Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 15, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: January 25, 2024

Dear Administrator:

On March 13, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 5, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 25, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / 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
travis.ahrens@state.mn.us
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
	245452	A. BUILDING _____ B. WING _____	C 01/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/22/24 through 1/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		2/26/24

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

Electronically Signed | 02/15/2024

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, 8.4.9.5.1, and 8.4.9.7. This had the potential to affect all 116 residents, all staff, and any visitors in the facility. Findings include: A review of facility documentation on 1/23/2024 between 9:30 a.m. and 2:30 p.m., revealed the facility lacked evidence of monthly emergency generator inspections between May 2023 and December 2023, weekly emergency generator inspections, and evidence of completion of a four (4) hour load bank test within the last 36 months. During interview on 1/23/2024 between 9:30 a.m. and 2:30 p.m., the administrator and director of facilities verified the lack of documentation.	E 041	Upon further review with vendor had completed the four-hour emergency generator test on 9/19/2023. The weekly and monthly inspections and testing of the emergency generator is organized in a manner that can be verified that all of the required inspections were completed. The Facilities Director will create a task for emergency generators and monitor for compliance. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	
F 000	INITIAL COMMENTS On 1/22/24 through 1/25/24, 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: H54528971C (MN00098410), H54528967C (MN00094747), H54528970C (MN00090987), H54528968C (MN00091407),	F 000		

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F 000	Continued From page 4 H54528966C (MN00094282), H54528969C (MN00094732) and H5452083C (MN76444). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		2/26/24

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F 550	Continued From page 5 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified morning and rising routine was implemented for 1 of 2 residents (R21, R51) reviewed for dignity. Findings include: R21: R21's quarterly Minimum Data Set (MDS) dated 11/21/23, indicated R21 had intact cognition, did not reject cares, and was always incontinent of urine and frequently incontinent of bowels. MDS data also indicated R21 required partial to moderate assistance with personal hygiene activities of daily living (ADLs) and was dependent on staff for toileting hygiene and toileting transfers. R21's diagnoses included overactive bladder, anxiety, depression, thoughts	F 550	R21 and R51 care plans were reviewed and personalized, and a dignified morning and rising routine was implemented. R21 had her bowel and bladder evaluation redone. R21 assessed for a toileting program in order to help maintain/restore her bowel and bladder function. R21 care plan updated showing preference to use an electric shaver for facial hair removal, electric shaver provided for R21 use. R51□s care plan has been updated to reflect preference in caregivers. Current like dependent residents□ ADLs are being performed with no issues. Current like dependent residents□ care plans reviewed for accuracy and revised as needed. Care Sheets have been	

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F 550	Continued From page 6 of suicide, diabetes, and pain. R21's Care Area Assessment (CAA) dated 8/22/23, triggered for urinary incontinence and identified R21 always incontinent of bladder and always wearing incontinent products throughout the assessment period. R21's care plan dated 3/16/21, indicated R21 had bladder incontinence with interventions of providing perineal cares after each incontinent episode, checking resident every two hours and assisting with toileting as needed, and providing a bedpan/bedside commode. R21's bowel and bladder comprehensive evaluation dated 8/21/23, indicated R21 was able to ask to use the restroom and had functional incontinence (decreased mental awareness, decreased or loss of mobility or personal unwillingness). Furthermore, the evaluation indicated R21 had not been assessed for a toileting program and was on a check and change plan. During observation and interview on 1/22/24 at 1:19 p.m., R21 had white stubble hair on her chin, upper lip and the side of her mouth approximately 1/4-inch to 1/2-inch in length. R21 stated she was not okay with how long it was and endorsed she had been offered to shave, however, she declined stating she preferred to use Nare. R21 stated she was told she was unable to use the hair removal cream due to the risk of skin burns. During continuous observation on 1/24/24 between 9:37 a.m. and 1:48 p.m., nursing assistants (NA)-B and C entered R21's room at 9:37 a.m. to provide morning cares. R21 was	F 550	updated for dependent residents needing assistance with ADLs including incontinent care and resident preferences where appropriate. ADL care needs will be reviewed with each MDS/Care Conference. Direct care staff, MDS, and Unit Manager will work together to update ADL care needs on the care plan/Kardex. Nursing staff have been re-educated on providing/offering ADL assistance to dependent residents per the residents preferences and needs including provision of incontinent care, personal hygiene routine and to respect the resident s choice DON/Designee will complete random audits for 6 ADL dependent residents each week x 4 weeks to ensure provision of ADL care which includes provision of incontinent care. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 550	Continued From page 7 assisted out of bed using a mechanical standing lift and once in a standing position, NA-C used hygienic wipes to cleanse R21's perineal area. R21 stated she needed to urinate and instructed the NAs to "put a diaper on." NA-C put a brief on, pulled up R21's pants, and NA-B used the remote to lower the mechanical lift and assisted R21 into a seated position in her wheelchair. No offer to use the toilet or commode, or to check and change her incontinence brief was made. NA-B stated they would check her brief after breakfast. NA-C stated that R21 was on a check and change program for urinating and could indicate when she needed the toilet for a bowel movement. Additionally, NA-C stated R21 had a history of skin break down, so they encouraged repositioning but R21 refused at times. No offer was made to assist R21 shave her facial hair before she was brought out for breakfast in the dining room. At 11:38 a.m., R21 continued to sit at the dining room table without being offered to use the bathroom or to be checked and changed. At 12:27 p.m., NA-B and NA-C offered to bring R21 back to her room for repositioning and incontinence care, and R21 refused and told them to leave her alone. NA-C educated R21 on the importance of repositioning and incontinence care, and stated she would document the refusal and let the nurse know. R21 asked NA-C to bring her back to her room, and NA-C offered to check and change if needed at this time. At 1:48 p.m., NA-B verified that R21 had been incontinent, and her soiled brief was changed. During interview on 1/25/24 at 8:37 a.m., the licensed practical nurse (LPN)-C stated she would expect if R21 stated she needed to urinate, the NAs should have offered her a means to be toileted as it was "inappropriate" to let R21 sit	F 550		

