

Electronically Delivered June 1, 2022

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

RE: CCN: 245625

Cycle Start Date: March 24, 2022

Dear Administrator:

On May 25, 2022, 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

Mishing

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered

June 1, 2022

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

Re: Reinspection Results

Event ID: CGXY12

Dear Administrator:

On May 25, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 24, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

M. Pris

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered June 1, 2022

CMS Certification Number (CCN): 245625

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

Dear Administrator:

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

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

Effective May 20, 2022 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

M. This

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered April 11, 2022

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

RE: CCN: 245625

Cycle Start Date: March 24, 2022

Dear Administrator:

On March 24, 2022, 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.

Episcopal Church Home Gardens April 11, 2022 Page 2

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:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us

Office: (651) 238-8786 Mobile (651) 238-8786

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

Episcopal Church Home Gardens April 11, 2022 Page 3

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 June 24, 2022 (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 September 24, 2022 (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

Episcopal Church Home Gardens April 11, 2022 Page 4

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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Pais

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

PRINTED: 05/06/2022 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	NG		COMPLETED	
		245625	B. WING		l l	C 24/2022	
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP COI 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
	compliance with Ap Preparedness Requestions and conducted during a	h 3/24/22, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance.					
F 000	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.	F 0	00			
	recertification surve facility. A complaint conducted. Your fac compliance with the	h 3/24/22, a standard ey was conducted at your investigation was also cility was found to be NOT in e requirements of 42 CFR 483, ments for Long Term Care					
		olaints were found to be ED: H5625032C (MN81574), IN81182).					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
I ABORATORY	onsite revisit of you validate substantial regulations has bee	acceptable electronic POC, an ir facility may be conducted to compliance with the en attained.	NATI IPF	TITLE		(X6) DATE	

Electronically Signed 04/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY PLETED
		245625	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER	240020			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2022
EPISCOF	PAL CHURCH HOME	GARDENS		1	860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Ex CFR(s): 483.10(a)(§483.10(a) Resider	1)(2)(b)(1)(2)	F 5	550			5/20/22
	The resident has a self-determination, access to persons a	right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manne promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source.					
		e right to exercise his or her of the facility and as a citizen					
	resident can exercis	facility must ensure that the se his or her rights without on, discrimination, or reprisal					
	free of interference reprisal from the fac	resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245625	B. WING		C 03/24/2022	
	PROVIDER OR SUPPLIER PAL CHURCH HOME	GARDENS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	exercise of his or his subpart. This REQUIREMENT by: Based on observatoreview the facility face assistance with dree (R41) reviewed for Findings include: R41's quarterly Min 2/7/22, indicated Raimpaired and require assistance for all ace R41's diagnoses in (a degenerative disaffecting muscle convoluntary movement and psychotic disored R41's cognitive loss assessment (CAA) had cognitive impaired for dementia. R41's care plan (CR41 had an ADL seed dementia, impaired further indicated R41 assistance by 1 states as needed for weak CP further indicated assistance by 2 states as tand lift. R41's CP provide opportunities	er rights as required under this er rights as required under this NT is not met as evidenced ion, interview, and document illed to maintain dignity during ssing for 1 of 1 residents dignity. Imal Data Set (MDS) dated 41 was moderately cognitively ed 1 or 2-person extensive ctivities of daily living (ADLs). cluded history of stroke, ataxia ease of the nervous system introl or coordination of its), dementia, depression, der. Sidementia care area dated 8/9/21, indicted R41 rment related to (r/t) diagnosis P) dated 5/26/20, indicated elf-care deficit related to mobility, and ataxia. R41's CP 11 required extensive ff to dress and assist of 2 staff the care deficit related to mobility, and ataxia. R41's diagnosis eff with transfers using an EZ instructed caregivers to es for positive interaction, stop then passing by and ensure	F 550	1. NA was provided education on providing care in a way that maintaidignity for R41. Education was provided and of care to completion, ensities the call light is within reach. Addition NA was educated on ensuring if cannot complete, that dignity can be maintained for the resident. A team huddle with similar education was completed with additional staff on 2 floor. 2. 56/56 residents have the potential affected by the deficient practice. 3. A policy and procedure regarding Maintaining Dignity and Resident R will be developed. All staff providin cares will be educated on the new pand procedure for maintaining Dignity Residents rights. 4. DON, Nurse Managers or design conduct audits of resident care for potentially affected residents. Audit occur a minimum of 4x/month for the consecutive months. Results of find will reviewed with IDT and monitore the facility QA meeting. 5. Deficiency will be corrected and substantial compliance will be achied. May 20th, 2022.	rided to e plan, suring nally re is and al to be gights g policy aity and hee will hree dings ed at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245625	B. WING		03/3	24/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	1 03/2	.4/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	R41's nursing care	ge 3 sheet (NCS) instructed staff to n reach and perform frequent	F 550			
	visual checks. R41' extensive assist of	s NCS indicated R41 required 1 for dressing.				
	observed:	observation the following was				
	was in R41's room morning cares. R41 at this time. -at 8:49 a.m. N	a.m. nursing assistant (NA)-D assisting with completion of appeared receptive of cares A-D left R41's room and went				
	then into another re -at 8:55 a.m. Refacing the halfway o	rent resident's room (R13) and sident's room (R11). 41 was sitting in wheelchair open door. R41 had on a shirt, to just above the knees.				
	R41's incontinent by blanket was on the R41's right. R41 was attempting to pull the call light was on the	rief was visible at her crotch. A floor next to the wheelchair on as tugging at her pants tem up over her legs. R41's bed and not in R41's				
	would have come ri it did not feel good	41 stated, "I wish she [NA-D] ght back." R41 further stated sitting like that and that she k41 stated, "I wonder what she				
	[NA-D] is doing. Wh -at 9:03 a.m. No without looking into	nat is she [NA-D] thinking of?" A-E walked by R41's room her room.				
	R41 was observed attempting to pull the to self-propel towar	41 stated, "I don't like this." with pants still at knee level em up further. R41 attempted d door and then backward and unsuccessful. R41 again				
	stated, "What is she -at 9:07 a.m. N	· ·				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	DING		MPLETED
		245625	B. WING	i	03	C /24/2022
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 550	without looking into -at 9:09 a.m. Refrom hallway with p attempt to pull them unsuccessfulat 9:14 a.m. Nat 9:15 a.m. N. while R41 still tugge pull them up on her -at 9:16 a.m. N. R41 was heard say -at 9:17 a.m. N. without looking into -at 9:18 a.m. Re the hallway with her R41's thighs were e cover them with the -at 9:24 a.m. ar maintenance staff v -at 9:26 a.m. Re hallway with her pa attempted to self-pr hands on the whee pants dropped belo her hands from the pulled them back u -at 9:37 a.m. N. of R11's room and o -at 9:40 a.m. N. stand to assist R41 they pulled up her p back to a seated po During interview on stated R41 was a 2 the use of the EZ si (NA-D) and (NA-E)	R41's room. R41's room. 41 was still sitting in full view ants half on and continued to a up herself but was A-D came out of R11's room. A-D re-entered R11's room ed on her pants attempting to own. A-D came out of R11's room. ing, "I want to go." A-D walked by R41's room R41's room. 41 still sitting within view from pants only to her knees. exposed, and she attempted to	F 5	550		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245625	B. WING			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	00/2	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	with her pants halfw was not within reach During interview on registered nurse (R have had to wait 48 return to assist pulli stated no elder (restong and should not During interview on member (FM)-A stated was exposed to the FM-A further stated she tried to do somunsuccessful. During interview on of nursing (DON) stated should have been on NA-D should have it should have let her delayed. DON stated staff provide care in elders' dignity. A facility policy on deprovided.	vay up and that her call light h. 3/23/22, at 11:23 a.m. (N)-B stated R41 should not 8 minutes for someone to ing up her pants. RN-B further sident) should ever wait that the exposed to the hallway. 3/23/22, 1:35 p.m. family ated if (R41) was aware she hallway, she would hate it. I (R41) would get frustrated if ething herself and was 3/23/22, at 2:48 p.m. director tated the expectation was R41 covered up. DON further stated returned to check on R41 and know she would be further ed the expectation was that in such a way as to protect the dignity was requested but not	F 55			
F 689 SS=D	rights indicated eve rights included the r Free of Accident Ha	azards/Supervision/Devices	F 68	9		5/20/22
	§483.25(d) Acciden The facility must en §483.25(d)(1) The r					

PRINTED: 05/06/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245625	B. WING _			2 4/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	L-1/LULL
EPISCOF	PAL CHURCH HOME	GARDENS		1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From paras free of accident §483.25(d)(2)Each supervision and assaccidents. This REQUIREMENT by: Based on observator review, facility staff interventions for 3 of R45) and the facility appropriate fall interventions for 3 of R45) reviewed for Findings Include: R8's diagnoses obtorecorded printed 3/3 disease, dementia, R8's admission Min 12/27/21, indicated impairment and recorded printed and recorded printed and recorded printer and recorded impairment and recorded impairment and recorded impairment and recorded printed and recorded printed and recorded impairment and recorded impairm	ge 6 hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document failed to follow the of 4 residents (R8, R12, and of failed to implement reventions for 1 of 4 residents	F 68	DEFICIENCY)	fall and R45 place in all to be eviewed and set to Nurses as, and follow e. as those	
	nonskid socks and plan also included i checks and monitor to ask for assistant plan further indicate of daily living due to The care plan then	proper fitting shoes. R8's care interventions of frequent for safety, and to remind R8 is if feeling weak. The care and R8 had a deficit in activities in Dementia, and delusions. Indicated R8 was independent needed encouragement to use		Nurse Managers, DON or designed ensure they are individualized and appropriate for each elder within a of a fall and intervention implement Audits will be completed of all resident fall care plan and interventions during MDS assessment period to ensure interventions remain appropriate and appropriate appropriate and appropriate and appropriate and appropriate and appropriate and	week tation. dents ing the that	

