Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2023

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 28, 2023, we notified you a remedy was imposed. On October 18, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 15, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 12, 2023 be discontinued as of September 15, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2023

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 28, 2023, we informed you of imposed enforcement remedies.

On September 14, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0918 -- S/S: F -- NFPA 101 -- Electrical Systems - Essential Electric Syste Bld: 01

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 12, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 28, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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 - Health Regulation Division 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 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 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 February 3, 2024 (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.

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.

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	R **09/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST 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
{K 000}	INITIAL COMMENTS Based on a review of the facility's plan of correction, the facility is NOT in compliance with the federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 918} SS=F	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 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	{K 918}		9/15/23

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

Electronically Signed | 09/18/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	R **09/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST 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
{K 918}	Continued From page 1 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 REQUIREMENT is not met as evidenced by: Based on a review of the facility's plan of correction, the facility is NOT in compliance with the federal requirements identified as deficient at the time of their recertification survey. No documentation was provided to confirm 36 month - 4 hour load bank testing has been completed. Conversation with facility on 09/13/2023 - 0830 HRS - revealed that 36 month - 4 hour load bank testing had yet to be scheduled / completed	{K 918}	36 month - 4 hour load bank test was completed by Zeigler on 9/15/2023. Contract was initiated to be done on an annual basis and put into TELS. Maintenance Director is responsible for ongoing compliance.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 28, 2023

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 12, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Episcopal Church Home Gardens will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 12, 2023. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 - Health Regulation Division 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 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 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 February 3, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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
E 000	Initial Comments On 7/31/23-8/3/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 7/31/23-8/3/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56254005C (MN00094232), H56254003C (MN00086968), H56253997C (MN00094753), H56253998C (MN00083125). 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	F 000		

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

Electronically Signed | 09/01/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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	Continued From page 1 regulations has been attained.	F 000		
F 554 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 a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 resident (R14) observed with medications at bedside. Findings inclued: R14's annual Minimum Data Set (MDS) dated 7/17/23, indicated R14 had intact cognition and diagnoses of mild intermittent asthma, heart disease , and chronic kidney disease. It further indicated R6 required extensive assistance with all activities of daily living (ADL) except walking in room/corridor in which she required limited assistance. R14's medical record lacked a doctor's order to be able to self administer her medication. R14's Self Administration of Medications assessment dated 7/16/23, indicated R14 had no desire to self administer medications. During observation and interview on 8/1/23 at 12:09 p.m., R14 was sitting in her recliner with	F 554	Plan of correction for residents cited with this survey: A self-administration of medication assessment was completed on R14 on 8/2/2023. Albuterol inhaler was identified as being safe for elder to self-administer. Doctor order was obtained on 8/3/2023 for albuterol inhaler and to self-administer. Voltaren gel, OTC pills labeled restless leg and OTC eye drops were locked up by nursing in medication cabinet. R14 only desired to have self-administration of medication orders for albuterol inhaler. Plan to address/prevent this deficiency for other residents: Following the MDS schedule elders will be asked if they have desire to self-administer medications. The self-administration assessment will be completed upon admission, quarterly, and if significant change for on all residents and doctors' orders obtained if deemed appropriate to self-administer. Measures put in place to prevent reoccurrence: Education will be completed for all licensed facility staff who administer medications on the medication	9/12/23

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

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

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F 554	Continued From page 2 her bedside table next to her. On the bedside table she had 2 albuterol inhalers, a tube of Voltaren gel, a bottle of over the counter (OTC) pills labeled restless leg, and a bottle of OTC eye drops. R14 stated she didn't think she had been assessed to administer her own medications. During an interview on 8/1/23 at 5:48 p.m., licensed practical nurse (LPN)-C verified R14 had medications on her bedside table and stated they should be locked in the medication cabinet. LPN-C further stated the medications were expired and would call the doctor to follow up. During an interview on 8/2/23 at 10:37 a.m., LPN-D stated residents needed to be assessed before they can administer their own medications and if they haven't been assessed, then all medications need to be locked in the medicine cabinet in their room. During an interview on 8/2/23 at 2:35 p.m., RN-A stated residents need to have a doctor's order and be assessed to administer their own medications. RN-A also verified R16 doesn't have an order and her assessment indicated she didn't want to administer her own medications. The risks of having medications on a residents bedside table and they haven't been assessed were she can overdose herself or another elder wandering can take it. During an interview on 8/3/23 at 3:03 p.m., the DON stated the SAM-assessment, do that quarterly, R14 does not desire to administer her meds, medications should be locked up in the med cabinet, the nurses should know what's it's used for and what it is. Someone else could get a hold of the medication, or R14 could possibly not	F 554	administration policy specific to self-administration assessment needs to be completed if a resident wishes to self-administer, the nurse must obtain an order from the doctor and if an elder does not self-administer medication the medication must be locked up in the medication cabinet. Plan to monitor: Each house will have 3 elders audited each week for 4 weeks on self-administration of medications then audited with the quarterly MDS schedule. 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 or designee	

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F 554	Continued From page 3 take the correct dose. The medications on the bedside table were all expired also. Also we need a doctor's order for a SAM. The facility policy Medication Self Administration Safety Screen and/or Self Administration revised 11/2018, indicated review of the SAM will determine appropriateness of self-admistration of medications, include whether the resident can self administer medications unsupervised, with supervision, or is not safe to administer medications. A physician order will be obtained indicating which medications the resident may self administer and with or with out supervision.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		9/12/23

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F 584	Continued From page 4 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain sanitary equipment for 1 of 1 residents (R45) reviewed for environmental cleanliness. Findings include: R45's quarterly Minimum Data Set (MDS) dated 7/2/23, indicated R45 had severe cognitive impairment and diagnosis of stroke. R45's MDS further indicated R45 had a mechanically altered diet and required tube feedings. An observation on 7/31/23 at 7:09 a.m., R45 was in bed. Next to R45's bed was a pole with a pump that was used to administer R45's tube feeding. On the bottom feet of the pole were small and large drops of a tan/brown dry substance. In between the feet of the pole the same substance	F 584	Plan of correction for residents cited with this survey: R45 tube feeding pole and carpet was cleaned. R45 tube feeding was discontinued on 8/14/2023 and removed from resident room. Plan to address/prevent this deficiency to other residents: Like resident equipment reviewed to ensure it is sanitary. No other residents with tube feeding poles were identified. When medical equipment is in use cleaning directions will be in the elders MAR/TAR. Measures put in place to prevent reoccurrence: Education will be completed for all licensed staff who administer tube feeding on cleaning of non-critical care items when visibly soiled	

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F 584	Continued From page 5 was on the carpet. An observation on 8/1/23 at 4:11 p.m., R45 was sitting in her wheelchair. R45's tube feeding pole was up towards the head of the bed. The same tan/brown dry substance was on the feet of the pole. When interviewed on 8/2/23 at 7:49 a.m., housekeeper (HSK)-A was not sure if equipment was cleaned by the housekeeping team. When interviewed on 8/2/23 at 8:01 a.m., family member (FM)-B verified the dirty pole and stated she had seen the "mess" on the tube feeding pole before and had wondered if that was tube feeding or how it happened. FM-B stated she was unsure if R45 was aware of it or had seen the tan/brown dried substance, but acknowledged the pole being dirty would bother R45. When interviewed on 8/2/23 at 9:06 a.m., nursing assistant (NA)-B stated she was not sure who cleaned poles or equipment in rooms. NA-B had not noticed the tan/brown substance as she does not administer R45's tube feed. When interviewed on 8/2/23 at 9:22 a.m., licensed practical nurse (LPN)-A verified the tan/brown substance on R45's tube feeding pole and had not noticed it before. Furthermore, LPN-A stated anyone who sees it should be able to just clean it. LPN-A was not aware if housekeeping was responsible or not. When interviewed on 8/3/23 at 1:51 p.m., registered nurse (RN)-B had not been aware of any concerns with dried tan/brown substance on R45's tube feeding pole. RN-B stated ultimately it	F 584	and adding cleaning routine per infection control equipment and care items policy to the MAR/TAR. Plan to monitor: 6 resident care areas/care equipment will be audited for cleanliness for 4 weeks. 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 or designee	

