DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 21, 2026

Administrator
EPISCOPAL CHURCH HOME THE GARDENS
1860 UNIVERSITY AVENUE WEST
SAINT PAUL, MN 55104

RE: CCN:245625

Cycle Start Date: April 9, 2026

Dear Administrator:

On April 9, 2026, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

- 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 July 9, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by October 9, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
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SAINT PAUL, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: 1F344F-H1

Dear Administrator:

The above facility survey was completed on April 9, 2026 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 - 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 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 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING B. WING	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE GARDENS	1860 UNIVERSITY AVENUE WEST , SAINT PAUL, Minnesota, 55104

(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
E0000	Initial Comments On 4/6/26 through 4/9/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/11/2026
F0000	INITIAL COMMENTS On 4/6/26 through 4/9/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H56251062C(2592912), H56251060C(2619327), and H56251061C (2567390) NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/11/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	All kitchenettes were immediately cleaned. Undated, opened, and expired food items were discarded. The remaining items were properly sealed, labeled, and dated. All residents who reside in the facility are at risk of foodborne illnesses related to improper food storage	05/11/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026

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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were stored in a manner to prevent spoilage and freezer burn and failed to ensure food items in 6 out of 6 kitchenettes were sealed, labeled and dated. This had the potential to affect all residents who reside in the facility. Findings include: An observation on 4/7/26 at 3:22 p.m., the 2nd floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles, hot dog buns and a container of red and white substance. Nursing assistant (NA)-H verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 8:16 a.m., the 3rd floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, pepperoni, english muffins, omelets and bacon. NA-G verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/7/26 at 2:29 p.m., the 4th floor kitchenette was reviewed. The freezer had undated, opened packages of omelets, pancakes, french toast, corn dogs, bacon, sausages, Toaster Strudel, and White Castle burgers. Additionally, the refrigerator had an undated bowl of noodles, undated Tupperware container of beans, and a bag of opened	F0812	Continued from page 1 practices in the unit kitchenettes. All kitchenettes were audited to ensure food items are sealed, labeled, dated, and not expired. The facility's Food Storage policy was reviewed and remains current. The facility will educate all staff on proper food storage practices, including sealing, labeling, and dating for all food items. Supplies such as labels, bags, and containers were verified to be available in all kitchenettes. The Culinary Manager or their Designee will conduct daily kitchenette audits for 4 weeks, and if compliant, reduce audits to weekly for two months to ensure compliance with food storage practices. Results of audits and recommended changes in process will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026	05/11/2026

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F0812 SS = F	Continued from page 2 carrots that were expired on 3/25/26 . NA-F verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/7/26 at 2:13 p.m., the 5th floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, bacon, and omelets. NA-A verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 7:44 a.m., the 6th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, french toast, bagels and meat patties. NA-E verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 7:27 a.m., the 7th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles and french toast. NA-D verified these items and stated all items should have been sealed, dated and labeled. During interview on 4/8/26 at 12:28 p.m., chef manager (CM) expected any opened food items were sealed, dated and labeled. The kitchenettes had Ziplock bags, markers and deli containers with lids for storage use. CM further stated the kitchenettes were overseen by a multidisciplinary team. The CM oversaw education, ordered, stocked supplies and provided stocking sheets for staff. The nursing department oversaw the NAs. During interview on 4/9/26 at 12:40 p.m., administrator stated they expected all staff to handle and store food properly. Additionally, any opened items were to be labeled, dated and sealed. The rationale for proper food storage decreased the risk of food borne illness. A facility policy titled Episcopal Homes Refrigerator and Food Storage, directed staff to ensure opened freezer foods are sealed to prevent freezer burn and spoilage. Furthermore, all foods must be sealed, labeled and dated. .	F0812		05/11/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide	F0880	Staff involved were immediately re-educated on proper hand hygiene and glove use, including changing gloves between dirty and clean tasks. Appropriate signage and supplies for enhanced barrier precautions were implemented for Resident R19. All residents that require Enhance barrier precautions were reviewed to ensure those Enhanced Barrier Precautions are in place. Resident	05/11/2026

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F0880 SS = E	Continued from page 3 a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 3 R54 was monitored to ensure compliance with droplet precautions when out of the room. All residents who reside in the facility are at risk for infection transmission related to improper hand hygiene, glove use, and failure to follow transmission-based precautions. All residents who require specific signage for PPE have been audited to ensure the proper signage is posted and PPE is in place. The facility's Infection Control policies, including Hand Hygiene, Enhanced Barrier Precautions, and Transmission-Based Precautions, were reviewed and remain current. The facility will educate all staff on proper infection control practices, including PPE use, specifically when to use enhanced barrier precautions, when to gown, hand hygiene, and adherence to isolation precautions. The DON or designee will conduct infection control audits daily for four weeks, and if compliant, reduce to 6 random audits weekly for six weeks to ensure compliance. Results of audits will be brought to the QA Committee for further review and recommendations. Date for compliance: 5/11/2026	05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026

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F0880 SS = E	Continued from page 4 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate glove use and hand hygiene for 1 of 1 resident (R19) during personal cares. The facility further failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R19) who had a nephrostomy tube and for 1 of 1 resident (R4) who had a catheter and was receiving catheter cares. The facility also failed to ensure 1 of 1 resident (R54) on droplet precautions was wearing a mask when out of her room. This had the potential to affect all 10 residents residing on the 3rd floor. Findings include: Hand Hygiene/Glove Use R19's significant change Minimum Data Set (MDS) dated 1/7/26, indicated R19 had intact cognition, was dependent on staff for toileting and personal hygiene, and was always incontinent of urine and frequently incontinent of bowel. R19's diagnoses included chronic kidney disease, anxiety, and need for assistance with personal care. R19's care plan revised 4/6/26, indicated R19 required assistance of one for personal hygiene and substantial to total assistance for toileting. During observation on 4/7/26 at 10:05 a.m., nursing assistant (NA)-A entered R19's room and offered a brief change. R19 stated that she did need to be changed and cleaned. NA-A donned gloves and put the head of the bed flat, lifted R19's gown and removed her brief which was dirty with bowel movement (BM). NA-A wiped R19's bottom of the BM and completed peri care. Without changing gloves, NA-A placed a new brief, pulled R19's gown	F0880		05/11/2026