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F 550	Continued From page 8 through breakfast and lunch in a potentially incontinent brief. LPN-C stated NAs were expected to honor a resident's individual choices, but the NAs should have informed and educated the resident about the risk for skin breakdown. LPN-C also stated that R21 should not have the facial hair and being too busy is not an acceptable reason for not providing grooming cares. Furthermore, LPN-C stated if staff are too busy during the morning hours, the expectation is that they go back later to offer cares. During interview on 1/25/24 at 12:25 p.m., the director of nursing (DON) stated if a resident said they needed to use the bathroom, staff were expected to transfer them to the toilet, and not doing so could be a dignity issue. Facility policy titled Bowel and Bladder Assessment and management dated 10/01/15, stated the facility will ensure that each elder with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder function as possible. The policy identified purposes of bowel and bladder assessments, including to improve the morale and maintain/restore the elder's dignity and respect. Facility policy titled Standard of Care/Elder Rights dated 9/01/15, indicated elders would be provided with the necessary care and services per our policies and procedures to attain or maintain the highest practicable, physical, mental and psychosocial wellbeing in accordance with their comprehensive assessments, elder rights, needs, preferences and plan of care. The policy listed the minimal requirements as including assistance or supervision of shaving as needed to keep	F 550		

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F 550	Continued From page 9 clean and well groomed. R51: R51's quarterly Minimum Data Set (MDS) dated 11/29/23, indicated she had moderate cognitive impairment, required substantial up to dependent assistance with dressing and personal hygiene, and was dependent on staff for both sitting to standing transfers. R51's diagnoses included depression, dementia, and anxiety. R51's Care Area Assessment (CAA) dated 3/06/23, indicated R51 required staff assistance of one or two for dressing and two for transfers. R51's care plan dated 12/01/23, indicated R51 could verbalize preference in caregivers. R51's care plan lacked indication of preference for male or female caregivers. During observation on 1/23/24 between 8:35 a.m. and, R51 was lying in bed with her blankets pulled up to her stomach. She had a t-shirt and buttoned pajama shirt on, and both were pulled up and exposed her left breast. At 8:41 a.m., nursing assistants (NA)-D and NA-B entered her room and announced they were going to get R51 up and out of bed. R51 asked why the male NA was in her room. NA-B stated it was for R51's assistance. Neither NA offered to find a female caregiver per R51's preference. NA-B assisted R51 to sit up on the edge of her bed and removed her pajama top and t-shirt, which exposed R51's bare chest. NA-D was standing behind a mechanical standing lift facing R51. R51 continued to question why the male NA was in the room and asked him to open the door and leave. NA-B helped R51 into a shirt, then adjusted her feet onto the mechanical lift platform. NA-B	F 550		

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F 550	Continued From page 10 applied the transfer sling, buckled the calf safety belt, and explained the transfer process. NA-D used the remote to raise R51 into a standing position. NA-B removed R51's soiled brief, which left her genital area exposed. R51 asked the male NA to open the door and leave. Neither NA made an offer to honor this request at this time. NA-B used hygienic wipes to cleanse the perineal area before a clean brief was applied and R51's pants were pulled up. NA-D used the remote to lower the mechanical lift and assisted R51 into a seated position into her wheelchair. NA-D and NA-B unbuckled the safety straps, removed the transfer sling and NA-D left the room with the mechanical lift. During interview on 1/25/24 at 8:37 a.m., licensed practical nurse (LPN)-C stated if a resident was asking for a male NA to leave during cares, staff were expected to try to find a female caregiver as an alternative to alleviate the stress to the resident and promote the resident's privacy and dignity. During interview on 1/25/24 at 12:25 p.m., the director of nursing (DON) stated if a resident was expressing discomfort with a male caregiver being in the room during morning cares and undressing, the expectation was that the male caregiver should step out. Furthermore, the DON stated R51's preferences could change day-to-day, and staff are expected accommodate her preferences at the time. The DON stated it would be a dignity concern to not accommodate R51's request of having a male caregiver step out of the room during cares. Facility policy titled Resident Bill of Rights dated 11/28/16, stated a facility must treat each resident	F 550		

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F 550	Continued From page 11 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Facility policy titled Standard of Care/Elder Rights dated 9/01/15, indicated elders would be provided with the necessary care and services per our policies and procedures to attain or maintain the highest practicable, physical, mental and psychosocial wellbeing in accordance with their comprehensive assessments, elder rights, needs, preferences and plan of care. The policy listed the minimal requirements as including considerate treatment at all times with privacy respected and safeguarded.	F 550		
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 2 of 2 residents (R42, R97) observed with medications at the bedside. Findings include: R42's admission Minimal Data Set (MDS) dated	F 554	The medications were immediately removed from R42 and R97 rooms. A Self Administration of Medication Assessment (SAM) order was completed for both R42 and R97. Current physician□s ordered medication were reviewed with R97. The facility policy titled Self-Administration of Medication Current residents was reviewed and is current. Current	2/26/24

