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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carondelet Village Care Center	525 Fairview Avenue South Saint Paul, MN 55116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement care plan interventions for 1 of 1 resident (R34) reviewed with a history of falls. Findings include:Findings:R34's Optional State Assessment (OSA) dated 8/8/25, indicated moderate cognitive impairment, did not reject care, required extensive assistance with bed mobility, transfers, and toilet use. R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated R34 used a walker and wheelchair, had Parkinsonism (a syndrome characterized by different movement disorders such as walking and balance problems), heart failure, non-Alzheimer's dementia, and an artificial hip joint. Further, R34 fell two or more times with no injury since the prior assessment and fell one time with a non-major injury. R34's care sheet updated 11/17/25, indicated R34 required assist of one with a gait belt and rolling walker to use the bathroom and further indicated R34's walker was to always remain within reach because R34 self-transferred in the room and was at risk for falling. R34's care plan dated 8/19/25, indicated R34 had limited physical mobility due to Parkinsonism, cardiac disease and would self-transfer or self-ambulate often when in the room with or without adaptive equipment and required assist of 1 staff for transfers and ambulation. R34 had impaired cognition and required cueing, reorienting, and supervision as needed, additionally R34 was incontinent. R34 was at risk for falls due to dementia, Parkinsonism, and heart disease and required signage on the walker to remind R34 to take it with wherever she went. R34's Resident Occurrence Report dated 4/29/25, indicated R34 had fallen in her room, sustained a hip fracture and interdisciplinary team (IDT) interventions were deferred until R34 returned from the hospital. A handwritten note on the form indicated physical therapy (PT) and occupational therapy (OT) was initiated with a review date 5/7/25. R34's Resident Occurrence Report dated 6/22/25, indicated R34 fell while standing and washing her hands and the long-term interventions included R34 being in her wheelchair for all cares. Additionally, staff were educated on the use of a gait belt and use of a walker when completing cares. R34's Resident Occurrence Report and Falls Follow Up Forms dated 7/4/25, indicated R34 was on the floor and had a bump and bruise to the top of her right hand. Further, a long-term intervention included a sign was placed to always keep the walker with R34. R34's Resident Occurrence Report and Falls Follow Up Form dated 8/20/25, indicated R34 did not have her walker and fell going back to bed and sustained an abrasion and laceration. Further, the form indicated R34's walker was not within reach and staff were educated to keep the walker by R34 and follow the care plan. R34's care conference note dated 8/25/25, indicated R34 fell recently and sustained a laceration of her forehead and a skin tear on her wrist. Additionally, staff were re-educated to always have the walker right beside R34. During observation on 11/18/25 at 9:50 a.m., licensed practical nurse (LPN)-A left R34's room and R34's walker was folded up against the wall next to R34's television. A nebulizer was heard running and LPN-A stated she would be back. R34 was not observed to be near the walker. During interview and observation on 11/18/25 at 9:56 a.m., LPN-A verified R34 was receiving a nebulizer in her room. During observation on 11/18/25 at 10:00 a.m., LPN-A went into R34's room and turned off the nebulizer. R34's walker was still folded up by the television. At 10:02 a.m., LPN-A walked out of R34's (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and the walker remained folded next to the television and away from R34. During observation on 11/18/25 at 10:04 a.m., R34 was in her wheelchair in her room with the call light next to her. Signage was located on the walker that indicated to always keep the walker with R34. R34's walker was folded in the corner by the television and out of R34's reach. During interview and observation on 11/18/25 at 10:07 a.m., nursing assistant (NA)-A stated they looked at the care plan to know what cares a resident required. NA-A stated R34 hadn't fallen recently but was at risk for falling and was supposed to have the walker with her at all times in case R34 tried to self-transfer to aide in her balance and further stated R34 even had a sign on her walker as a reminder. NA-A verified R34's walker was in the corner and stated the walker should be by R34. NA-A unfolded the walker and placed it next to R34. During interview on 11/18/25 at 10:12 a.m., LPN-A stated nurses looked at the care plan to know what cares a resident required and the NA's used care sheets. During interview on 11/18/25 at 10:17 a.m., NA-B viewed R34's care sheet dated 11/17/25, and verified the care sheet indicated R34's walker was to be kept within reach at all times. NA-B stated R34 needed the walker because she tried to get out of the chair or bed by herself and was prone to falls. During interview on 11/18/25 at 10:20 a.m., LPN-A stated care sheets were updated with the care plan and added she hadn't worked in R34's neighborhood for approximately four months and stated R34 needed the walker in case R34 got up on her own and if R34 didn't have her walker, her safety would be at risk. LPN-A further stated it was on R34's care plan to be within reach and added R34 could get up on her own and suffer injuries from a fall that possibly could have been prevented. LPN-A acknowledged she was not previously aware it was part of R34's care plan. During interview on 11/18/25 at 1:23 registered nurse (RN)-A stated staff entered the resident room after a fall to determine the cause and document the fall in the electronic medical record (EMR). A falls form was completed by floor staff. The clinical coordinators conducted the investigation. Falls were discussed at IDT, an intervention was implemented. After a week, the intervention was re-evaluated to determine if