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F0880 SS = E	Continued from page 5 down, repositioned her legs by grasping her feet, and adjusted the bed using the bed controls. During interview on 4/7/26 at 10:12 a.m., NA-A stated she did not change gloves after cleaning the BM and was not aware she needed to do so. During interview on 4/7/26 at 1:55 p.m., registered nurse (RN)-A stated gloves should be removed and hand hygiene completed after performing peri care. During interview on 4/8/26 at 10:23 a.m., licensed practical nurse (LPN)-A stated expectation for staff to change gloves and perform hand hygiene after performing peri care and before moving on to other resident care. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated staff were expected to change gloves and perform hand hygiene when going from dirty to clean areas during resident care. EBP R19 R19's significant change MDS dated 1/7/26, indicated R19 had intact cognition, was dependent on staff for most activities of daily living (ADLs), and had an indwelling catheter (nephrostomy tube). R19's diagnoses included chronic kidney disease, obstructive uropathy (blockage in the urinary system that impedes urine flow), and need for assistance with personal care. R19's care plan focus initiated on 9/5/25, indicated R19 had a nephrostomy tube for right kidney and instructed staff to perform nephrostomy tube care as ordered. R19's need for EBP related to the presence of a nephrostomy tube was added on 4/7/26. During observation on 4/6/26 at 2:54 p.m., R19's doorway lacked signage indicating R19 required any infection control precautions. During observation and interview on 4/7/26 at 9:10 a.m., R19's doorway lacked signage indicating R19 required any infection control precautions. R19's full nephrostomy bag was visible and lying on top of her sheet. R19 stated staff were responsible for emptying the nephrostomy bag. During observation on 4/7/26 at 10:05 a.m., NA-A entered R19's room, donned gloves but did not don a gown. NA-A performed personal cares; a brief change, peri care, and resident repositioning without	F0880		05/11/2026

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F0880 SS = E	Continued from page 6 using EBP. During observation and interview on 4/7/26 at 12:04 p.m., R19's room had a sign indicating EBP and there was an isolation cart outside her room containing gloves. The sign instructed staff to perform hand hygiene, and don gloves and gown when entering to perform any high-contact resident care activities. NA-A stated while looking at the sign that a gown was only required when there was contact with the resident. NA-A stated was not aware R19 required EBB before now, and stated should have been wearing a gown this morning while preforming cares. During interview on 4/7/26 at 1:55 p.m.,RN--A stated residents with indwelling devices such as nephrostomy tube should be on EBP. RN-A further stated staff should wear gown and gloves when emptying nephrostomy bag, changing the dressing around the tube, and during any high contact care. During interview on 4/8/26 at 10:23 a.m.,LPN-A stated EBP should be in place for any resident with a nephrostomy tube. LPN-A could not explain why R19 had not been on EBP prior to yesterday (4/7/26). LPN-A further stated staff should follow EBP when working with R19 during nephrostomy care and all other high-contact care. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated residents with a nephrostomy tube should be on EBP and could not explain why R19 was not on EBP prior to yesterday. R4 R4'a quarterly Minimum Data Set (MDS) dated 3/25/26, indicated intact cognition and diagnoses of quadriplegia (paralysis of all four limbs), flaccid neuropathic bladder (type of bladder dysfunction characterized by an inability to contract properly, leading to urinary retention and overflow incontinence), and a need for assistance with personal care. It further indicated R4 had an indwelling catheter and was dependent on staff for toileting. During interview on 4/6/25 at 5:50 p.m., R4 stated some staff wear personal protective equipment (PPE) when they perform catheter cares and some don't. This concerned her as she had been having a lot more urinary tract infections (UTI) recently.	F0880		05/11/2026

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F0880 SS = E	Continued from page 7 During observation on 4/8/26 at 9:59 a.m., R4 put on her call light and nursing assistant (NA)-C answered it. R4 and NA-C went into the bathroom where NA-C was emptying R4's catheter bag into a graduated cylinder and then emptied the graduated cylinder into the toilet. NA-C was wearing gloves but wasn't wearing a gown. During interview on 4/8/26 at 10:10 a.m., NA-C verified R4 was on EBP and the sign on the door indicated they should have been wearing a gown when performing catheter cares, stating they forgot to put one on but should have. R54 R54's quarterly MDS dated 1/7/26, indicated intact cognition and diagnoses of dementia and chronic obstructive pulmonary disease (COPD). It further indicated R54 required staff assistance with mobility. R54's physician's order, indicated ok for polymerase chain reaction test (test to determine if a certain virus is present) one time only for respiratory symptoms until 4/7/26. R54's progress note dated 4/6/2026, indicated R54 continues not to feel well. Cough noted from 4/3/26 continues. Lungs sounds, crackles lower left and inspiratory wheeze. Call placed to nurse practioner (NP) office for new orders. During observation 4/6/26, at approximately 12:30 p.m., R54 was in the therapy room riding a stationary bike. The physical therapist (PT)-A was also in the room standing beside her. Neither R54 nor PT-A were wearing masks or eye protection. At approximately 1:00 p.m. R54, PT-A, and LPN-C were in the therapy room and LPN-C was handing R54 and PT-A masks to wear. A few minutes later, PT-A brought R54 out of the therapy room and into her room via her wheelchair and then exited her room. Once outside the room, PT-A used hand sanitizer but did not remove their mask. The sign on the wall beside R54's door indicated she was on droplet precautions, and everyone must clean their hands (including before entering and when leaving the room), make sure their eyes, nose, and mouth are fully covered before room entry, and remove face protection before exiting the room. During interview on 4/6/26 at approximately 1:10 p.m. PT-A verified R54 was on droplet precautions but didn't know why. PT-A further verified the sign on the wall next to R54's door and stated "I assume	F0880		05/11/2026