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F 554	Continued From page 12 1/5/24, indicated intact cognition, required setup or clean up assist for oral hygiene, was dependent on toileting hygiene, and required partial to moderate assist with upper and lower body dressing. R42's Medical Diagnosis form indicated the following diagnoses: unspecified injury of left lower leg, difficulty in walking, unspecified asthma, and muscle weakness. R42's physician orders dated 12/30/23, indicated the following medication order: albuterol sulfate HFA inhalation aerosol solution 108 (90 base) microgram (MCG)/ACT (actuation); 2 puffs inhale orally every four hours related to unspecified asthma. R42's physician orders were reviewed and lacked an order to self administer medications. R42's Self Administration of Medication form dated 12/30/23, indicated R42 had no desire to self administer medications and under the heading titled, "Physician order" indicated R42 could not self administer medications. R42's care plan dated 1/2/24, indicated the following interventions: educate R42, family, and caregivers regarding the side effects and overuse of inhalers and nebulizers, give medications as ordered, monitor/document side effects and effectiveness, administer medication/puffers as ordered. During observation on 1/22/24 at 1:24 p.m., R42 had an albuterol metered dose inhaler (MDI) located in R24's room on the bedside table.	F 554	residents were reviewed for status of SAM and any resident requests to self-administer medications were reviewed for adherence to policy. Education to facility nurses to follow the facility policy titled Self-Administration of Medication including sections discussing the need to complete a SAM assessment and obtain an order for Self-Administration of Medications if applicable. Education at Resident Council and encourage families to not bring any medications to the residents rooms but instead talk to the nurse to obtain an order for medications that they believe their loved ones need. DON/Designee will complete audits for residents to review status of SAM and any resident requests to self-administer medications were reviewed for adherence to policy. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 554	Continued From page 13 During observation on 1/23/24 at 1:11 p.m., R42 was in her room and an albuterol MDI was located on R42's bedside table. During observation on 1/23/24 at 1:36 p.m., nursing assistant (NA)-A entered R42's room and asked R42 if she had her call light and at 1:39 p.m. left R42's room. During observation on 1/24/24 at 7:10 a.m., an unidentified staff left R42's room. R42 was sitting up in the wheelchair listening to the news and had an albuterol MDI located on the bedside table. During observation on 1/24/24 at 7:16 a.m., licensed practical nurse (LPN)-A entered R42's room and stated she had medications. R42 had the albuterol MDI located on the bedside table in her room. During observation on 1/24/24 at 7:19 a.m., LPN-A entered R42's room and left again. During interview on 1/24/24 at 7:20 a.m., licensed practical nurse (LPN)-A stated R42 self administers her albuterol and verified R42 had an albuterol MDI on the bedside table. LPN-A reviewed R42's physician orders and verified there was no order for R42 to self administer the albuterol MDI. LPN-A further stated the SAM assessment wasn't updated because the SAM indicated R42 did not want to self administer medications. LPN-A stated she would update the manager and provider and added when a resident wants to self administer a medication, a SAM assessment is completed. During interview on 1/24/24 between 7:29 a.m.,	F 554		

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F 554	Continued From page 14 and 7:32 a.m., the nurse manager LPN-B stated if a resident wanted to self administer a medication, an assessment was completed to see if a resident was capable and then an order was requested from the physician and stated R42 should have had an updated SAM assessment and a physician's order. LPN-B stated R42 wanted to keep her inhaler and would complete a SAM assessment. During interview on 1/25/24 at 8:29 a.m., the director of nursing (DON) stated when a resident wanted to self administer medications, an assessment was completed to ensure they are able to complete correctly and then an order is obtained from the provider. DON stated they have on call nurses and may have staff who were unfamiliar with the process. R97's significant change Minimum Data Set dated 12/07/23, indicated intact cognition with diagnoses of Parkinson's disease and motor sensory neuropathy (a disease characterized by muscle shrinking and wasting, weakness, and decreased sensation that result in difficulty using the legs or feet and arms or hands). R97's physician orders dated 1/19/24, indicated the following orders: - MiraLax oral powder 17 gram (GM)/scoop (polyethylene glycol 3350) to give 17 gram by mouth as needed for constipation for day 3 no bowel movement (BM). - Senna oral tablet 8.6 milligrams (mg)	F 554		

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F 554	Continued From page 15 (sennosides) to give 2 tablets by mouth one time a day for constipation. R97's self-administration of medication assessment dated 11/02/23, indicated he had no desire to self-administer medications and indicated R97 was not safe to self-administer medications under the header titled, "IDTC feels resident is safe to self administer listed medications". R97's physician orders were reviewed and lacked order to self-administer medications. R97's care plan dated 11/03/23, indicated the following interventions: monitor for constipation. Implement bowel regimen if no BM every three days. R97's nursing progress note dated 1/19/24, indicated R97's wife brought in bottles of Miralax and Senna. Registered nurse (RN)-A indicated there were no active orders for these medications and the triage provider was contacted about R97's complaints of constipation. RN-A noted new orders were received for these medications and bowel monitoring. R97's progress notes were reviewed and lacked indication that these medications were removed from R97's room. During observation on 1/22/24 at 2:49 p.m., R97 was in his room and there was a bottle of MiraLax on the folding table at his bedside. Additionally, there was a bottle of jock itch powder spray and psoriasis control face and body cream. During observation on 1/24/24 at 12:30 p.m., R97	F 554		

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F 554	Continued From page 16 was in his room and stated he got a new powder. He had a bottle of Miralax, two bottles of jock itch spray, psoriasis control face and body cream, and a bottle of Equate medicated body powder. During interview on 1/25/24 at 10:29 a.m., licensed practical nurse (LPN)-C stated R97's family member had brought in medications from home for him and staff offered to remove them from his room and either keep them for him or for the family member to bring them back home. LPN-C stated staff attempted to remove the medications from his room, but he became upset. LPN-C acknowledged a self-administration assessment would be necessary for R97, however, stated that due to tremors, the safety of self-administration was in question. During interview on 1/25/24 at 12:25 p.m., the director of nursing (DON) stated for a resident to keep medications in their room, a self-administration assessment and physician's order would be necessary. Facility policy titled Self-Administration of Medication dated 11/13/17, indicated when an elder requests to self-administer medications, the interdisciplinary team (IDT) will assess the elder to determine if self-administration of medications is clinically appropriate, safe, and feasible to honor the request and preference of the elder to maintain elder's independence consistent with the individualized plan of care. An elder may only self-administer medications after the IDT has determined which medications may be safely self-administered. The IDT will consider the following: the medications are appropriate and safe for self-administration, the elder's cognitive status, including their ability to correctly identify	F 554		

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F 554	Continued From page 17 their medication, the elder's ability to follow directions, ensure storage of medication in the elder's room must be such that it will prevent access by other elders, medication shall not be retained by the elder after the medication expiration date. Determination of the elder's ability to self-administer will be documented in the medical record and on the care plan, additionally, a physician's order will be obtained and recorded in the medical record and must include which specific medications can be kept at the bedside.	F 554		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		2/26/24