Facility ID: 30004

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245625	B. WING				24/2022
NAME OF F	PROVIDER OR SUPPLIER	210020			TREET ADDRESS, CITY, STATE, ZIP CODE	03/2	24/2022
NAME OF F	-NOVIDEN ON SOFFLIEN				860 UNIVERSITY AVENUE WEST		
EPISCOF	PAL CHURCH HOME	GARDENS			AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 7	F 6	89			
	her call light for assistance and required a walker when transferring.				followed by the staff. Results of fin will be documented and reviewed vand monitored at the facility QA me	vith IDT	
	During a continuous	continuous observation; 5. Deficiency will be corrected and substantial compliance will be achi		Ū			
	chair located outsid the hallway. R8 did wheelchair next to h -at 6:32 p.m. nu to R8 "you are just will be right back." F outside of her room get R8's walker or w walked down the har roomat 6:34 p.m. Ri was sitting in and w	ursing assistant (NA)-B states fine, you can sit right there, I R8 observed sitting in a chair in the hallway. NA-B did not wheelchair at this time, but allway into another resident's 8 stood up from the chair she ralks back into her room, ker or wheelchair and closes			May 20th 2022	eved by	
	On 3/22/22, at 1:47 next to the bed with or sock on her right wheelchair was not During observation edge of her bedat 2:05 p.m. Ri edge of the bed pla her feet. At this time member walked pa	p.m. R8 observed standing her left shoe on, and no shoe foot. R8's walker or within reach at this time. R8 sat back down on the 8 was observed bent over the cing her socks and shoes on e, NA-A and another staff ss R8's room, however neither red what R8 was doing and the hallway.					
	NA-A asked R8 if sl	ion on 3/23/22, at 9:40 a.m. he could help R8 into the ransfer into the bathroom, R8					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION	COM	PLETED
		245625	B. WING	i			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	was observed to or the other foot had rand NA-A had R8 was a walker or a transf stated R8 normally NA-A further stated walk with a walker.' proceeded to get R seated on the toilet R8. NA-A then stated other resident's rook. R8's Fall Risk Evaluindicated R8 had a for falls. R8's undated nursing indicated R8 was a and staff were to ginot using it. During an interview indicated she had rebeing a fall risk. NA wanders around the During an interview RN-A indicated R8 monitor R8's where R8 will walk off with was to reminder R8 ensure R8 was using ambulating.	ally have one nonskid sock on, so shoe or nonskid sock on, so shoe or nonskid sock on, walk into the bathroom without fer belt. During transfer NA-A does not walk with a walker., "I don't ever see her [R8] 'During this time, NA-A 8's walker after R8 was and placed the walker next to ed R8 will leave her walker in ms. Justion dated 12/20/21, history of falls, and was at risk and assistant care sheet high fall risk, used a walker we R8 her walker if she was a for 3/23/22, at 9:22 a.m. NA-A lever heard anything about R8 and further indicated R8 e unit. Justion of the walker if she was a fall risk, and staff are to abouts. RN-A further indicated iout using her walker and staff as to use her walker and to any her walker when obtained from the admission		689			
	cognitive impairme	24/22, included vertigo, nt, syncope (temporary loss of d collapse, depression,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245625	B. WING			24/2022
NAME OF	PROVIDER OR SUPPLIER	210020		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2022
EDISCO	DAL CUUDCUUCME	CARRENC		1860 UNIVERSITY AVENUE WEST		
EPISCOI	PAL CHURCH HOME	JAKDENS		SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Alzheimer's, right for and mobility, and di R12's quarterly MD had severe cognitive extensive assist of and required supernambulating in her roannual MDS dated indicated being at riunsteadiness with the diagnoses, medicated use to self transferror R12's Fall Risk Evaluation and transled to Evaluation indicated brace, ask staff for light. R12's care plan with indicated R12 had a due to vertigo, imparand right foot drop, indicated R12 was a to ensure her call light anticipate her need caused falls. R12's instructions for a legal During a continuous On 3/22/22, at 10:2 slightly opened, R15 room.	ot drop, abnormalities of gait fficulty walking. S dated 1/3/22, indicated R12 re impairment and required one person for transferring vision of one staff when com or on the unit. R12's 7/7/21, Care Area Assessment ransitions, history of falls, ransitions, history of falls, rions and has had multiple falls ring. Illuation dated 12/29/21, reat risk for falls and self referring without calling for previous falls. The Fall Risk da R12 was to wear a right foot rassistance and to use her call the an initiated date of 6/30/21, rectivity of daily living deficit raired balance, gait disorder a high fall risk and staff were get was within reach, and her right foot drop had care plan did not provide g brace.	F 6	89		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG	COI	COMPLETED	
		245625	B. WING		ı	C / 24/2022
	PROVIDER OR SUPPLIER PAL CHURCH HOME	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODI 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	-at 11:05 a.m. If recliner chairat 11:25 a.m. If closedat 11:33 a.m. If twice while R12's dand did not stop to continued around the recliner chair with reach. During another conduction of 3/23/22, at 7:07 walking in her room at 7:41 a.m. Reclinering R12's room medications and National linensat 7:44 a.m. be room, R12 was observed under the at 7:52 a.m. Nand left the room, Nocks, leg brace or within reach. R12's progress not indicated R12 had afloor. The progress intervention for R12 transferring. R12's	R12 was no longer in the R12's door was completely NA-A walked by R12's room oor was completely closed check on R12. NA-A ne corner the stairway. R12 was observed seated in no shoes on, R12 wore white action, a leg brace was amp stand and R12's call light h. tinuous observation; a.m. R12 was observed n, no staff present in the room. N-C and NA-C observed m, RN-C gave R12 A-C gathered garbage and oth RN-C and NA-C exited the served seated in a recliner s on and neither staff R12's leg brace which was	F6	89		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION		E SURVEY PLETED
		245625	B. WING				C 24/2022
	PROVIDER OR SUPPLIER	GARDENS		18	TREET ADDRESS, CITY, STATE, ZIP CODE 860 UNIVERSITY AVENUE WEST AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	call light for help. R12's progress note indicated R12 had a floor. The progress for R12 was remind and walker which in prior to ambulating progress note dated not using her right I the fall on 1/20/22. R12's progress note indicated R12 had a included R12 was to the remarkable of the R12's progress note indicated R12 had a included R12 forgot staff were to offer to R12's progress note indicated R12 had a included leaving R1 to use call light and note dated 9/28/21, awareness of her sistenger than she with R12's undated nursing was a high fall risk, vertigo (dizziness) a leg brace on when all puring an interview NA-C indicated R12 normally does not palways dressed her	e dated 1/20/22, at 10:21 p.m. a fall and was found on the note indicated interventions ler signs were put on the wall indicated R12 to ask for help or transferring. A follow up of 1/21/22, indicated R12 was eg brace, and walker prior to de dated 12/22/21, at 7:49 p.m. a fall, and interventions of wear nonskid socks. The dated 12/3/21, at 3:05 p.m. a fall, and interventions to wear right leg brace and of put it on for her. The dated 9/25/21, at 12:30 p.m. a fall, and interventions 2's door open, reminding R12 to not walk alone. A follow up indicated R12 had poor afety and she believed to be was. The dated R12 had poor afety and she believed to be was.	F	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245625	B. WING		1	C 24/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2022
EPISCO	PAL CHURCH HOME (GARDENS		1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE
F 689	use her call light and During an interview RN-C indicated R12 be applied in the me During an interview director of nursing (expectation was state such as keeping the shoes or nonskid so use their walkers, k within reach and state leg brace if the falls. R45's quarterly Mir 2/14/22, indicated of Parkinson's disease movement disorder mobility, muscle we behavioral disturban neuromuscular scorequired extensive a limited assistance w history of two or moone fall with injury. R45's care plan las R45 had an activitie self-care performan of extensive assist care plan further ind falls with intervention light were within reach	d to keep it within reach. on 3/23/22, at 8:37 a.m. 2 had a leg brace that was to ornings. on 3/24/22, at 11:09 a.m. DON) indicated her aff to follow the interventions e doors open, the use of ocks, encouraging residents to eeping walkers and call lights aff should be offering to apply resident allows to prevent nimum Data Set (MDS) dated liagnoses which included e, extrapyramidal and exakness, dementia with nee, lack of coordination, and liosis. It further indicated R45 assistance with transfers, with ambulation, and a fall ore falls without injury, and at revised on 2/28/22, included es of daily living (ADL) nee deficit with an intervention of one with transfers. R45's cluded R45 was at high risk for ons to ensure walker and call	F6	589		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245625	B. WING		- 1	C 24/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	24/2022
EPISCO	PAL CHURCH HOME	GARDENS		1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE
F 689	walker within reach R45's fall risk asses R45 was a fall risk, and had risk factors functional status, Pi dizziness/lighthead in decision making judgement. R45's care area ass 8/25/21, indicated C risk for falling. "Risk behaviors, unsteadi for scheduled antid medications. Incont cognitive impairment disorganized thinkir of pain, and diagno- psychosis, depress disorder/dyskinesia Physical Device rev when walks and lea go to and from dest reminders and mon away without his wa awareness due to c During observation sat in a chair in his were not within reac During observation sat in a chair in his few steps forward v was a book on the f stepped on it and h pages. The surveyor	at all times. ssment dated 2/9/22, indicated had a history of multiple falls, which included: decline in arkinson's disease, edness, uses a walker, decline skills, dementia, and impaired casesment (CAA) dated casesment include: wandering mess with transitions, orders epressant and cardiovascular inence of bowel and bladder, int, inattention, and ingrelated to dementia. Report ses of Parkinson's disease, ion, movement and hypertension. Per view (8/23/21) R45 shuffles ins to the left. Uses walker to cinations. Does need constant itoring for safety as will walk alker. Alteration in safety cognitive impairments." on 3/22/22, at 10:26 a.m. R45 room. His walker and call light	F6	689		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245625	B. WING			C 24/2022
	ROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	1 00/	L-112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
	call light was laying within reach. During observation sat at the table in the was not within reach. During observation sat in the recliner in was pushed up aga of the end table, no During observation sat in a chair in his middle of the room, R45's incident note was found sitting in to two leather chairs dated 11/1/21, indicinterventions: staff checks, offer to toil light within reach, a for assistance. R45's incident note was found sitting or his head lying on the incident report date impulsive and does assistance." It further interventions: "staff frequently and ensuall times. Remind e shift."	ght to request assistance. The on the floor under his bed, not on 3/23/22, at 9:27 a.m. R45 and dining room. His walker h. on 3/23/22, at 10:55 a.m. R45 at the common area. His walker his the wall on the other side to within reach. on 3/24/22, at 10:47 a.m. R45 room. His walker was in the not within reach. dated 10/31/21, indicated R45 his bedroom on the floor next is A follow up incident report	F	689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	I ' '	DING		COM	E SURVEY IPLETED
		245625	B. WING	<u> </u>		l	C 24/2022
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP (1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	CODE		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 689	room 439." A follow 12/7/21, indicated Fto use it almost all cinterventions. R45's incident note "elder was walking the floor. When eld under the bed. He I rotation of extremiti his left shoulder. He around the unit learnurse practioner (I monitor resident an spoke with R45's whim tomorrow. Spoelder to be in a whe talk to family and gris concerned about falls." A follow up in indicated "elder doe assistance due to cindependent with tracked any new intervention." R45's incident note "Elder was assisted became agitated an and then slid down buttocks." A follow 1/31/22, lacked any R45's incident note "found elder sitting side but was not lay down and put a pillo by am nurse. This is symptoms) injuries	y up incident report dated R45 "has a walker but forgets day." It lacked any new a dated 12/21/21, indicated without his walker and fell to be was found his head was has no inward or outward lies. He does have a scrape on the denies pain. He often walks wing his walker behind. Called NP) and she ordered to had update as needed. Also wife. She will be here to see the with her about the need for the let back to us next week. She will be here to see this falls and the frequency of the incident report dated 12/22/21, the solution is ansfer and ambulation." It		689			

NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME GARDENS STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME GARDENS XAIN TAULI, MIN 55104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SAINT PAULI, MIN 55104 (X4) ID PRETRY REQUIATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 16 The incident lacked any additional interventions or follow up at time of survey. During an interview on 3/23/22, at 10:50 a.m. nursing assistant (NA)-G stated R45 had used his call light one time since she started working for the facility a month and a half ago. NA-G further stated R45 will "grab his walker when he's back in his room he will just try to get up and go." During an interview on 3/23/22, at 11:00 a.m. NA-H stated R45 "doesn't know how to use his call light, he will use his walker but when he wanders he will forget and just walks around without it." During an interview on 3/23/22, at 11:18 a.m. licensed practical nurse (LPN)-A stated R45 wasn't able to use his call light and had never seen him use it. She further stated R45 would occasionally remember to use his walker but would often forget. During an interview on 3/23/22, at 11:05 a.m. registered nurse (RN)-B stated she was responsible for initiating the care plan (When there was a new admit) and the Minimum Data Set (MDS) nurse completes it. She further stated fit was her responsibility (along with the other			245625	B. WING		1	
EPISCOPAL CHURCH HOME GARDENS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 16 The incident lacked any additional interventions or follow up at time of survey. During an interview on 3/23/22, at 10:50 a.m. nursing assistant (NA)-G stated R45 had used his call light one time since she started working for the facility a month and a half ago. NA-G further stated R45 will "grab his walker when staff direct him to, but when he wants to get up, he will just get up and go. That's why we try to keep him out here [dining room] because when he's back in his room he will just try to get up and go. During an interview on 3/23/22, at 11:00 a.m. NA-H stated R45 "doesn't know how to use his call light, he will use his walker but when he wanders he will forget and just walks around without it." During an interview on 3/23/22, at 11:18 a.m. licensed practical nurse (LPN)-A stated R45 wasn't able to use his call light and had never seen him use it. She further stated R45 would occasionally remember to use his walker but would often forget. During an interview on 3/23/22, at 11:05 a.m. registered nurse (RN)-B stated she was responsible for initiating the care plan (when there was a new admit) and the Minimum Data Set (MDS) nurse completes it. She further stated it was her responsibility (along with the other	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2022
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 16 The incident lacked any additonal interventions or follow up at time of survey. During an interview on 3/23/22, at 10:50 a.m. nursing assistant (NA)-G stated R45 had used his call light one time since she started working for the facility a month and a half ago. NA-G further stated R45 will 'grap his walker when start direct him to, but when he wants to get up, he will just get up and go. That's why we try to keep him out here [dining room] because when he's back in his room he will just try to get up and go." During an interview on 3/23/22, at 11:00 a.m. NA-H stated R45 "doesn't know how to use his call light, he will use his walker but when he wanders he will forget and just walks around without it." During an interview on 3/23/22, at 11:18 a.m. licensed practical nurse (LPN)-A stated R45 would occasionally remember to use his walker but would often forget. During an interview on 3/23/22, at 11:05 a.m. registered nurse (RN)-B stated she was responsible for initiating the care plan (when there was a new admit) and the Minimum Data Set (MDS) nurse completes it. She further stated it was her responsibility (along with the other	EPISCOF	PAL CHURCH HOME	GARDENS				
The incident lacked any additonal interventions or follow up at time of survey. During an interview on 3/23/22, at 10:50 a.m. nursing assistant (NA)-G stated R45 had used his call light one time since she started working for the facility a month and a half ago. NA-G further stated R45 will "grab his walker when staff direct him to, but when he wants to get up, he will just get up and go. That's why we try to keep him out here (dining room) because when he's back in his room he will just try to get up and go." During an interview on 3/23/22, at 11:00 a.m. NA-H stated R45 "doesn't know how to use his call light, he will use his walker but when he wanders he will forget and just walks around without it." During an interview on 3/23/22, at 11:18 a.m. licensed practical nurse (LPN)-A stated R45 wasn't able to use his call light and had never seen him use it. She further stated R45 would occasionally remember to use his walker but would often forget. During an interview on 3/23/22, at 11:05 a.m. registered nurse (RN)-B stated she was responsible for initiating the care plan (when there was a new admit) and the Minimum Data Set (MDS) nurse completes it. She further stated it was her responsiblity (along with the other	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
nurses) to put in interventions after a resident had a fall and to add new interventions in order to prevent future occurrences. During an interview on 3/24/22, at 8:25 a.m. NA-I stated "once in a while he (R45) uses his call	F 689	The incident lacked follow up at time of During an interview nursing assistant (N call light one time s the facility a month stated R45 will "gra him to, but when he get up and go. That here [dining room] It room he will just try During an interview NA-H stated R45 "call light, he will use wanders he will forgwithout it." During an interview licensed practical newasn't able to use it seen him use it. Shoccasionally rement would often forget. During an interview registered nurse (R responsible for initiation there was a new ad Set (MDS) nurse coit was her responsition nurses) to put in inta fall and to add ne prevent future occur.	I any additonal interventions or survey. on 3/23/22, at 10:50 a.m. NA)-G stated R45 had used his ince she started working for and a half ago. NA-G further b his walker when staff direct wants to get up, he will just its why we try to keep him out because when he's back in his to get up and go." on 3/23/22, at 11:00 a.m. doesn't know how to use his walker but when he get and just walks around on 3/23/22, at 11:18 a.m. urse (LPN)-A stated R45 his call light and had never e further stated R45 would her to use his walker but on 3/23/22, at 11:05 a.m. N)-B stated she was atting the care plan (when limit) and the Minimum Data completes it. She further stated collity (along with the other erventions after a resident had we interventions in order to irrences.	F6	689		

