Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
Episcopal Church Home of Minnesota
1879 FERONIA AVENUE
SAINT PAUL, MN 55104

RE: CCN:245452

Cycle Start Date: May 7, 2026

Dear Administrator:

On May 7, 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 August 7, 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 November 7, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING B. WING	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	1879 FERONIA AVENUE , 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 5/4/26 through 5/7/26, 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		05/20/2026
F0000	INITIAL COMMENTS On 5/4/26 through 5/7/26, 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:H54521737C (2708137), H54521738C (2696355), H54521740C (2592811), H54521739C (2591832). 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		05/20/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761	All identified medication storage issues for R8 and R87 were corrected immediately, including securing medications, removing discontinued medications, and properly storing insulin pens.	06/16/2026

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

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F0761 SS = E	Continued from page 1 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored appropriately, securely, and not expired for 3 of 5 medication carts reviewed for medication storage. This had the potential to affect all the residents who received medications from those carts or resided in or visited the area of the facility in which those medication carts were located. In addition, the facility failed to ensure a medication for one resident (R8) was not left at the bedside of a different resident (R87), contributing to inappropriate medication storage practices for the facility. Findings include: Unsecured medications R4's provider order dated 4/2/26, indicated, "Insulin Aspart Subcutaneous Solution Pen-injector 100 unit/ml [Insulin Aspart]" (short acting insulin used to treat diabetes). R4's order dated 4/28/26, indicated, "Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml [Insulin Glargine]" (long-acting insulin used to treat diabetes).	F0761	Continued from page 1 An audit of all medication carts and storage areas was completed to ensure proper storage, labeling, and security. Nursing staff re-educated on medication storage policy, insulin handling, and security expectations. A process was implemented to ensure discontinued medications are promptly removed. Pharmacy implemented new insulin pen labeling for open and expiration date and single bag delivery to keep insulin pens separate. Facility reviewed policy Bedside Medication Storage and Drug Storage Policy the policies were update. DON/Designee will complete random audit of medication carts and storage areas to ensure proper storage, labeling, and security 3x a week for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

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F0761 SS = E	Continued from page 2 R122's provider order dated 4/13/26, indicated, "Insulin Lispro [1 unit dial] Subcutaneous Solution Pen-injector 100 unit/mil [Insulin Lispro]." R122's provider order dated 4/6/26, indicated, "Acetaminophen Oral Tablet 500 mg." During continuous observation on 5/6/26 at 2:04 p.m., one medication cart located outside the transitional care unit (TCU) team room and adjacent to a common area with a television, sofa, table and several chairs, had a small med cup with two white pills sitting beside a large bottle of Tylenol. No staff were seen in the area. -At 2:09 p.m., registered nurse (RN)-I went to the med cart and gathered medications from the cart and walked away, leaving the two pills and bottle of Tylenol sitting unsecured on the med cart. -At 2:15 p.m., RN-I walked back to the cart, charted in the computer and at 2:19 p.m., walked away from the cart, again leaving the medication unsecured on top of the medication cart. -At 2:21 p.m., RN-I returned to the med cart, retrieved the cup with the two pills and disposed of them in the TCU team room. During interview on 5/6/26 at 2:22 p.m., RN-I stated she did leave the med cup with the two pills, which were Tylenol (acetaminophen), and the container of Tylenol out on the med cart unsecured. RN-I stated she prepared the medication and then discovered R122 was in therapy when she attempted to administer the medication. RN-I stated the medication was just Tylenol, but she still should not have left it sitting out since anyone walking by could have grabbed it. During observation and interview on 5/7/26 at 9:02 a.m., a tote sat next to the TCU medication cart and contained a clear plastic graduated cylinder with three insulin pens inside. The three insulin pens were not in individual plastic bags and were touching each other. There were no staff around and the tote was sitting between the med cart and the TV in the small common area. RN-I approached the cart and was asked about the insulin pens. RN-I stated insulin pens were normally stored in the top drawer of the med cart, she opened the top drawer and exposed several other insulin pens stored appropriately. RN-I stated the insulin pens should not be left out in the open and unsecured since anyone could have walked by and grabbed one. RN-I further stated the insulin pens were normally in	F0761		06/16/2026

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F0761 SS = E	Continued from page 3 individual plastic bags and confirmed the three that were out were not in bags and were touching each other. RN-I stated the pens should not have been stored like that. RN-I identified one of the pens were Lispro and was labeled for R122. RN-I identified the other two pens as Aspart and Lantus (Glargine) and stated they were labeled for R4. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated expectation for medications to be stored in the med carts and not left out unsecured which could allow residents, visitors or other staff to grab them. In addition, RN-A stated insulin pens should be stored in the top drawer of the med carts and not in the transport totes. Resident insulin pens should not be stored in direct contact with other resident's insulin pens to reduce the risk of cross contamination. R34's quarterly MDS dated 3/12/26, identified severely impaired cognition, diagnoses of diabetes mellitus and non-Alzheimer's dementia. R34 received insulin injections seven out of seven days in the lookback period. R34's nursing progress note dated 12/13/25 at 14:39 (2:39 p.m.), identified due to persistent increased blood sugars this day the nurse practitioner was updated and gave a one-time order for six units of insulin aspart (rapid-acting insulin). R34's corresponding Medication Administration Record (MAR) dated 12/13/25, identified the insulin aspart was given as ordered one time. R34's Physician's Orders form dated 3/26/26, identified to discontinue Lantus insulin (long-acting insulin also known as insulin glargine) R34's corresponding MAR dated 3/1/26 through 3/31/26, identified insulin glargine give four units subcutaneously (between the skin and muscle) one time daily related to type two diabetes. The order included a start date of 1/22/25 and discontinue date of 3/26/26. During an interview and observation on 5/7/26 at 10:50 a.m., registered nurse (RN)-E reviewed the insulin storage for the household. Included was an insulin aspart pen with a handwritten label including R34's name, which was not dated when opened. RN-E verified the insulin aspart was not a current order. Additionally, a Lantus insulin pen with a faded pharmacy label on it including R34's name was present. RN-E reviewed R34's orders and found the Lantus was discontinued on 3/26/26, neither pen	F0761		06/16/2026