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F0880 SS = E	Continued from page 8 so" when asked if they should be following the directions indicated on the sign. They also verified they should have been wearing eye protection and changing masks upon leaving R54's room. During interview on 4/6/26 at 6:15 p.m. R54 was sitting in her recliner in her room and she was coughing. She stated some of the staff wear PPE when they are providing cares and some don't, "it just depends." During interview on 4/7/26 at 1:14 p.m., LPN-C stated R54 had been put on droplet precautions because she was having cold symptoms last week but R54 told her she didn't feel sick. Then they called the nurse practitioner again this week because R54 told her she wasn't feeling well and LPN-C wanted to do more in-depth testing. LPN-C stated R54 was permitted to leave her room if she was wearing a mask and verified neither R54 nor PT-A had been wearing masks during therapy on 4/6/26 and they had given them both masks to wear. During interview on 4/8/26 at 1:32 p.m. the DON/Infection Preventionist (IP) stated R54 was symptomatic and placed on droplet precautions. She should not leave the room but if someone on droplet precautions does have to leave the room, they should wear a mask and if staff were working with them (therapy) they should also be wearing a mask and eye protection. Facility policy Hand Hygiene dated 10/2/24, indicated, “Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately before and after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other elders, personnel, equipment and/or the environment.” Facility policy Enhanced Barrier Precautions dated 10/2024, indicated criteria for implementing EBP included, “Presence of wounds and/or indwelling medical devices, even if there is no known infection or colonization with an MDRO [multidrug-resistant organism].” The facility policy on droplet precautions dated 10/2/24, indicated to limit the movement and transportation of the elder to essential purposes only, the elder should wear a mask when out of their room. Provide meals, therapies, and activities in the elder's room whenever possible during the acute phase of illness with consultation with the IP.	F0880		05/11/2026

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F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were safe for self-administration of medication (SAM) for 1 of 1 residents (R36) observed with a medication at the bedside. Findings include: R36's quarterly Minimum Data Set (MDS) dated 3/20/26, indicated R36 had intact cognition and required set up/clean up assistance to partial/moderate assistance for all self-care activities of daily living (ADLs). R36's diagnoses included multiple sclerosis (a disease affecting the nervous system and may cause weakness, numbness, and difficulty walking), chronic obstructive pulmonary disease (COPD), arthritis, and need for assistance with personal care. R36's care plan revised 12/8/25, indicated R36 had inability to manage self-care related to functional and cognitive decline. R36's care plan further indicated R36 had multiple sclerosis which affected ADL independence. The care plan identified R36 wanted to be involved in her care and medications, but instructed staff to administer medications as ordered. R36's care plan lacked specific information regarding self-administration of medications. R36's provider orders indicated the following: -11/02/23, R36 was ok to self-administer medications after set-up. -5/20/24, R36 required Ipratropium Bromide nasal solution 0.06% - 2 sprays in each nostril three times a day. -12/4/24, R36 required Fluticasone Propionate suspension 50mcg/act -2 sprays in each nostril every day. R36's medication administration record (MAR) dated 4/2026, indicated the Ipratropium Bromide nasal	F0554	Resident R36 had medications immediately removed from the bedside. The resident was reassessed by the interdisciplinary team and determined not appropriate for self-administration. Physician orders, MAR, and care plan were updated to reflect staff administration of all medications. All residents who reside in the facility with orders for self-administration of medications are at risk for having medications at the bedside without a current assessment, appropriate physician order, and MAR documentation reflecting self-administration status. All residents with orders for self-administration of medications were audited to ensure a current assessment is in place, physician orders specify which medications may be self-administered, and the MAR reflects accurate administration instructions. The facility Self-Administration of Medication policy was reviewed and remains current. The facility will educate licensed nursing staff on requirements for self-administration, including need for current assessment, physician order specifying medications, and accurate MAR documentation. The DON or their Designee will audit four residents per week with self-administration orders to ensure compliance with policy for four weeks, and if compliant will reduce audits to four times per month for three months. Results of audits and recommended changes in process will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026	05/11/2026

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F0554 SS = D	Continued from page 10 spray was scheduled for morning, evening, and bedtime. The MAR did not indicate this could be left at the bedside or could be self-administered. R36's MAR further indicated that the Fluticasone Propionate nasal spray was scheduled for 6:00 a.m. and was documented as given on 4/2 through 4/6 and 4/8. R36's SAM assessment dated 3/3/26, indicated R36 had "No desire to self-administer." The SAM assessment further indicated the interdisciplinary team (IDT) did not feel the resident was safe for SAM. R36's provider progress noted dated 3/24/26 indicated under the Assessment/Plan that R36 provided unreliable information and could not complete assessments due to her history of and advanced dementia. During observation and interview on 4/8/26 at 8:16 a.m., licensed practical nurse (LPN)-B gathered R36's morning medications for administration which included nine oral medications and one nasal spray. LPN-B entered R36's room and administered the oral medications. LPN-B asked if he could administer her Ipratropium Bromide nasal spray and R36 picked up a bottle of that nasal spray from her side table and stated she had already used that this morning. R36 stated she self-administered the nasal spray at her bedside (Ipratropium Bromide) in the morning and occasionally in the afternoon if she felt she needed it. R36 initially stated she was not aware of a second nasal spray, but when LPN-A showed her the medication, which was stored in her locked in-room medicine cabinet, she thought it looked familiar. R36 could not recall using the Fluticasone Propionate this morning and thought she took that nasal spray in the afternoon. LPN-B stated R36 had been assessed as appropriate for self-administration of medications. During interview on 4/8/26 at 10:23 a.m., LPN-A stated R36 had memory issues and could not be trusted to provide accurate information regarding which medications she took and when. LPN-A reviewed R36's most recent SAM assessment and confirmed R36 had been assessed as not appropriate for SAM. LPN-A stated R36 had an order which indicated it was ok for SAM but stated R36 was no longer appropriate for SAM and should not have the nasal spray at the bedside. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated in order for a medication to be	F0554		05/11/2026