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			PLETED
	245625	B. WING		l	C 24/2022
			STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	1 007	2412022
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
because he forgets stands up and goes During an interview director of nursing (managers were resplans and put in intenurses). The DON interventions were requarterly basis. She after every fall, and up with possible interventions. The Eshouldn't be on their interventions. The Eshouldn't be on their light if he's not goin During a follow up in a.m. the director of expected staff to for resident's care plant.	to use his walker and he just is." on 3/23/22, at 12:33 p.m. (DON) stated the nurse ponsible to create the care erventions (along with the further indicated the re-evaluated on the MDS on a eralso stated she was notified assisted the nurses to come erventions. The IDT team oot cause and suggest DON also stated "I agree that it are to remind him to use his call grouse it." Interview on 3/24/22, at 11:09 nursing (DON) stated she llow the interventions in each is.	F 6	89		
"All elders who are falls will be identifie precautions will be decrease the numb Assistive Devices - CFR(s): 483.60(g) §483.60(g) Assistiv The facility must preand utensils for resappropriate assistancan use the assistiv meals and snacks.	assessed as being at risk for d and individualized fall developed in an effort to er of falls whenever possible. Eating Equipment/Utensils e devices ovide special eating equipment idents who need them and note to ensure that the resident we devices when consuming	F 8	10		5/20/22
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa because he forgets stands up and goes During an interview director of nursing (managers were res plans and put in inte nurses). The DON i interventions were i quarterly basis. She after every fall, and up with possible inte would look for the re interventions. The Di shouldn't be on the light if he's not goin During a follow up i a.m. the director of expected staff to fo resident's care plan The facilities policy "All elders who are falls will be identifie precautions will be decrease the numb Assistive Devices - CFR(s): 483.60(g) §483.60(g) Assistiv The facility must pre and utensils for res appropriate assista can use the assistiv meals and snacks. This REQUIREMEN	PROVIDER OR SUPPLIER PAL CHURCH HOME GARDENS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 because he forgets to use his walker and he just stands up and goes." During an interview on 3/23/22, at 12:33 p.m. director of nursing (DON) stated the nurse managers were responsible to create the care plans and put in interventions (along with the nurses). The DON further indicated the interventions were re-evaluated on the MDS on a quarterly basis. She also stated she was notified after every fall, and assisted the nurses to come up with possible interventions. The IDT team would look for the root cause and suggest interventions. The DON also stated "I agree that it shouldn't be on there to remind him to use his call light if he's not going to use it." During a follow up interview on 3/24/22, at 11:09 a.m. the director of nursing (DON) stated she expected staff to follow the interventions in each resident's care plan. The facilities policy on falls dated 1/1/15, includes "All elders who are assessed as being at risk for falls will be identified and individualized fall precautions will be developed in an effort to decrease the number of falls whenever possible. Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER PAL CHURCH HOME GARDENS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 because he forgets to use his walker and he just stands up and goes." During an interview on 3/23/22, at 12:33 p.m. director of nursing (DON) stated the nurse managers were responsible to create the care plans and put in interventions (along with the nurses). The DON further indicated the interventions were re-evaluated on the MDS on a quarterly basis. She also stated she was notified after every fall, and assisted the nurses to come up with possible interventions. The IDT team would look for the root cause and suggest interventions. The DON also stated "I agree that it shouldn't be on there to remind him to use his call light if he's not going to use it." During a follow up interview on 3/24/22, at 11:09 a.m. the director of nursing (DON) stated she expected staff to follow the interventions in each resident's care plan. The facilities policy on falls dated 1/1/15, includes "All elders who are assessed as being at risk for falls will be identified and individualized fall precautions will be developed in an effort to decrease the number of falls whenever possible. Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER 245625 PROVIDER OR SUPPLIER PAL CHURCH HOME GARDENS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY BY TAKE AND THE APPROPRIATION) COntinued From page 17 Decause he forgets to use his walker and he just stands up and goes." During an interview on 3/23/22, at 12:33 p.m. director of nursing (DON) stated the nurse managers were responsible to create the care plans and put in interventions (along with the nurses). The DON further indicated the nurse would look for the root cause and suggest interventions. The IDT team would look for the root cause and suggest interventions. The DON also stated "I agree that it shouldn't be on there to remind him to use his call light if he's not going to use it." During a follow up interview on 3/24/22, at 11:09 a.m. the director of nursing (DON) stated she expected staff to follow the interventions in each resident's care plan. 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Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) \$483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		245625	B. WING			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 810	Based on observator review the facility farequipment was avain meals for 1 of 1 resequipment. Findings include: R52's quarterly Min 3/2/22, indicated R5 impaired and require assistance with eat Alzheimer's disease muscle weakness. R52's nutrition caredated 6/9/21, indicated to rel CAA further indicate [sic] self with sufficity (needs feeding assisted to rel CAA further indicate [sic] self with sufficity (needs feeding assisted feeding feed	ge 18 tion, interview, and document ailed to ensure adaptive illable and provided during sident reviewed for adaptive imal Data Set (MDS) dated 52 was moderately cognitively red 1-person extensive ing. R52's diagnoses included e, dementia, and generalized area assessment (CAA) ated R52 had inadequate oral ated to (r/t) cognition. R52's red R52 "Can physically feeds ent cueing and redirection ist from staff d/t [due to] revised 12/27/21, indicated e oral intake r/t poor cognition. Staff to provide adaptive rough and curved utensils. Sheet (NCS) instructed staff to couragement to improve intake. ed. MUGS for soups and hot e dated 12/22/21, at 15:33 red, "Adaptive plate and to unit for Elder to try. Dtreed concerns that Elder seems	F 810	1. NA was provided education on adaptive equipment and following plan. Education was also provided other staff on the 3rd floor. Care shas reviewed and updated to ensuadaptive equipment was appropriatup to date. 2. 14/56 residents have the potentiaffected by the deficient practice. 3. A policy and procedure around adaptive equipment will be develop Staff working with potentially affect residents will be educated on the policy and procedure. 4. DON, Nurse Managers, Dietetic Technician or Designee will conduct audits of resident care of those respotentially affected to ensure adaptequipment is in place and utilized. will occur a minimum of 4x/month three consecutive months. Audits continue during the MDS review pethose residents using adaptive equipment during the MDS review pethose residents using adaptive equipment at the facility QA meeting. Deficiency will be corrected and substantial compliance will be achimal to a policy.	the care to neet ure te and ial to be use of ped. ted new ct sidents tive Audits for will eriod for uipment II T and g. I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	NG		MPLETED
		245625	B. WING_		_ I	C /24/2022
	PROVIDER OR SUPPLIER	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 810	plate to mouth. Floor R52's progress note p.m. indicated, "Dtr she observed Elder at a meal and it sign amount of food that lipped plate to POC R52's progress note p.m.) indicated, " expectations with di providing redirection herself prior to prov R52's physician ord "ADAPTIVE EQUIP Curved Utensils, So Provide Elder with a meals." During observation was seated at the di unidentified visitor f had a regular plate constantly tried to p An unidentified nurs encouraged R52 to back to the table. T over and took a spo assisted R52 with a During observation was seated at the di independently. R52 regular utensils.	shed ability to get food from or staff update on trial." e dated 12/27/21, at 10:45 [daughter], updated writer that using the curved silverware nificantly decreased the spilled. Will add it and the Plan of Care]." e dated 3/15/22, at 16:35 (4:35 Reviewed the care plan tr [daughter] including staff and allowing Elder to feed iding assistance." der dated 12/27/21, indicated, PMENT: Lipped Plate, Rt Hand oup in mug with meals. adaptive equipment items at on 3/21/22, at 5:28 p.m. R52 lining table next to an or a different resident. R52 and regular silverware. R52 ush chair back and stand up. Sing assistant (NA) eat and pushed her chair he unidentified visitor reached conful of R52's food and	F 8			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245625	B. WING _		1	2 4/2022
	PROVIDER OR SUPPLIER PAL CHURCH HOME	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104	,	
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F 810	indicated instruction adaptive equipment looked in the book at food to be cut in bit and curved utensils did not have curved utensil drawer and store them on this upon the control of the	binder on the unit that his for special diets and it for each resident. NA-E and confirmed R52 required e sized pieces, soup in a cup in NA-E further confirmed R52 if utensils. NA-E opened the stated, "They do not even unit." on 3/23/22, at 12:50 p.m. R52 lining table eating soup from a open-faced egg salad lar utensils on a regular plate. ficulty loading her spoon with lad. Much of the soup was on 62's lap. 3/23/22, at 12:54 p.m. NA-F wanted R52 to be lating. NA-F reviewed the NCS should receive her soup in a led and stated R52 did not mug. 3/24/22, at 8:53 a.m. dietary tated being involved in the daptive equipment for R52 led the staff to provide the did adaptive equipment for every in 3/24/22, at 9:14 a.m. N)-B stated the expectation or	F 81			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DAT COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	240020	1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2022
NAIVIL OI	FROVIDER OR SOFFLIER			1860 UNIVERSITY AVENUE WEST		
EPISCO	PAL CHURCH HOME (GARDENS		SAINT PAUL, MN 55104		
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F 810	During interview on director of nursing ((resident) had an or the expectation was available and provide	3/24/22, at 10:52 a.m. DON) stated if an elder reder for adaptive equipment as that the equipment was ded at each meal.	F8	310		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ING	LE CONSTRUCTION 01 - EPISCOPAL CHURCH HOME	' '	E SURVEY PLETED
		245625	B. WING			03/2	23/2022
	PROVIDER OR SUPPLIER PAL CHURCH HOME	GARDENS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104		
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K 000	INITIAL COMMEN	rs	K 0	00			
	FIRE SAFETY						
	conducted by the M Public Safety, State 03/23/2022. At the Church Home Gard compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) 101, Life Safe	ety recertification survey was linnesota Department of Erire Marshal Division on time of this survey, Episcopal dens was found not in Erequirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 the and the 2012 edition of the are Facilities Code.					
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO ' SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).					
_ABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

04/21/2022

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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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - EPISCOPAL CHURCH HOME **GARDENS** B. WING 245625 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1860 UNIVERSITY AVENUE WEST EPISCOPAL CHURCH HOME GARDENS** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 1 K 000 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 MN is a 7-story building with a lower-level parking garage. The original building was constructed in 2012 and was determined to be of Type II(222) construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms.