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F0761 SS = E	Continued from page 4 should be in the insulin storage and usually, when a medication was discontinued, they would be removed from storage and given to the clinical manager to dispose. During observation on 5/7/26 at 10:28 a.m., an unattended medication cart was observed on the May unit. On top of the medication cart, there was a bottle of acetaminophen 500 milligrams tablets, and a teriparatide injection 560 micrograms over 2.24 milliliters. During continuous observation between 10:28 a.m. and 10:42 a.m., four staff members and a family member walked by the medication cart. During interview on 5/7/26 at 10:42 a.m., licensed practical nurse (LPN)-B stated she gave a shot to a resident before she went to check on another resident. LPN-B stated she needed to put the injectable medication in the refrigerator in the nurse's station and lock the bottle of Acetaminophen in the medication cart, but she forgot to do it. LPN-B added "I just forgot to put away the medications, somebody could have grabbed the medications." Medication left in wrong resident's room R87's admission MDS dated 4/8/26, identified R87 had intact cognition and required substantial to maximal assistance for most activities of daily living (ADLs). R87's diagnosis included neovascular secondary angle closure glaucoma (severe glaucoma involving blood flow to the eye resulting in increased intraocular pressure and potential vision loss) affecting the left eye. R87's provider orders did not indicate Diclofenac (topical pain gel). R8's provider orders dated 11/29/25, indicated, "Diclofenac Sodium External Gel 1%...Topical." During observation and interview on 5/4/26 at 5:41 p.m., R87 sitting in recliner with a bedside table in front of him. There was a bag with a tube of Diclofenac gel sitting on the table. R87 stated did not know what that medication was or what it was used for. With further inspection, the prescription label on the tube of medication indicated it was for a different resident (R8). R87 could not explain why it was left on his table. Licensed practical nurse (LPN)-D entered room and was asked about the medication. LPN-D picked up the bag, looked at the label and stated it belonged to a different resident and then set it back down on R87's table. LPN-D stated it must have been left there by the day shift	F0761		06/16/2026

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F0761 SS = E	Continued from page 5 and could not explain why it was in the wrong resident's room. During interview on 5/4/26 at 5:51 p.m., LPN-A entered R87's room and stated the medication must have been accidentally left on the table earlier in the day and could not otherwise explain why. During follow up interview on 5/6/26 at 1:48 p.m., LPN-A stated would not expect a medication for one resident to be left in a different resident's room. LPN-A stated medication should be stored securely and only left at the bedside of the correct resident if the resident was assessed safe to self-administer medication and safely store the medication at the bedside. During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated expectation for all medications to be securely stored in medication carts and not left out unsupervised and would not expect medications for one resident to be left in a different resident's room. DON further stated insulin pens should be stored in the top drawer of the locked medication cart and should not be stored in the tote that was used to transport the insulin pens to the resident room for administration. DON stated each insulin pen should be stored in a separate plastic bag designated for each individual resident and should never be stored together, unprotected from other resident's insulin pens which could cause cross contamination. In addition, DON stated that insulin pens should be discarded when expired. Facility policy Medication Storage Policy dated 1/1/2015, indicated lockable medicine carts, cabinets, and drawers were provided for proper storage of medications. The policy lacked reference to expired medications. Facility policy Bedside Medication Storage, undated, indicated medications were stored at the bedside only when the resident was assessed safe for self-administration and storage of medication. The policy further indicated, "All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage."	F0761		06/16/2026
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	F0880	Staff have been reeducated on appropriate hand hygiene and gloving practices with Resident R21 during incontinent care, R29 has nails trimmed to desired length and cleaned before and after meals. Staff involved were immediately re-educated on proper hand hygiene practices during cares, for residents prior to meals and after contaminated	06/16/2026

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F0880 SS = E	Continued from page 6 prevention and control program designed to provide 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	F0880	Continued from page 6 supplies were discarded. R115 has received all services with staff wearing appropriate PPE and proper signage and supplies provided outside the resident room. Facility-wide infection control audits and education completed focusing on staff hand hygiene and glove use during cares and hand hygiene for residents at meal time and PPE practices for residents on precautions. Full house audit for residents on EBP was completed to ensure all proper infection control practices are followed to include wearing proper PPE, signage and supplies are available. Re-education provided on hand hygiene, to address resident preferred nail length, glove use, and PPE. Standardized Enhanced Barrier Precaution process implemented with signage and PPE bins, to include staff to review new admissions for proper infeciton control practices. Hand hygiene incorporated into meal service workflow reminding residents to wash hands before meals, staff will assist residents as needed. Facility policy hand hygiene and EBP policy were reviewed and updated. DON/Designee will complete Weekly infection control audits for staff hand hygiene and glove use during cares and for residents needing assist with hand hygiene at meal time and PPE practices for residents on precautions to include wearing proper PPE, proper signage and supplies. Audits completed 3x a week audits for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

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F0880 SS = E	Continued from page 7 staff involved in direct resident contact. §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 hand hygiene for 1 of 1 resident (R21) during incontinence cares and for 1of 1 resident (R29) during meal service which had the potential to affect all 14 residents in that household. The facility further failed to ensure appropriate personal protective equipment (PPE) was being worn for 1 of 2 residents (R115) on enhanced barrier precautions (EBP). Findings include: Incontinence Care R21's admission Minimum Data Set (MDS) dated 3/10/26, identified severely impaired cognition, was always incontinent of bowel and bladder, and dependent on staff for toileting and lower body dressing. R21 had diagnoses of non-Alzheimer's dementia and acute cystitis with hematuria (bladder inflammation with blood in the urine). R21 was taking an antibiotic with an indication identified. R21's Urinary Incontinence Care Area Assessment (CAA) dated 3/10/26, identified an admission following hospitalization due to having a UTI (bladder infection) with no complications noted. R21 was always incontinent of B&B (bowel and bladder) during the reference period. Staff were directed to continue to provide assist with peri care after each incontinent episode.	F0880		06/16/2026

