DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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.

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

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

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 03/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/21/22 through 3/24/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/21/22 through 3/24/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5625032C (MN81574), and H5625033C (MN81182). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104**

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		5/20/22

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain dignity during assistance with dressing for 1 of 1 residents (R41) reviewed for dignity. Findings include: R41's quarterly Minimal Data Set (MDS) dated 2/7/22, indicated R41 was moderately cognitively impaired and required 1 or 2-person extensive assistance for all activities of daily living (ADLs). R41's diagnoses included history of stroke, ataxia (a degenerative disease of the nervous system affecting muscle control or coordination of voluntary movements), dementia, depression, and psychotic disorder. R41's cognitive loss/dementia care area assessment (CAA) dated 8/9/21, indicted R41 had cognitive impairment related to (r/t) diagnosis of dementia. R41's care plan (CP) dated 5/26/20, indicated R41 had an ADL self-care deficit related to dementia, impaired mobility, and ataxia. R41's CP further indicated R41 required extensive assistance by 1 staff to dress and assist of 2 staff as needed for weakness and behaviors. R41's CP further indicated R41 required extensive assistance by 2 staff with transfers using an EZ stand lift. R41's CP instructed caregivers to provide opportunities for positive interaction, stop and talk with R41 when passing by and ensure call light was within reach.	F 550	1. NA was provided education on providing care in a way that maintains dignity for R41. Education was provided to NA on following the care sheet, care plan, provision of care to completion, ensuring the call light is within reach. Additionally NA was educated on ensuring if care is not complete, that dignity can be maintained for the resident. A team huddle with similar education was completed with additional staff on 2nd floor. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. A policy and procedure regarding Maintaining Dignity and Resident Rights will be developed. All staff providing cares will be educated on the new policy and procedure for maintaining Dignity and Residents rights. 4. DON, Nurse Managers or designee will conduct audits of resident care for potentially affected residents. Audits will occur a minimum of 4x/month for three consecutive months. Results of findings will reviewed with IDT and monitored at the facility QA meeting. 5. Deficiency will be corrected and substantial compliance will be achieved by May 20th, 2022.	

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F 550	Continued From page 3 R41's nursing care sheet (NCS) instructed staff to place call light within reach and perform frequent visual checks. R41's NCS indicated R41 required extensive assist of 1 for dressing. During continuous observation the following was observed: On 3/23/22, at 8:41 a.m. nursing assistant (NA)-D was in R41's room assisting with completion of morning cares. R41 appeared receptive of cares at this time. -at 8:49 a.m. NA-D left R41's room and went in and out of a different resident's room (R13) and then into another resident's room (R11). -at 8:55 a.m. R41 was sitting in wheelchair facing the halfway open door. R41 had on a shirt, and pants pulled up to just above the knees. R41's incontinent brief was visible at her crotch. A blanket was on the floor next to the wheelchair on R41's right. R41 was tugging at her pants attempting to pull them up over her legs. R41's call light was on the bed and not in R41's immediate reach. -at 9:00 a.m. R41 stated, "I wish she [NA-D] would have come right back." R41 further stated it did not feel good sitting like that and that she felt embarrassed. R41 stated, "I wonder what she [NA-D] is doing. What is she [NA-D] thinking of?" -at 9:03 a.m. NA-E walked by R41's room without looking into her room. -at 9:05 a.m. R41 stated, "I don't like this." R41 was observed with pants still at knee level attempting to pull them up further. R41 attempted to self-propel toward door and then backward and toward bed but was unsuccessful. R41 again stated, "What is she [NA-D] doing?" -at 9:07 a.m. NA-D came out of R11's room but did not walk toward R41's room. NA-E came	F 550		