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - EPISCOPAL CHURCH HOME **GARDENS** B. WING 245625 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1860 UNIVERSITY AVENUE WEST EPISCOPAL CHURCH HOME GARDENS** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 000 | Continued From page 2 K 000 The facility has a capacity of 60 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 345 Fire Alarm System - Testing and Maintenance K 345 5/20/22 SS=F CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced Based on a review of available documentation K345 ☐ Fire Alarm System ☐ Testing and and staff interview, the facility failed to test and Maintenance inspect the fire alarm system per NFPA 101 (2012 1. Integrated Fire and Security was edition), Life Safety Code, section 9.6.1.3, and contacted to inspect the smoke detectors. NFPA 72 (2010 edition), National Fire Alarm and The inspection was completed on Signaling Code, sections 14.4.5.3 through 4/19/2022 and a copy of the report has 14.4.5.3.3. This deficient finding could have a been placed in the LSC book. No widespread impact on the residents within the additional concerns noted at this time. facility. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. A policy/procedure around smoke Findings include: detector maintenance will be developed. On 03/23/2022 at 09:15 AM, it was revealed by a The smoke detector sensitivity report will review of available documentation that there is no be added to the preventative maintenance documentation on the last time the smoke schedule through our building detector sensitivity test was completed. management system, TELS. 4. Maintenance Director or designee will An interview with the Facility Maintenance audit to ensure smoke detector sensitivity

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - EPISCOPAL CHURCH HOME S		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1860 UNIVERSITY AVENUE WEST			
EPISCOF	PAL CHURCH HOME	GARDENS		SAINT PAUL, MN 55104			
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K 345	Continued From particle Contin	age 3 is deficiency finding at the time	K 34	report is complete within the retimeframe. Progress on plan of will be reported and reviewed a facilities quality assurance comsafety committee. 5. Deficient practice was corre 4/18/2022. Plan of correction to completed by May 20th 2022.	correction t the mittee and cted on		
K 346 SS=F	Fire Alarm System CFR(s): NFPA 101		K 34			5/20/22	
	services for more approved, the authority notified, and the but approved fire water parties left unprotes fire alarm system 19.6.1.6	e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or an h shall be provided for all ected by the shutdown until the has been returned to service.					
	Based on a review and staff interview a fire alarm out of (2012 edition) sect finding could have residents within the Findings include: On 03/23/2014 at 9	9:35 AM, it was revealed by a		K346 Fire Alarm System - Out 1. The fire watch log and protocompleted for any future outage 2. 56/56 residents have the pobe affected by the deficient pra 3. The fire watch procedure wireviewed and updated. The fire will be added to the preventative maintenance schedule through building management system, 4. Maintenance Director or design to the protocomplete through building management system, 4. Maintenance Director or design.	col will be es. tential to ctice. I be e watch log e our		
	alarm out of service the hours of out of implementing the f	documentation that the fire see policy was not complete with service time before fire watch protocol. The Facility Maintenance		4. Maintenance Director or des audit to ensure the policy is foll fire watch log is completed with required timeframe. Progress of correction will be reported and the facilities quality assurance of	owed and in the n plan of reviewed at		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - EPISCOPAL CHURCH HOME **GARDENS** B. WING 245625 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1860 UNIVERSITY AVENUE WEST EPISCOPAL CHURCH HOME GARDENS** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 346 | Continued From page 4 K 346 Director verified this deficiency finding at the time and safety committee. 5. Plan of correction to be completed by of discovery. May 20th 2022. K 354 5/20/22 K 354 Sprinkler System - Out of Service CFR(s): NFPA 101 SS=F Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation K354 ☐ Sprinkler System - Out of Service and staff interview, the facility failed to implement 1. The fire watch log and protocol will be completed for any future outages. an automatic fire sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety 2. 56/56 residents have the potential to Code, section 9.7.6, and NFPA 25 (2011 edition), be affected by the deficient practice. Standard for the Inspection, Testing, and 3. The fire watch procedure will be Maintenance of Water-Based Fire Protection reviewed and updated. The fire watch log Systems, Chapter 15. This deficient finding could will be added to the preventative have a widespread impact on the residents within maintenance schedule through our the facility. building management system, TELS. 4. Maintenance Director or designee will Findings include: audit to ensure the policy is followed and fire watch log is completed within the On 03/23/2014 at 9:35 AM, it was revealed by a required timeframe. Progress on plan of review of available documentation that the fire correction will be reported and reviewed at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EPISCOPAL CHURCH HOME GARDENS		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245625	B. WING			03/2	23/2022
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K 521	Continued From page 6 Findings include: On 03/23/2022 at 9:25 AM, it was revealed by a review of available documentation that there was no record of the last time that the fire or smoke dampers were tested.		K 521		committee.	ported and reviewed at the facilities ality assurance committee and safety mmittee. Deficient practice will be corrected on 2/2022. Plan of correction to be	
		ne Facility Maintenance s deficiency finding at the time	K 7	712			5/20/22
	signal and simulatic conditions. Fire drill unexpected times uleast quarterly on ewith procedures an established routine between 9:00 PM announcement manalarms. 19.7.1.4 through 19	ne transmission of a fire alarm on of emergency fire Is are held at expected and under varying conditions, at each shift. The staff is familiar d is aware that drills are part of . Where drills are conducted and 6:00 AM, a coded y be used instead of audible 0.7.1.7					
	by: Based on a review and staff interview, fire drills per NFPA Code sections, 19. deficient finding coon the residents wire Findings include:	of available documentation the facility failed to conduct 101 (2012 edition), Life Safety 7.1.4 through 19.7.1.7. This uld have a widespread impact			K712 ☐ Fire Drills 1. A fire drill was completed on 3/31/2022 at 10pm. Paperwork was added to the LSC book on 3/31/202 2. 56/56 residents have the potenti be affected by the deficient practice 3. The fire drill policy will be review updated. The fire drill schedule in will be reviewed to ensure all shifts scheduled for a fire drill throughout	22. al to e. ed and ΓELS are	

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

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - EPISCOPAL CHURCH HOME **GARDENS** B. WING 245625 03/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1860 UNIVERSITY AVENUE WEST EPISCOPAL CHURCH HOME GARDENS** SAINT PAUL, MN 55104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 712 | Continued From page 7 K 712 review of available documentation that the facility year. was missing the fire drill for the 3rd quarter night 4. Maintenance Director or designee will shift. audit to ensure fire drills are complete within the required timeframe. Progress An interview with the Facility Maintenance on plan of correction will be reported and Director verified this finding at the time of reviewed at the facilities quality assurance committee and safety committee. Copies discovery. of the fire drill reports will also be forwarded to the facility Administrator 5. Plan of correction to be completed by May 20th 2022. K 914 Electrical Systems - Maintenance and Testing K 914 5/20/22 SS=F CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:

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

PRINTED: 04/26/2022 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG 01 - EPISCOPAL CHURCH HO NS	l` ′00M	E SURVEY PLETED	
		245625	B. WING		03/	03/23/2022	
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME GARDENS				STREET ADDRESS, CITY, STATE, 1860 UNIVERSITY AVENUE WE SAINT PAUL, MN 55104	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 914	Based on a review and staff interview inspect electrical reproach from the part of the par	w of available documentation the facility failed to test and ecceptacles in resident sleeping 9 (2012 edition), Health Care ection 6.3.4.1.1. This deficient a widespread impact on the e facility. 9:30 AM, it was revealed by a edocumentation that the facility d its outlet testing in all resident at two years. The last date	K 9	K914 ☐ Electrical System Maintenance and Testing 1. Receptacle testing of has started. 2. 56/56 residents have be affected by the deficition 3. A policy for receptact be developed and adder The receptacle testing standard to the preventative schedule in our building software, TELS. 4. Maintenance Director audit TELS monthly to be testing is complete withing time frame. Progress on will be reported and revifacilities quality assurant safety committee. 5. Plan of correction to May 20th 2022.	g on resident rooms the potential to ent practice. The outlet testing will do to the LSC book. The chedule will be the maintenance management the ror designee will ensure receptacle on the required plan of correction the ewed at the ce committee and		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 11, 2022

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

Re: State Nursing Home Licensing Orders

Event ID: CGXY11

Dear Administrator:

The above facility was surveyed on March 21, 2022 through March 24, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Episcopal Church Home Gardens April 11, 2022 Page 2

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us

Office: (651) 238-8786 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Ping

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 05/06/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

A. BUILDING:

C

B. WING

03/24/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PISCOF	PAL CHURCH HOME GARDENS	/ERSITY AV UL, MN 551	ENUE WEST 04	
(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) COMPLET DATE
2 000	Initial Comments	2 000		
	****ATTENTION*****			
	NH LICENSING CORRECTION ORDER			
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.			
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.			
	You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.			
	INITIAL COMMENTS: On 3/21/22 through 3/24/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