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F0554 SS = D	Continued from page 11 left at the bedside for SAM, there had to be an order and an assessment. The SAM assessment should identify the medication and indicate that the resident understood when and how to administer it. DON further stated R36 was not appropriate for SAM and should not have any medications left at the bedside. A facility policy titled Self-Administration of Medication dated 11/13/17, indicated a resident could only be considered safe for SAM after an assessment and the IDT determined which medications would be safe for SAM. The policy further indicated the following: -The SAM assessment must include evaluation of the resident's ability to follow administration instructions including dose and time of administration. -A periodic re-evaluation should be completed based on cognitive changes. -A physician order would be obtained and must include which specific medications could be kept at the bedside.	F0554		05/11/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F0583	Resident R19's care plan was reviewed and updated to reflect privacy preferences. Staff were immediately re-educated to ensure doors are closed, and privacy is maintained during all personal care for all residents. All residents who require assistance with personal care are at risk of a lack of privacy during care if doors and/or privacy measures are not implemented. 2 random audits will be conducted on all three shifts to ensure privacy measures are maintained. The facility's Dignity policy was reviewed and remains current. The facility will educate all staff on maintaining resident privacy, including closing doors, knocking prior to entry, and ensuring residents are not exposed during care. The DON or their Designee will conduct privacy observations three times per week for four weeks, and if compliant, reduce to three audits a month for three months. Results of audits and recommended changes will be brought to the QA Committee for review and recommendations.	05/11/2026

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F0583 SS = D	Continued from page 12 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal privacy was maintained for 1 of 1 residents (R19) observed during personal cares. Findings include: R19's annual Minimum Data Set (MDS) dated 1/7/26, indicated R19 had intact cognition, was dependent on staff for toileting and personal hygiene, and was always incontinent of urine and frequently incontinent of bowel. R19's diagnoses included chronic kidney disease, anxiety, and need for assistance with personal care. R19's care plan revised 4/6/26, indicated R19 required assistance of one for personal hygiene and substantial to total assistance for toileting. During observation on 4/7/26 at 10:05 a.m., nursing assistant (NA)-A entered R19's room and offered a brief change. R19 stated that she did need to be changed and cleaned. NA-A donned gloves and put the head of the bed flat, lifted R19's gown and removed her brief. NA-A did not close R19's door, which was open to the hallway. NA-A walked into the bathroom to obtain a new brief, while R19 waited, exposed from mid abdomen down. R19 was able to roll to her left side facing the window as her back side faced the door. While NA-A wiped R19's bottom physical therapist (PT)-A knocked once on the open door, did not wait for a response, and walked into R19's room as her bottom was exposed. PT-A stopped turned around and stated he would come back in a bit. NA-A completed peri care and placed a new brief. During interview on 4/7/26 at 10:16 a.m., NA-A stated she should have closed R19's door for privacy and agreed that PT-A had walked in and saw R19's exposed bottom.	F0583	Continued from page 12 Date of compliance: 5/11/2026	05/11/2026

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F0583 SS = D	Continued from page 13 During interview on 4/7/26 at 10:18 a.m., R19 stated she wished the door would have been shut during peri care and was wondering why PT-A had just walked right in. During interview on 4/7/26 at 1:55 p.m., registered nurse (RN)-A stated resident doors should be closed during personal cares to protect their privacy. During interview on 4/8/26 at 10:23 a.m., licensed practical nurse (LPN)-A stated expected staff to close a resident's door during cares for privacy. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) expected privacy to be maintained for all residents. Resident's door should be closed during brief changes and other personal cares. A facility policy titled Dignity dated 10/15/24, the facility was committed to providing care and services in such a way to maintain each resident's "dignity, individuality, privacy, autonomy, and self-worth." The policy further indicated, "Residents are provided privacy during personal care, bathing, dressing, toileting, and medical treatments." The policy further indicated, "staff will knock and request permission before entering resident rooms whenever possible."	F0583		05/11/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered and maintained as ordered by the provider for 1 of 2 residents (R15) reviewed for respiratory care. Findings include: R15's quarterly Minimum Data Set (MDS) dated 2/12/26, indicated R15 was cognitively intact, was	F0695	Resident R15's oxygen was immediately adjusted to match the provider's order, tubing was labeled and dated, and staff were re-educated. The resident was assessed with no adverse outcomes noted. All residents who reside in the facility with oxygen therapy orders are at risk for oxygen not being administered per provider order, improper placement of oxygen devices, and a lack of labeling of tubing. All residents receiving oxygen therapy were audited to ensure oxygen flow rate matches the provider's orders; tubing is labeled and dated, and oxygen is in proper use. The facility's Safe Oxygen Use policy was reviewed and remains current. The facility will educate nursing and nursing assistant staff on oxygen administration, including maintaining the ordered flow rate, proper placement, and notifying licensed staff of discrepancies. The DON or their Designee will audit four residents per week receiving oxygen therapy for four weeks, and if compliant, reduce audits to four times per	05/11/2026