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F 550	Continued From page 4 out of R44's room and walked by R41's room without looking into R41's room. -at 9:09 a.m. R41 was still sitting in full view from hallway with pants half on and continued to attempt to pull them up herself but was unsuccessful. -at 9:14 a.m. NA-D came out of R11's room. -at 9:15 a.m. NA-D re-entered R11's room while R41 still tugged on her pants attempting to pull them up on her own. -at 9:16 a.m. NA-D came out of R11's room. R41 was heard saying, "I want to go." -at 9:17 a.m. NA-D walked by R41's room without looking into R41's room. -at 9:18 a.m. R41 still sitting within view from the hallway with her pants only to her knees. R41's thighs were exposed, and she attempted to cover them with the top of her pants. -at 9:24 a.m. an unidentified male maintenance staff walked past R41's room. -at 9:26 a.m. R41 still sitting in full view from hallway with her pants to her knees. R41 attempted to self-propel in wheelchair with her hands on the wheels of the wheelchair. R41's pants dropped below her knees, and she moved her hands from the wheels back to her pants and pulled them back up to just above her knees. -at 9:37 a.m. NA-D and NA-E both came out of R11's room and entered R41's room. -at 9:40 a.m. NA-D and NA-E used the EZ stand to assist R41 to a standing position while they pulled up her pants and then lowered her back to a seated position in her wheelchair. During interview on 3/23/22, at 9:37 a.m. NA-D stated R41 was a 2 person assist and required the use of the EZ stand. NA-D further stated she (NA-D) and (NA-E) had been tied up with other residents. NA-D acknowledged R41 was sitting	F 550		

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F 550	Continued From page 5 with her pants halfway up and that her call light was not within reach. During interview on 3/23/22, at 11:23 a.m. registered nurse (RN)-B stated R41 should not have had to wait 48 minutes for someone to return to assist pulling up her pants. RN-B further stated no elder (resident) should ever wait that long and should not be exposed to the hallway. During interview on 3/23/22, 1:35 p.m. family member (FM)-A stated if (R41) was aware she was exposed to the hallway, she would hate it. FM-A further stated (R41) would get frustrated if she tried to do something herself and was unsuccessful. During interview on 3/23/22, at 2:48 p.m. director of nursing (DON) stated the expectation was R41 should have been covered up. DON further stated NA-D should have returned to check on R41 and should have let her know she would be further delayed. DON stated the expectation was that staff provide care in such a way as to protect the elders' dignity. A facility policy on dignity was requested but not provided. Review of the facility annual training on resident rights indicated every elder had rights and those rights included the right to dignity.	F 550		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		5/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 6 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility staff failed to follow the interventions for 3 of 4 residents (R8, R12, and R45) and the facility failed to implement appropriate fall interventions for 1 of 4 residents (R45) reviewed for falls. Findings Include: R8's diagnoses obtained from the admission recorded printed 3/24/22, included Alzheimer's disease, dementia, delirium and depression. R8's admission Minimum Data Set (MDS) dated 12/27/21, indicated R8 had severe cognitive impairment and required supervision during transfers. The admission MDS's Care Area Assessment indicated R8 was at risk for falling due to wandering, unsteadiness, medications and diagnoses. 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	F 689	1. Care plans and care sheets were reviewed for R8, R12 and R45 and updated to reflect interventions for fall prevention that were appropriate and individualized for each resident. NAs and nurses working with the R8, R12 and R45 were educated on interventions in place and follow through of interventions in place by use of care plan and care sheets. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. Facilities policy on falls will be reviewed and updated to include implementing appropriate, individualized interventions and communicating new interventions. Staff will be educated on the changes to the policies policy and procedure. Nurses will be educated on fall interventions, communication of interventions and follow up of new interventions put in place. 4. Follow up of all falls, interventions implemented and follow through of those falls Interventions will be reviewed by the Nurse Managers, DON or designee to ensure they are individualized and appropriate for each elder within a week of a fall and intervention implementation. Audits will be completed of all residents fall care plan and interventions during the MDS assessment period to ensure that interventions remain appropriate and are	

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F 689	Continued From page 7 her call light for assistance and required a walker when transferring. During a continuous observation; On 3/21/22, at 6:24 p.m. R8 observed seated in a chair located outside of her room at the head of the hallway. R8 did not have walker or a wheelchair next to her. -at 6:32 p.m. nursing assistant (NA)-B states to R8 "you are just fine, you can sit right there, I will be right back." R8 observed sitting in a chair outside of her room in the hallway. NA-B did not get R8's walker or wheelchair at this time, but walked down the hallway into another resident's room. -at 6:34 p.m. R8 stood up from the chair she was sitting in and walks back into her room, without using a walker or wheelchair and closes the door to her room. During another continuous observation; On 3/22/22, at 1:47 p.m. R8 observed standing next to the bed with her left shoe on, and no shoe or sock on her right foot. R8's walker or wheelchair was not within reach at this time. During observation R8 sat back down on the edge of her bed. -at 2:05 p.m. R8 was observed bent over the edge of the bed placing her socks and shoes on her feet. At this time, NA-A and another staff member walked pass R8's room, however neither staff member observed what R8 was doing and kept walking down the hallway. During an observation on 3/23/22, at 9:40 a.m. NA-A asked R8 if she could help R8 into the bathroom. During transfer into the bathroom, R8	F 689	followed by the staff. Results of findings will be documented and reviewed with IDT and monitored at the facility QA meeting. 5. Deficiency will be corrected and substantial compliance will be achieved by May 20th 2022	