the intervention was effective. RN-A stated she expected the care sheet to be followed. During interview on 11/18/25 at 1:47 p.m., physical therapist (PT)-A stated R34 was seen by PT and was on a walking program. PT-A stated R34 was at risk for falls due to Parkinsonism and a history of falling and further stated R34 was probably impulsive; if R34 self-transferred, it would be better to have the walker with her at all times and expected the care sheet to be followed. During interview on 11/18/25 at 2:46 p.m., with the director of nursing (DON) and the regional director of clinical services (RDCS), the DON stated R34 fell during a self-transfer in July and IDT placed a sign to keep the walker with R34 at all times and stated they expected staff to keep the walker with R34 at all times. Further, when R34 fell on 8/20/25, the DON verified R34 did not have her walker within reach and RDCS stated staff were educated to follow the care plan. A policy, Fall Prevention and Management Program Policy, dated 9/2025, indicated the purpose of the policy was to provide a procedure for residents at risk for falls, assess fall risk factors, provide guidelines for fall and repeat fall preventative interventions. Prevention strategies include care plans will indicate the resident specific interventions to prevent falls. All staff are responsible for implementing the intent and directives contained within the policy and creating a safe environment.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 residents (R34, R38) were offered and/or provided updated vaccination for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings:Review of the current, 10/26/24, Centers for Disease Control (CDC) Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. Additionally, if an adult 50 years or older received PCV13 only, a single dose of PCV21 or PCV20 may be given after one year of receiving the PCV13 dose. R34:R34's quarterly Minimum Data Set (MDS) dated [DATE], indicated R34 admitted [DATE], and further, R34's pneumococcal vaccine was up to date.R34's Physician's Orders form indicated the following order: 12/4/24, may receive pneumococcal vaccinations if not already received.R34's Pneumococcal Vaccinations Consent form signed 12/4/24, indicated R34 wanted to receive the pneumococcal vaccinations that were recommended according to ACIP/CDC.R34's Minnesota Immunization Report (MIIC) dated 12/19/24, indicated R34 received PPSV23 on 3/25/2005, and PCV13 on 2/23/15. R34's Care Conference Summary note dated 5/19/25 indicated R34 was due for a pneumococcal vaccination. R34's Immunizations form saved 11/19/25, indicated R34 was [AGE] years old and received PPSV23 on 3/25/2005, and PCV13 on 2/23/15. The form lacked information R34 received PCV20 or PCV21.R34's medical record was reviewed and lacked evidence a shared clinical decision-making conversation took place or that R34 received PCV20 or PCV21. R38:R38's comprehensive MDS dated [DATE], indicated R38 admitted to the facility 10/16/25, and R34's pneumococcal vaccinations were up to date. R38's Physician's Orders form indicated R38 was [AGE] years old and had an order dated 10/16/25, to receive pneumococcal vaccinations if not already received.R38's medication administration record (MAR) and treatment administration record (TAR) dated October 2025 and November 2025 were reviewed and lacked information R38 received pneumococcal vaccinations.R38's Pneumococcal Vaccinations Consent form dated 10/16/25, indicated R38's pneumococcal vaccination status was up to date.R38's Immunizations form indicated R38 received PCV13 on 9/15/2015. No other pneumococcal vaccinations were documented as administered. The form lacked information PCV20 or PCV21 was administered at least 1 year after PCV13 was given. During interview on 11/19/25 at 1:32 p.m., with the infection preventionist (IP) and regional director of clinical services (RDCS), the IP stated on admission, the health unit coordinator accesses the MIIC, and the facility provides information on the pneumococcal vaccine and obtain consents. IP stated they used the CDC PneumoRecs Advisor application for use in determining residents eligible for vaccination and stated R34 was due for additional vaccination and would check to see if a conversation took place. Further, RDCS would check the MIIC for R38 and verified R38 was also due for another pneumococcal vaccination. During interview on 11/19/25 at 3:12 p.m., IP stated she would ask for an order for the pneumococcal vaccination for R38 and would update R38's family and would investigate whether a conversation took place for R34.During interview on 11/20/25 at 11:04 a.m., with RDCS and the director of nursing, the RDCS verified information in R34's and R38's medical record was correct. The DON stated they had vaccination plans and RDCS stated when a resident admitted to the facility, pneumococcal vaccinations were administered and further stated R34 and R38, missed them, and should have gotten the vaccinations.During interview on 11/20/25 at 11:21 a.m., IP stated it was their responsibility to see if pneumococcal vaccinations were up to date and offer the vaccinations to help elderly residents build an immunity to pneumonia and further stated it was important for vaccinations to be as up to date as possible.A policy, Pneumococcal Vaccination Policy, dated November 2024, (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated each resident was offered the pneumococcal immunization unless the immunization was contraindicated, declined, or the resident has already been immunized, and the purpose of pneumococcal vaccinations was to reduce the incidence of pneumococcal disease and the morbidity and mortality attributed to this infection. All residents who have never received a pneumococcal vaccination will be offered the vaccine upon admission and as needed in accordance with current ACIP/CDC recommendations. Each resident's pneumococcal immunization status will be determined upon admission or soon thereafter and if vaccination has occurred, the vaccination date will be documented in the resident's medical record. Complete shared clinical decision making if applicable.