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F 584	Continued From page 6 was the nursing staff responsibility to ensure equipment was clean in resident rooms and if anything needs to be cleaned or picked up it should just be done. Furthermore, RN-B stated residents should be comfortable in their room. A facility policy titled Infection Control-Equipment and Care items dated 3/10/20, directed staff to clean non-critical items when visibly soiled, per manufactures guidelines. Furthermore, a nurse or designee was responsible for cleaning of pumps and poles.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		9/12/23

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F 609	Continued From page 7 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report a fall with major injury for 2 of 5 residents (R6, R27) reviewed for accidents. Findings include: R6's admission Minimum Data Set (MDS) dated 5/4/23, indicated intact cognition and diagnoses of congestive heart failure (CHF), unspecified fall, abnormalities of gait and mobility, low back pain, and history of falling. It further indicated R6 was independent with all activities of daily living (ADL), occasionally incontinent of bladder, frequently incontinent of bowel, had a previous fall history prior to admission, and had received an antidepressant 7/7 and a diurectic 6/7 days in the look back period. R6's Care Plan dated 4/28/23, included R6 was at high risk for falls related to a history of impaired mobility, diabetes, dementia, CHF, a history of falls, and a recent fall on 5/16/23. It further included interventions to anticipate and meet the resident's needs, ensure his call light was within reach and encourage him to use it for assistance as needed, promptly respond to all requests for assistance, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, follow facility fall protocol, provide a safe environment, place walker within reach, frequent reminders to use call light, physical therapy to evaluate and treat as ordered or as needed. No	F 609	Plan of Correction for resident cited: It is the policy of Episcopal Church Home – The Gardens that potential incidents of abuse or neglect be filed in accordance with federal regulations and in accordance with the facility Abuse Reporting and Investigation procedure. Plan to address/prevent this deficiency for other residents: Staff educated on facility abuse reporting and investigation procedure. Measures put in place to prevent reoccurrence: Facility staff are educated during orientation and annual training that all allegations of abuse made by residents and/or their family members are to be reported to the Administrator or DON immediately. Facility staff will be educated on the ECH abuse reporting and investigation procedure. Plan to monitor: The facility DON and Administrator will audit all incident reports and family concerns weekly for one month. These results will be reviewed by the facility Quality Assurance committee until compliance is shown to be effective. Responsible for maintaining compliance: Director of Nursing and Administrator	

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F 609	Continued From page 8 new interventions were noted after 5/9/23 fall. R6's progress note dated 5/9/23 indicated the following: -What occured: R6 was found on the floor by the nursing assistant (NA). -Assessment/appearance: R6 was sitting on the floor near the foot of the bed, his back was resting on the TV table/wall by the bathroom door. -Approaches previously care planned: call light -Approaches to prevent reoccurences: encouraged to use call light when he needed assistance. R6's incident report dated 5/9/23, indicated R6's call light was on, when NA went to resident's room and found him on the floor. Upon arrival, noticed the resident was sitting on the floor near the foot of the bed and his back was resting on the TV table/wall by the bathroom door. R6 stated he was trying to go to bed, lost his balance, bumped his armpit on the bedframe and fell but he did not hit his head. The incident report lacked any documentation of an investigation, route cause analysis, or new interventions to prevent future falls. R6's progress note dated 5/16/2023, indicated the following: -What occured: R6 had an unwitnessed fall in his room while attempting to use the bathroom. -Assessment/Appearance: R6 did not have his rolling walker, there were no lights on in the bedroom or bathroom, he had an unsteady gait and was not aware of the safety concern, all of which contributed to him falling. -Approaches previously care planned: call light within reach and frequent visual checks -Approaches to prevent reoccurrences: frequent	F 609		

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F 609	Continued From page 9 reminders to use call button for assistance, place walker within reach, and frequent visual checks. R6's incident report dated 5/17/23, indicated R6 was found sitting on the floor in his bedroom. He stated "I lost my balance and ended up on the floor sitting on my bottom." It further indicated, an investigation and interview with staff and resident indicated that care plan interventions were in place. Resident was independent with his ADL's, elder (resident) has a history of falls due to unsteady gait and weakness. Interventions: frequent reminders to use call light for assistance, place walker within reach, frequent visual checks, offer to toilet, anticipate needs, and physical and occupational (PT/OT) therapy on-going. R6's progress note dated 5/17/2023, indicated R6 complained of severe pain 10/10 in his lower back. Resident had a fall at 2100 (9:00 p.m.) while trying to ambulate to the restroom. Call to provider to request an x-ray and pain medication. Per physician, send patient to the hospital. R6's progress noted dated 5/17/2023 at 13:19 (1:19 p.m.), indicated R6 was sent to the hospital by ambulance for evaluation. His son was notified and will meet R6 at the hospital. R6's progress noted dated 5/17/2023 at 15:52 (3:52 p.m.), indicated called the hospital for an update, spoke with the nurse (unknown) who stated "elder was admitted with lumbar spine compression fracture, spine surgery was consulted, and they want him to wear a brace for 8-10 weeks while the fracture heals." Unable to determine a discharge date. During an interview on 8/3/23 at 3:03 p.m., the	F 609		

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F 609	Continued From page 10 director of nursing (DON) stated she used the Care Providers Decision Tree on Reportable Events to determine if a fall was reportable. She would look for suspicious activity with the fall or if there was an injury and they don't know how it happened, they would report it. She would also look for mistreatment, neglect, or abuse in the fall itself. In regards to R6's fall on 5/16/23 (where he sustained a lumbar fracture), the facility didn't report it because they knew how he received the injury and they didn't suspect any abuse or mistreatment. An example of a fall they would report would be if a resident fell out of a Hoyer lift and only one staff was using the lift instead of two and staff weren't following plan of care. Requested a policy regarding reporting falls, however no policy provided. Requested a copy of the Care Providers Decision Tree on Reportable Events, however it was not provided.	F 609		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		9/12/23

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F 676	Continued From page 11 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a walking program for 1 of 1 residents (R25) reviewed for restorative rehabilitation. Findings include: R25's annual Minimum Data Set (MDS) dated 7/12/23, indicated R25 was cognitively intact and had diagnoses of stroke and dementia. R25's MDS further indicated R25 required assist of one for walking. R25's assistance of daily living (ADL) care area assessment (CAA) dated 7/12/23, indicated R25	F 676	Plan of correction for residents cited in this survey: It is the policy of the Gardens to provide the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including walking programs. R25 care plan and NA task care sheets reviewed and remains current. Plan to address/prevent this deficiency for other residents: All resident orders and tasks will be audited for restorative programs. Measures put in place to prevent	

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F 676	Continued From page 12 was unsteady with transitions, required staff assistance to stabilize, and required limited assistance with transfers and ambulation. R25's care plan revised 5/20/22, indicated R25 had limited physical mobility related to a fall with fractures, weakness and history of stroke. R25's care plan further indicated R25 required assistance of 1 person, gait belt, and walker for mobility. R25's nursing assistant care sheet revised 8/2/23, indicated R25 had a restorative nursing program and required ambulation with assist of one staff, gait belt and walker twice a day. Furthermore, the care sheet indicated documentation was required and family will walk with resident "in addition" to the walking program. R25's restorative nursing care sheet documentation dated 7/2023, directed staff to offer to ambulate elder twice a day as he accepts, with assist of one person, gait belt and 4 wheeled walker. Furthermore, the task sheet indicated R25 walked once and declined three times. The other remaining 30 days lacked documentation or had "not applicable" documented. R25's provider order dated 5/4/23, directed nursing to remind nursing assistants (NA) to offer ambulation program every day and evening shift for strengthening. When observed and interviewed on 7/31/23 at 8:53 a.m., R25 was seated in a recliner in his room. R25 stated he liked to walk and wished he could walk more often. R25 stated he had trouble remembering to ask staff to go for a walk and had been told "he was responsible for asking staff to	F 676	reoccurrence: Education will be provided to staff who carry out the restorative program on completing the task according to the resident care plan and document in POC appropriately. Plan to monitor: Director of nursing or designee will audit the POC charting for residents who are on restorative programs following the MDS schedule. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of nursing or designee	