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F 689	Continued From page 8	F 689		

was observed to only have one nonskid sock on, the other foot had no shoe or nonskid sock on, and NA-A had R8 walk into the bathroom without a walker or a transfer belt. During transfer NA-A stated R8 normally does not walk with a walker. NA-A further stated, "I don't ever see her [R8] walk with a walker." During this time, NA-A proceeded to get R8's walker after R8 was seated on the toilet and placed the walker next to R8. NA-A then stated R8 will leave her walker in other resident's rooms.

R8's Fall Risk Evaluation dated 12/20/21, indicated R8 had a history of falls, and was at risk for falls.

R8's undated nursing assistant care sheet indicated R8 was a high fall risk, used a walker and staff were to give R8 her walker if she was not using it.

During an interview on 3/23/22, at 9:22 a.m. NA-A indicated she had never heard anything about R8 being a fall risk. NA-A further indicated R8 wanders around the unit.

During an interview on 3/23/22, at 10:08 a.m. RN-A indicated R8 was a fall risk, and staff are to monitor R8's whereabouts. RN-A further indicated R8 will walk off without using her walker and staff was to reminder R8 to use her walker and to ensure R8 was using her walker when ambulating.

R12's diagnoses obtained from the admission recorded printed 3/24/22, included vertigo, cognitive impairment, syncope (temporary loss of consciousness) and collapse, depression,

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F 689	Continued From page 9 Alzheimer's, right foot drop, abnormalities of gait and mobility, and difficulty walking. R12's quarterly MDS dated 1/3/22, indicated R12 had severe cognitive impairment and required extensive assist of one person for transferring and required supervision of one staff when ambulating in her room or on the unit. R12's annual MDS dated 7/7/21, Care Area Assessment indicated being at risk for falls due to wandering, unsteadiness with transitions, history of falls, diagnoses, medications and has had multiple falls due to self transferring. R12's Fall Risk Evaluation dated 12/29/21, indicated R12 was at risk for falls and self ambulation and transferring without calling for help contributed to previous falls. The Fall Risk Evaluation indicated R12 was to wear a right foot brace, ask staff for assistance and to use her call light. R12's care plan with an initiated date of 6/30/21, indicated R12 had activity of daily living deficit due to vertigo, impaired balance, gait disorder and right foot drop. The care plan further indicated R12 was a high fall risk and staff were to ensure her call light was within reach, anticipate her needs and her right foot drop had caused falls. R12's care plan did not provide instructions for a leg 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.	F 689		

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F 689	Continued From page 10 -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 walking in her room, no staff present in the room. -at 7:41 a.m. RN-C and NA-C observed entering R12's room, RN-C gave R12 medications and NA-C gathered garbage and linens. -at 7:44 a.m. both RN-C and NA-C exited the room, R12 was observed seated in a recliner chair with no shoes on and neither staff attempted to apply R12's leg brace which was observed under the lamp stand. -at 7:52 a.m. NA-C brought R12 breakfast and left the room, NA-C did not offer to apply socks, leg brace or ensured R12's call light was within reach. R12's progress note dated 3/13/22, at 9:29 p.m. indicated R12 had a fall and was found on the floor. The progress note indicated previous intervention for R12 was to call for help when transferring. R12's progress note indicated approaches to prevent reoccurrences was R12 was reorient to call light and was advised to use	F 689		

