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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 6R9L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00486

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245452**

2. STATE VENDOR OR MEDICAID NO. (L2) **419042400**

3. NAME AND ADDRESS OF FACILITY
(L3) **EPISCOPAL CHURCH HOME OF MINNESOTA**
(L4) **1879 FERONIA AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55104**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/02/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81	50		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 02/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/09/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245452

February 27, 2018

Ms. Melissa Schneider, Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Dear Ms. Schneider:

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

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

Effective January 2, 2018 the above facility is certified for:

50	Skilled Nursing Facility Beds
81	Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

Electronically delivered
February 27, 2018

Ms. Melissa Schneider, Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: Project Numbers S5452027, H5452033, H5452034

Dear Ms. Schneider:

On November 21, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 26, 2017. (42 CFR 488.422)

Also, on November 21, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 2, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 2, 2017, and failure to achieve substantial compliance at the recertification survey completed on November 2, 2017. The most serious deficiencies at the time of the November 2, 2017 survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 2, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on October 2, 2017, and a PCR completed on November 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the survey, completed on October 2, 2017 and November 2, 2017, as of January 2, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 2, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of November 21, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 2, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 2, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 2, 2018, is to be rescinded.

In our letter of November 21, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 2, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 2, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6R9L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00486

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2. STATE VENDOR OR MEDICAID NO. (L2) **419042400**

3. NAME AND ADDRESS OF FACILITY
(L3) **EPISCOPAL CHURCH HOME OF MINNESOTA**
(L4) **1879 FERONIA AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55104**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81	50		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 12/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/10/2018 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
November 21, 2017

Ms. Melissa Schneider, Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: Project Number S5452027, H5452033 and H5452034

Dear Ms. Schneider:

On October 13, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on October 2, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 2, 2017, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with federal certification deficiencies. The most serious deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective November 26, 2017. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 2, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 2, 2018. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective January 2, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Episcopal Church Home Of Minnesota is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 2, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 2, 2018 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 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
F 000	INITIAL COMMENTS On October 30, 31, November 1, and 2, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (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 determine if the practice of self-administration of medications was safe for 1 of 1 resident (R 28) observed to have medications left on the dining room table to take without staff supervision.	F 176	Plan of correction for residents cited with this survey: R28 was assessed as not appropriate for Self-Medication Administration. Per facility Medication Administration policy facility nurses must and will visualize R28 taking medication.	1/2/18

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

Electronically Signed | 12/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 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
F 176	Continued From page 1 Findings include: R28's care plan revised 2/16/17, indicated R28 had cognitive impairment related to chronic pain and psychotropic drug use. R28's care plan did not address self-administration of any medications. R28's quarterly Minimum Data Set (MDS) dated 7/17/17, indicated R28 was cognitively intact and required extensive assistance from staff with all activities of daily living except eating which R28 was independent with. R28's diagnosis listed on the Orders Summary report signed 10/5/17, included hypertension, diabetes, depression, pain, frequency of urination and spinal stenosis. Order Summary Report signed 10/5/17, included order dated 5/31/17, that R28 was to receive Oxybutynin Chloride (a medication to treat overactive bladder, also called Ditropan) 5 mg (milligram) daily. Order Summary Report instructed staff to give R28 Tylenol 500 mg 2 tablets for pain, atenolol 25 mg for high blood pressure gabapentin 300 mg for spinal stenosis (narrowing of the spine) metformin 500 mg for diabetes, ferrous gluconate 324 mg for anemia and Paxil 30 mg for anxiety. The Order Summary Report did not contain an order for R28 to self-administer any medications. R28's Self Administration Assessment dated 10/17/17, indicated, "physical or cognitive limits prohibit self-administration (STOP assessment)." R28's hand written Physician's Order sheet signed 10/31/17, instructed staff to discontinue Ditropan and start Detrol LA (a medication for the treatment of over active bladder) 2 mg.	F 176	Plan to address/prevent this deficiency for other residents: Policy on Medication Administration updated to include, “The person administering the medications must watch the patient swallow the medications and document in the E-MAR after the elder has taken/received the medication before proceeding to the next elder. Measures put in place to prevent reoccurrence: Education will be completed for all licensed facility staff who administer medications on the medication administration policy and on the necessity to view the resident taking the medication given. Plan to monitor: Medication administration audits will be done 2x weekly for 4 weeks and 1x weekly for 3 months. Results of audits will be summarized and reported at the facility QA meetings and will continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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	245452	A. BUILDING _____ B. WING _____	11/02/2017