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F 676	Continued From page 13 walk". When observed on 8/2/23 at 8:28 a.m., R25 was sitting in his recliner watching television. When observed on 8/2/23 at 10:50 a.m., R25 was sitting in the recliner watching television. When observed and interviewed at 8/2/23 at 12:54 p.m., R25 was sitting in the recliner watching television. R25 stated he had not gone for a walk today and would like to get up but wasn't sure if staff was available or not. When interviewed on 8/2/23 at 12:56 p.m., nursing assistant (NA)-D verified R25 required assist of one staff and walker for ambulation. NA-D stated, "sometimes staff walk R25 if R25 asked to walk". NA-D further stated R25's family will remind him to walk as well and verified any walk on the unit or refusal of walking was documented on the task sheet in the medical record. Furthermore, NA-D stated R25 had not walked in the hallway today as he had not asked to do so. When interviewed on 8/3/23 at 1:44 p.m., registered nurse (RN)-B expected residents on a walking program to be walked. RN-B verified this task was outlined on the care sheets and staff should initiate and offer to walk R25. RN-B stated R25 enjoyed walking. Furthermore, RN-B verified R25's task sheet lacked documentation staff had offered to walk R25. When interviewed on 8/3/23 at 4:00 p.m., the director of nursing (DON) expected restorative or walking programs to be listed on residents care plan and task sheets. Furthermore, DON	F 676		

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F 676	Continued From page 14 expected staff to offer and document walking or refusals of walking. A facility policy for restorative nursing program was requested, however was not received.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor, assess, and ensure provider wound care orders were followed for 1 of 1 resident (R51) who had facility acquired pressure ulcers. Findings include: R51's annual Minimum Data Set (MDS) dated 5/3/23, indicated R51 was cognitively intact and had diagnoses of peripheral vascular disease (PVD, poor blood flow to extremities), diabetes, and stage 2 pressure ulcers (a shallow wound with skin loss and pink or red base).	F 686	Plan of correction for residents cited with this survey: R51 pressure ulcer care plan was reviewed immediately. R51 wound is monitored and assessed weekly per facility policy and continues to be followed by Vascular Clinic. The wound is improving as evidenced by decreased size. Wound treatment order reviewed with nurse clarifying dressing supplies. Plan to address/prevent this deficiency for other residents: Education will be completed for all facility licensed nurses on the facility policy for resident skin care	9/12/23

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F 686	Continued From page 15 R51's pressure injury care area assessment (CAA) dated 5/3/23, indicated R51 was at risk for worsening pressure ulcers related to limited to extensive assist with mobility, limited range of motion to left lower extremity, stage 2 pressure injury and history of diabetes, PVDs and right below the knee amputation. R51's care plan revised 6/23/23, indicated R51 had history of pressure injuries related to decreased mobility and impaired circulation. R51's care plan instructed staff to assess, measure, and record wounds weekly. Any wound decline required provider notification. Furthermore, R51's care plan indicated nurse will perform a weekly skin assessment on bath day. R51's risk management reports for new wounds were requested however was not recieved. A review of R51's provider orders revealed: -an order dated 4/5/23, indicated R51 required weekly wound round assessment and measurement of all wounds every Wednesday. -an order dated 7/28/23, indicated R51's wounds required dressings changed every three days. The order instructed staff to wash left leg and wounds with dilute hibicleans (antimicrobial wash) and pat dry. Place MediHoney alginate (a wound dressing that helps promote wound healing) on wounds, gauze, rolled gauze, stockinette, and Rooke boot to R45's left lateral leg, left anterior ankle, and left lateral ankle wounds. Furthermore, the order indicated no foam border dressing and no telfa dressing (non-adherent dressing) was to be used.	F 686	specific to weekly wound round on pressure injuries, orders/treatments being followed and completing a risk management on any new skin concerns. Weekly wound audits will be done for any resident with a pressure ulcer. A plan of care and services audit has been conducted for 100% of the residents with pressure ulcers to ensure appropriate care, services and documentation is in place. Measures put in place to prevent reoccurrence: Facility policy for proper treatment, notification, and documentation of pressure ulcers will be reviewed with all licensed nurses. The Director of Nursing will be responsible for ongoing education of current and new licensed nurses. Plan to monitor: Nurse manager will make weekly wound rounds of residents with current pressure ulcers. Audits of weekly documentation will be done at random 2x weekly for 4 weeks. Audits will continue as warranted and reports will be given at QA ongoing quarterly until the committee is satisfied and the plan of correction is working. Responsible for maintaining compliance: Director of Nursing or designee	

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F 686	Continued From page 16 A review of R51's Wound Weekly Rounds assessments from 5/1/23- 7/31/23, indicated a weekly assessment with measurements were completed 3 out of the 14 weeks and last measurements were on 7/10/23. An observation on 8/3/23 at 11:57 a.m., licensed practical nurse (LPN)-A completed R51's wound cares. After hand hygiene, R51's Rooke boot and stockinette was removed from the left leg. LPN-A then removed rolled gauze and a telfa dressing to reveal a left outer ankle wound and a left posterior calf wound. R51 had closed wound on the top of the foot and a scabbed area on the top of the left great toe. After hand hygiene, LPN-A cleansed R51's wounds with the diluted hibicleans and completed measurements. After glove exchange and hand hygiene, a MediHoney dressing was cut and placed on R51's lateral ankle and calf wound and then a small piece of hydrofera blue dressing (an antibacterial dressing) was placed on top of the lateral ankle wound. R51's calf and ankle wound were then covered with telfa dressing and rolled gauze dressing was placed to secure telfa dressing. A clean stockinette was then placed on R51's left leg before replacing the Rooke boot. When interviewed on 8/3/23 at 12:11 p.m., LPN-A verified R51 had the pressure areas for about three months. LPN-A further stated R51's wounds were measured with each dressing change and were documented in the weekly wound assessment each time. LPN-A verified she utilized hydrofera blue and then asked, "can I not use it"? LPN-A stated it was used to help secure the MediHoney dressing. LPN-A verified R51's order had not instructed staff to place hydrofera blue or telfa dressing. LPN-A was not	F 686		

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F 686	Continued From page 17 aware of the order stating no telfa prior to reviewing order today. LPN-A clarified with registered nurse (RN)-B and stated telfa dressing could be used, but the foam boarder dressing was no longer used as it caused irritation on R51's skin. When interviewed on 8/3/23 at 2:04 p.m., RN-B stated when a new wound was discovered on a resident a risk management report was filed to help determine interventions and understand how the wound happened. RN-B verified there were no risk management reports for R51's wounds. RN-B stated R51 had fragile skin and the pressure injuries were believed to be caused by a hard splint and had been managed by the nurse practitioner (NP)-A monthly. RN-B stated in between appointments, staff were expected to monitor and measure wounds weekly and complete dressing changes as ordered every three days. RN-B verified the missing wound assessments and measurements from R51's medical record. RN-B stated measurements were an important part of monitoring to track improvement or worsening of the wounds. RN-B was not aware of the most recent measurements of R51's wounds and verified the last time R51's wounds were measured in the facility prior to today was 7/10/23. RN-B stated R51 had seen NP-A last week, but the facility only received the after-visit summary and was not aware of any treatments or measurements that were completed in clinic. The facility did not have access to the provider notes and the notes were not provided. RN-B further verified the hydrofera blue was no longer part of the wound treatment and would need to verify if it was okay to use. However, RN-B believed telfa dressing was okay to use but also acknowledged R51's order	F 686		