04/21/22

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPLE	
711012711	or contribution	IDENTIFICATION NOMBER.	A. Building:			
		30004	B. WING		03/24	/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
2 000	The following compuNSUBSTANTIATE and H5625033C (Mand H5625033C). Please indicate in your and identify the date Minnesota Department the State Licensing Federal software. The state Licensing Federal software. The assigned to Minnesota Department of the findings in the far leading of the correction order the findings which a statute after the state as evidence by. For findings are the Sugand Time Period for You have agreed to receipt of State lice the Minnesota Department of State of the Minnesota Department of Headyou electronically. It is necessary for State of the Word "CO available for text. Yes	plaints were found to be ED: H5625032C (MN81574) IN81182). Four electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting Correction Orders using any numbers have been entered to the easigned tag number eff column entitled "ID Prefix entered to the easigned tag number eff column entitled "ID Prefix entered to the easigned tag number eff column entitled "ID Prefix entered to the easigned tag number entered to the entered tag number entered to the entered tag number entered to the electronic elect	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Methologorection and the Time Period Following the States of Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF TO THIS O DN FOR	
	heading completion be corrected prior to the Minnesota Depart	n date, the date your orders will to electronically submitting to artment of Health. The facility and therefore a signature is				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 2 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Γ			(X3) DATE SURVEY COMPLETED	
741212741	or contraction	BENTH ION TON NOMBER.	A. BUILDING:				
		30004	B. WING		03/2	24/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 000	not required at the state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLATOUR TO FEDE	bottom of the first page of	2 000				
2 830	830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830			5/20/22	
	by: Based on observation review, facility staff interventions for 3 of R45) and the facility appropriate fall interventions for Findings Include: R8's diagnoses obtoxics.	of 4 residents (R8, R12, and y failed to implement rventions for 1 of 4 residents		corrected.			

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 3 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		30004	B. WING		03/2	4/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EPISCO	EPISCOPAL CHURCH HOME GARDENS 1860 UNI SAINT PA			ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	disease, dementia,	delirium and depression.				
	12/27/21, indicated impairment and req transfers. The admit Assessment indicated	imum Data Set (MDS) dated R8 had severe cognitive juired supervision during ission MDS's Care Area ted R8 was at risk for falling insteadiness, medications and				
	R8's care plan with an initiated date of 12/20/21, indicated R8 had the potential for injury due to falls and included interventions of wearing nonskid socks and proper fitting shoes. R8's care plan also included interventions of frequent checks and monitor for safety, and to remind R8 to ask for assistance if feeling weak. The care plan further indicated R8 had a deficit in activities of daily living due to Dementia, and delusions. The care plan then indicated R8 was independent with transfers and needed encouragement to use her call light for assistance and required a walker when transferring.					
	During a continuous	s observation;				
	chair located outsid the hallway. R8 did wheelchair next to I -at 6:32 p.m. nu to R8 "you are just will be right back." I outside of her room get R8's walker or w walked down the har roomat 6:34 p.m. Ri was sitting in and w	p.m. R8 observed seated in a e of her room at the head of not have walker or a ner. ursing assistant (NA)-B states fine, you can sit right there, I R8 observed sitting in a chair in the hallway. NA-B did not wheelchair at this time, but allway into another resident's 8 stood up from the chair she ralks back into her room, ker or wheelchair and closes				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 4 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30004	B. WING		03/2	2 4/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	the door to her roor	n.				
	During another con	tinuous observation;				
	next to the bed with or sock on her right wheelchair was not During observation edge of her bed. -at 2:05 p.m. Redge of the bed pla her feet. At this time member walked pa staff member observation of the walking down. During an observation During an observation During an observation of the other foot had not and NA-A had R8 was a walker or a transfistated R8 normally NA-A further stated walk with a walker. In proceeded to get R	p.m. R8 observed standing her left shoe on, and no shoe foot. R8's walker or within reach at this time. R8 sat back down on the 8 was observed bent over the cing her socks and shoes on e, NA-A and another staff ss R8's room, however neither ved what R8 was doing and the hallway. Son on 3/23/22, at 9:40 a.m. he could help R8 into the ransfer into the bathroom, R8 sly have one nonskid sock on, so shoe or nonskid sock on, walk into the bathroom without er belt. During transfer NA-A does not walk with a walker. Solve I'l don't ever see her [R8] During this time, NA-A S's walker after R8 was and placed the walker next to				
	R8. NA-A then state other resident's roo	ed R8 will leave her walker in ms.				
		uation dated 12/20/21, history of falls, and was at risk				
	indicated R8 was a	ng assistant care sheet high fall risk, used a walker ve R8 her walker if she was				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 5 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30004		B. WING		C 03/24/2022	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	-1/2022
EPISCOPAL CHURCH HOME GARDENS			'ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From page 5		2 830			
	indicated she had n being a fall risk. NA wanders around the During an interview RN-A indicated R8 monitor R8's where R8 will walk off with	on 3/23/22, at 10:08 a.m. was a fall risk, and staff are to abouts. RN-A further indicated out using her walker and staff to use her walker and to				
	R12's diagnoses obtained from the admission recorded printed 3/24/22, included vertigo, cognitive impairment, syncope (temporary loss of consciousness) and collapse, depression, Alzheimer's, right foot drop, abnormalities of gait and mobility, and difficulty walking.					
	had severe cognitive extensive assist of and required super ambulating in her reannual MDS dated indicated being at runsteadiness with the extensive assistance of the extensive assistance and the extensive assistance as a single assistance and the extensive assistance as a single assistance as a single assistance as a single assistance and the extensive assistance as a single assistance and the extensive as a single assistance and the extensive assistance and the extensive assistance as a single assistance and the extensive as a single assistance and the extensive assistance and the extens	S dated 1/3/22, indicated R12 re impairment and required one person for transferring vision of one staff when com or on the unit. R12's 7/7/21, Care Area Assessment isk for falls due to wandering, ransitions, history of falls, tions and has had multiple falls ring.				
	indicated R12 was ambulation and tranhelp contributed to Evaluation indicated	uluation dated 12/29/21, at risk for falls and self nsferring without calling for previous falls. The Fall Risk d R12 was to wear a right foot assistance and to use her call				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 6 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30004	B. WING		03/2	2 4/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	-1/2022
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI	ENUE WEST 04		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	indicated R12 had a due to vertigo, impa and right foot drop. indicated R12 was to ensure her call liganticipate her need	h an initiated date of 6/30/21, activity of daily living deficit aired balance, gait disorder. The care plan further a high fall risk and staff were ght was within reach, s and her right foot drop had care plan did not provide g brace.				
	During a continuous observations;					
	On 3/22/22, at 10:24 a.m. R12's door observed slightly opened, R12 could not be observed in the room. -at 10:48 a.m. R12 observed through the slightly opened door seated in a recliner chair. -at 11:05 a.m. R12 was no longer in the recliner chair. -at 11:25 a.m. R12's door was completely closed. -at 11:33 a.m. NA-A walked by R12's room twice while R12's door was completely closed and did not stop to check on R12. NA-A continued around the corner the stairway. -at 11:36 a.m. R12 was observed seated in recliner chair with no shoes on, R12 wore white socks. During interaction, a leg brace was observed under a lamp stand and R12's call light was not within reach. During another continuous observation; On 3/23/22, at 7:07 a.m. R12 was observed					
	entering R12's roor	N-C and NA-C observed n, RN-C gave R12 A-C gathered garbage and				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 7 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30004	B. WING			C 24/2022
	PROVIDER OR SUPPLIER	1860 UN	DDRESS, CITY, S	,	•	
EPISCO	PAL CHURCH HOME	GARDENS SAINT P	AUL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	-at 7:44 a.m. boroom, R12 was obschair with no shoes attempted to apply observed under the -at 7:52 a.m. Nand left the room, Nocks, leg brace or within reach. R12's progress note indicated R12 had a floor. The progress intervention for R12 transferring. R12's approaches to prev was reorient to call call light for help. R12's progress note indicated R12 had a floor. The progress for R12 was remind and walker which in prior to ambulating progress note dated not using her right in the fall on 1/20/22. R12's progress note indicated R12 had a included R12 was to R12's progress note indicated R12 had a included R12 forgot staff were to offer to R12's progress note indicated R12 had a included R12 forgot staff were to offer to R12's progress note indicated R12 forgot staff were to offer to R12's progress note indicated R12 forgot staff were to offer to R12's progress note	oth RN-C and NA-C exited the served seated in a recliner on and neither staff R12's leg brace which was lamp stand. A-C brought R12 breakfast NA-C did not offer to apply ensured R12's call light was e dated 3/13/22, at 9:29 p.m. a fall and was found on the note indicated previous was to call for help when progress note indicated ent reoccurrences was R12 light and was advised to use a fall and was found on the note indicated interventions for transferring. A follow up d 1/21/22, indicated R12 was eg brace, and walker prior to be dated 12/2/21, at 7:49 p.m. a fall, and interventions o wear nonskid socks.				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 8 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION	I NUMBER:	A. BUILDING:		COMP	COMPLETED	
							С	
		30004		B. WING		03/2	24/2022	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EPISCO	PAL CHURCH HOME	GARDENS			ENUE WEST			
			SAINT PA	UL, MN 551	T			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 8		2 830				
	included leaving R12's door open, reminding R12 to use call light and to not walk alone. A follow up note dated 9/28/21, indicated R12 had poor awareness of her safety and she believed to be stronger than she was.							
	R12's undated nurs was a high fall risk, vertigo (dizziness) a leg brace on when	had fallen many t and R12 was to h	times due to					
	During an interview on 3/23/22, at 7:36 a.m. NA-C indicated R12 was a fall risk and that R12 normally does not put on her call light. NA-C had always dressed herself in the mornings, but staff were suppose to help R12 and reminder her to use her call light and to keep it within reach.							
	During an interview RN-C indicated R12 be applied in the m	2 had a leg brace						
	During an interview director of nursing (expectation was state such as keeping the shoes or nonskid suse their walkers, kwithin reach and state leg brace if the falls. R45's quarterly Mir 2/14/22, indicated of Parkinson's disease movement disorder mobility, muscle we behavioral disturbaneuromuscular scorequired extensive limited assistance visited	DON) indicated haff to follow the interest open, the ocks, encouraging eeping walkers a aff should be offer resident allows to himum Data Set (liagnoses which interest of eakness, demention of the coordinate of	der derventions use of gresidents to and call lights ring to apply prevent mDS) dated and figait and a with lination, and dicated R45 ansfers,					

