFORMATION, or does are reported to the supervision is provided to nursing students when providing care to ensure residents plan of care are followed. The DON, or designee, could edvalop monitoring systems to ensure ongoing compliance. If MAN PERIOD FOR CORRECTION: Twenty-one (21) days. If MAN PERIOD FOR CORRECTION: Twenty-one			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:										
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