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During observation on 11/1/17, at 9:08 a.m., RN-C was observed to leave medication cup containing Oxybutynin 5 mg, Tylenol 500 mg 2 caplets, atenolol 25 mg, gabapentin 300 mg, metformin 500 mg, ferrous gluconate 324 mg and Paxil 30 mg on the dining room table in front of R28 and walk back to the nurse's station. Surveyor observed R28 take all medications in the medication cup one at a time.

During interview on 11/1/17, at 9:39 a.m. RN-C verified the medication cup was left on the table and he had walked back to the nurse's desk because R28 would insult staff and call staff names if they stayed and watched her take the medication. RN-C verified he had placed the medication in front of her and could not see the medication from the nurse's desk because her back was to the desk and there was a column in the way. RN-C stated R28 did not have an order for self-administration and he should have stayed where he could see R28 swallow the pills.

During interview on 11/1/17, at 1:25 p.m. the director of nurses (DON) stated staff were to observe a resident take medications unless there was an assessment that the resident was safely able to take the medications by themself, a physician's order to self-administer medications and a care plan for self-administering medications.

Self Administration of Medication policy revised 11/1/16, instructed staff, "An elder may not be permitted to administer or retain medication in his/her room unless so ordered, in writing by an MD/NP [medical doctor/nurse practioner] and an assessment has been conducted showing the

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F 176	Continued From page 3 elder is safe to perform the task on admission quarterly, as needed and with a significant change in condition."	F 176		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 19 residents (R136, R19) were assisted to eat in a dignified manner. Findings include: R136's care plan revised 12/22/15, indicated R136 had a deficit in self performance of activities of daily living due to dementia, Alzheimer's and limited mobility. Care plan indicated R136 was totally dependent on staff for eating and staff were to monitor R136 for increased difficulty chewing or swallowing. R136's quarterly Minimum Data Set (MDS) dated 8/3/17, indicated R136 was severely cognitively impaired. R136 required extensive two person assist with all activities of daily living except eating for which R136 required extensive assistance of one person. R136's MDS included diagnosis of Alzheimer's and dysphagia (difficulty swallowing). During observation of dining on 10/31/17, at 9:25 a.m. homemaker-A was observed standing while giving R136 a glass of nectar thick juice. Homemaker-A was again observed standing next	F 241	Plan of correction for residents cited in this survey: Homemaker A and NAR-B were given immediate education on the importance of sitting with a resident while dining to respect each resident's dignity. Plan to address/prevent this deficiency for other residents: Policy on dining with residents updated to include, "To protect the elder's dignity the licensed staff member must sit down with the elder and remain seated while offering food or drinks." Measures put in place to prevent reoccurrence: Education will be done for all staff on the dining with elder's policy by the date of compliance. Plan to monitor: Dining room audits will be done at various meal times 2x weekly for 4 weeks and 1x weekly for 3 months. Results of audits will be summarized and reported at the facility QA meetings and	1/2/18

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F 241	Continued From page 4 to R136 while feeding R136 a magic cup (a frozen calorie dense, high protein supplement that is pudding consistency when melted) and thickened milk. Licensed practical nurse (LPN)-D was sitting at the table with R136. During interview on 10/31/17, at 10:22 a.m. LPN-D stated she did not know if it was okay for staff to stand while feeding a resident. R19's care plan revised 8/15/16, indicated R19 had inadequate oral intake related to poor appetite and staff were to encourage intake at meals and encourage consumption of fluids. R19's significant change Minimum Data Set (MDS) dated 9/28/17, indicated R19 was severely cognitively impaired. R19 required extensive one person assist with all activities of daily living except eating for which R19 required supervision. During random observation of dining on 11/2/17, at 12:53 p.m. nursing assistant (NA)-B was seen standing across the table from R19. NA-B picked up a glass of juice and leaned across the table to hold the glass to R19's lips, so R19 could drink the juice. NA-B then took the empty glass into the kitchenette. During interview on 11/2/17, at 12:56 NA-B verified that she had been standing to feed R19 and stated R19 was almost done and wanted to have her finish so the glass could be taken to the kitchenette. During interview on 11/2/17, at 9:41 a.m. the director of nurse (DON) stated homemaker-A had personal care assistant training (PCA) which included feeding residents. The DON said, "It is not acceptable for anyone to stand and feed a resident. It is a dignity issue."	F 241	will continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Administrator	
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3)	F 246		1/2/18