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F0880 SS = E	Continued from page 8 R21's ADL (activities of daily living) care plan dated 3/31/26, identified one staff was required for toileting. During an observation on 5/4/26 at 4:54 p.m., nursing assistant (NA)-D brought R21 who was in her wheelchair, to her bedroom. NA-C entered shortly thereafter. NA-D and NA-C assisted R21 into her bed using a full body mechanical lift. While R21 was laying on her back, NA-C put on gloves, opened R21's incontinence brief and using wet wipes, cleaned up bowel movement from R21's groin at the front of the brief, and tucked the soiled wet wipes into the brief. R21 was assisted to roll on her side and NA-C cleaned up the rest of the bowel movement from R21's buttocks and tucked the soiled wet wipes into the brief. NA-C removed the soiled brief containing the soiled wipes, rolled it all up and put in the garbage. With the soiled gloves still on, NA-C put a new brief under R21, opened a jar of emollient ointment, and using the same soiled gloves, scooped out the ointment and applied it to R21's backside. Then NA-C removed her soiled gloves and put them in the garbage can. R21 was assisted to roll on her back, and the new brief was fastened. NA-C exited the room to dispose of the garbage.NA-C had contaminated the outside of R21's brief and the emollient jar by handling the items with soiled gloves. During an interview on 5/4/26 at 5:02 p.m., NA-C stated her gloves should have been changed right after incontinence cares. NA-C also said it was a mistake to go into the emollient jar with soiled gloves as the emollient was used on R21's legs also. During an interview on 5/4/26 at 6:25 p.m., NA-D stated gloves should be changed right after incontinence cares, disposed of, and new ones put on before touching anything else. During an interview on 5/4/26 at 6:27 p.m., registered nurse (RN)-F stated he expected gloves to be changed, hand hygiene performed right after incontinence cares and before touching anything else. RN-F stated he would have to dispose of the emollient jar as it may be contaminated with feces which could contribute to UTI. R29 R29's annual MDS dated 4/15/26, indicated severely impaired cognition, diagnoses of dementia, and no	F0880		06/16/2026

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F0880 SS = E	Continued from page 9 rejection of care behaviors noted. It further indicated R29 required assistance from staff with personal hygiene. R29's care plan dated 4/22/26, indicated R29 demonstrated ADL self-care performance deficit related to decreased cognition/confusion, impaired mobility. Non-compliant in waiting for assistance with an intervention requiring moderate to maximal assist of 1. During observation on 5/5/26 at 1:05 p.m., R29 was sitting in a chair in the dining room. The fingernails on both hands were approximately two inches long and had brown matter caked underneath them. During observation on 5/6/26 at 11:25 a.m., R29 was sitting at the dining room table drinking juice and waiting for lunch. The fingernails on both hands were approximately 2 inches long and had brown matter caked underneath them. At 11:45 a.m., NA-A set her lunch plate in front of her but did not offer to wash R29's hands or use hand sanitizer before she started eating. R29 proceeded to pick up her roll and eat it with her hands. Then she would pick up pieces of food (salad) off of her plate with her fingers and eat it. At 12:11 p.m., NA-A gave R29 ice cream for dessert. She ate the ice cream with a spoon, but when the ice cream was gone, she stuck her fingers in the cup and then proceeded to lick them. She then used her hands to brush the crumbs from her lunch off the table onto the floor. At 12:33 p.m., R29 left the table in her wheelchair and headed down the hallway towards her room. NA-A did not offer to wash R29's hands or use hand sanitizer when she was finished eating. During observation on 5/7/26 at 7:36 a.m., R29 was sitting in the dining room eating oatmeal and was using a spoon. The fingernails on both hands were approximately 2 inches long and had brown matter caked underneath them. When she had finished eating her oatmeal, she stuck her fingers in the bowl and then licked her fingers. NA-A asked R29 if she was done with her oatmeal and then took the bowl away. R29 picked up her spoon and started eating her yogurt with a spoon. At 8:23 a.m. R29 was sitting at the table eating orange slices. When she was finished, she started to fall asleep. NA-A asked her if she wanted to go back to her room to take a nap. NA-A assisted R29 to stand up and grab her walker and she headed back down the hallway towards her room. NA-A did not offer to wash her hands or use hand sanitizer. During observation and interview on 5/7/26 at 8:50	F0880		06/16/2026

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F0880 SS = E	Continued from page 10 a.m., NA-B stated NAs were responsible for ensuring the residents hands and fingernails were clean and they were expected to wash the resident's hands (or use hand sanitizer) before and after meal service. NA-B verified R29's fingernails were long and had brown matter underneath them that appeared to have been there for a while, stating R29 often eats with her hands. During interview on 5/7/26 at 8:57 a.m.NA-A stated nursing assistants were responsible for ensuring resident's hands and fingernails were clean stating they have manicure sticks they can use on the resident's shower day, or they can wash them and clean underneath the nails if needed. NA-A further stated the NAs were also responsible for offering to wash the resident's hands or use hand sanitizer after meal service. During interview on 5/7/26 at 9:10 a.m., RN-B stated nursing staff (NAs and nurses) should be offering to clean the resident's nails at least once a week on their bath day and as needed, or they can soak their hands and clean underneath their nails. This is important to prevent germs from spreading. EBP R115's census identified he was admitted on 4/28/26. R115's in-house nurse practitioner (NP) initial intake document dated 5/1/26, identified diagnoses of cellulitis, abscess of right lower extremity (RLE) and history of sepsis. R115 had a right lower extremity wound which was "really weepy" and required a towel underneath the leg to absorb drainage. A wound consult was ordered. R115's wound care orders dated 4/30/26, identified clean leg with antimicrobial cleansing solution, dry well, apply skin prep to peri-wound, xeroform (protective wound dressing) to wound bed, cover with non-adherent gauze, add ABD pad (consists of a soft outer nonwoven layer and fluff filler to absorb and disperse fluid) as needed if drainage, secure with kerlix (gauze). R115's care plan dated 4/30/26, identified actual impairment to skin integrity of bilateral lower extremity wound with interventions to follow facility protocols for treatment of injury. The care plan	F0880		06/16/2026