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F 583	Continued From page 18 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 1 residents (R51) reviewed who required staff assistance with personal care. Findings include: R51's quarterly Minimum Data Set (MDS) dated 11/29/23, indicated she had moderate cognitive impairment, required substantial up to dependent assistance with dressing and was dependent on staff for both sitting to standing transfers as well as transferring in and out of the tub. R51's diagnoses included depression, dementia, and anxiety. During observation on 1/24/24 at 8:57 a.m., R51 was lying in bed and wore a long-sleeved shirt under a hospital gown. Nursing assistants (NA)-B and C entered the room and assisted R51 into the bath chair using a mechanical standing lift. One R51 was in a standing position, NA-B removed her soiled incontinence brief and NA-C used the remote to lower R51 into a seated position onto the bath/shower chair. The back of the bath/shower chair had an approximate 4-inch gap between the seat and the back of the chair	F 583	R51 will receive personal cares to ensure personal privacy is maintained. The facility policy titled Standard of Care/Elder Rights was reviewed and is current. Current residents will receive care to ensure personal privacy is respected and safeguarded at all times. Education to nursing staff to ensure personal privacy is always respected and safeguarded. Included in the education is for residents who require staff assistance with personal care; on how to transport residents to the tub room in a dignified manner. DON/designee will audit 3 times a week x4 weeks observing staff while transporting residents to ensure personal privacy is followed and adhered to. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 583	Continued From page 19 where R51's uncovered lower back and upper buttocks were exposed. NA-B and NA-C removed the safety buckles and transfer sling from R51 and moved the mechanical standing lift into the hallway. NA-C and NA-B wheeled the bath/shower chair with R51 in it outside of her room and down the hallway to the tub room. R51 had her hospital gown on and pulled down and across her front lap to cover herself. R51's upper buttocks were left exposed. During interview on 1/25/24 at 9:27 a.m., licensed practical nurse (LPN)-C stated a resident being pushed down the hallway in a bath/shower chair with their buttocks exposed was a dignity issue. During interview on 1/25/24 at 12:25 p.m., the director of nursing (DON) stated staff are expected to cover a resident fully if they are pushing a resident in a bath/shower chair to the tub room. The DON indicated it was a privacy issue if a resident was not fully covered. Facility policy titled Standard of Care/Elder Rights dated 1/01/15, indicated the care at Episcopal Church Homes and the Gardens focuses on quality of life, maintain each elder's dignity and confidentiality in an elder centered and individualized way. Furthermore, the policy indicated the requirements included considerate treatment at all times with privacy respected and safeguarded.	F 583		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and	F 685		2/26/24

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F 685	Continued From page 20 hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide follow up vision services for 1 of 1 resident (R21) reviewed for vision treatment. Findings include: R21's quarterly Minimum Data Set (MDS) dated 11/21/23, indicated R21 had intact cognition and had adequate vision with corrective lenses. R21's diagnoses included glaucoma (disease damaging the optic nerve) and cataracts in both eyes (clouding of the lens of the eye). R21's Care Area Assessment (CAA) dated 8/22/23, indicated she had the potential for visual impairment due to cataracts and glaucoma diagnoses and wore glasses. R21's care plan dated 9/01/22, identified interventions to prevent decline in visual function as arranging consultation with eye care practitioner as required. A provider progress note dated 7/13/23, indicated R21 was seen on that date for a comprehensive eye visit with the following appointment	F 685	R21 has been provided follow-up vision services. All residents have the potential of being affected if vision services are not provided. The process was reviewed, and going forward, the medical records staff will forward the providers notes to the nurse managers. Each nurse manager will go through all orders and ensure that the orders are followed as written. If a Provider is unable to come in a timely manner, the nurse manager will arrange to have the resident see an outside provider if the situation warrants such an intervention. DON/designee will audit once a week for 4 weeks reviewing vision visits to make sure all orders are properly transcribed and followed. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 685	Continued From page 21 recommendations: - Return visit in 3 months for intraocular pressure check. - Recommended to return in 6 months for dilated eye examination. - If patient is able to get out to see their outside eye doctor for their glaucoma testing, it is recommended that they do so. R21's electronic health record (EHR) was reviewed and lacked documentation of scheduled appointments. During interview on 1/25/24 at 8:37 a.m., licensed practical nurse (LPN)-C verified R21 had not been seen for a vision exam since 7/13/23. LPN-C stated the facility has in-house providers, including vision services, who make their own schedules and appointments. LPN-C stated after a resident is seen, someone from medical records was responsible for following up on the recommendations made. Additionally, LPN-C stated that if an appointment was cancelled, someone from medical records would be responsible for rescheduling that appointment. LPN-C stated that follow-up appointments are necessary. During interview on 1/25/24 at 12:25 p.m., the director of nursing (DON) stated in-house providers sent notes and recommendations to medical records who would be responsible for sorting through them and sending them to nurse managers. If an appointment was missed, medical records would be expected to have that list and pass it on to nurse managers. During interview on 1/25/24 at 2:19 p.m., medical records personnel (MR) stated the process was	F 685		

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F 685	Continued From page 22 to review the notes after appointments and pass them on to the nurse manager. The MR stated it was difficult to read every note and acknowledged there was not a good process or system in place in the event an appointment was cancelled or missed. No vision policy available.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was free of accident hazards for 1 of 1 residents (R39) found to have a space heater operating in their room. Findings include: R39's quarterly Minimum Data Set (MDS) dated 8/22/23, identified R39 had intact cognition. R39 had diagnoses of Diabetes Mellitus with Diabetic Polyneuropathy (affects multiple peripheral sensory and motor nerves that branch out from the spinal cord into the arms, hands legs and feet), and major depressive disorder. R39 required supervision with bed mobility, transfers, walking between locations in his room, toileting	F 689	The space heater has been removed from R39 room 104. All rooms have been checked to verify no space heaters are in use. R39 room is a comfortable temperature. The Facilities Director will create a task for checking rooms for space heaters. Information on the facility space heater policy will be given to staff, discussed at the next Resident Council. Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.	2/26/24