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F 246	Continued From page 5 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 2 of 2 (R117, R19) residents observed. Findings include R117's quarterly Minimum Data Set (MDS) dated 7/19/17, indicated R117 was moderately cognitively impaired. R117 required extensive two person assist with bed mobility, toileting, personal hygiene, dressing, and total dependence two person assist with transfers. R117's care plan indicated R117 was at moderate risk for falls related to confusion. The care plan indicated call light should be within reach, encourage R117 to use it for assistance, and R117 required prompt response for assistance requests. During observation on 10/30/17, at 6:00 p.m. R117 was sitting in wheelchair at the foot of the bed. R117 indicated he wanted the call light and asked for assistance, as it was not within reach. The call light was observed wrapped around overhead transfer lift bar above R117's bed.	F 246	Plan of correction for residents cited in this survey: R117 and R19 were corrected on site at the time of survey by placing call light within reach of residents. Plan to address/prevent this deficiency for other residents: Facility call light policy reviewed and includes, “It is the policy of this facility that call lights will be within easy reach of the elder and will be answered in an efficient manner.” Measures put in place to prevent reoccurrence: Education will be done with all facility care staff on the call light policy and the importance of regularly rounding to ensure call lights are within reach of each resident in their rooms. Plan to monitor: Individual resident audits will be done 2x a week for 4 weeks and 1x weekly for 3 months. Results of audits will be summarized and reported at the facility QA meetings and will continue thereafter until the committee determines the plan of correction is successful.	

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F 246	Continued From page 6 Writer turned call light on and nursing assistant (NA)-A came into the room. NA-A observed call light wrapped around the overhead transfer lift bar above R117's bed. NA-A removed call light and gave it to R117 seated in wheelchair. NA-A stated R117 was able to use call light for assistance. During interview on 10/30/17, at 6:05 p.m. licensed practical nurse (LPN)-A stated R117 prefers call light wrapped around transfer lift grab bar to call for assistance during the night. LPN-A indicated staff would have come soon to get R117 ready for bed. During interview on 10/31/17, at 10:02 a.m. LPN-B stated R117's call light should be within reach for use. During interview on 10/31/17, at 3:43 p.m. the director of nursing (DON) stated her expectation was staff should keep residents call light within reach. The facility's call light policy dated 1/1/15, indicated "call lights will be within easy reach of the elder." R19's care plan revised 12/5/16, indicated R19 was at high risk for falls related to need for assistance with activities of daily living and narcotic drug usage. The care plan indicated staff were to ensure call light was within reach, encourage R19 to use it for assistance, and R19 required prompt response to all requests for assistance.	F 246	Responsible for maintaining compliance: Administrator	

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F 246	Continued From page 7 R19's significant change Minimum Data Set (MDS) dated 9/28/17, indicated R19 was severely cognitively impaired. R19 required extensive one person assist with bed mobility, toileting, personal hygiene, dressing, and transfers. During observation on 10/30/17, at 2:35 p.m. R19 was observed lying in bed with call light lying on the floor out of reach of R19. Licensed practical nurse (LPN)-C stated R19 was able to use the call light but did not use it always. Requested staff member come to residents room. At 2:42 p.m. nursing assistant (NA)-B entered room and picked the call light up off the floor and gave it to R19. NA-B stated R19 used her call light daily. During interview on 11/1/17, at 1:25 p.m. the director of nursing (DON) stated her expectation was staff would keep call lights within reach of all residents who were able to use a call light. The facility's call light policy dated 1/1/15, indicated "call lights will be within easy reach of the elder."	F 246		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		1/2/18