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F 686	Continued From page 18 indicated no telfa use. When interviewed on 8/3/23 at 4:05 p.m., the director of nursing (DON) stated staff were expected to report any new pressure injuries or skin alterations right away and a risk management report should be completed. DON further indicated their prior wound program was bought out and the facility had not been aware they were no longer going to be coming out. A new wound program would be starting soon. DON verified staff were expected to monitor and assess wounds weekly which included measurements. DON further stated R51's wound care orders or interventions were expected to be followed and if staff had questions, the clinic should be called to clarify. When interviewed on 8/4/23 at 11: 40 a.m., NP-A verified R51 had very fragile skin and any pressure on the skin for an extended period could lead to the development of a pressure ulcer. R51's wounds require very close monitoring. NP-A further stated the last two visits, R51's wounds were getting smaller, and she was "cautiously optimistic". NP-A expected the facility to follow the order for weekly wound monitoring and measurement. Furthermore, NP-A expected staff to follow the wound care and dressing change instructions ordered. NP-A verified the MediHoney should be used and the hydropera blue was discontinued a while back. NP-A further stated a telfa dressing was not to be used. NP-A had been frustrated as R51 had been sent to the clinic many times with the wrong dressing in place. NP-A stated telfa dressings increased moisture around the wound and was the "worst dressing for wound healing".	F 686		

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F 686	Continued From page 19 A facility policy titled Pressure Ulcer Prevention revised 1/15/23, directed staff to follow wound care protocols to prevent pressure injury and monitor any current pressure injury. The protocol for stage 2 pressure injuries include filing a risk management report, measure and assess wounds weekly and notification and obtainment of provider orders for treatment.	F 686		
F 689 SS=G	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 record review, the facility failed to implement individualized fall interventions for 2 of 3 residents (R27, R35) and failed to ensure a route cause analysis was completed and new interventions were implemented following a fall for 1 of 1 resident (R6), who was at risk for and had a history of falls. This resulted in harm when R6 had a subsequent fall on 5/16/23 and sustained a lumbar fracture. Findings include: R6's admission Minimum Data Set (MDS) dated 5/4/23, indicated intact cognition and diagnoses of congestive heart failure (CHF), unspecified fall, abnormalities of gait and mobility, low back pain,	F 689	1. Care plans and care sheets were reviewed for R8, R12 and R45 and updated to reflect interventions for fall prevention that were appropriate and individualized for each resident. NAs and nurses working with the R8, R12 and R45 were educated on interventions in place. 2. 59/59 residents have the potential to be affected by the deficient practice. 3. Facilities policy on falls was reviewed and remains current. Facility will continue to determine root cause of fall through completing risk mgmt. Staff will be educated on new fall interventions and follow through. 4. Follow up of all falls, interventions implemented and follow through of those	9/12/23

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F 689	Continued From page 20 and history of falling. It further indicated R6 was independent with all activities of daily living (ADL), occasionally incontinent of bladder, frequently incontinent of bowel, had a previous fall history prior to admission, and had received an antidepressant 7/7 and a diuretic 6/7 days in the look back period. R6's Care Area Assessment (CAA) dated 5/4/23, indicated R6 was at risk for falling and risk factors included: history of falling, incontinence, orders for scheduled antidepressants, cardiovascular (heart) medications, diuretics, and diagnoses of depression, dementia, arthritis, diabetes mellitus, and CHF. R6's care plan dated 4/28/23 included R6 was at high risk for falls related to a history of impaired mobility, diabetes, dementia, CHF, a history of falls, and a recent fall on 5/16/23. It further included interventions to anticipate and meet the resident's needs, ensure his call light was within reach and encourage him to use it for assistance as needed, promptly respond to all requests for assistance, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, follow facility fall protocol, provide a safe environment, place walker within reach, frequent reminders to use call light, physical therapy to evaluate and treat as ordered or as needed. R6's care plan dated 5/12/23, indicated R6 had an ADL self-care performance deficit related to weakness, recent closed fracture of L2 vertebrae (lumbar fracture) with interventions of "toilet use: independent. Extensive assist by 1 staff for toileting as needed." and "transfer: independent. Extensive assistance by 1 staff to move between surfaces every shift as necessary." It further	F 689	falls Interventions will be reviewed by the Nurse Managers, DON or designee to ensure they are individualized and appropriate for each elder within a week of a fall and intervention implementation. Audits will be completed of all residents fall care plan and interventions during the MDS assessment period to ensure that interventions remain appropriate and are followed by the staff. Results of findings will be documented and reviewed with IDT and monitored at the facility QA meeting.	

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F 689	Continued From page 21 indicated R6 had limited physical mobility with an intervention of "ambulation: independent. Limited assist of 1 staff as needed, uses a walker. A review of R6's fall risk management reports indicated: -On 5/9/23, indicated R6's call light was on, when NA went to resident's room and found him on the floor. Upon arrival, noticed the resident was sitting on the floor near the foot of the bed and his back was resting on the TV table/wall by the bathroom door. R6 stated he was trying to go to bed, lost his balance, bumped his armpit on the bedframe and fell but he did not hit his head. The risk management lacked any documentation of an investigation, root cause analysis, or new interventions to prevent future falls. Approaches previously care planned: call light within reach. Approaches to prevent reoccurrences: encouraged to use call light when he needed assistance. -On 5/17/23, indicated R6 was found sitting on the floor in his bedroom. He stated "I lost my balance and ended up on the floor sitting on my bottom." It further indicated, an investigation and interview with staff and resident indicated that care plan interventions were in place. Resident was independent with his ADL's, elder (resident) has a history of falls due to unsteady gait and weakness. Approaches previously care planned: call light within reach and encourage to use call light when he needed assistance and frequent visual checks. Approaches to prevent reoccurrences: frequent reminders to use call button for assistance, place walker within reach, and frequent visual checks. -On 6/18/23, indicated nursing assistant found R6 sitting on the floor against the wall in his bathroom. R6 stated he saw broken pieces of	F 689		

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F 689	Continued From page 22 glass on the floor, and he was trying to kick it aside, lost his balance, and fell. It further indicated an investigation and interview with staff and R6 indicated care plan interventions were in place. Approaches previously care planned: Education provided to R6 to call for assistance. Approaches to prevent reoccurrences: staff will continue frequent visual checks and R6's son brought a reacher from home to assist him to pick up objects off the floor. -On 7/22/23, indicated R6 fell in the bathroom at around 8:00 p.m. He was found sitting on the floor, blood flowing from the back of his head. The writer called for emergency services to transfer him to the hospital for further examination and treatment. It further indicated an investigation and interview with staff and R6 indicated the care planned interventions were in place. Resident had some degree of cognitive impairment which limits his understanding of his physical limitations. He needs contact guard assistance of 1 with ambulation/transfer from room to the bathroom/hallway due to unsteady gait and was care planned as such, however, after review of R6 care plan it lacked documentation of the need for contact guard assistance of 1 with ambulation/transfer. R6 prefers to be independent with ADL's. Approaches previously care planned: staff will continue to encourage elder to call for assistance. Approaches to prevent reoccurrences: offer to toilet every 2-3 hours and as needed and continue frequent visual checks. R6's progress note dated 5/17/2023, indicated R6 complained of severe pain 10/10 in his lower back. Resident had a fall at 2100 (9:00 p.m.) while trying to ambulate to the restroom. Call to provider to request an x-ray and pain medication.	F 689		