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F 689	Continued From page 23 and personal hygiene and limited assistance with dressing, walking in corridor and locomotion off the unit, and no functional limitation in range of motion for upper and lower extremities. During observation and interview on 1/22/24 at 2:17 p.m. R39 was laying in his bed. There was a black Lasko brand, model number U12104 fan/heater on the dresser with the power on. R39 indicated he complained on his room being too cold, and the facility provided it a couple of weeks ago. R39 could not say which staff provided it. R39 indicated he faced the heater to blow hot air towards his feet, and it kept his room warm. The Lasko instructions for use, dated 12/19, did not identified if the heater or fan would be hot when in use or if it would shut off if tipped over. During interview on 1/24/24 at 12:22 p.m., the administrator indicated there was a space heater in R39's room last week, and he had the staff remove it. He indicated he thought R39's family brought in another one after the facility removed the first one. Email on 1/24/24 at 10:30 a.m., the Director of Facilities indicated the heater showed up the previous Friday (1/19/24). Facility Space Heater policy dated March 2023, identified space heaters were not to be used unless approved by the MDH and /or fire marshal.	F 689	The Administrator or designee will be responsible for compliance.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		2/26/24

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F 756	Continued From page 24 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist (CP) failed to report irregularities to the provider for 1 of 1 residents (R27) reviewed who was due for a gradual	F 756	R27 GDR is completed. Current like dependent residents have been reviewed by consulting pharmacist	

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F 756	Continued From page 25 dosage reduction (GDR) of an antipsychotic. Findings include: R27's undated Census form identified an admission date of 2/8/23. R27's quarterly Minimum Data Set (MDS) dated 8/9/23, identified mild depression, intact cognition and diagnoses of non-Alzheimer's dementia, depression, and bipolar disorder. R27 had no behaviors or rejection of care and antipsychotic medications were taken seven out of seven days on a routine basis only. Additionally, a GDR had not been attempted and there was no physician documentation for contraindication of a GDR. R27's admission Care Area Assessment (CAA) dated 2/14/23, identified R27 had bipolar disorder and received antipsychotic medications daily without adverse effects. R27 had no behaviors during the lookback period. Staff would continue to observe for changes and update the doctor as needed. Sources: Resident interview and observation, chart review, and MAR. R27's medication orders identified a start date of 2/8/23, for olanzapine (antipsychotic) 20 milligrams (mg) give one tablet by mouth one time a day related to bipolar disorder. R27's quarterly Psychoactive Medication Review progress notes dated 5/9/23, 8/7/23 and 11/1/24, identified no side effects were noted, mood was stabilized, no GDR had been attempted in the past quarter. R27's Pharmacy Note progress notes dated	F 756	for GDR and if necessary, submitted MRR to provider. If Necessary, the Provider will include a clinical rationale why a GDR is contraindicated. Facility will educate nurse managers/social workers on the facility policy titled Psychoactive Medications, including the CP conducting monthly drug regimen reviews and reported concerns to the prescriber and DON for action to taken if warranted. DON/designee will audit 3 random residents from Consulting Pharmacist GDP recommendations list per week for 4 weeks; Audit will check if provider documented a rational for continued use, or if they ordered a GDR. Audit will 3 random residents from GDP recommendations list per week for 4 weeks The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 756	Continued From page 26 2/10/23 through 1/13/24, lacked notation a GDR was due and lacked clinical rationale for the GDR being contraindicated. R27's corresponding CP Medication Regimen Review (MRR) Pharmacy forms dated 2/10/23 through 1/13/23, lacked notation a GDR was due and lacked clinical rationale for the GDR being contraindicated. R27's provider notes dated 4/20/23, 7/7/23, 9/20/23, 11/13/23 and 1/19/24, lacked lacked notation a GDR was due and lacked clinical rationale for the GDR being contraindicated. During an interview on 1/25/24 at 12:10 p.m., the CP stated for new admissions, after three months a resident's psychotropic medications should be reviewed for a GDR. The CP stated R27 had no GDR due to family's request, however, this was not documented in the medical record. The CP also stated he had not sent a MRR form to the provider asking for clinical rationale, however, he would probably write one this week recommending a GDR. During an interview on 1/25/23 at 12:28 p.m. the assistant director of nursing (ADON) stated the facility had GDR meetings monthly and reviewed residents due for a GDR. The ADON stated if a resident was due for a GDR the provider would need to document a rationale for continued use, or order a GDR. The ADON stated the CP would provide a form to the provider to sign regarding the findings. The ADON stated R27 was doing well and agreed there was no documentation from the pharmacist or provider in R27's medical record regarding a GDR being clinically contraindicated.	F 756		

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F 756	Continued From page 27 During an interview on 1/25/24 at 2:08 p.m. the director of nursing (DON) stated potential GDR's were reviewed at monthly meetings. Additionally a provider rationale should be in the medical record in accordance with the regulations. The DON stated GDR's were important to ensure the lowest dose was used to minimize side effects and that the medication was still necessary. The DON stated she would expect the CP to write a MRR form to the provider if a resident was due for GDR. The facility policy titled Psychoactive Medications dated 3/1/18, identified residents who received psychotropic medications would have GDR per standard guidelines unless a reduction was clinically contraindicated. The CP conducted monthly drug regimen reviews and reported concerns to the prescriber and DON for action to be taken when warranted.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		2/26/24

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F 758	Continued From page 28 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted, or obtain adequate medical justification for the continued use of an antipsychotic medications for 1 of 1 residents	F 758	R27 GDR is completed. Current like dependent residents have been reviewed by consulting pharmacist for GDR and if necessary, submitted MRR	