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F 329	Continued From page 8 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents did not receive excessive medication doses when 2 of 5 residents (R202, R196) reviewed for unnecessary medications received excessive doses of acetaminophen (a pain reliever and fever reducer) (greater than 3,000 milligrams) (mg) in a 24 hour period. In addition, 1 of 5 residents (R129) had the potential to receive	F 329	Plan of correction for residents cited in this survey: R202's order for Acetaminophen tablet 325 mg give 2 tablets by mouth every 4 hours as needed for pain was discontinued by the Nurse Practitioner on 11/02/2017. Resident's current order of Tylenol Extra Strength Tablet 500mg (Acetaminophen) give 2 tablets by mouth 3 times a day for pain	

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F 329	Continued From page 9 greater than 3,000 milligrams in a 24 hour period. Findings include: Review of the face sheet revealed R202 admitted to the facility on 8/31/16, with diagnoses which included pain. Review of R202's physician orders revealed: "Acetaminophen tablet 325 mg Give 2 tablets by mouth every 4 hours as needed for Pain" with a start date of 7/12/17. "Tylenol Extra Strength Tablet 500 mg (Acetaminophen) Give 2 tablets by mouth three times a day for pain" with a start date of 10/21/17. Review of the medication administration record revealed R202 received greater than 3,000 mg of acetaminophen on the following days since 10/21/17. -10/21: received 4,300 mg -10/24: received 3,650 mg -10/25: received 3,650 mg -10/26: received 3,650 mg -10/28: received 3,650 mg R202 also had house standing orders that would include acetaminophen 650 mg orally every 4 hours for pain/fever (acetaminophen not to exceed 3 grams per 24 hours) The record indicated that R202's medication regimen was last reviewed by the consultant pharmacist on 10/4/17, and the consultant pharmacist had not yet completed the November 2017 review. During interview on 11/1/17, at 12:41 p.m.	F 329	was reviewed and is under the 3000mg a day limit. Standing house orders were updated to include that the standing order for Acetaminophen 650mg orally every 4 hours does not apply to any patient with scheduled or PRN Acetaminophen. R196's Tylenol tablet (Acetaminophen) changed 11/01/2017 by the physician to give 1000mg by mouth 2x a day for pain. .5 Percocet tablet 5-325mg by mouth every 24 hours as needed for pain related to fracture unchanged resulting in daily maximum of 2162.5mg under the 3000mg limit. Standing house orders were updated to include that the standing order for Acetaminophen 650mg orally every 4 hours does not apply to any patient with scheduled or PRN Acetaminophen. R129's Butal bital-APAP-Caffine tablet 5-325-40mg was updated 11/2/17 by the physician to be give 1 tablet by mouth every 4 hours as needed for headache DO NOT EXCEED 3000mg in 24 hours. Tylenol tablet (Acetaminophen) order give 1000mg by mouth every 6 hours as needed for headache not to exceed 3000mg in 24 hours was discontinued 12/01/2017. Tylenol Extra Strength 500mg by mouth 1x per day for generalized pain. Standing house orders were updated to include that the standing order for Acetaminophen 650mg orally every 4 hours does not apply to any patient with scheduled or PRN Acetaminophen. Plan to address/prevent this deficiency for other residents: Facility standing house	