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F0880 SS = E	Continued from page 11 lacked EBP interventions. During an observation on 5/4/26 at 11:36 a.m., R115 was seated in his wheelchair. His RLE was wrapped in gauze up to the knee, covered with a grip sock and elevated on a folding chair. R115 stated he had an infection while in the hospital. He had a lower leg wound that had a once weekly dressing change, however it was recently changed to daily dressings as the weekly one would get too saturated and leak. During an observation and interview on 5/4/26 at 11:50 a.m., nursing assistant (NA)-E entered R115's room with a mechanical standing lift to complete a transfer. NA-E did not put on any PPE for the transfer. After NA-E exited the room, she was asked if R115 required EBP and she R115 was not on precautions, because there was no bin outside the room of PPE and no signage near the door. NA-E stated that was the reason she did not put a gown on to help R115 with his transfer. During an interview on 5/4/26 at 11:58 a.m., NA-F stated if a resident was on EBP a gown should be on for all high contact cares. Additionally, a sign and bin would be outside each room. NA-F looked at R115's room and said there was no PPE bin or signage for EBP and was unsure if EBP was in place. During an interview on 5/4/26 at 12:20 p.m., RN-G who was working with R115 today, stated if a resident was on EBP they needed a gown and gloves on for all direct care, including transfers. Though RN-G had been working with R115 today, she was unsure if he was on EBP and wanted to check with the nurse manager. During an interview and observation on 5/4/26 at 12:25 p.m., RN-G returned with a printed EBP instructions sign for R115's doorway and said he should be on EBP due to the wound. RN-G stated the wound was weeping fluid today when the nurse practitioner changed the dressing. During an interview on 5/4/26 12:26 p.m., RN-A stated R115 should have EBP in place as he was admitted with a wound. Each room on EBP should have their own bin and signage directing staff to follow EBP PPE precautions.	F0880		06/16/2026

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F0880 SS = E	Continued from page 12 During an observation on 5/4/26 at 12:30 p.m., NA-F placed a full PPE bin outside of R115's room. During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated gloves should be changed immediately after incontinence cares, hand hygiene should be completed and new gloves put on if needed, and a resident with a weeping wound should be placed on enhanced barrier precautions for infection control purposes. During interview on 5/7/26 at 10:08 a.m., DON stated if a resident's fingernails are dirty the nursing staff are expected to clean them. They are also expected to be offering to wash the residents' hands or use hand sanitizer if they are visibly soiled after meal service. A facility policy regarding hand hygiene dated 10/2/24, indicated hands must be washed with soap and water if they are visibly soiled. Alcohol based hand sanitizer may be used for hand hygiene unless hands are visibly soiled. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether 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. Hand hygiene is essential in order to prevent the transmission of infectious agents.	F0880		06/16/2026
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 medication was administered safely for 2 of 2 (R68, R117) who had been assessed as unable to safely self-administer medications. Findings include:	F0554	Unauthorized medications were removed from R68 and R117 resident rooms immediately. Resident R68 and R117 were reassessed for Self Administration of Medications (SAM). Audit completed of all residents for bedside medications and SAM status. Staff Re-education on SAM requirements. SAM requires assessment, care plan, and provider order prior to implementation. Added into admission/readmission assessment if the residents wants to SAM, then would trigger a SAM assessment and IDT determination prior to implementation. Policy Bedside Medication Storage was reviewed and updated. SAM policy was reviewed and updated.	06/16/2026

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F0554 SS = D	Continued from page 13 R117 R117's care plan dated 4/27/26, indicated R117 had an ADL self-care deficit related to a functional ability decline due to right scapula and rib nonunion (unhealed fracture). The care plan further indicated R117 had altered respiratory status and difficulty breathing related to COPD (chronic obstructive pulmonary disease) and OSA (obstructive sleep apnea). R117's provider orders dated 4/26/26, indicated "Calcium Carbonate Antacid Oral Tablet Chewable 1000 MG…Give 1 tablet by mouth one time a day for Supplement." R117's provider orders lacked evidence of Symbicort (budesonide/formoterol) inhaler. R117's electronic medical record (EMR) lacked evidence of orders allowing SAM and medications to be left at bedside. R117's SAM assessment dated 4/26/26, indicated R177 did not desire to self-administer medications and agreed to have medications administered by the facility. During observation and interview on 5/4/26 at 1:42 p.m., R117 was in their room in recliner with a bedside table adjacent to the chair. There was an unlabeled inhaler and also a small medicine cup with 2 chewable disks inside. R117 stated she used the inhaler on occasion and would take those chewable tablets later. During observation and interview on 5/4/26 at 1:56 p.m., licensed practical nurse (LPN)-C confirmed the medications on R117's bedside table included a Symbicort inhaler and two Tums. LPN-C stated R117 was not assessed as safe for SAM and those medications should not have been left at the bedside. LPN-C stated if a resident refused to take a scheduled medication when offered, it should be removed and not left at the bedside. During interview on 5/6/26 at 1:48 p.m., LPN-A stated would not expect medications to be left at the bedside unless the resident was assessed as safe for SAM. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated in order for medications to be left at the bedside, the resident must be assessed as safe for SAM. RN-A stated R117 had not been assessed as safe for SAM and therefore, the medication should not have been left at her bedside.	F0554	Continued from page 13 Audits to ensure medication was administered safely for residents assessed for appropriate SAMS status to safely self administer medications and audit resident rooms for unsecured medications. Audits completed 3x a week for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