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F 758	Continued From page 29 (R27) reviewed who was due for a GDR. Findings include: R27's undated Census form identified an admission date of 2/8/23. R27's quarterly Minimum Data Set (MDS) dated 8/9/23, identified mild depression, intact cognition and diagnoses of non-Alzheimer's dementia, depression, and bipolar disorder. R27 had no behaviors or rejection of care and antipsychotic medication was taken seven out of seven days on a routine basis only. Additionally, a GDR had not been attempted and there was no physician documentation for contraindication of a GDR. R27's admission Care Area Assessment (CAA) dated 2/14/23, identified R27 had bipolar disorder and received antipsychotic medications daily without adverse effects. R27 had no behaviors during the assessment period. Staff would continue to observe for changes and update the doctor as needed. R27's care plan dated 2/10/23, identified olanzapine (antipsychotic medication) was used for bipolar disorder and interventions included consulting with pharmacy and provider to consider dosage reduction when clinically appropriate, at least quarterly. R27's medication orders identified a start date of 2/8/23, for olanzapine 20 milligrams (mg) give one tablet by mouth one time a day related to bipolar disorder. R27's Pharmacy Note progress notes dated 2/10/23 through 1/13/24, lacked clinical rationale	F 758	to provider. If Necessary, the Provider will include a clinical rationale why a GDR is contraindicated. Facility will educate nurse managers/social workers on the facility policy titled Psychoactive Medications, including the CP conducting monthly drug regimen reviews and reported concerns to the prescriber and DON for action to taken if warranted. DON/designee will audit 3 random residents from Consulting Pharmacist GDP recommendations list per week for 4 weeks; Audit will check if provider documented a rational for continued use, or if they ordered a GDR. Audit will 3 random residents from GDP recommendations list per week for 4 weeks The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 758	Continued From page 30 from the provider for continued use, and lacked orders for GDR. R27's corresponding CP Medication Regimen Review (MRR) Pharmacy forms dated 2/10/23 through 1/13/23, lacked clinical rationale from the provider for continued use, and lacked orders for GDR. R27's quarterly Psychoactive Medication Review progress notes dated 5/9/23, 8/7/23 and 11/1/24, identified no side effects were noted, mood was stabilized, and no GDR had been attempted in the past quarter. R27's provider notes dated 4/20/23, 7/7/23, 9/20/23, 11/13/23 and 1/19/24, lacked clinical rationale from the provider for continued use, and lacked orders for GDR. During an interview on 1/25/24 at 12:10 p.m., the CP stated for new admissions, after three months a resident's psychotropic medications should be reviewed for a GDR. The CP stated R27 had no GDR due to family's request, however, this was not documented in the medical record. The CP also stated he had not sent a MRR form to the provider asking for clinical rationale for continued use, however, he would probably write one this week recommending a GDR. During an interview on 1/25/23 at 12:28 p.m., the assistant director of nursing (ADON) stated the facility had GDR meetings monthly and reviewed residents due for a GDR. The ADON stated if a resident was due for a GDR the provider would need to document a rationale for continued use, or order a GDR. The ADON stated the CP would provide a form to the provider to sign regarding	F 758		

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F 758	Continued From page 31 the findings. The ADON stated R27 was doing well and agreed there was no documentation from the pharmacist or provider in R27's medical record regarding a GDR. During an interview on 1/25/24 at 2:08 p.m. the director of nursing (DON) stated potential GDR's were reviewed at monthly meetings. Additionally a provider rationale should be in the medical record in accordance with the regulations. The DON stated GDR's were important to ensure the lowest dose was used to minimize side effects and that the medication was still necessary. The DON stated she would expect the CP to write a MRR form to the provider if a resident was due for GDR. The facility policy titled Psychoactive Medications dated 3/1/18, identified residents who received psychotropic medications would have GDR per standard guidelines unless a reduction was clinically contraindicated. The CP conducted monthly drug regimen reviews and reported concerns to the prescribers and DON for action to be taken when warranted.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		2/26/24

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F 812	Continued From page 32 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: During observation and interview, the facility failed to ensure the use of hair restraints during food preparation. This had potential to affect all 116 residents. During observation on 1/23/24 at 1:45 p.m., cook (C)-A prepared chicken on pans before placing into oven. C-A had facial hair and wore a face mask. During observation on 1/23/24 at 2:33 p.m., C-B had a beard which was uncovered. C-B covered and dated multiple pans of Swedish meatballs. C-B stirred taco meat which was cooling. During observation and interview on 1/25/24 at 9:19 a.m., C-A had facial hair and wore a mask while preparing turkey and bread. C-A stated they wore a mask to cover their facial hair. C-B had a beard which was uncovered and poured liquid into a mixture and prepared other ingredients for a dessert. C-B stated they prepared food for Episcopal Church Home and the Transitional Care Unit. C-B stated they used a trimmer to keep their beard hair maintained. During interview on 1/25/24 at 1:07 p.m., the culinary director (CD) had facial hair and wore a	F 812	The facility policy, Personal Hygiene, has been reviewed; included in the policy is hair restraints during food preparation. All residents could be affected if proper use of hair nets is not used during food preparation. Dietary staff have been educated on the facility policy, Personal Hygiene; including section on the use of hair restraints during food preparation. The Culinary Director will create an audit for the use of hair restraints and monitor for compliance. Completion will be audited 3x a week for 4 weeks and results will be brought to QAPI committee meeting for review and discussion. The Administrator or designee will be responsible for compliance.	

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	245452	A. BUILDING _____ B. WING _____	C 01/25/2024

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F 812	Continued From page 33 face mask. CD stated masks were not appropriate beard restraints. CD stated they had staff trim their beards and had not enforced hair restraints for beards. CD agreed C-B did not wear a beard restraint. The facility policy "Personal Hygiene" undated, indicated food service personnel must wear beard and mustache restraints when facial hair is present.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		2/26/24

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F 883	Continued From page 34 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 resident (R102) were offered or received the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The Pneumococcal Vaccine Timing for Adults from the CDC form dated 3/15/23, indicated	F 883	R102 has discharged from the facility. All residents have been offered the influenza and pneumococcal immunizations vaccines. The policy for influenza and pneumococcal immunizations has been reviewed and has been updated with a new policy titled, Vaccination-Residents; updates specifically include all new admissions to	