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F 329	Continued From page 10 licensed practical nurse (LPN)-B stated R202 received scheduled acetaminophen 1,000 mg three times a day and should only receive 3,000 grams in 24 hours. During interview on 11/2/17, at 11:52 a.m. the director of nursing (DON) stated her expectation for maximum acetaminophen dosage per day was 3,000 mg. During interview on 11/2/17, at 11:56 a.m. clinical manager (CM)-A stated his expectation for maximum acetaminophen dosage per day was 3,000 mg. CM-A confirmed R202 received the acetaminophen as needed orders in October. CM-A indicated should probably discontinue the acetaminophen as needed order and would consult the physician. During interview on 11/2/17, at 2:11 p.m. the consultant pharmacist indicated the acetaminophen maximum dosage should definitely be under 4,000 mg per day. The consultant pharmacist indicated during monthly medication reviews he writes comments to indicate as needed or routine scheduled medications do not exceed that amount. Review of current physician orders for R196 on 11/1/17 revealed an order dated 10/15/17 that read, "Acetaminophen Tablet Give 1300 mg by mouth every 8 hours..." Another order dated 10/15/17 read, "Percocet Tablet 5-325 MG (Oxycodone-Acetaminophen) Give 0.5 tablet by mouth every 24 hours as needed for Pain related to FRACTURE..." The medication administration record showed that R196 received the medications of both of these orders on 10/20/17 and 10/31/17, resulting in acetaminophen intake	F 329	orders updated to read “Acetaminophen 650mg PO q 4 hours prn for pain (acetaminophen not to exceed 3grams per 24 hours) *** This order does not apply to any patient/elder with scheduled or prn acetaminophen. To avoid any instance of standing house order causing a resident to received more than 3000mg in 24 hours. Measures put in place to prevent reoccurrence: Education done for all licensed staff who administer medication on the importance of never exceeding 3000mg of acetaminophen in 24 hours. Consultant pharmacist and facility medical director updated on facility policy not to exceed 3000mg of acetaminophen in 24 hours. Consultant pharmacist will report any potential for exceeding 3000mg in monthly drug review. Plan to monitor: Audits of resident’s medication orders will be done 2x weekly for 4 weeks and 1x weekly for 3 months to identify any potential for exceeding 3000mg in 24 hours. Results of audits will be summarized and reported at the facility QA meetings and will continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 329	Continued From page 11 for those days of 4,062.5 mg. The record showed that R196's medication regimen was last reviewed by the consultant pharmacist on 10/10/17, and the consultant pharmacist had not yet done the November 2017 review. When interviewed on 11/1/17 at 1:04 p.m., licensed practical nurse (LPN)-E explained that R196 was diagnosed with compression spinal fractures in a local hospital on 10/12/17, and returned from that hospital stay with the current acetaminophen and oxycodone-acetaminophen orders. The nurse practitioner (NP)-A caring for this resident was interviewed on 11/1/17 at 1:20 p.m., and stated that he was not aware the resident had been in the hospital and received new acetaminophen orders, and would change the current orders immediately because he did not want the resident to receive more than 3,000 mg of acetaminophen per day. According to the current physician orders, R129 had the potential to receive an excessive amount of acetaminophen (a pain reliever and fever reducer.) The current physician order sheets revealed R129 was admitted on 3/4/13, with diagnose of Alzheimer's disease, age related osteoporosis, anxiety and pain, unspecified. The current physician orders indicated R129 had physician orders that read: - Tylenol 1000 milligram (mg) orally every 6 hours as needed, not to exceed 3000 mg in 24	F 329		

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F 329	Continued From page 12 hours - Butalbital/APAP/caffeine 50/325/40 mg 1 tablet orally every 4 hours as needed for headaches - Tylenol Extra Strength 500 mg (acetaminophen) give one time a day related to generalized pain R129 also had standing house orders that would include acetaminophen 650 mg orally every 4 hours for pain/fever (acetaminophen not to exceed 3 grams per 24 hours.) With the scheduled Tylenol Extra Strength 500 mg tablet and the multiple as needed orders for Tylenol and Butalbital there would be the potential to exceed three grams in twenty-four hours. During the month of October, R129 had requested the Butalbital-APAO-Caffeine tablet fifteen times and five times had requested more than one dose. The Tylenol 1,000 mg was requested four times in October 2017. A review of the October and November medication administration sheets indicated R129 had not received excessive amounts of acetaminophen. On 11/2/17, at 10:13 a.m. registered nurse (RN)-A reviewed the physician orders and verified there was the potential to exceed the 3,000 mg of acetaminophen the way the orders were written. RN-A explained R129 preferred the Butalbital/APAP/caffeine for headaches. On 11/2/17, at 10:30 a.m. the clinical manager (CM)-B indicated the orders should be clarified and the physican contacted to obtain an order to clarify. On 11/2/17, at 2:05 p.m the consultant pharmacist indicated not being aware of what	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 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
F 329	Continued From page 13 R129 was taking on an as needed basis as last review was 10/4/17, and he would be reviewing the medical record soon. The consultant pharmacist did indicate there was a potential of exceeding the recommended Tylenol dose.	F 329		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 6 residents (R177, R28) were free of medication errors. This resulted in a facility medication error rate of 7.69% (percent). Findings include: Gastrostomy tube (G-Tube) administration: R177's quarterly Minimum Data Set (MDS) dated 8/24/17, indicated R177 was severely cognitively impaired and was dependent on staff with activities of daily living. R177's diagnoses listed on the Order Summary Report dated 11/2/17, included dysphagia (difficulty swallowing), and traumatic brain injury. In addition, the orders read, Nothing by mouth. The Order Summary Report did not include an order to crush medications or to give them together.	F 332	Plan of correction for residents cited in this survey: For R177 education was immediately done at time of survey with LPN-C on the facility policy to separate each medication and give one at a time during G-Tube Medication administration. For R28 error was corrected on site during survey. Education was done immediately with RN-C on the discontinuation of Oxybutynin. Plan to address/prevent this deficiency for other residents: Facility tube feeding policy and procedure reviewed to include, “Administer each medication separately, dilute them appropriately as needed. Flush the tube with 15cc of water after each dose, taking into account resident's volume status. Administer diluted crushed tablets first, liquids next and thick liquids last. (Grind simple complex tablets to a	1/2/18