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F 689	Continued From page 23 Per physician, send patient to the hospital. R6's progress noted dated 5/17/2023 at 13:19 (1:19 p.m.) indicated R6 was sent to the hospital by ambulance for evaluation. His son was notified and will meet R6 at the hospital. R6's progress noted dated 5/17/2023 at 15:52 (3:52 p.m.), indicated called the hospital for an update, spoke with the nurse (unknown) who stated, "elder was admitted with lumbar spine compression fracture, spine surgery was consulted, and they want him to wear a brace for 8-10 weeks while the fracture heals." Unable to determine a discharge date." During an interview on 8/3/23 at 11:40 a.m., the nurse manager registered nurse (RN)-A stated the process when a resident fall was for the nurse to assess the resident, make sure they don't have a fracture, check their vital signs, and their range of motion (ROM). If the resident was suspected of having a fracture, the nurse should leave them on the floor, call 911, and then notify the doctor, family, nurse manager, director of nursing (DON), and administrator. RN-A stated since she was the nurse manager it was her responsibility to investigate the incident and try to figure out the cause. The nurses would be responsible for taking the resident's VS and performing neurological checks for 72 hours (after the fall occurred) and the DON would look at the camera footage to see the last time staff was in the resident's room. RN-A further stated they discuss each fall at the IDT meeting and put measures in place to prevent future falls, but any nurse can put interventions in place. RN-A verified R6 had fallen on 5/9/23 and there was no documentation that an investigation, route cause analysis, or new	F 689		

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F 689	Continued From page 24 interventions had been put into place stating, "I probably investigated this, but I probably didn't document it." RN-A further stated R6 wanted to be independent and therefore won't put on his call light, stating it wasn't an appropriate fall intervention. She also stated R6 had a fall intervention of frequent checks but was unable to give a specific amount of time of how often frequent checks should be done. RN-A stated she "doesn't like to give a specific time because staff might be busy with other elders [residents]. I encourage night shift to take a peek on him at night, because one of R6's falls was during the night." RN-A also verified R6 had an intervention for staff to offer to assist him to use the toilet, but he does not wait for assistance and toilets himself, therefore it was not an appropriate intervention. R6's care plan indicated he was independent with transfers and mobility but needed assistance of 1 staff as needed. RN-A was unable to explain how staff were supposed to make that determination and stated the therapy department was responsible for determining how much assistance R6 needed. During an interview on 8/3/23 at 3:03 p.m., the director of nursing (DON) stated the process for when a resident fall would be to report the fall to a nurse (if it is an NA), the nurse would complete an assessment, take VS, and then once the resident had been taken care of, record it in risk management. If the nurses document it the correct way it will automatically go into the progress notes. The risk management talks about the assessment and what interventions to put in place. Whoever (nurse) was responsible for the resident should try to put in a new intervention, they also know they can call the DON and and she will help them come up with some	F 689		

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F 689	Continued From page 25 interventions. The nurses are responsible for filling out an incident report and the next working day they review the fall in the IDT meeting. They (management) investigates the fall and do a root cause analysis. If it happened in a common area or a resident's room, they look at the cameras to give them clues on what was going on at that time and put any new interventions in place. The DON stated she makes sure a follow up note has been done, the nurse filling out the report signs off on it, the nurse manger, and the administrator. The DON verified there was no root cause analysis or new interventions implemented following R6's fall on 5/6/23. She also stated regular rounding should be done every 2-3 hours, and frequent checks were considered "more than that. There's not really a checklist, or a set time." The DON verified if R6 wasn't using his call light and was toileting himself without asking for assistance then those wouldn't be appropriate interventions. During a continuous observation on 8/3/23 following events occured: -7:56 a.m. R6 came out of his room, with his back brace on and walked down the hallway independently (using his walker) to the dining room and sat down at the table. There was no staff present in the hallway while he was walking. -8:02 a.m. R6 was sitting at dining room table, eating breakfast. -8:24 a.m. R6 stood up from the table independently, grabbed onto his walker (which was sitting next to him), and walked down the hallway to his room, went in and shut the door. There was no staff in the hallway while he was walking. -9:01 a.m. R6 was in his room with the door closed, no staff have checked on him or offered	F 689		

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F 689	Continued From page 26 to assist him to use the toilet. -9:26 a.m. R6 was in his room with the door closed, no staff have checked on him or offered to assist him to use the toilet. -9:58 a.m. NA-I entered R6's room and asked him if he needed anything. R6 stated he hadn't seen the nurse yet and NA-I offered to get the nurse for him. It had been approximately 1.5 hours since staff had checked on/seen R6. During interview on 7/31/23 at 9:57 a.m., R6 stated he doesn't need assistance with cares, (getting up, walking, or using the bathroom) and he doesn't use his call light because he doesn't need help. R6 further stated he doesn't remember any one at the facilty telling him he needed to use his call light before getting up. During an interview on 8/3/23 at 7:58 a.m., NA-J stated R6 needs assistance with cares but he doesn't use his call light to request help. During an interview on 8/3/23 at 9:55 a.m., RN-C stated nursing assistants are supposed to do rounds every 2-3 hours and frequent checks should be done every hour. During an interview on 8/3/23 at 10:01 a.m., NA-K stated R6 was independent but he needed assistance from staff to check on him after he goes to the bathroom to clean up after him and he doesn't use his call light when he needs to use the bathroom or to get up and walk around. NA-K stated frequent checks should be done every 2-3 hours but R6 doesn't need frequent checks. During an interview on 8/3/23 at 1:30 p.m., the rehabilitation program manager stated they received orders for therapy for R6 on 5/15/23,	F 689		

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F 689	Continued From page 27 due to a history of falls, back pain, and lumbar fracture. R6 had a PT evaluation on 5/22/23, was discharged on 6/12/23 due to a hospitalization, and then started again on 6/19/23. R6 has PT but was not on an ambulation or gait program. The rehabilitation program manager further stated R6 shouldn't be walking independently. He needs supervision, he abandons his walker, and he's not been cleared by therapy to ambulate independently. R27's quarterly Minimum Data Set (MDS) dated 4/26/23, indicated R27 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment, required extensive assist of two staff with bed mobility and toileting and one person assist with transfers. R27's diagnoses included non-traumatic brain dysfunction and Alzheimer's disease. R27's fall care plan dated 4/7/22, indicated R27 had a high risk for falls with interventions which included, call light is within reach and encourage me to use it for assistance; floor mat next to bed, updated on 8/1/23 for the new intervention implemented for the fall on 7/25/23. Physician progress notes dated 7/26/23, indicated facility updated triage yesterday that patient fell overnight and had pain to right knee. X-ray was done yesterday which found comminuted intra-articular fractures (a fracture that crosses into the surface of a joint, resulting in damage to the cartilage) in the right tibia.	F 689		

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F 689	Continued From page 28 R27's Falls Risks Evaluation dated 7/30/23, indicated date of last fall on 7/25/23, new intervention included a matt on the floor just in case she falls, which is unlikely because she is not able to move in bed without assistance. R27's nursing assistants care sheets undated, indicated Safety: fall risk: place call light within reach, prefers bed in low position at all times, frequent visual checks and floor mat next bed (SIC). During the following observations R27 did not have a floor mat in her room or on the floor near her bed: -8/1/23, at 11:35 a.m., no floor mat in place near bed. -8/1/23, at 4:47 a.m., no floor mat in place near bed. -8/1/23, at 6:39 a.m., no floor mat in place near bed. -8/2/23, at 8:37 a.m., no floor mat in place near bed. -8/2/23, at 1:55 p.m., no floor mat in place near bed. While observing R27 on 8/3/23 at 9:08 a.m., one floor mat was noted to right side of bed near window, however, the left side of R27's bed had no floor mat near bed which is the side of the bed R27 gets out of bed on. During observation and interview on 8/2/23 at 9:18 a.m., nursing assistant (NA)-A and another NA were getting R27 changed in bed. No floor mat was near bed or in room. When asked if R27 had a floor mat, NA-A stated she had never seen a floor mat in R27's room.	F 689		