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F0695 SS = D	Continued from page 14 dependent on staff for most self-care activities of daily living (ADLs), bed mobility and transfers. R15's diagnoses include chronic respiratory failure with hypoxia (low oxygen), chronic obstructive pulmonary disease (COPD), anxiety, and dyspnea (shortness of breath). R15's provider orders dated 7/29/25, included the following: -Oxygen via nasal cannula at 4 liters per minute (lpm) continuous for dyspnea. -Change cannula/mask and tubing, date and initial weekly every Tuesday evening. R15's shortness of breath interview and evaluation assessment dated 1/26/26, indicated R15 was oxygen dependent. R15's care plan dated 8/6/25, indicated R15 had orders for oxygen therapy related to diagnoses and R15's oxygen saturations would drop into the 80s when oxygen was removed. The care plan instructed staff to administer oxygen via nasal cannula as ordered. During observation and interview on 4/6/26 at 2:03 p.m., R15 was lying in bed with the oxygen tubing/nasal cannula wrapped up and hanging off the oxygen concentrator out of R15's reach. The oxygen concentrator was on and set to 3 lpm. R15 stated she was supposed to have her oxygen on at 5 lpm. R15 stated she did not currently feel she was in any respiratory distress but could not remember how long she was without oxygen. R15's oxygen tubing was not labeled as to when it had been last changed. During observation on 4/7/26 at 8:19 a.m., R15 was in bed sleeping with the nasal cannula positioned on her chin rather than in her nares. The oxygen concentrator was set to 3 lpm. The oxygen tubing was not labeled as to when it had been last changed. During observation on 4/7/26 at 8:21 a.m., nursing assistant (NA)-I entered R15's room and delivered her breakfast tray. R15 did not address the oxygen tubing positioned on R15's chin or setting. During observation and interview on 4/7/26 at 8:32 a.m., NA-I and NA-B entered R15's room to boost her up in bed for breakfast. R15's oxygen tubing was now lying to the side of her on the bed. Neither NA-I nor NA-B addressed the oxygen tubing or flow	F0695	Continued from page 14 month for three months to ensure compliance. Results of audits and recommended changes will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026	05/11/2026

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F0695 SS = D	Continued from page 15 rate. After the NAs left the room, R15 stated she took the oxygen off for breakfast and would replace it once she was done eating. During observation and interview on 4/7/26 at 11:19 a.m., R19 in bed with the oxygen nasal cannula in her nares. The oxygen concentrator was set at 3 liters per minute. NA-B entered R15's room and stated R15 was on continuous oxygen at 4 lpm. When asked to confirm the flow rate, NA-B confirmed the flow rate was currently set at 3 lpm but should be on 4 and changed it to 4 lpm. During interview on 4/7/26 at 11:27 a.m., registered nurse (RN)-A stated R15 was on continuous oxygen and that staff should encourage her to keep it on at all times. RN-A further stated she thought the flow rate could be adjusted during the day but could not find any reference to those instructions in R15's electronic health record (EHR). RN-A confirmed R15's oxygen order was for continuous oxygen at 4 lpm. RN-A further stated oxygen tubing was changed weekly and should be labeled to identify when it had been changed last. RN-A further stated NAs should not adjust oxygen flow rate and that NA-B should have notified a nurse about R15's incorrect oxygen flow rate. During interview on 4/8/26 at 10:20 a.m., licensed practical nurse (LPN)-A stated the oxygen flow rate should match the provider order, and oxygen tubing should be labeled and dated. LPN-A further stated NAs should not adjust the flow rate but rather notify a nurse when found to be incorrect. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) expected R15's oxygen to be administered as ordered by the provider and tubing labeled and dated when to indicate when it was last changed. DON further stated NAs were not supposed to adjust oxygen flow rate and NA-B should have notified a nurse instead. A facility policy Safe Oxygen Use and Storage dated 8/28/20, indicated staff would take measures to ensure residents were educated and encouraged to use oxygen in a safe manner and any concerns would be reported to the RN.	F0695		05/11/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must	F0756	Resident R10's provider was contacted, and medication orders were clarified. Parameters for bowel medications were established and documented on the MAR. All residents who reside in the facility and receive	05/11/2026

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EPISCOPAL CHURCH HOME THE GARDENS	1860 UNIVERSITY AVENUE WEST , SAINT PAUL, Minnesota, 55104

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F0756 SS = D	Continued from page 16 be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 3/16/26, indicated R10 had moderate cognitive impairment, was frequently incontinent of bowel, and was taking opioid medications during the seven-day	F0756	Continued from page 16 medications are at risk for consultant pharmacy recommendations not being addressed promptly. All pharmacy recommendations from the past three months were reviewed to ensure appropriate follow-up and resolution. The facility policy for pharmacy and drug regimen was reviewed and remains current. The facility will educate licensed nursing staff on timely review and follow-up of pharmacy recommendations, including the expectation of resolution within 30 days. A tracking system has been implemented to ensure recommendations are monitored through to completion. The DON/designee will audit pharmacy recommendations monthly for three months to ensure timely follow-up and documentation. Results of audits and recommended changes in processes will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026	05/11/2026