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F0554 SS = D	Continued from page 14 During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated medications should not be left at the bedside unless the SAM assessment was completed indicated the resident was safe for SAM. Facility policy Bedside Medication Storage, undated, inidcated, "All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage." R68 R68's quarterly MDS dated 4/14/26, indicated R68 was cognitively intact, had no hallucinations or delusions. MDS indicated R68 was set up assistance with activity of daily living and supervision with mobility. MDS indicated diagnoses of chronic obstructive pulmonary disease, cellulitis of lower limbs, and left knee surgery. A review of R68's orders indicated the following: -On 1/26/26, R68 may not self-administer medication. -On 3/6/26, required a topical analgesic external gel 4% apply to affected areas. R68's care plan revised on 4/3/26, indicated she was at risk for impaired comfort related to pain. Interventions directed staff to give pain medication as ordered, monitor effectiveness of pain interventions, provide non-pharmacological measures and report unrelieved pain and condition of change to primary care provider. R68's SAM assessment dated 3/6/26, indicated R68 was not safe to self-administer medications. Furthermore, the comment section indicated R68 hoarded and used multiple over the counter medications. During observation on 05/04/2026 at 5:29 p.m., R68 had Biofreeze (topical analgesic) roll-on located in a bin on bedside table in her room. R68 was sitting in chair and stated she puts it on by herself. During observation on 05/05/2026 at 9:49 a.m., R68 had Biofreeze located in a bin on bedside table in room. During observation on 05/06/2026 at 10:53 a.m. R68 had Biofreeze located in a bin on bedside table in	F0554		06/16/2026

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F0554 SS = D	Continued from page 15 room. Nursing assistant (NA)-I confirmed that there was Biofreeze in R68's room as R68 applied it when it was needed. During interview on 5/6/26 at 11:45 a.m., LPN-B stated residents' medications should be locked up. Additionally, an assessment for SAM was required and order from the physician was necessary for residents to self-administer medications. Facility policy Self-Administration of Medication dated 11/13/17, indicated residents could only self-administer medications after the IDT (interdisciplinary team) had determined which medications could be safely self-administered. The policy further indicated, if a resident was found safe for SAM per the licensed nurse assessment and IDT determination, a provider order would also need to be obtained which would specify which medications could be kept at the bedside. During interview on 5/6/26 at 1:28 p.m., RN-H stated for residents to self-administer medications was a physician order was required. The resident needed to be cognitively able to safely take the medication, know the name of medication, and how often to take it. During interview on 5/7/26 at 10:22 a.m., director of nursing (DON) stated they expected residents who self-administered medications to have a physician's order. The resident needed to be cognitively able to understand the medication and its use. Additionally, a SAM assessment was to be completed quarterly for residents to help determine if they were safely able to self-administer medications.	F0554		06/16/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical	F0580	Primary care provider was notified of a change in condition for resident R21. Audit of recent resident condition changes completed to verify provider notification and follow-up. Reeducation of nursing staff for change in condition, to include how to pull 24 hour report in PCC, timely communication and documentation, Wound tracking log implemented with weekly review. Facility Skin Care Policy dated 3/2025 was reviewed and updated. Facility policy Change in Condition was reviewed and is current Weekly chart audits for proper communication and	06/16/2026

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F0580 SS = D	Continued from page 16 complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the primary care provider (PCP) was notified of a change in condition for 1 of 2 residents (R21) reviewed for a change of condition. Findings include: R21's admission Minimum Data Set (MDS) dated	F0580	Continued from page 16 documentation for change in condition with primary provider. Audits completed 3x a week for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

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F0580 SS = D	Continued from page 17 3/19/26, identified she had severely impaired cognition, no behaviors or rejection of care and was dependent on staff for toileting, bed mobility, transfers and lower body dressing. Diagnoses included diabetes mellitus and non-Alzheimer's dementia. R21 was admitted with an unstageable pressure ulcer/injury, was at risk for developing pressure ulcers/injuries and did not have foot problems. Skin interventions included pressure reducing devices for bed and pressure ulcer/injury care. R21's pressure ulcer Care Area Assessment (CAA) dated 3/10/26, identified she was admitted with left heel unstageable PI (pressure injury), dressing applied, to be seen by the wound nurse. R21's care plan dated 3/31/26, identified she had a pressure ulcer related to immobility with interventions to administer treatments, monitor for effectiveness, provide education, monitor nutrition and pressure relieving mattress on bed. The care plan lacked notation of any toe concerns. R21's weekly Skin and Body Audit form dated 4/4/26, identified the tip of right first toe (the big toe) had ischemic (dark or dusky color indicative of insufficient blood flow) tissue measuring 1.2 centimeters (cm) long by 0.9 cm wide. R21's nursing progress note dated 4/4/26 at 14:43 (2:43 p.m.), identified an on-call senior care nurse practitioner was notified of the ischemic tissue on the tip of the right first toe with instructions to continue monitoring with an update to the PCP wound nurse on Monday (4/6/26). R21's consultant wound care nurse practitioner (NP)-B visit note dated 4/16/26, identified the unstageable pressure ulcer to the left heel was healed, no new skin issues were reported to NP-B and to reconsult with any new concerns. NP-B was not updated on the new skin alteration to the right first toe observed on 4/4/26. R21's consultant wound care NP-A visit note dated 5/5/26, identified a non-pressure wound of the right first toe and full thickness of unknown duration, at least greater than 14 days. The estimated time to heal was one to two months. Care goals included to decrease wound area, improve new tissue growth, prevent infection, close monitoring, debridement, education and off-loading. Wound measurements were 1.2 cm long by 1.8 cm wide. The wound measurements had increased in width by 0.9 cm since it was last measured on 4/4/26. New orders	F0580		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	**1879 FERONIA AVENUE , SAINT PAUL, Minnesota, 55104**