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F 689	Continued From page 29 During interview with nurse manager (NM) on 8/2/23 at 2:42 p.m., NM stated after R27's fall on 7/25/23, NM implemented floor mat to floor, and updated the care plan and nursing assistants care sheets as a fall intervention. During interview on 8/3/23 at 11:42 p.m., family member (FM)-A stated usually visited with R27 around 2-3 times a week and the sister also visited about 3-4 times a week. FM-A stated had never seen a floor mat when came to visit resident prior to 8/3/23. FM-A was visiting with R27 during interview with surveyor on 8/3/23. When interviewed on 8/2/23 at 3:00 p.m., NA-B stated, "When I take care of a resident, I look at the nursing assistant care sheets to know how to care for the resident. I have never seen a floor mat in R27's room and I have worked here for about two months and have been working with R27." When interviewed on 8/3/23 at 4:18 p.m., director of nursing (DON) explained she was told the floor mat had been implemented right after R27's fall on 7/25/23 and did not know until today when the NM mentioned to her the floor mat was not placed until after interview with surveyor on 8/2/23. DON stated she believed NM got busy and did not get a chance to place the floor mat timely, per care plan intervention for falls. R45's quarterly Minimum Data Set (MDS) dated	F 689		

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F 689	Continued From page 30 7/2/23, indicated R45 was cognitively impaired and had diagnoses of stroke, dementia, and Parkinson's disease. Furthermore, R45's MDS indicated R45 was a fall risk and required extensive assist with one person for transfers and ambulation. R45's fall Care Area Assessment (CAA) dated10/3/22, indicated R45 was a fall risk related to Parkinson's disease, impaired balance, gait problems and impaired judgement. R45's care plan revised 5/27/23, indicated R45 was a high fall risk related to impaired balance, stroke, and Parkinson's disease. Staff were directed to anticipate and meet my needs, assist to toilet per toileting plan, frequent safety checks, encourage use of call light and ensure it was within reach, and have walker in front of resident to assist with attempts to walk unassisted. A review of R45's fall risk management report indicated: -on 6/16/23, R45 had an unwitnessed fall in the lounge area. Approaches previously care planned was frequent safety checks and pivot transfer only. Approaches to prevent reoccurrence was staff to maintain frequent visual checks and continue to have staff monitor her when in the lounge and continue to educate to ask for assistance. -on 6/17/23, R45 had an unwitnessed fall in lounge area. Approaches previously care planned included constant visual checks and anticipating needs. Approaches to prevent reoccurrences was to continue with care plan. No new intervention indicated. -on 6/28/23, R45 had an unwitnessed fall in her	F 689		

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F 689	Continued From page 31 room. Approaches to previously care planned included visual checks and toileting program. Approaches to prevent reoccurrences was a perimeter mattress. -on 7/3/23, R45 had a witnessed fall while trying to self-transfer in her room. R45 was sent to the emergency room for a face hematoma. Fall discussed in morning meeting and fall interventions remain in place. No new intervention indicated. -on 7/17/23, R45 had an un-witnessed fall and was found sitting on the floor outside nursing station. Fall discussed in morning meeting and R45 forgot to use call light for assistance and continued to self- transfer without walker. R45 will continue therapy. No new intervention indicated. -on 7/19/23, R45 had an unwitnessed fall in her bathroom with tube feeding pole tipped over and tube stretched. Approaches previously care planned include assistive devices of walker and wheelchair, to be in lounge for close monitoring, and permitter mattress. Approaches to prevent reoccurrence was to have call light in reach and educate resident to use and adjust tube feeding times. -on 7/21/23, R45 had a witnessed fall in the lounge. R45 got up from chair and was attempting to walk when she fell. Approaches to prevent reoccurrence was keep walker with seat in front of resident for use if attempts to self-transfer and continue therapy. R45's hourly rounding documentation from 7/26/23-8/2/23, was reviewed and lacked consistent documentation hourly rounding had occurred including an entire evening shift on 8/2/23.	F 689		

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F 689	Continued From page 32 An observation on 8/1/23 at 9:46 a.m., R45 was sleeping in bed. R45's call light was on the floor to the right side of R45's bed and not in reach. Next to the door was a folded walker placed up against the wall. A 4-wheeled rolling walker with a seat was placed against the wall away from the bed and just in front of the door. An observation at 8/2/23 at 3:11 p.m., R45 was sitting in the wheelchair in the lounge area sleeping. At 3:30 p.m., nursing assistant (NA)-H pushed R45 back into her room. At 4:11 p.m. R45 was sitting in the wheelchair in her room. R45's call light was over by the bed and not in reach. A walker was folded up and placed against the wall and a 4-wheeled walker was close to the door. Neither of the walkers were in reach of R45. An observation on 8/2/23 at 8:09 a.m., R45 was seated in a chair in the lounge. R45's walker was not in the lounge and was noted in her room. When interviewed on 8/2/23 at 8:01 a.m., family member (FM)-A stated R45 was very impulsive and often attempted to get up without help and had multiple falls. FM-A further stated R45 required assistance with any transfer or ambulation. FM-A stated R45's walker was not always nearby and so when R45 would attempt to get up and walk, she would usually fall. FM-A discussed with the facility the desire to have R45's walker in place so maybe R45 would use it and not fall if attempting to self-transfer. FM-A thought this was happening. FM-A further verified R45 rarely used the call light and stated the facility tried to encourage her to use it but did not feel any education was going to be useful as R45 wouldn't remember.	F 689		

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F 689	Continued From page 33 When interviewed on 8/2/23 at 9:06 a.m., NA-C stated R45 was able to make some needs known when asking simple questions. NA-C stated sometimes R45 wanted to walk in her room to the bathroom and when she wanted to walk a walker and gait belt was used. If R45 did not want to walk, a gait belt was used to transfer into the wheelchair and R45 was wheeled into the bathroom and then transferred with assist of one. NA-C stated R45 did not wait for help and really did not use the call light. R45 was quick and so staff had her out in the lounge most of the time so there was more staff around. NA-C staff would place R45's walker next to the door or away from her so she would be discouraged from using it. When interviewed on 8/2/23 at 9:06 a.m., licensed practical nurse (LPN)-A stated after a resident falls, the floor nurse filled out a risk management form to document what happened and some immediate interventions. LPN-A stated usually, the interventions that are put in place was to keep call light in reach and re-educate about call light use. LPN-A stated R45 was impulsive and a high risk for falls. Currently, R45 was on hourly checks by either the NA or the nurse. Upon review of the hourly checks, LPN-A verified there was some missing times, and the entire evening shift was blank from 8/2/23. When interviewed on 8/3/23 at 1:53 p.m., registered nurse (RN)-B stated falls were discussed in morning meetings and the root cause and interventions were discussed and nurse managers update care plan and care sheets. RN-B stated R45 was very impulsive and had some changes in mobility related to a stroke. R45 did not use a call light and would walk	F 689		

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F 689	Continued From page 34 without her walker. RN-B stated family wanted R45's walker next to her so if she did get up R45 may use it. RN-B verified some of the interventions listed for R45 may not be appropriate or individualized due to R45's impulsiveness and stated R45 was now on hourly checks as well. RN-B expected staff to follow the fall interventions on R45's care plan and care sheets. A facility policy titled Fall Risk Assessment revised 4/2022, directed staff to implement individualized fall precautions for all residents who are at risk for falls. Furthermore, the policy directed staff to initiate, review and revise the care plan as appropriate and communicate interventions to staff.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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	F 761		9/12/23