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F0756 SS = D	Continued from page 17 lookback period. R10's diagnoses included adjustment disorder with mixed anxiety and depressed mood, chronic pain syndrome, and constipation. R10's care plan dated 12/17/25, indicated R10 used antidepressant medication and instructed staff to monitor adverse medication reactions such as constipation fecal impaction (when stool becomes hardened and stuck in the rectum due to long term constipation. The care plan further indicated R10 had chronic pain syndrome and instructed staff to give pain medications as ordered. R10's consultant pharmacy review (CPR) dated 10/26/25, indicated, "The resident has orders for MiraLAX PRN [as needed] for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use [e.g. which to use first] or, if a duplication, consider discontinuing one of the above." The CPR had an undated handwritten note stating "use MiraLAX first" and was signed by an unidentified nurse practitioner. R10's CPR dated12/14/25, indicated "The resident has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above." The CPR had an undated handwritten note that indicated it was faxed to provider per licensed practical nurse (LPN)-A. R10's CPR dated 2/11/26 indicated, "The resident has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above." The CPR had a handwritten note that indicated R10's medication administration record (MAR) was updated 3/4/26 by LPN-A. R10's monthly MARs dated 10/2025 through 2/2026, indicated, "MiraLAX Oral Packet 17 GM…Give 17 gram by mouth every 24 hours as needed for Constipation." And "Docusate Sodium Oral Capsule 100MG…Give 1 capsule by mouth every 24 hours as needed for Constipation." The monthly MARs lacked evidence of any instruction as to which medication to give first for constipation. During interview on 4/9/26 at 12:51 p.m., director of nursing (DON) expected R10's CPR would have been	F0756		05/11/2026

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F0756 SS = D	Continued from page 18 addressed timelier. DON stated the process for CPR was the clinical pharmacist would email the recommendations to the DON and each of the clinical nurse managers (CNM). The CNM who was responsible for the resident in the recommendation would forward to the provider if appropriate or address the recommendation if it was a nursing issue. DON further stated urgent recommendations should be addressed promptly, and less urgent ones should be addressed in one to two months at the most. During interview on 4/9/26 at 1:00 p.m., CP expected facilities to address the CPR within 30 days or so. CP stated should not have to issue the same recommendation without being addressed multiple times and would have expected R10's duplicate medications to have been addressed sooner than five months. Facility policy for pharmacy recommendation review was requested but was not provided.	F0756		05/11/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 4/6/26 through 4/9/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H56251062C(2592912), H56251060C(2619327), and	20000		05/11/2026

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

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20000	Continued from page 1 H56251061C (2567390). NO licensing orders were issued. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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.	20000		05/11/2026
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	21100	Corrected	05/11/2026

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21100	Continued from page 2 Based on observation, interview, and document review, the facility failed to ensure foods were stored in a manner to prevent spoilage and freezer burn and failed to ensure food items in 6 out of 6 kitchenettes were sealed, labeled and dated. This had the potential to affect all residents who reside in the facility. An observation on 4/7/26 at 3:22 p.m., the 2nd floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles, hot dog buns and a container of red and white substance. Nursing assistant (NA)-H verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 8:16 a.m., the 3rd floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, pepperoni, english muffins, omelets and bacon. NA-G verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/7/26 at 2:29 p.m., the 4th floor kitchenette was reviewed. The freezer had undated, opened packages of omelets, pancakes, french toast, corn dogs, bacon, sausages, Toaster Strudel, and White Castle burgers. Additionally, the refrigerator had an undated bowl of noodles, undated Tupperware container of beans, and a bag of opened carrots that were expired on 3/25/26 . NA-F verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/7/26 at 2:13 p.m., the 5th floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, bacon, and omelets. NA-A verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 7:44 a.m., the 6th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, french toast, bagels and meat patties. NA-E verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 7:27 a.m., the 7th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles and french toast. NA-D verified these items and stated all items should have been sealed, dated and labeled. During interview on 4/8/26 at 12:28 p.m., chef	21100		05/11/2026

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21100	Continued from page 3 manager (CM) expected any opened food items were sealed, dated and labeled. The kitchenettes had Ziplock bags, markers and deli containers with lids for storage use. CM further stated the kitchenettes were overseen by a multidisciplinary team. The CM oversaw education, ordered, stocked supplies and provided stocking sheets for staff. The nursing department oversaw the NAs. During interview on 4/9/26 at 12:40 p.m., administrator stated they expected all staff to handle and store food properly. Additionally, any opened items were to be labeled, dated and sealed. The rationale for proper food storage decreased the risk of food borne illness. A facility policy titled Episcopal Homes Refrigerator and Food Storage, directed staff to ensure opened freezer foods are sealed to prevent freezer burn and spoilage. Furthermore, all foods must be sealed, labeled and dated. SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could develop and implement policies and procedures, train staff, and ensure food is stored in a manner to minimize the possible development of food borne illness. Develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		05/11/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426	An employee completed a TB screening, including a QuantiFERON-TB Gold test on 1/15/2026, followed by a chest x-ray on 4/9/2026. The employee was determined to be negative for tuberculosis. All facility staff have the potential to be affected by this deficient practice. Moving forward, all staff will complete a TB symptom screen and either a QuantiFERON or Mantoux test, with a chest x-ray completed when indicated, prior to or upon hire in accordance with requirements. An audit of all current staff was conducted. Any staff found without appropriate TB screening (QuantiFERON, Mantoux, and/or chest x-ray as indicated) will have required testing completed to ensure compliance.	05/11/2026