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F 883	Continued From page 35 adults aged 19-64 years old with immunocompromising conditions (chronic renal failure, generalized malignancy, leukemia, lymphoma) who have only had Prevnar 13 would have to receive PCV20 after 1 year as an option or PPSV23 after one year and review the pneumococcal vaccine recommendations again when the patient turns 65 years old in order to be up to date with vaccinations. R102's admission Minimum Data Set (MDS) dated 12/21/23, indicated intact cognition, renal insufficiency, renal failure, or end stage renal disease; further, R102's pneumococcal vaccination was up to date. R102's Clinical Resident Profile form dated 1/25/24, indicated R102 was 64 years old. R102's Medical Diagnosis form indicated R102 had the following diagnoses: unspecified atrial fibrillation, weakness, chronic kidney disease stage 3A, and acute kidney failure. R102's Minnesota Immunization Information Connect (MIIC) dated 1/25/24, indicated R102 received a Prevnar 13 pneumococcal vaccine on 9/28/20. R102's Clinical Immunizations form dated 1/25/24, indicated R102 received a Prevnar 13 pneumococcal vaccine on 9/28/20. No additional pneumococcal vaccinations were documented. R102's Standing Orders for Skilled Nursing Facilities form revised 2023, and signed by the medical director (MD) on 9/13/23, indicated per CDC guidelines, administer pneumococcal vaccinations unless contraindicated.	F 883	both TCU and LTC will be offered the pneumococcal vaccination. Facility updated the immunization consent form to include the pneumococcal vaccine upon admission. Education will be provided to all facility nurses on the requirement to offer the pneumococcal vaccination to all residents per the new policy titled, Vaccination-Residents. DON/Designee will Audit 3 new admissions a week for 4 weeks, audit will verify that the influenza and pneumococcal immunizations have been offered. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 883	Continued From page 36 R102's medication administration record was reviewed for December 2023, and January 2024, and lacked evidence additional pneumococcal vaccine was administered. R102's Clinical Allergies form dated 1/25/24, indicated allergies to Morphine, cilantro, and nickel. R102's electronic medical record lacked evidence R102 had received the CDC recommended pneumococcal vaccine or indication why it should not be given. During interview 1/25/24 between 10:12 a.m., and 10:37 a.m., the IP stated she had the CDC schedule for pneumococcal vaccinations and R102 required either PCV20 or PPSV23 but because R102 was in the transitional care unit (TCU), she was not offered vaccination because the facility would have to pick up the cost for the vaccine. IP further stated they offered residents in the TCU flu vaccinations, but did not offer pneumococcal vaccinations and added R102 did not refuse the medication because she couldn't refuse it, it wasn't offered. During interview on 1/25/24 at 12:11 p.m., the director of nursing (DON) stated they did not offer everything because it was available, and expected there to be a conversation with the physician if the physician ordered the vaccine, and if it wasn't ordered; it was up to the provider to have a discussion with the patient and added it was not up to the facility. During interview on 1/25/24 at 12:22 p.m., DON clarified in their policy that elders were long term	F 883		

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F 883	Continued From page 37 care residents, and TCU residents were patients and stated they did not offer pneumococcal vaccines to patients on the TCU, and further stated they would not have that conversation with the patients, and if the provider wanted to address the vaccine, they could but the facility would not. During interview on 1/25/24 at 1:36 p.m. IP stated the MIIC indicated under the heading "Recommended Date" for Pneumo-conj indicated "Max age exceeded" however, the MIIC is not in accordance with the CDC vaccination schedule that considered additional information such as chronic conditions for determining vaccination timing. During interview on 1/225/24 at 1:36 p.m., IP stated at this time the facility did not review vaccinations needed upon discharge. A policy Pneumococcal Vaccination dated 11/15/23, indicated all elders will receive immunizations and vaccinations that aid in preventing infectious diseases unless medically contraindicated, otherwise ordered by the elder's attending physician or the elder/responsible party refuse after risks and benefits were discussed. Contraindications for the vaccine included previous vaccination, follow intervals per health department recommendations, pregnancy and lactation, caution must be given for elders with Hodgkin's disease or who are on immunosuppressive therapy. Elders without proof of previous pneumococcal vaccination will be offered the vaccine after education is provided. Consent from the elder or representative must be obtained prior to administration and documented. The elder has	F 883		

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F 883	Continued From page 38 the right to refuse the vaccination. Vaccination refusal and reason why will be documented on the consent form and in the clinical record. Document administration of the vaccine in the MAR and the progress notes. No additional policies were provided.	F 883		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, Episcopal Church Home Of Minnesota was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/15/2024

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. The Episcopal Church Home of Minnesota is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and	K 000		

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K 000	Continued From page 2 the addition meet the construction type allowed for existing buildings, the 3 buildings will be surveyed as one building. The facility has a capacity of 131 beds and had a census of 116 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222		2/26/24

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K 222	Continued From page 3 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code section 7.2.1.6.1.1 (4). These deficient findings	K 222	" 1. The stairwell door next to resident room 233 has delayed egress installed on it, the door does have a sign installed saying, "PUSH UNTIL ALARM SOUNDS	

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K 222	Continued From page 4 could have a patterned impact on the residents within the facility. Findings include: 1. On 01/23/2024 at 12:56 PM, it was revealed by observation that the stairwell door next to resident room 233 has delayed egress installed on it, but the door does not have a sign saying, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". 2. On 01/23/2024 at 01:16 PM, it was revealed by observation that the door leading to the loading dock exit has delayed egress installed on it, but the door does not have a sign saying, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 222	DOOR CAN BE OPENED IN 15 SECONDS". 2. The door leading to the loading dock exit has delayed egress installed on it, the door does have a sign installed saying, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". " The Facilities Director will create a task in TELS for checking egress exit doors. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code,	K 225	" The exit door out of the stairwell labeled "Stair F level 1 through 2" has been repaired and opens with less than	2/26/24

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K 225	Continued From page 5 sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/23/2024 at 12:56 PM, it was revealed by observation that the exit door out of the stairwell labeled "Stair F level 1 through 2" was difficult to open exceeding 30lbf to set the door in motion. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 225	30 lbf. " The Facilities Director will create a task in TELS for checking egress exit doors. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	
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 a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 at 12:56 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the battery-powered emergency lighting in the facility had been inspected.	K 291	" A complete list of all emergency lights in the building has been revised to include their location. A schedule for monthly and annual testing has been created. " The Facilities Director will create a task in for emergency lights and monitor for compliance. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be	2/26/24

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K 291	Continued From page 6 An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 291	responsible for compliance.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		2/26/24

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K 321	Continued From page 7 Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/23/2024 at 12:47 PM, it was revealed by observation that the soiled linen room on the second floor near resident room 215 had tape covering the strike plate causing the door to not latch. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 321	" The soiled utility room on second floor near resident room 215 properly latches. " Doors in the facility will be routinely monitored to ensure they meet compliance. " Doors in the facility will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		2/26/24