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F 761	Continued From page 35 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 an antibiotic medication was properly labeled and secured for 1 of 1 residents (R38) reviewed for antibiotic use. Findings include: R38's significant change Minimum Data Set (MDS) dated 5/22/23, indicated R38 was cognitively intact and had diagnoses of multiple sclerosis (disease that disrupts the nerve signals between brain and body), enlarged prostrate and urine retention. R38's provider order dated 5/17/23, indicated R38 required gentamicin (antibiotic) 200 milligrams/liter bladder irrigation on Monday, Wednesday, and Friday for prophylactic urinary tract infection. When observed on 8/2/23 at 3:21 p.m., licensed practical nurse (LPN)- B entered R38's room to administer R38's antibiotic medication. LPN-B entered R38's room and asked R38 if he was ready for the medication and R38 replied yes. LPN-B then retrieved a graduate cylinder with a 60 milliliter (ml) syringe containing clear liquid inside of it that was placed on top of R25's medication cabinet located inside his room. There was no label on the syringe or the	F 761	Plan of correction for residents cited in this survey: The medication identified was secured and labeled at time of survey. Plan to address/prevent this deficiency for other residents: Education will be completed with all licensed nurses on properly labeling and securing medication. Measures put in place to prevent reoccurrence: Education will be completed with all licensed staff administering medications on properly labeling and securing medication. Plan to monitor: Random audits of improperly stored medications and labeling will be completed 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing or designee	

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F 761	Continued From page 36 graduate. LPN-B had taken down the graduate and syringe indicating R25 preferred the medication to be at room temperature, so LPN-B had placed the graduate and syringe in R38's room about 20 minutes earlier. When interviewed on 8/2/23 at 3:32 p.m., LPN-B stated R38 received the antibiotic wash three times a week to help prevent urinary tract infections. LPN-B stated R38 liked the medication at room temperature before administering and verified the syringe was too large to lock in R38's medication cabinet. LPN-B further stated she felt the medication was safe to be in R38's room until the medication was room temperature and could be given. LPN-B verified the medication was not labeled and was unattended for approximately 20 minutes. LPN-B further stated normally all medications would be locked up, however the medication did not fit in the locked cabinet. When interviewed on 8/3/23 at 1:35 p.m., registered nurse (RN)-B stated all medications should be locked up for safety. Furthermore, if medications did not fit in the resident locked medication cabinet they should be placed in the locked medication room until administered. When interviewed on 8/3/23 at 3:58 p.m., the director of nursing (DON) expected medications to be stored in the medication room or the residents locked medication cupboard in their room. Furthermore, the DON stated medications should not be left unlocked in residents room as that would create a safety risk. A facility policy titled Med Storage dated 1/1/15, ensured the facility maintained equipment and	F 761		

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 37 supplies that included lockable medication rooms to ensure proper storage of medications.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide 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 §483.70(e) 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;	F 880		9/12/23

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

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F 880	Continued From page 38 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 personal protective equipment (PPE) was utilized to prevent the spread of infection when rinsing contaminated laundry. Furthermore, the facility failed to transport clean laundry in a manner which ensured protection from dust and soil. This	F 880	Plan of Correction for Residents Cited in this Survey: It is the policy of the Gardens to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of	

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F 880	Continued From page 39 had the potential to impact all 60 residents who reside in the facility. Findings include: R51's annual Minimum Data Set (MDS) dated 5/3/23, indicated R51 was cognitively intact and had diagnoses of heart disease and diabetes. R10's quarterly MDS dated 5/1/23, indicated R10 had cognitive impairment and diagnosis of dementia. An observation on 7/31/23 at 9:03 a.m., a white laundry basket was on the floor outside of R51's room. The laundry basket contained two small piles of clean folded clothes and the clothes were not covered. R51 stated "that's a job for me to do later" and indicated his clean clothes needed to be put away. An observation on 8/1/23 at 9:03 a.m., a white laundry basket was on the floor outside of R10's room. The laundry basket contained one pile of clean folded clothes and the clothes were not covered. When interviewed on 8/1/23 at 6:04 p.m., nursing assistant (NA)-E stated the facility laundered residents clothing and personal items and sent linens and towels out to be cleaned. NA-E stated each resident had a white basket for their dirty laundry that is kept in their room. Each resident had a day of the week laundry was completed. Evening shift NAs placed the resident's laundry basket of dirty clothes outside of their room on the floor. Night shift NAs then washed and folded the residents' dirty items and placed them back in their basket. The basket of clean clothing was	F 880	communicable diseases and infections. Facility purchased new laundry baskets with lids and wheels for all residents. PPE was stocked in soiled utility room. Plan to address/prevent this deficiency for other residents: The facility purchased new laundry baskets that have lids and wheels on them for all residents. Laundry duties by shift procedure was updated to include the covered laundry basket. NAR will be trained on the facility's policy for linen handling to reflect the wearing of appropriate PPE when handling contaminated laundry and clean laundered clothes must be transported with the lid down on the basket to protect from dust and soil. Measures put in place to prevent reoccurrence: Education will be completed with current staff who launder residents clothing on the linen handling policy and laundry duties by shift procedure. Plan to monitor: Audits will be conducted to ensure staff are wearing the appropriate PPE while washing out items soiled with bodily fluids and that clean linen is covered while in transport back to the resident room 2x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance:	

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

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F 880	Continued From page 40 then placed on the floor outside of the resident's room. Then the day NA would take the basket and help the resident put their clean clothes away. NA-E verified laundry baskets were ok to be on the floor and the clean laundry did not need to be covered when transporting back to room or when the basket was placed on the floor. NA-E stated if a resident had soiled clothing with bodily fluids, staff would bag up the soiled clothing and rinse the clothes out in the hopper sink in the dirty utility room. The rinsed-out clothes were then washed right away instead of waiting until laundry day. Upon review of the 6th floor soiled utility room with NA-E the soiled utility room had gloves, but no other PPE was available. NA-E further stated gloves were the only PPE was required to wash out items that had been soiled with bodily fluids. When interviewed on 8/1/23 at 6:33 p.m., NA-F verified evening shift staff removed the white laundry baskets with dirty laundry and placed them outside the resident's room on the floor. Night shift staff then washed and folded the laundry and placed it back outside the resident door for day shift to put away. NA-F stated any clothing items that were soiled with bodily fluids were rinsed and washed right away. However, at times the bag of wet clothing would be placed back in the resident's laundry basket and it would wait until the next laundry day. NA-F stated clean laundry did not need to be covered when transported or placed outside of the resident room. NA-F reviewed the 7th floor soiled utility room to observe where resident items soiled with bodily fluids were rinsed out. NA-F verified the room contained gloves and no other stocked PPE and stated additional PPE was not required but a gown to use would be nice. "Sometimes staff	F 880	Infection Preventionist or designee	

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

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F 880	Continued From page 41	F 880		

wear a garbage bag because of the splashing that occurred when rinsing items out". NA-F further stated everyone was trained differently on the laundry process and it was confusing.

When interviewed on 8/2/23 at 8:16 a.m., NA-G stated residents had laundry scheduled on different days of the week. Night shift staff washed clothing , folded them, and placed them back in the resident laundry basket. The basket was set outside the resident room and day shift put clothes away. NA-G stated clean and folded laundry was not covered and was transported with the baskets. Upon review of the 5th floor soiled utility room, NA-G verified the only PPE in the room was gloves. NA-G verified soiled resident clothing was first rinsed out in the soiled room before washing and gowns were not needed when rinsing soiled clothing.

When interviewed on 8/3/23, at 1:39 p.m., registered nurse (RN)-B stated the morning and evening staff gathered residents' dirty laundry and placed it outside of the resident room on the floor. The night shift washed clothes, folded items and delivered the basket of clean folded clothes back to the resident room and sets the basket outside on the floor. Day shift then put the clean clothes away. RN-B was not aware of clean laundry needing to be covered or if staff needed to wear PPE when rinsing clothing soiled with bodily fluids.