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F 689	Continued From page 11 call light for help. R12's progress note dated 1/20/22, at 10:21 p.m. indicated R12 had a fall and was found on the floor. The progress note indicated interventions for R12 was reminder signs were put on the wall and walker which indicated R12 to ask for help prior to ambulating or transferring. A follow up progress note dated 1/21/22, indicated R12 was not using her right leg brace, and walker prior to the fall on 1/20/22. R12's progress note dated 12/22/21, at 7:49 p.m. indicated R12 had a fall, and interventions included R12 was to wear nonskid socks. R12's progress note dated 12/3/21, at 3:05 p.m. indicated R12 had a fall, and interventions included R12 forgot to wear right leg brace and staff were to offer to put it on for her. R12's progress note dated 9/25/21, at 12:30 p.m. indicated R12 had a fall, and interventions 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 nursing care sheets indicated R12 was a high fall risk, had fallen many times due to vertigo (dizziness) and R12 was to have a right leg brace on when ambulating. 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	F 689		

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F 689	Continued From page 12 use her call light and to keep it within reach. During an interview on 3/23/22, at 8:37 a.m. RN-C indicated R12 had a leg brace that was to be applied in the mornings. During an interview on 3/24/22, at 11:09 a.m. director of nursing (DON) indicated her expectation was staff to follow the interventions such as keeping the doors open, the use of shoes or nonskid socks, encouraging residents to use their walkers, keeping walkers and call lights within reach and staff should be offering to apply the leg brace if the resident allows to prevent falls. R45's quarterly Minimum Data Set (MDS) dated 2/14/22, indicated diagnoses which included Parkinson's disease, extrapyramidal and movement disorder, abnormalities of gait and mobility, muscle weakness, dementia with behavioral disturbance, lack of coordination, and neuromuscular scoliosis. It further indicated R45 required extensive assistance with transfers, limited assistance with ambulation, and a fall history of two or more falls without injury, and one fall with injury. R45's care plan last revised on 2/28/22, included R45 had an activities of daily living (ADL) self-care performance deficit with an intervention of extensive assist of one with transfers. R45's care plan further included R45 was at high risk for falls with interventions to ensure walker and call light were within reach at all times. R45's nursing assistant care sheet (undated) included a section on safety which indicated R45 was a fall risk and to place his call light and	F 689		

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F 689	Continued From page 13 walker within reach at all times. R45's fall risk assessment dated 2/9/22, indicated R45 was a fall risk, had a history of multiple falls, and had risk factors which included: decline in functional status, Parkinson's disease, dizziness/lightheadedness, uses a walker, decline in decision making skills, dementia, and impaired judgement. R45's care area assessment (CAA) dated 8/25/21, indicated CAA triggered as R45 was at risk for falling. "Risk factors include: wandering behaviors, unsteadiness with transitions, orders for scheduled antidepressant and cardiovascular medications. Incontinence of bowel and bladder, cognitive impairment, inattention, and disorganized thinking related to dementia. Report of pain, and diagnoses of Parkinson's disease, psychosis, depression, movement disorder/dyskinesia, and hypertension. Per Physical Device review (8/23/21) R45 shuffles when walks and leans to the left. Uses walker to go to and from destinations. Does need constant reminders and monitoring for safety as will walk away without his walker. Alteration in safety awareness due to cognitive impairments." During observation on 3/22/22, at 10:26 a.m. R45 sat in a chair in his room. His walker and call light were not within reach. During observation on 3/22/22, at 2:39 p.m. R45 sat in a chair in his room. He stood up and took a few steps forward without using his walker. There was a book on the floor in front of him, he stepped on it and his feet started to slip on the pages. The surveyor intervened (in fear of him falling), placed his walker in front of him, and	F 689		

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F 689	Continued From page 14	F 689		

looked for the call light to request assistance. The call light was laying on the floor under his bed, not within reach.

During observation on 3/23/22, at 9:27 a.m. R45 sat at the table in the dining room. His walker was not within reach.

During observation on 3/23/22, at 10:55 a.m. R45 sat in the recliner in the common area. His walker was pushed up against the wall on the other side of the end table, not within reach.

During observation on 3/24/22, at 10:47 a.m. R45 sat in a chair in his room. His walker was in the middle of the room, not within reach.

R45's incident note dated 10/31/21, indicated R45 was found sitting in his bedroom on the floor next to two leather chairs. A follow up incident report dated 11/1/21, indicated the following interventions: staff will continue frequent visual checks, offer to toilet, anticipate needs, place call light within reach, and encourage elder to use it for assistance.