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21426	Continued from page 4 (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a chest x-ray (CXR) was completed for 1 of 5 employees (nursing assistant (NA)-J) reviewed for tuberculosis (TB) testing who had a positive TB blood test. Findings include: Review of employee NA-J's QuantiFERON-TB Gold lab result dated 1/20/26, identified a positive (abnormal) result. The screening document indicated, "Please contact [NA-J] to come back into the clinic for a chest x-ray & TB brief." During interview on 4/9/26 at 12:41 p.m., director of nursing (DON) stated NA-J had a positive TB blood test and was not immediately sent for a CXR. DON stated as soon as the oversight was discovered, NA-J was removed from the schedule and sent in for a CXR. During interview on 4/9/26 at 1:22 p.m., administrator stated it was discovered yesterday (4/8/26), that NA-J had a positive TB blood test upon hire and with initial TB blood test resulted on 1/20/26, and had not received a follow up CXR. The administrator stated the process was for occupational health to send a referral for the CXR to human resources (HR) and then HR would follow up with the employee. The administrator stated NA-J should have been referred immediately for a CXR and could not explain how it was missed. Administrator stated expectation for confirmation of negative TB for all employees prior to starting work. Facility policy TB Control Plan dated 12/12/12, identified the purpose was to provide early identification, isolation, and treatment for any persons who have active TB. The plan further indicated all new employees would be screened for TB and if identified with a positive TB blood test, "They will be required to receive a chest radiograph to exclude a diagnosis of active infectious TB disease before having direct patient/resident contact." SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and	21426	Continued from page 4 The facility's TB policy was reviewed and remains current. All staff were re-educated on TB policy and procedures, with emphasis on completing required screening (Mantoux, QuantiFERON, and/or chest x-ray as indicated) prior to the first day of employment. The HR team or designee will conduct four audits per week for four weeks and if compliant will be followed by four audits per month for three months to ensure ongoing compliance. Results of audits and recommended changes in process will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026.	05/11/2026

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21426	Continued from page 5 procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		05/11/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for	21530	Corrected	05/11/2026

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21530	Continued from page 6 review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10’s quarterly Minimum Data Set (MDS) dated 3/16/26, indicated R10 had moderate cognitive impairment, was frequently incontinent of bowel, and was taking opioid medications during the seven-day lookback period. R10’s diagnoses included adjustment disorder with mixed anxiety and depressed mood, chronic pain syndrome, and constipation. R10’s care plan dated 12/17/25, indicated R10 used antidepressant medication and instructed staff to monitor adverse medication reactions such as constipation fecal impaction (when stool becomes hardened and stuck in the rectum due to long term constipation. The care plan further indicated R10 had chronic pain syndrome and instructed staff to give pain medications as ordered. R10’s consultant pharmacy review (CPR) dated 10/26/25, indicated, “The resident has orders for MiraLAX PRN [as needed] for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use [e.g. which to use first] or, if a duplication, consider discontinuing one of the above.” The CPR had an undated handwritten note stating "use MiraLAX first” and was signed by an unidentified nurse practitioner. R10’s CPR dated12/14/25, indicated “The resident has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above.” The CPR had an undated handwritten note that indicated it was faxed to provider per licensed practical nurse (LPN)-A. R10’s CPR dated 2/11/26 indicated, “The resident	21530		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE GARDENS	**1860 UNIVERSITY AVENUE WEST , SAINT PAUL, Minnesota, 55104**

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21530	Continued from page 7 has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above." The CPR had a handwritten note that indicated R10's medication administration record (MAR) was updated 3/4/26 by LPN-A. R10's monthly MARs dated 10/2025 through 2/2026, indicated, "MiraLAX Oral Packet 17 GM…Give 17 gram by mouth every 24 hours as needed for Constipation." And "Docusate Sodium Oral Capsule 100MG…Give 1 capsule by mouth every 24 hours as needed for Constipation." The monthly MARs lacked evidence of any instruction as to which medication to give first for constipation. During interview on 4/9/26 at 12:51 p.m., director of nursing (DON) expected R10's CPR would have been addressed timelier. DON stated the process for CPR was the clinical pharmacist would email the recommendations to the DON and each of the clinical nurse managers (CNM). The CNM who was responsible for the resident in the recommendation would forward to the provider if appropriate or address the recommendation if it was a nursing issue. DON further stated urgent recommendations should be addressed promptly, and less urgent ones should be addressed in one to two months at the most. During interview on 4/9/26 at 1:00 p.m., CP expected facilities to address the CPR within 30 days or so. CP stated should not have to issue the same recommendation without being addressed multiple times and would have expected R10's duplicate medications to have been addressed sooner than five months. Facility policy for pharmacy recommendation review was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon ASAP. Audits should be developed to monitor timeliness of action from physicians, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take that findings/education to the Quality	21530		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/09/2026**

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21530	Continued from page 8 Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		05/11/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were safe for self-administration of medication (SAM) for 1 of 1 residents (R36) observed with a medication at the bedside. Findings include: R36’s quarterly Minimum Data Set (MDS) dated 3/20/26, indicated R36 had intact cognition and required set up/clean up assistance to partial/moderate assistance for all self-care activities of daily living (ADLs). R36’s diagnoses included multiple sclerosis (a disease affecting the nervous system and may cause weakness, numbness, and difficulty walking), chronic obstructive pulmonary disease (COPD), arthritis, and need for assistance with personal care. R36’s care plan revised 12/8/25, indicated R36 had inability to manage self-care related to functional and cognitive decline. R36’s care plan further indicated R36 had multiple sclerosis which affected ADL independence. The care plan identified R36 wanted to be involved in her care and medications, but instructed staff to administer medications as ordered. R36's care plan lacked specific information regarding self-administration of medications. R36’s provider orders indicated the following: -11/02/23, R36 was ok to self-administer medications after set-up. -5/20/24, R36 required Ipratropium Bromide nasal	21565	Corrected	05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/09/2026**