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F0580 SS = D	Continued from page 18 were issued to apply Betadine (an antiseptic) once daily and as needed. During an observation and interview on 5/4/26 at 4:54 p.m., nursing assistant (NA)-D brought R21 into her room. The top of R21's right first toe was exposed and black on the top slightly larger than a dime in size. NA-D stated R21 had a bruise on the top of her right first toe and was unsure how long the skin alteration was present and estimated a week or more. During an interview on 5/6/26 at 7:51 a.m., licensed practical nurse (LPN)-A stated yesterday, on 5/5/26, the wound provider NP-A debrided (medical removal of dead, damaged, or infected tissue from a wound to promote healing) R21's right first toe wound, and they were waiting for the wound provider's transcription of the visit. During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, electronic chart and 24-hour nursing report sheets and stated the order for 4/6/26 to update the PCP wound care provider should have been completed and was not. Because of the lack of notification, consistent monitoring was not completed of the necrotic right first toe. During an interview on 5/6/26 at 1:07 p.m., consultant wound care NP-A, stated as soon as a facility noticed a new skin alteration, they should contact the wound care team so they can examine during their next wound rounds and update their records. NP-A expected any directions for wound care should be followed. NP-B stated it was not a significant change in the past month to R21's right first toe wound and expected it to be treatable. NP-A was not concerned that the wound had increased in size since first noticed on 4/4/26, and stated sometimes wounds increase in size before they begin to improve and his assessment showed R21's wound was stable. NP-A stated if R21's skin alteration had been addressed on 4/6/26, as ordered, it could have decreased in size by this time. During an interview on 5/6/26 at 12:03 p.m., senior care NP-C stated their on-call service was notified of the new skin alteration on 4/4/26 with orders to monitor and update the wound provider next business day (4/6/26). NP-C wrote new orders for R21 regarding blood pressure on 4/6/26, however she was not personally updated by the facility of R21's new skin alteration on the right first toe, so it was not addressed in her orders. NP-C stated she relied on the nursing staff to provide updates on	F0580		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	**1879 FERONIA AVENUE , SAINT PAUL, Minnesota, 55104**

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F0580 SS = D	Continued from page 19 changes in condition, and no information about the right first toe alteration was in their records between 4/4/26 and 5/4/26. During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated the facility should have updated the PCP or wound provider on 4/6/26, as identified in the on-call order, and entered into the electronic medical record to ensure consistent monitoring of the skin alteration was completed to ensure follow up. On 5/7/26 at 12:17 p.m., a phone call was placed to NP-B to inquire about his last wound care visit with R21 on 4/16/26 and if he was updated on the new skin alteration on the right first toe. On 5/14/26 at 1:50 p.m., NP-B's medical liaison (ML) returned the previous phone call. The ML stated she reviewed the phone logs and records, and their service was not updated on 4/6/26 or any date thereafter, of R21's new skin alteration on the right first toe, and she would have expected their services to be updated to complete a new assessment and form a treatment plan. The facility's Change in Condition policy dated 5/4/22, identified to promptly notify the resident, his/her attending MD (medical doctor) or other person as indicated by the resident of changes in the resident's condition. The MD should be notified if there was a discovery of injury of unknown source and a need to alter the resident's medical treatment. Additionally, documentation should be entered in the medical record of all information related to the change in condition, the notifications and interventions.	F0580		06/16/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document	F0684	For resident R21 facility ensured a new skin alteration was comprehensively assessed and monitored consistently in accordance with nursing standards of practice, and that orders for monitoring and referral were entered in the electronic medical records for new skin alterations. R21 was assessed by the facility wound nurse to ensure proper follow up and care. Audit of recent condition changes completed to verify provider notification and follow-up. Reeducation of nursing staff for change in condition, to include how to pull 24 hour report in PCC, timely communication and documentation per the comprehensive assessment, Wound tracking log	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

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F0684 SS = D	Continued from page 20 review, the facility failed to ensure a new skin alteration was comprehensively assessed and monitored consistently in accordance with nursing standards of practice, and that orders for monitoring and referral were entered into the electronic medical record (EMR) for 1 of 2 residents (R21) reviewed for new skin alterations. Findings include: R21's admission Minimum Data Set (MDS) dated 3/19/26, identified she had severely impaired cognition, no behaviors or rejection of care and was dependent on staff for toileting, bed mobility, transfers and lower body dressing. Diagnoses included diabetes mellitus and non-Alzheimer's dementia. R21 was admitted with an unstageable pressure ulcer/injury, was at risk for developing pressure ulcers/injuries and did not have foot problems. Skin interventions included pressure reducing devices for bed and pressure ulcer/injury care. R21's pressure ulcer Care Area Assessment (CAA) dated 3/10/26, identified she was admitted with left heel unstageable PI (pressure injury), dressing applied, to be seen by the wound nurse. R21's care plan dated 3/31/26, identified she had a pressure ulcer related to immobility with interventions to administer treatments, monitor for effectiveness, provide education, monitor nutrition and pressure relieving mattress on bed. The care plan lacked notation of any toe concerns or interventions. R21's weekly nurse Skin and Body Audit forms identified: -4/4/26, tip of right first toe (the big/great toe) had ischemic (dark or dusky color indicative of insufficient blood flow) tissue measuring 1.2 centimeters (cm) long by 0.9 cm wide. -Wound assessments were not obtained 4/8/26 through 4/13/26, due to R21's hospitalization. -4/21/26, no notation of the right first toe alteration. -4/25/26, hard dark tissue observed on the right first toe. The audit lacked measurements of the skin alteration. -5/2/26, cyanosis and bruising on the right first toe. The audit lacked measurements of the skin alteration.	F0684	Continued from page 20 implemented with weekly review. Facility Skin Care Policy dated 3/2025 was reviewed and updated. Facility policy Change in Condition was reviewed and is current Audits for proper communication and documentation for treatment orders, the audit includes a review of new skin conditions and to ensure they were comprehensively assessed and monitoring orders placed. Audits completed 3x a week for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