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K 324	Continued From page 8 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect their kitchen hood and install the required safety features per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1, 19.3.2.5.3 (9), 19.3.2.5.4, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility provided a kitchen hood inspection report dated 11/09/2023, but they could not provide a report for an inspection being completed six months before the last inspection. 2. On 01/23/2024 at 12:21 PM, it was revealed by observation that the lock out devices that are installed on the residential stoves/ ovens in the facility do not have a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of	K 324	" Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available to install. The kitchen hood suppression system inspection has been completed by a vendor on 11/9/2023. The residential stoves have a lockout device installed that incorporates a 120 minute timer. The kitchen hood suppression system inspection will be scheduled for future completion. A task has been created in TELS to ensure compliance. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance	

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K 324	Continued From page 9 staff action. An interview with the Administrator and Director of Facilities verified these deficient findings at the time of discovery.	K 324		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.4, and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.15.5.3. This deficient finding could have a patterned impact on the residents within the facility.	K 351	" Facility secured vendor and the vendor has committed to completing the work as soon as they can schedule labor and materials are available. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion.	2/26/24

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K 351	Continued From page 10 Findings include: On 01/23/2024 at 01:43 PM, it was revealed by observation that there are no fire sprinklers installed in the elevator machine room that is in the basement in the boiler room. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 351	" The Administrator or designee will be responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler	K 353	" The five-year internal pipe inspection has been completed by contractor. Annual and quarterly sprinkler tests will be	2/26/24

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K 353	Continued From page 11 system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that the annual fire sprinkler inspection report dated 07/11/2023 that the facility provided at the time of survey stated that the five-year internal pipe inspection was due, but the facility could not provide documentation showing that it had been completed. 2. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a quarterly fire sprinkler inspection was completed during the second or fourth quarter of 2023. 3. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by observation that the gauges on the fire sprinkler riser are older than five years. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 353	scheduled for future completion. The inspection of the gauges of the fire sprinkler riser has been completed. A task has been created to ensure compliance. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		2/26/24

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K 372	Continued From page 12 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 observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 01/23/2024 at 11:29 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near the front reception desk. 2. On 01/23/2024 at 11:33 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near resident room 109 caused by low voltage wires. 3. On 01/23/2024 at 11:53 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors	K 372	" The penetration in the smoke barrier above the smoke barrier doors near the front reception desk have been filled to complete the smoke barrier. 2. The penetration in the smoke barrier above the smoke barrier doors near resident room 109 caused by low voltage wires have been filled to complete the smoke barrier. 3. The penetration in the smoke barrier above the smoke barrier doors near the soiled linen room on the third floor caused by an electrical conduit have been filled to complete the smoke barrier. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	

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K 372	Continued From page 13 near the soiled linen room on the third floor caused by an electrical conduit. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the second or third shift during the third quarter of 2023.	K 712	" A calendar was created to outline all dates and times that fire drills will occur in 2024. " The Fire Drill Calendar will be monitored for compliance. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	2/26/24

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K 712	Continued From page 14 An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 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 a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that the fire door inspection that	K 761	" The annual inspection of fire rated doors was completed. " A schedule was created to routinely monitor fire doors, including the annual fire door inspection. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	2/26/24

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K 761	Continued From page 15 was provided at the time of the survey did not list what doors were inspected or what items were inspected the report listed what sections of the building the doors were inspected in. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 761		
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and a review of available documentation and staff interview, the facility failed to implement and follow a space heater policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by observation and a review of available documentation that the space heater policy that the facility provided at the time of the survey stated, "It is the policy of Episcopal Homes that space heaters are not to be used unless approved by the MDH and/or fire marshal.", and there were two space heaters found in resident	K 781	" The space heater has been removed from resident room 104 and the chapel on second floor. All rooms have been checked to verify no space heaters are in use. " The Facilities Director will create a task for checking rooms for space heaters. Information on the facility space heater policy will be given to staff, discussed at the next Resident Council. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be	2/26/24

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K 781	Continued From page 16 spaces during the survey. 2. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by an interview with the Minnesota Department of Health that they witnessed a space heater being used in resident room 104. When I inspected resident room 104 the resident informed me that staff had taken the space heater that was being used, and when we stepped outside of the room a staff member informed me that he was able to show me what space heater was being used. The staff brought me to a nursing office and showed me a black space heater that they said was previously being used in resident room 104. 3. On 01/23/2024 at 12:52 PM, it was revealed by observation that there was a space heater that was plugged in found in the chapel on the second floor. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 781	responsible for compliance.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		2/26/24

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K 901	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a NFPA 99 risk assessment. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 901	" The NFPA 99 Risk Assessment has been completed. " The safety Committee will review the Risk Assessment annually and as needed. " Safety Committee Minutes will be reviewed to ensure compliance " The Administrator or designee will be responsible for compliance.	
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	K 914		2/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

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

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K 914	Continued From page 18 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 testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.3.2.1, 6.3.4.1.3, 6.3.4.2.1.1 and 6.3.4.2.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that the resident room electrical receptacle inspection documentation that the facility provided at the time of the survey was not filled out completely, and the inspection report did not list what items were being inspected. 2. On 01/23/2024 at 12:58 PM, it was revealed by observation that the electrical receptacle located in resident room 238 near the reclining chair had a broken grounding plug stuck in the grounding outlet. An interview with the Administrator and Director of Facilities verified these deficient findings at the time of discovery.	K 914	" The NFPA 99 documentation for patient care receptacle testing was completed. The electrical receptacle located in resident room 238 near the reclining chair has been repaired. " A schedule was created to routinely monitor electrical receptacles " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		2/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

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

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K 918	Continued From page 19 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 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 available documentation	K 918	" Upon further review with vendor had	

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

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K 918	Continued From page 20 and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, 8.4.9.5.1, and 8.4.9.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that monthly inspections were completed on the emergency generator between May 2023 and December 2023. 2. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have completed any weekly inspections of the emergency generator. 3. On 01/23/2024 between 09:30 AM and 02:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank test has been completed within the last 36 months. An interview with the Administrator and Director of Facilities verified this deficient finding at the time of discovery.	K 918	completed the four-hour emergency generator test on 9/19/2023. The weekly and monthly inspections and testing of the emergency generator is organized in a manner that can be verified that all of the required inspections were completed. " The Facilities Director will create a task for emergency generators and monitor for compliance. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.	