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F 332	Continued From page 14 R177's G-Tube medication administration and enteral feeding was observed from 8:13 a.m. until 8:34 a.m. Licensed practical nurse (LPN)-C was observed to crush Lasix (a medication to remove excess fluids) 20 milligrams (mg), Famotidine (medication for acid reflux) 20 mg and a multivitamin and place them in a small plastic medicine cup. LPN-C then opened a Gabapentine 300 mg capsule and poured the contents into the plastic medicine cup. LPN-C added 30 cubic centimeters (cc) of tap water to the medicine cup to dissolve the medications. LPN-C said, "This is the worst to dissolve. I think it is because the multivitamin has a coating on it." LPN-C drew the mixture of medicines up in a syringe and pushed the medication into R177's G-tube. LPN-C flushed the G-Tube with 25 cc of tap water. After completing R177's oral care LPN-C crushed Baclofen (medication for muscle spasms) 5 mg and Propranolol HCL (a medication for high blood pressure) 40 mg and placed them in a medicine cup. LPN-C added 30 cc of tap water to the medicine cup to dissolve the medications. LPN-C drew the mixture of medicines up in a syringe and pushed the medication into R177's G-tube. LPN-C flushed the G-Tube with 100 cc of water. During interview on 11/1/17, at 1:00 p.m. LPN-C stated she had thought she could mix all of the medications together but preferred to separate the blood pressure medications. During interview on 11/1/17, at 1:03 p.m. registered nurse (RN)-B stated it was best to give each medication separately but LPN-C does give some of the medications together. During interview on 11/01/17, at 1:25 p.m. the	F 332	fine powder and dilute with sterile water or according to facility protocol). (Open hard gelatin capsules and mix power with sterile water or according to facility protocol.)" Facility administration of medication policy reviewed to include, "The person administering medications must ensure that the right medications, right dose, right time and right method of administration are verified before the medication is administered." Measures put in place to prevent reoccurrence: Education will be completed for all licensed facility staff who administer medications on the medication administration policy and tube feeding policy. Plan to Monitor: Medication administration audits will be done 2x weekly for 4 weeks and 1x weekly for 3 months. Audit sample will at various times select a resident receiving medication via G Tube. Results of audits will be summarized and reported at the facility QA meetings and will continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 332	Continued From page 15 director of nurses (DON) stated crushed medications were not to be given together without a specific order. DON stated staff are to give the medications as ordered by the resident's physician. R28's quarterly Minimum Data Set (MDS) dated 7/17/17, indicated R28 was cognitively intact and required extensive assistance from staff with all activities of daily living except eating which R28 was independent with. R28's diagnosis listed on the Orders Summary report signed 10/5/17, included frequency of urination and spinal stenosis. Order Summary Report dated 10/5/17, included order dated 5/31/17, that R28 was to receive Oxybutynin Chloride (a medication to treat overactive bladder, also called ditropan) 5 mg daily. Physician's Orders dated 10/31/17, instructed staff to discontinue Ditropan and start Detrol LA (a medication for the treatment of overactive bladder) 2 mg. During observation on 11/1/17, at 9:08 a.m., RN-C was observed to leave medication cup containing Oxybutynin 5 mg and the rest of R28's medications on the dining room table in front of R28 and walk back to the nurses station. Surveyor observed R28 take all medications in the medication cup one at a time. During interview on 11/1/17, at 9:39 a.m. RN-C verified Oxybutynin had been discontinued yesterday but was still in the package with the R28's other pills. RN-C verified R28 did not receive Detrol LA because it was not yet available. During interview on 11/2/17, at 11:00 a.m. facility	F 332		