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F0684 SS = D	Continued from page 21 R21's nursing progress note dated 4/4/26 at 14:43 (2:43 p.m.), identified the on-call provider was notified of the ischemic tissue on the tip of the right first toe with instructions to continue monitoring with an update to the PCP wound nurse on Monday (4/6/26). R21's Medication Administration Record (MAR), Treatment Administration Record (TAR) and EMR dated 4/1/26 through 5/4/26, lacked orders to monitor ischemic tissue on the right first toe or to update the PCP wound nurse on 4/6/26. The on-call provider's orders given on 4/4/26, had not been transcribed into the EMR for staff to monitor and document, therefore no further measurements were obtained and the PCP wound nurse was not updated on 4/6/26, of the new skin alteration. R21's consultant wound care nurse practitioner (NP)-B visit note following hospitalization dated 4/16/26, identified an unstageable pressure ulcer to the left heel was healed, no new skin issues were reported to NP-B and to reconsult with any new concerns. R21's consultant wound care NP-A visit note dated 5/5/26, identified a non-pressure wound of the right first toe and full thickness of unknown duration, at least greater than 14 days. The estimated time to heal was one to two months. Care goals included to decrease wound area, improve new tissue growth, prevent infection, close monitoring, debridement, education and off-loading. Wound measurements were 1.2 cm long by 1.8 cm wide. The wound measurements had increased in width by 0.9 cm since it was last measured on 4/4/26. New orders were issued to apply Betadine (an antiseptic) once daily and as needed. During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, EMR and 24-hour nursing report sheets and stated the order on 4/4/26, to update the PCP wound care provider on 4/6/26, should have been completed and was not. Because the order was not transcribed into the EMR, consistent monitoring was not completed of the ischemic right first toe. During an interview on 5/6/26 at 1:07 p.m., consultant wound care NP-A, stated any directions for wound care should be followed. NP-B stated it was not a significant change in the past month to R21's right first toe wound and expected it to be treatable. NP-A stated if R21's skin alteration had been addressed on 4/6/26, as ordered, it could have	F0684		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

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F0684 SS = D	Continued from page 22 decreased in size by this time. During an interview on 5/6/26 at 7:51 a.m., licensed practical nurse (LPN)-A stated he could not find documentation the wound had been measured or comprehensively assessed since it was first noticed on 4/4/26. LPN-A stated orders from the weekend on-call providers should be entered into the EMR. During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, electronic chart and 24-hour nursing report sheets and stated the weekend order to monitor the wound and to update the PCP wound care provider on 4/6/26, should have been completed and was not. During an interview on 5/6/26 at 12:03 p.m., senior care NP-C stated in the case of new ischemic skin alterations in a toe, she would expect nursing staff to document at least daily assessments in the medical record of the condition, signs of infection, circulation in the feet, and to update the provider on any worsening. Part of determining the progress or lack of progress in a wound included skin measurements. During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated that she expected staff to follow the facility policy to complete and document Skin and Body audits every week which would include measurements and progress of the wound. Additionally, providers should be updated on skin alterations to ensure proper follow up. The facility's Skin Care policy dated 3/2025, identified for an existing ulcer, the assessment would: • Differentiate the type of ulcer (pressure-related versus non-pressure related) • Determine the ulcer's stage • Describe the ulcer's characteristics • Determine if infection is present • Assess pain • Note any dressings and treatments that have occurred. Additionally, the comprehensive assessment would initiate care plan directives including daily monitoring of skin with cares, at least weekly	F0684		06/16/2026

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F0684 SS = D	Continued from page 23 documentation in conjunction with bath day, monitoring of the ulcer's characteristics, progress toward healing, and potential complications.	F0684		06/16/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was safe to have a lift reclining chair for 1 of 1 resident (R92) reviewed for falls. Findings include: R92's admission Minimum Data Set (MDS) dated 4/23/26, identified R92 had severe cognitive impairment, had lower extremity impairment on one side of the body, had a history of falls, was dependent on staff for transfers, and received antipsychotic, antianxiety, antidepressant, and opioid medications. R92's diagnoses included dementia, disorientation, anxiety, muscle weakness, and right pubis fracture. R92's care plan printed 5/7/26, indicated R92 was "HIGH risk for falls r/t [related to] impaired mobility, confusion, dementia" and instructed staff to ensure call light was in reach and encourage R92 to use it. The care plan identified R92 had an ADL (activities of daily living) self-care deficit and required two staff to assist with transfers using a sara steady (standing lift) as needed. The care plan did not identify R92 had a lift reclining chair. R92's physical device review dated 4/19/26, identified R92 used a low bed and a walker, however, did not identify an electric recliner chair or any other lift type reclining chair.	F0689	R92 was assessed for use of the lift reclining chair. During the remainder of R92's stay at the facility, the facility ensured R92 was safe in a nonreclining chair. R92 has moved back home and is no longer at the facility. Audit assessed all residents using lift reclining chairs was safe to have a lift reclining chair. Formal lift reclining chair assessment process implemented. Therapy and/or nursing must approve use. Care plan documentation required. Facility created an assessment and a policy on physical device assessments that is current. Nursing and therapy staff educated on the physical device process and policy. Audits to ensure new residents for proper assessment and use of a lift reclining chairs. Audits completed 2x a week for 4 weeks, then weekly for 4 weeks. Then Monthly for one month, results reviewed in QAPI.	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