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 9 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED		
			B. WING			C	
		30004	B. WING _		03/2	24/2022	
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY				
EPISCO	PAL CHURCH HOME	GARDENS	0 UNIVERSITY A NT PAUL, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	history of two or mone fall with injury. R45's care plan las R45 had an activitie self-care performar of extensive assist care plan further included a section of was a fall risk and the walker within reach walker within reach R45's fall risk asses R45 was a fall risk, and had risk factors functional status, Padizziness/lighthead in decision making judgement. R45's care area ass 8/25/21, indicated Crisk for falling. "Risk behaviors, unstead for scheduled antid medications. Incont cognitive impairment disorganized thinking pain, and diagnopsychosis, depress disorder/dyskinesia Physical Device revenue when walks and leago to and from desireminders and money composition of the pain walks and leago to and from desireminders and money composition of the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from desireminders and money care in the pain walks and leago to and from the pain walks and leago to and from the pain walks and leago to and from the pain walks and leago to an	ore falls without injury, and trevised on 2/28/22, includes of daily living (ADL) and deficit with an intervent of one with transfers. R45 cluded R45 was at high ristons to ensure walker and cach at all times. Stant care sheet (undated) on safety which indicated light and at all times. Sesment dated 2/9/22, indicated light and at all times. Sesment dated 2/9/22, indicated light and at all times. Sesment dated 2/9/22, indicated light and at all times. Sesment dated 2/9/24, indicated light and at all times. Sesment dated 2/9/26, indicated light and at all times. Sesment dated 2/9/27, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times. Sesment dated 2/9/28, indicated light and at all times.	ded ation 's sk for call R45 cated alls, n ecline aired at ng ers cular der, eport e, s r to tant				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 10 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30004	B. WING			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS 1860 UN	DDRESS, CITY, S IVERSITY AV AUL, MN 551		·	
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	awareness due to describe a chair in a chair in his were not within read During observation sat in a chair in his few steps forward was a book on the stepped on it and his pages. The surveyof falling), placed his will looked for the call light was laying within reach. During observation sat at the table in the was not within reach. During observation sat in the recliner in was pushed up against in the recliner in was pushed up against in a chair in his middle of the room, R45's incident note was found sitting in to two leather chairs dated 11/1/21, indicting interventions: staff checks, offer to toil light within reach, a for assistance.	cognitive impairments." on 3/22/22, at 10:26 a.m. R45 room. His walker and call light ch. on 3/22/22, at 2:39 p.m. R45 room. He stood up and took a vithout using his walker. There floor in front of him, he is feet started to slip on the or intervened (in fear of him walker in front of him, and ight to request assistance. The on the floor under his bed, no on 3/23/22, at 9:27 a.m. R45 at the common area. His walker h. on 3/23/22, at 10:55 a.m. R45 at the common area. His walker twithin reach. on 3/24/22, at 10:47 a.m. R45 room. His walker was in the not within reach. dated 10/31/21, indicated R45 his bedroom on the floor next is A follow up incident report				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 11 of 23

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
,			A. BUILDING:			
		30004	B. WING		03/2	: 4/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was found sitting or his head lying on the incident report date impulsive and does assistance." It furth interventions: "staff frequently and ensuall times. Remind eshift." R45's incident note "elder was found sir room 439." A follow 12/7/21, indicated F to use it almost all conterventions. R45's incident note "elder was walking the floor. When eld under the bed. He is rotation of extremitic his left shoulder. He around the unit leavenurse practioner (Is monitor resident an spoke with R45's whim tomorrow. Spot elder to be in a whetalk to family and go is concerned about falls." A follow up in indicated "elder doe assistance due to condependent with tralacked any new interventions.	an the floor in his bedroom, with the bed frame. A follow up d 11/11/21, indicated "elder is not use the call light for the indicated the following will continue to monitor elder use walker is in front of him at lider to use his walker every dated 12/5/21, indicated titing on the floor in front of the up incident report dated 12/45 "has a walker but forgets day." It lacked any new dated 12/21/21, indicated without his walker and fell to the er was found his head was has no inward or outward the es. He does have a scrape on the denies pain. He often walks wing his walker behind. Called NP) and she ordered to did update as needed. Also if the indicated if the ind	2 830			
	"Elder was assisted	I with dressing when he nd stepped back into the bed				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 12 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30004	B. WING		C 03/24/2022	
					03/2	4/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EPISCO	EPISCOPAL CHURCH HOME GARDENS SAINT F			ENUE WEST 04		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From page 12		2 830			
	and then slid down the bed landing onto his buttocks." A follow up incident report dated 1/31/22, lacked any new interventions.					
	"found elder sitting side but was not lay down and put a pillo by am nurse. This r symptoms) injuries all extremeties. VSS	dated 3/13/22, indicated on the floor leaning to the left ving on the floor. Laid him ow for comfort until assessed nurse found no s/s (signs and ROM (range of motion) intact S (vital signs). Will monitor." any additonal interventions or survey.				
	nursing assistant (N call light one time s the facility a month stated R45 will "gra him to, but when he get up and go. That	on 3/23/22, at 10:50 a.m. NA)-G stated R45 had used his ince she started working for and a half ago. NA-G further b his walker when staff direct wants to get up, he will just 's why we try to keep him out because when he's back in his to get up and go."				
	NA-H stated R45 "c call light, he will use	on 3/23/22, at 11:00 a.m. loesn't know how to use his e his walker but when he get and just walks around				
	licensed practical n wasn't able to use h seen him use it. Sh	on 3/23/22, at 11:18 a.m. urse (LPN)-A stated R45 nis call light and had never e further stated R45 would nber to use his walker but				
	registered nurse (R	on 3/23/22, at 11:05 a.m. N)-B stated she was ating the care plan (when				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 13 of 23

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		30004		B. WING			C 24/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME (GARDENS		/ERSITY AVI UL, MN 551	ENUE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	there was a new ad Set (MDS) nurse coit was her responsit nurses) to put in intra fall and to add new prevent future occur. During an interview stated "once in a whight, but we are available because he forgets stands up and goes. During an interview director of nursing (managers were resplans and put in interventions were replans and put in interventions were replans and put in interventions. The Exhouldn't be on their interventions. The Exhouldn't be on their interventions and going. During a follow up in a.m. the director of expected staff to for resident's care plan. The facilities policy "All elders who are falls will be identified precautions will be idecrease the numb."	mit) and the Minimus ampletes it. She furth collity (along with the derventions after a resew interventions in order rences. on 3/24/22, at 8:25 and he (R45) uses his allable to check on his to use his walker and sillon. on 3/23/22, at 12:33 DON) stated the nurponsible to create the reventions (along with further indicated the re-evaluated on the first earlier and suggest assisted the nurses erventions. The IDT poot cause and suggest on the reserventions. The IDT poot cause and suggest on the reservention of the reserv	ner stated other sident had der to a.m. NA-I is call im often id he just a p.m. se he care h the MDS on a s notified to come team est gree that it is his call at 11:09 id she in each at risk for fall rt to possible.				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 14 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		30004	B. WING		03/2	4/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830 2 945	falls, accidents and proper assessment implemented. They policies and proced and monitoring con these policies could results of these auditacility's Quality Asset TIME PERIOD FOR (21) days. MN Rule 4658.0530	es and procedures related to resident supervision to assure and interventions are being could re-educate staff on the ures. A system for evaluating sistent implementation of I be developed, with the dits being brought to the surance Committee for review. R CORRECTION: Twenty-one	2 830 2 945			5/20/22
	personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a renhances each res Adaptive self-help of contribute to the reseating. Food and fl be observed and de reported to the nurs resident's care duri observation of a de	g personnel. Nursing ermine that residents are scribed. Residents needing be promptly assisted upon and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in uid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent as must be reported to the				
	This MN Requirements	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 15 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30004	B. WING		C 03/24/2022	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	-1/2022
EPISCO	PAL CHURCH HOME	GARDENS	/ERSITY AVI UL, MN 551	ENUE WEST 04		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From page 15		2 945			
	Based on observation, interview, and document review the facility failed to ensure adaptive equipment was available and provided during meals for 1 of 1 resident reviewed for adaptive equipment.			corrected.		
	Findings include:					
	3/2/22, indicated R4 impaired and requirassistance with eat	imal Data Set (MDS) dated 52 was moderately cognitively red 1-person extensive ing. R52's diagnoses included e, dementia, and generalized				
	R52's nutrition care area assessment (CAA) dated 6/9/21, indicated R52 had inadequate oral intake related to related to (r/t) cognition. R52's CAA further indicated R52 "Can physically feeds [sic] self with sufficient cueing and redirection (needs feeding assist from staff d/t [due to] cognitive impairment vs physical ability."					
		P) revised 12/27/21, indicated e oral intake r/t poor cognition.				
	equipment: Serve s	staff to provide adaptive coups and hot cereal in a mug. ht] hand curved utensils.				
	provide cueing/ence	sheet (NCS) instructed staff to ouragement to improve intake. ed. MUGS for soups and hot				
	(3:33 p.m.) indicate silverware brought [daughter] expresse	e dated 12/22/21, at 15:33 d, "Adaptive plate and to unit for Elder to try. Dtreed concerns that Elder seems shed ability to get food from				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 16 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30004	B. WING			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS 1860 UNI		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 945	plate to mouth. Floor R52's progress note p.m. indicated, "Dtr she observed Elder at a meal and it sign amount of food that lipped plate to POC R52's progress note p.m.) indicated, " expectations with d providing redirection herself prior to prov R52's physician ord "ADAPTIVE EQUIP Curved Utensils, So Provide Elder with a meals." During observation was seated at the d unidentified visitor of had a regular plate constantly tried to p An unidentified nurs encouraged R52 to back to the table. T over and took a spo assisted R52 with a During observation was seated at the d independently. R52 regular utensils. During interview on stated there was a	or staff update on trial." e dated 12/27/21, at 10:45 [daughter], updated writer that using the curved silverware nificantly decreased the spilled. Will add it and the [Plan of Care]." e dated 3/15/22, at 16:35 (4:35 Reviewed the care plan tr [daughter] including staff and allowing Elder to feed riding assistance." ler dated 12/27/21, indicated, PMENT: Lipped Plate, Rt Handoup in mug with meals. adaptive equipment items at on 3/21/22, at 5:28 p.m. R52 lining table next to an for a different resident. R52 and regular silverware. R52 bush chair back and stand upsing assistant (NA) eat and pushed her chair he unidentified visitor reached conful of R52's food and				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 17 of 23