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21565	Continued from page 9 solution 0.06% - 2 sprays in each nostril three times a day. -12/4/24, R36 required Fluticasone Propionate suspension 50mcg/act -2 sprays in each nostril every day. R36's medication administration record (MAR) dated 4/2026, indicated the Ipratropium Bromide nasal spray was scheduled for morning, evening, and bedtime. The MAR did not indicate this could be left at the bedside or could be self-administered. R36's MAR further indicated that the Fluticasone Propionate nasal spray was scheduled for 6:00 a.m. and was documented as given on 4/2 through 4/6 and 4/8. R36's SAM assessment dated 3/3/26, indicated R36 had "No desire to self-administer." The SAM assessment further indicated the interdisciplinary team (IDT) did not feel the resident was safe for SAM. R36's provider progress noted dated 3/24/26 indicated under the Assessment/Plan that R36 provided unreliable information and could not complete assessments due to her history of and advanced dementia. During observation and interview on 4/8/26 at 8:16 a.m., licensed practical nurse (LPN)-B gathered R36's morning medications for administration which included nine oral medications and one nasal spray. LPN-B entered R36's room and administered the oral medications. LPN-B asked if he could administer her Ipratropium Bromide nasal spray and R36 picked up a bottle of that nasal spray from her side table and stated she had already used that this morning. R36 stated she self-administered the nasal spray at her bedside (Ipratropium Bromide) in the morning and occasionally in the afternoon if she felt she needed it. R36 initially stated she was not aware of a second nasal spray, but when LPN-A showed her the medication, which was stored in her locked in-room medicine cabinet, she thought it looked familiar. R36 could not recall using the Fluticasone Propionate this morning and thought she took that nasal spray in the afternoon. LPN-B stated R36 had been assessed as appropriate for self-administration of medications. During interview on 4/8/26 at 10:23 a.m., LPN-A stated R36 had memory issues and could not be trusted to provide accurate information regarding which medications she took and when. LPN-A	21565		05/11/2026

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21565	Continued from page 10 reviewed R36's most recent SAM assessment and confirmed R36 had been assessed as not appropriate for SAM. LPN-A stated R36 had an order which indicated it was ok for SAM but stated R36 was no longer appropriate for SAM and should not have the nasal spray at the bedside. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated in order for a medication to be left at the bedside for SAM, there had to be an order and an assessment. The SAM assessment should identify the medication and indicate that the resident understood when and how to administer it. DON further stated R36 was not appropriate for SAM and should not have any medications left at the bedside. A facility policy titled Self-Administration of Medication dated 11/13/17, indicated a resident could only be considered safe for SAM after an assessment and the IDT determined which medications would be safe for SAM. The policy further indicated the following: -The SAM assessment must include evaluation of the resident's ability to follow administration instructions including dose and time of administration. -A periodic re-evaluation should be completed based on cognitive changes. -A physician order would be obtained and must include which specific medications could be kept at the bedside. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the residents are deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.	21565		05/11/2026

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21565	Continued from page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		05/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - EPISCOPAL ...** B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/07/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Episcopal Church Home The Gardens was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - EPISCOPAL ...** B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: EPISCOPAL CHURCH HOME GARDENS is a 7-story building with a lower-level parking garage. The original building was constructed in 2012 and was determined to be of Type I (332) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. There are single station smoke alarms in all resident rooms. The facility has a capacity of 60 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT	K0000		

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K0000 Bldg. 01	Continued from page 2 MET as evidenced by:	K0000		
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, and NFPA 13 Standard for the Installation of Sprinkler Systems, Sections 8.6.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/07/2026 at 11:28 AM it was revealed by observation that items being stored in the 7th floor storage closet were closer than 18 inches to the sprinkler head. 2. On 04/07/2026 at 11:22 AM, it was revealed by observation that a wire was resting on the sprinkler pipe on the 2nd and 5th floor 3. On 04/07/2026 at 11:34 AM, it was revealed by	K0353	The 7th floor storage closet was immediately corrected by removing and repositioning items to ensure that 18 inches of clearance was maintained below the sprinkler head. The wire observed resting on sprinkler piping on floors 2 and 5 was removed from the pipe. The conduit observed resting on sprinkler piping on floors 6 and 7 was repositioned to ensure no contact with sprinkler piping. All residents who reside in the facility are at risk related to sprinkler system impairment if required clearances are not maintained and if foreign objects are in contact with sprinkler piping or heads. An immediate facility-wide inspection was completed on all floors to identify and correct any wires and conduit resting on the sprinkler piping and to ensure compliance with the 18-inch clearance requirement from sprinkler heads. Administrator will educate maintenance staff, housekeeping, and all department heads on sprinkler system clearance requirements, including maintaining 18 inches of clearance below sprinkler heads and ensuring no objects or utilities rest on sprinkler piping. The maintenance team or their designee will conduct weekly environmental rounds of all storage rooms, utility areas, and mechanical spaces for four weeks, then monthly for three months to ensure sprinkler system clearance compliance is maintained. Results of audits will be brought to the QA committee for review of findings and further recommendations. Date of compliance: 5/11/2026	05/11/2026

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K0353 SS = E Bldg. 01	Continued from page 3 observation that conduit was resting on the sprinkler pipe on the 6th and 7th floor. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K0353		05/11/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/07/2026 at 12:02 PM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors on the 3rd floor caused by wires. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K0372	The penetration identified in the smoke barrier on the 3rd floor was sealed using approved fire-rated materials to restore the smoke barrier's integrity. All residents who reside in the facility are at risk related to compromised smoke barrier integrity if penetrations in smoke barriers are not properly sealed and maintained. A facility-wide inspection was completed to identify additional penetrations in smoke barriers. The facility will educate maintenance staff and environmental services staff on identifying and immediately reporting any smoke barrier penetrations and ensuring only approved fire-rated materials are used for sealing penetrations. The maintenance team will conduct monthly life safety inspections of all smoke barriers for three months, then quarterly thereafter to ensure integrity is maintained. Results of audits will be brought to the QA Committee for review and recommendations. Date of compliance: 5/11/2026	05/11/2026