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F 332	Continued From page 16 administrator stated she expected medications to be given correctly. During interview on 11/2/17, at 2:04 p.m. consultant pharmacist stated if a medication is included in the passport but the resident did not have an order on the electric medication administration record for the medication, the staff should take it out of the passport and not give it. Consultant pharmacist stated crushed medications given through an enteral tube should not be mixed together unless the physician had assessed the patient and documented the reason the resident would need medications combined. The consultant pharmacist stated he had brought an addendum to the policy to the facility for review at quality assurance this month to address crushing medications. Facility provided Mervin LTC Pharmacy for Enteral Tube Medication Administration Procedure policy dated 10/22/13, as their facility policy. Policy indicated, "It is acceptable to administer 2-3 medications together if there are no contraindications to combining the medications. (This may be indicated for residents on a fluid restriction.) Dilute the med(s) appropriately as needed flush the tube with 15 cc's of water after each dose, taking into account the resident's volume status. Administer diluted crushed tablets first, liquids next and thick liquids last. Grind simple complex tablets to a fine powder and dilute with sterile water or according to facility policy. Open hard gelatin capsules and mix with sterile water or according to facility protocol." Facility policy lacked guidance for need to obtain a physician's order to crush medications or combine them together.	F 332		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		1/2/18

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F 428	Continued From page 17 CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (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,	F 428		

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F 428	Continued From page 18 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. (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: According to the current physician orders, R129 had the potential to receive an excessive amount of acetaminophen (a pain reliever and fever reducer.) The current physician order sheets revealed R129 was admitted on 3/4/13, with diagnose of Alzheimer's disease, age related osteoporosis, anxiety and pain, unspecified. The current physician orders indicated R129 had physician orders that read: - Tylenol 1000 milligram (mg) orally every 6 hours as needed, not to exceed 3,000 mg in 24 hours - Butalbital/APAP/caffeine 50/325/40 mg 1 tablet orally every 4 hours as needed for headaches - Tylenol Extra Strength 500 mg (acetaminophen) give one time a day related to generalized pain R129 also had standing house orders that would include acetaminophen 650 mg orally every 4 hours for pain/fever (acetaminophen not to exceed 3 grams per 24 hours.)	F 428	Plan of Correction for Residents Cited in this Survey: R129's Butal bital-APAP-Caffine tablet 5-325-40mg was updated 11/2/17 by the physician to be give 1 tablet by mouth every 4 hours as needed for headache DO NOT EXCEED 3000mg in 24 hours. Tylenol tablet (Acetaminophen) order give 1000mg by mouth every 6 hours as needed for headache not to exceed 3000mg in 24 hours was discontinued 12/01/2017. Tylenol Extra Strength 500mg by mouth 1x per day for generalized pain. Standing house orders were updated to include that the standing order for Acetaminophen 650mg orally every 4 hours does not apply to any patient with scheduled or PRN Acetaminophen. Plan to address/prevent this deficiency for other residents: Facility standing house orders updated to read "Acetaminophen 650mg PO q 4 hours prn for pain (acetaminophen not to exceed 3grams per 24 hours) *** This order does not	

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F 428	Continued From page 19 With the scheduled Tylenol Extra Strength 500 mg tablet and the multiple as needed orders for Tylenol and Butalbital there would be the potential to exceed three grams in twenty-four hours. During the month of October, R129 had requested the Butalbital-APAP-Caffeine tablet fifteen times and five times had requested more than one dose. The Tylenol 1,000 mg was requested four times in October 2017. A review of the October and November medication administration sheets indicated R129 had not received excessive amounts of Acetaminophen. A review of the Merwin Long Term Care Pharmacy dated 10/4/17, indicated a pharmacy review was completed and nonsignificant irregularities were noted. A pharmacy note was made indicated increase in headaches. On 11/2/17, at 10:13 a.m. registered nurse (RN)-A reviewed the physician orders and verified there was the potential to exceed the 3,000 mg of acetaminophen the way the orders were written. RN-A explained R129 preferred the Butalbital/APAP/caffeine for the headaches. On 11/2/17, at 10:30 a.m. clinical manager (CM)-B indicated the orders should be clarified and the physician contacted to obtain an order to clarify. On 11/2/17, at 2:05 p.m. the consultant pharmacist indicated not being aware of what R129 was taking on an as needed basis as last review was 10/4/17, and he would be reviewing the medical record soon. The consultant pharmacist did indicate there was a potential of exceeding the recommended Tylenol dose and another pharmacy review will be conducted for	F 428	apply to any patient/elder with scheduled or prn acetaminophen. To avoid any instance of standing house order causing a resident to received more than 3000mg in 24 hours. Measures put in place to prevent reoccurrence: Consultant Pharmacist educated on the facility's policy for not exceeding 3000mg of Acetaminophen in 24 hours and the necessity to report any potential for a resident to exceed 3000mg as an irregularity. Plan to monitor: Audits of resident's medication orders will be done 2x weekly for 4 weeks and 1x weekly for 3 months to identify any potential for exceeding 3000mg in 24 hours. Results of audits will be summarized and reported at the facility QA meetings and will continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 428	Continued From page 20 the month of November.	F 428		