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F0689 SS = D	Continued from page 24 During observation on 5/7/26 at 8:30 a.m., R92 was not in her room. The lift reclining chair was all the way up to an almost vertical position. During observation on 5/7/26 at 8:40 a.m., R92 transferred from standing with a walker to the lift chair with contact guard assistance by physical therapist assistant (PTA)-B. PTA-B used the lift chair remote to lower the chair to a seated position and then to a reclining position. PTA-B placed the lift chair remote and the call light both on the right side of R92's lap next to each other. During interview on 5/7/26 at 8:41 a.m., PTA-B was not aware of any assessment for safe use of the lift chairs. During interview 5/7/26 at 8:52 a.m., nursing assistant (NA)-H stated R92 required the sara steady lift for transfers from nursing staff and therapy used the lift chair. NA-H stated was not aware if R92 know how to use the lift chair, but she did use the call light on occasion. NA-H stated R92's cognition fluctuated and was not sure she always knew she was pushing the call light. During interview on 5/7/26 at 9:01 a.m., occupational therapy assistant (OTA)-A was not aware of any sort of lift chair assessment for residents. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated only nursing staff were supposed to use the lift chair for resident transfers when therapy indicated it was safe for the resident. RN-A further stated instructions for safe use would be on the resident's whiteboard and would also be in the resident's care plan. During interview on 5/7/26 at 9:20 a.m., director of therapy (DT) stated therapist working with the resident would do an informal evaluation of the lift chair and was not aware of any formal assessment. DT further stated was aware of a fall from a lift chair involving a different unidentified resident in long term care some time ago. DT stated maintenance ended up disabling the lift function of the recliner as a result of the findings of that fall investigation. DT	F0689		06/16/2026

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F0689 SS = D	Continued from page 25 further stated periodic evaluations should occur with resident's use of physical devices since their cognition can change. During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated the therapy department worked with residents who had lift chairs and was not aware of any formal assessment. DON stated was aware of previous fall from a lift chair when a resident accidently sat on the remote and unintentionally activated the lift function of the chair. DON stated R92 was cognitively impaired and could see her accidentally using the lift chair remote when she intended to push the call light. During follow up interview on 5/7/26 at 11:30 a.m., DON stated the electronic recliner was listed on physical device assessment form and was being used with other residents as a lift chair assessment and the facility would change the wording to indicate lift chair. DON further stated R92 should have had an assessment completed to determine if she was safe to have a lift chair. A facility policy on physical device assessments was requested but not provided.	F0689		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 6, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Episcopal Church Home of Minnesota, 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		05/20/2026

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: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

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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: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: The Episcopal Church of Mn is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of type II (222) construction. In 1971 an addition was constructed to the south side of the building that was determined to be type II (222) construction. In 2008 an addition was constructed to the north side of the building that was determined to be type II (222) construction. Because the original building and addition's meet the same construction type allowed for existing buildings all 3 buildings will be surveyed as one building. The facility has a capacity of 131 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	**1879 FERONIA AVENUE , SAINT PAUL, Minnesota, 55104**

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K0225 SS = F Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, section 7.1.3.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 5/6/2026 at 9:40 AM, it was revealed by observation that several items were being stored within the stair enclosure (Stair C) at the entrance of the basement level.. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K0225	Stored items were removed from Stair C. Staff were re-educated that stair enclosures must remain free of storage. Audit to inspect stair enclosures monthly for 3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	06/16/2026
K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0311	The missing ceiling section in the Nursing Storage Room was repaired and sealed. Ceiling integrity checks were added to routine maintenance inspections. Audit will inspect ceiling areas monthly for 3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	06/16/2026

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K0311 SS = F Bldg. 01	Continued from page 3 failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 5/6/2026, at 9:45 AM, observations and staff interview revealed that there was a section of ceiling missing in the Nursing Storage Room that would allow smoke and heat to escape delaying the activation of the sprinkler and fire alarm system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311		06/16/2026
K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K0321	The four pipe penetrations through the 1-hour fire wall were sealed. Penetration control was reinforced to ensure future openings are sealed promptly. Audit will inspect fire barrier penetrations monthly for 3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance	06/16/2026

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K0321 SS = F Bldg. 01	Continued from page 4 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the Life Safety Code NFPA 101 - 2012 edition 19.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 5/6/2026, at 9:55 AM, observations and staff interview revealed that there were 4 pipes penetrating the 1 hour fire wall that were not sealed to maintain a 1 hour rating. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		06/16/2026
K0362 SS = F Bldg. 01	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the	K0362	The two penetrations above the ceiling near Stair H were sealed. Barrier checks were reinforced to identify and correct above-ceiling penetrations. Audit will inspect above-ceiling barrier areas monthly for 3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	06/16/2026

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K0362 SS = F Bldg. 01	Continued from page 5 underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 5/6/2026, at 10:00 AM, it was revealed by observation that there were two penetrations on the 3rd floor above the ceiling near Stair H. This wall serves as a fire smoke barrier for this area. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K0362		06/16/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K0918	The facility completed generator battery testing for specific gravity or conductance and arranged annual fuel quality testing. The preventive maintenance schedule was updated to include required battery testing and annual fuel testing documentation for the Emergency Power Supply System. Compliance will be monitored through monthly generator log and documentation reviews for 3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	06/16/2026

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K0918 SS = F Bldg. 01	Continued from page 6 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 5/6/2026, at 9:15 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance and did not have documentation on the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		06/16/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 23, 2026

Administrator
Episcopal Church Home of Minnesota
1879 FERONIA AVENUE
SAINT PAUL, MN 55104

RE: CCN: 245452
Cycle Start Date: May 7, 2026

Dear Administrator:

On June 22, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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