When interviewed on 8/3/23 at 3:41 p.m., the infection preventionist (IP) verified personal laundry was done on each resident unit. IP stated clean clothing was not covered during transport and assumed any soiled clothing was washed either right away or placed back in the

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	245625	A. BUILDING _____ B. WING _____	C 08/03/2023

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F 880	Continued From page 42 resident room after rinsing in the soiled utility room. IP stated the use of gloves was required when rinsing items soiled with bodily fluids out in the soiled utility room, but if staff wanted to use PPE, they could. A facility policy titled Linen Handling dated 1/1/2015, directed staff to rinse linen soiled with body fluids in the soiled utility room before being sent to the laundry room. Furthermore, the policy directed workers to wear appropriate PPE when handling contaminated laundry, to include at a minimum; gown or apron and face protection when a possibility of splashing of body fluids was anticipated. The policy also directed staff to be transported and stored in a covered container.	F 880		

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/31/2023. At the time of this survey, EPISCOPAL CHURCH HOME GARDENS was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/06/2023

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. EPISCOPAL CHURCH HOME GARDENS is a 7-story building with a lower-level parking garage. The original building was constructed in 2012 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a capacity of 60 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed during documentation review that the documentation presented for review were generic in format, identifying only that emergency light(s) had passed 30 sec testing. 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed during documentation review that no documentation was presented as to emergency light(s) an when 90 min annual testing	K 291	How the deficiency was corrected: Emergency lighting will be added to TELS and tested on an annual basis. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 291	Continued From page 3 had occurred and the outcome of the testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 291		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.145.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that the manual fire alarm pull-station located in the entrance to the facility was fully obstructed by two shopping carts. An interview with the Maintenance Director verified this deficient finding at the time of	K 345	How the deficiency was corrected: Shopping carts were removed 07/31/23. New signage was placed at the pull station noting that the pull station must be free from obstruction. Completion date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 4 discovery.	K 345		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding a widespread impact on the residents within the facility. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that documentation presented for review was a template only, not completed, and not identifying adoption or implementation by the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	How the deficiency was corrected: Policy for fire watch procedures was updated. Fire watch log procedures were reviewed and staff educated on fire watch procedures. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		9/12/23

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(2). This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation in the Garage - Midway / Tower Storage Room that data cabling was attached to the sprinkler system piping.	K 353	How the deficiency was corrected: Data cabling was removed from the sprinkler pipes. A contract was initiated with Summit to complete the facility 5 year sprinkler system inspection/maintenance. Quarterly sprinkler test was completed. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 353	Continued From page 6 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation, that the vendor of record had indicated on the 2022 and 2023 annual inspection reports, that the sprinkler system was past due for the 5-year inspection. 3. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation, that there was no documentation was presented for review to confirm when the last 5-year sprinkler system inspection / maintenance had been completed -or- that the facility is up-to-date 5-year sprinkler system inspection / maintenance. 4. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation, that there was no documentation to confirm that quarterly sprinkler system inspection / testing had occurred for the 3rd and 4th quarters of 2022. 5. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation, that quarterly sprinkler system inspection / testing record were incomplete, not fully documenting the observations and finds of the quarterly inspection. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service	K 354		9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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K 354	Continued From page 7 Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to implement a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding a widespread impact on the residents within the facility. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that documentation presented for review was a template only, not completed, and not identifying adoption or implementation by the facility. An interview with the Maintenance Director	K 354	How the deficiency was corrected: Fire watch policy was updated to include building specific sprinkler system out of service policy. Completion Date: 9/12/23 Responsible for maintaining compliance: Maintenance Director	

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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K 354	Continued From page 8 verified this deficient finding at the time of discovery.	K 354		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.3, 7.2.4.4, 7.2.4.5,, 7.3.1.1.1 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation, that the fire extinguisher located in Otto Hall was full obstructed and non-accessible 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation, that the fire extinguisher located in the Elevator Equipment Room is not being inspected monthly, not capturing date of inspection and initials of individual performing the inspection	K 355	How the deficiency was corrected: The obstruction in front of the Otto hall fire extinguisher was removed. Signage was placed to instruct staff to not obstruct the fire extinguisher. The elevator equipment room and garage fire extinguishers were inspected and will be included in the monthly inspections ongoing. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 9 3. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation, that fire extinguishers located in the Garage of the facility are not being inspected monthly, not capturing date of inspection and initials of individual performing the inspection An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355		
K 372 SS=F	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: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient finding could have a	K 372	How the deficiency was corrected: Documentation produced smoke damper testing was completed in 2023. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 372	Continued From page 10 widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire / smoke damper testing of the facility is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372		
K 374 SS=F	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: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient	K 374	How the deficiency was corrected: The 2nd floor door was impacted by a bubble in the carpet which was fixed allowing the door to self close. Rubber gap sealing	9/12/23

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	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 374	Continued From page 11 findings could have a widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that the smoke barrier doors located on the 2nd floor of the building, adjacent to the Kitchen / Elevator area, did not self-close and seal the opening On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that both sets of smoke barrier doors located on the 1st floor of the building - Otto Hall, exhibited an air gap greater than 1/8 inch An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	was added to the Otto hall door to reduce the gap between the two doors to less than 1/8”. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 511	How the deficiency was corrected: All	9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 511	Continued From page 12 facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F), 110.27(A)(1) This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that unsecured electrical panels, in readily accessible in resident corridors, were found in the following locations: 7th Floor - bank of electrical panels in corridor; 6th Floor - bank of electrical panels in corridor; 5th Floor - bank of electrical panels in corridor. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	electrical panels were locked and secured 07/31/2023. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection	K 541		9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 541	Continued From page 13 in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.2, 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation in the Basement level, that it was not possible to confirm that the discharge cute in bio-hazard chute room was equip with the proper hardware that would facilitate the automatic closure and sealing of the vertical shaft in the event of a fire. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	How the deficiency was corrected: Contract initiated for fusible links to be added to discharge chute. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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K 761	Continued From page 14 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2, 6.1.4.3.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that the fire rated door of the Elevator Equipment Room was found in a state where the door would not latch to the strike plate - leaving the door in an open / unsecured state. 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual door inspections are being completed.	K 761	How the deficiency was corrected: Elevator equipment room door secured. 13 point door inspection paperwork will be completed annually. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 761	Continued From page 15 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility.	K 914	How the deficiency was corrected: Proper documentation for 4 point outlet testing has been implemented. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

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

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K 914	Continued From page 16 Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that the documentation presented for review was incomplete as it captured only one of the test requirements of outlet testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914		
K 918 SS=F	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	K 918		9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 17 components is established according to 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 REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2, 5.6.6 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that documentation presented did not identify the monthly measured KW loading of the generator during monthly maintenance / testing. Total KW loading information would identify whether annual 2-hour load-bank testing is required 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month -	K 918	How the deficiency was corrected: Contract with contracting generator testing vendor was updated to initiate annual 2 hour load bank testing and 36 month 4 hour load bank testing will be completed. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**07/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 18 4-hour load bank testing is occurring An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918		
K 920 SS=F	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 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: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section	K 920	How the deficiency was corrected: Extension cords have been removed by the facility Maintenance Director at time of survey on 7/31/2023.	9/12/23

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K 920	Continued From page 19 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on 6th Floor in Chaplains Office an extension cord was connected to a relocatable power tap. The extension cord was removed by the Maintenance Director upon discovery. 2. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on 4th Floor in Team Room that an extension cord was in use. The extension cord was removed by the Maintenance Director upon discovery. 3. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on 1st Floor in Otto Hall that an extension cord was in use. 4. On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on 1st Floor in Salon that two appliances were connected to a relocatable power tap An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	
K 923 SS=F	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	K 923		9/12/23

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K 923	Continued From page 20 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. 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: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012	K 923	How the deficiency was corrected: This room has been re-organized and appropriate signage for empty and full	

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K 923	Continued From page 21 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 11.6.5, 11.6.5.2, 11.6.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/31/2023 between 11:00 AM and 4:00 PM, it was revealed by observation that on 4th Floor in the Med Gas (O2) Storage Rooms there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	tanks have been posted. Staff is being trained to the new policy and procedure. A weekly check has been initiated by facility maintenance team. Completion Date: 09/12/23 Responsible for maintaining compliance: Maintenance Director	