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		30004	B. WING			C 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	GARDENS	NIVERSITY AVI PAUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 945	adaptive equipment looked in the book a food to be cut in bits and curved utensils did not have curved utensil drawer and a store them on this upper them on this upper them. During observation was seated at the distance of the egg sate that egg sat	t for each resident. NA-E and confirmed R52 required e sized pieces, soup in a cup s. NA-E further confirmed R52 dutensils. NA-E opened the stated, "They do not even unit." on 3/23/22, at 12:50 p.m. R5 lining table eating soup from open-faced egg salad lar utensils on a regular plate ficulty loading her spoon with lad. Much of the soup was of 52's lap. 3/23/22, at 12:54 p.m. NA-F wanted R52 to be ating. NA-F reviewed the NC should receive her soup in a ed and stated R52 did not mug. 3/24/22, at 8:53 a.m. dietary tated being involved in the daptive equipment for R52 ted the staff to provide the diadaptive equipment for every size adaptive equipment for every size adaptive equipment for every size adaptive equipment ded when ordered. RN-B should have soup in a handle should have soup in a handle	2 32 a s.			

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 18 of 23

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED			
					(
		30004	B. WING		1	24/2022			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•				
	1860 UNIVERSITY AVENUE WEST								
EPISCOF	PAL CHURCH HOME	GARDENS	UL, MN 551						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE			
2 945	45 Continued From page 18		2 945						
	the expectation was that the equipment was available and provided at each meal.								
	A facility policy on a requested but not p	ndaptive equipment was provided.							
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to ensuring residents have adaptive equipment with meals and following the care plan. The DON or designee, could provide training for all nursing staff related to residents who need adaptive equipment with meals and following the care plan based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.								
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/20/22			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a							
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview, and document ailed to maintain dignity during ssing for 1 of 1 residents dignity.		corrected.					

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 19 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
		30004		B. WING		I	C 24/2022
	PROVIDER OR SUPPLIER	GARDENS	1860 UNI		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From para Findings include: R41's quarterly Min 2/7/22, indicated R4 impaired and requir assistance for all ac R41's diagnoses indicated R41's diagnoses indicated R41's cognitive loss assessment (CAA) had cognitive impaired for dementia. R41's care plan (CR R41 had an ADL sedementia, impaired further indicated R4 assistance by 1 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 2 states as needed for weak CP further indicated assistance by 3 states as needed for weak CP further indicated assistance by 3 states as needed for weak CP further indicated assistance by 3 states as needed for weak CP further indicated assistance by 3 states as needed for weak CP further indicated as needed for weak	imal Data Set (M41 was moderate red 1 or 2-person ctivities of daily lively liv	ely cognitively extensive ving (ADLs). stroke, ataxia ous system tion of expression, area dicted R41 (r/t) diagnosis indicated ated to exia. R41's CP sive exist of 2 staff fors. R41's extensive using an EZ ivers to exaction, stop and ensure tructed staff to orm frequent R41 required following was existant (NA)-D	21805			

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 20 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		30004	B. WING			4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	GARDENS		ENUE WEST		
		SAINT PA	UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From page 20		21805			
21805	morning cares. R41 at this time. -at 8:49 a.m. No in and out of a diffethen into another recat 8:55 a.m. Refacing the halfway of and pants pulled up R41's incontinent by blanket was on the R41's right. R41 was attempting to pull the call light was on the immediate reach. -at 9:00 a.m. Rewould have come rist did not feel good felt embarrassed. Feli [NA-D] is doing. Where at 9:03 a.m. No without looking into at 9:05 a.m. Refact was observed attempting to pull the self-propel toward toward bed but was stated, "What is shed at 9:07 a.m. No but did not walk towout of R44's room a without looking into at 9:09 a.m. Refrom hallway with pattempt to pull them unsuccessful. -at 9:14 a.m. No at the self-propel toward bed but was stated. "What is shed at 9:09 a.m. Refrom hallway with pattempt to pull them unsuccessful. -at 9:14 a.m. No at the self-propel toward bed but was stated."	A-D left R41's room and went rent resident's room (R13) and esident's room (R13) and esident's room (R11). 41 was sitting in wheelchair open door. R41 had on a shirt, o to just above the knees. rief was visible at her crotch. A floor next to the wheelchair on as tugging at her pants arem up over her legs. R41's bed and not in R41's estated, "I wish she [NA-D] aght back." R41 further stated sitting like that and that she reat is she [NA-D] thinking of?" A-E walked by R41's room her room. 41 stated, "I don't like this." with pants still at knee level nem up further. R41 attempted door and then backward and a unsuccessful. R41 again to [NA-D] doing?" A-D came out of R11's room ward R41's room. NA-E came and walked by R41's room. R41's room. 41 was still sitting in full view ants half on and continued to a up herself but was A-D came out of R11's room.	21805			
	while R41 still tugge pull them up on her	A-D re-entered R11's room ed on her pants attempting to own. A-D came out of R11's room.				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 21 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		30004	B. WING			C 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	,	
EPISCO	PAL CHURCH HOME	GARDENS	IVERSITY AVI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	R41 was heard say -at 9:17 a.m. N. without looking into -at 9:18 a.m. R. the hallway with her R41's thighs were e cover them with the -at 9:24 a.m. ar maintenance staff v -at 9:26 a.m. R. hallway with her pa attempted to self-pr hands on the whee pants dropped belo her hands from the pulled them back u -at 9:37 a.m. N. of R11's room and v -at 9:40 a.m. N. stand to assist R41 they pulled up her p back to a seated po During interview on stated R41 was a 2 the use of the EZ si (NA-D) and (NA-E) residents. NA-D ac with her pants halfv was not within reac During interview on registered nurse (R have had to wait 48 return to assist pulli stated no elder (res long and should no	ing, "I want to go." A-D walked by R41's room R41's room. 41 still sitting within view from r pants only to her knees. exposed, and she attempted to e top of her pants. In unidentified male valked past R41's room. 41 still sitting in full view from Ints to her knees. R41 ropel in wheelchair with her Is of the wheelchair with her Is of the wheelchair. R41's w her knees, and she moved wheels back to her pants and p to just above her knees. A-D and NA-E both came out entered R41's room. A-D and NA-E used the EZ to a standing position while beants and then lowered her besition in her wheelchair. 3/23/22, at 9:37 a.m. NA-D person assist and required tand. NA-D further stated she had been tied up with other knowledged R41 was sitting vay up and that her call light				

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 22 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		30004		B. WING			C 24/2022
	PROVIDER OR SUPPLIER	GARDENS 18	60 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21805	was exposed to the FM-A further stated she tried to do som unsuccessful. During interview on of nursing (DON) st should have been on NA-D should have let her delayed. DON states staff provide care in elders' dignity. A facility policy on diprovided. Review of the facility rights indicated everights included the insurance of the staff on those policic staff on those policic could conduct audit residents with exposition and to ensure maintained.	hallway, she would hate (R41) would get frustrate thing herself and was 3/23/22, at 2:48 p.m. directed the expectation was evered up. DON further returned to check on R4 know she would be furthed the expectation was the such a way as to protect ignity was requested but by annual training on resiry elder had rights and the right to dignity. THOD OF CORRECTION in and/or design and/or designee courses on dignity and educates. The DON and/or design are offer sed body parts, are offer propriately cover their experience.	rector is R41 stated 1 and her hat ct the ident hose N: lident hose N: lide all signee houre red kposed	21805			

Minnesota Department of Health

STATE FORM 6899 CGXY11 If continuation sheet 23 of 23