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Episcopal Church Home of MN) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home 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 of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 3 buildings will be surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 131 beds and had a census of 121 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.	K 341	How the deficiency was corrected: Work Order ticket has been entered with our fire alarm vendor Simplex-Grinnell as of 11/29/2017. Expected visit prior to 12/8/17. Completion Date:12/08/2017 Responsible for maintaining compliance: Director of Plant Operations	12/8/17

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K 341	Continued From page 3 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: Found the Medical records room needs smoke detector's not heat detection installed. This deficient practice could affect the safety of all the residents, staff and visitors within the lower level area. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		12/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	**1879 FERONIA AVENUE SAINT PAUL, MN 55104**

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K 351	Continued From page 4 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: 1:Three fire sprinkler heads were found in the wheel chair wash room that are in the domestic water system. 2: Loading dock area does not have fire sprinkler protection covering the covered area. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment(s).	K 351	How the deficiency was corrected: Work Order ticket has been entered with our fire alarm vendor Simplex-Grinnell as of 11/29/2017. Expected visit prior to 12/8/17. Completion date: 12/8/2017 Responsible for maintaining compliance: Director of Plant Operations	

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

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EPISCOPAL CHURCH HOME OF MINNESOTA	**1879 FERONIA AVENUE SAINT PAUL, MN 55104**

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K 351	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351		
K 372 SS=D	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 REQUIREMENT is not met as evidenced by: 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. Findings Include:	K 372	How the deficiency was corrected: Fire caulking has been applied to this penetration. Additionally, we have pro-actively searched for other non-compliant penetrations throughout the building. We will also inform any vendor that might create penetrations of the need to fire caulk those on completions of their work. Completion Date: 11/10/2017 Responsible for maintaining compliance: Director of Plant Operations	11/10/17

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

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K 372	Continued From page 6 On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: Founded a penetration in smoke barrier by room 229 around wiring. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374	How the deficiency was corrected: Doors hinges were adjusted to reduce the gap between the two doors to less than 1/8".	11/30/17

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K 374	Continued From page 7 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: Found the Smoke barrier door by room 244 has a gap of over 1/8" and close does not close when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 374	Closers were adjusted to assure full closure of the doors. Completion Date: 11/30/2017 Responsible for maintaining compliance: Director of Plant Operations	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of	K 920		11/30/17

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K 920	Continued From page 8 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for	K 920	How the deficiency was corrected: Yellow extension cord has been removed and proper electrical cord management and a surge protector power strip has been installed. Completion Date: 11/30/2017 Responsible for maintaining compliance: Director of Plant Operations	

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K 920	Continued From page 9 which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: During the inspection found in the Social Services room on 3rd floor has a yellow extension cord being used for permanent power. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum	K 923		12/1/17

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K 923	Continued From page 10 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923	How the deficiency was corrected: This room has been re-organized and appropriate signage for empty and full tanks have been posted. Staff is being trained to the new policy and procedure. Completion Date: 12/01/2017 Responsible for maintaining compliance: Director of Plant Operations	

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K 923	Continued From page 11 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/2/2017, based on observation and interview revealed that the following include: During the inspection found the Oxygen room needs sign-age to what is full and empty cylinders. This deficient practice could affect the safety of all the residents, staff and visitors within the lower level area. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		