R45's incident note dated 11/10/21, indicated R45 was found sitting on the floor in his bedroom, with his head lying on the bed frame. A follow up incident report dated 11/11/21, indicated "elder is impulsive and does not use the call light for assistance." It further indicated the following interventions: "staff will continue to monitor elder frequently and ensure walker is in front of him at all times. Remind elder to use his walker every shift."

R45's incident note dated 12/5/21, indicated "elder was found sitting on the floor in front of

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F 689	Continued From page 15	F 689		

room 439." A follow up incident report dated 12/7/21, indicated R45 "has a walker but forgets to use it almost all day." It lacked any new interventions.

R45's incident note dated 12/21/21, indicated "elder was walking without his walker and fell to the floor. When elder was found his head was under the bed. He has no inward or outward rotation of extremities. He does have a scrape on his left shoulder. He denies pain. He often walks around the unit leaving his walker behind. Called nurse practioner (NP) and she ordered to monitor resident and update as needed. Also spoke with R45's wife. She will be here to see him tomorrow. Spoke with her about the need for elder to be in a wheel chair. She agreed and will talk to family and get back to us next week. She is concerned about his falls and the frequency of falls." A follow up incident report dated 12/22/21, indicated "elder doesn't use call light for assistance due to cognitive impairment. Elder is independent with transfer and ambulation." It lacked any new interventions.

R45's incident note dated 1/30/22, indicated "Elder was assisted with dressing when he became agitated and stepped back into the bed and then slid down the bed landing onto his buttocks." A follow up incident report dated 1/31/22, lacked any new interventions.

R45's incident note dated 3/13/22, indicated "found elder sitting on the floor leaning to the left side but was not laying on the floor. Laid him down and put a pillow for comfort until assessed by am nurse. This nurse found no s/s (signs and symptoms) injuries. ROM (range of motion) intact all extremeties. VSS (vital signs). Will monitor."

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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 "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 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 light, but we are available to check on him often	F 689		

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F 689	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.	F 689		
F 810 SS=D	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 by:	F 810		5/20/22

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F 810	Continued From page 18 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. Findings include: R52's quarterly Minimal Data Set (MDS) dated 3/2/22, indicated R52 was moderately cognitively impaired and required 1-person extensive assistance with eating. R52's diagnoses included Alzheimer's disease, dementia, and generalized muscle weakness. 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." R52's care plan (CP) revised 12/27/21, indicated R52 had inadequate oral intake r/t poor cognition. R52's CP directed staff to provide adaptive equipment: Serve soups and hot cereal in a mug. Lipped plate, R [right] hand curved utensils. R52's nursing care sheet (NCS) instructed staff to provide cueing/encouragement to improve intake. Assist of 1 as needed. MUGS for soups and hot cereal. R52's progress note dated 12/22/21, at 15:33 (3:33 p.m.) indicated, "Adaptive plate and silverware brought to unit for Elder to try. Dtr [daughter] expressed concerns that Elder seems	F 810	1. NA was provided education on use of adaptive equipment and following the care plan. Education was also provided to other staff on the 3rd floor. Care sheet was reviewed and updated to ensure adaptive equipment was appropriate and up to date. 2. 14/56 residents have the potential to be affected by the deficient practice. 3. A policy and procedure around use of adaptive equipment will be developed. Staff working with potentially affected residents will be educated on the new policy and procedure. 4. DON, Nurse Managers, Dietetic Technician or Designee will conduct audits of resident care of those residents potentially affected to ensure adaptive equipment is in place and utilized. Audits will occur a minimum of 4x/month for three consecutive months. Audits will continue during the MDS review period for those residents using adaptive equipment while dining. Results of findings will reviewed and documented with IDT and monitored at the facility QA meeting. 5. Deficiency will be corrected and substantial compliance will be achieved by May 20th 2022.	

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F 810	Continued From page 19 to be having diminished ability to get food from plate to mouth. Floor staff update on trial." R52's progress note dated 12/27/21, at 10:45 p.m. indicated, "Dtr [daughter], updated writer that she observed Elder using the curved silverware at a meal and it significantly decreased the amount of food that spilled. Will add it and the lipped plate to POC [Plan of Care]." R52's progress note dated 3/15/22, at 16:35 (4:35 p.m.) indicated, " ...Reviewed the care plan expectations with dtr [daughter] including staff providing redirection and allowing Elder to feed herself prior to providing assistance." R52's physician order dated 12/27/21, indicated, "ADAPTIVE EQUIPMENT: Lipped Plate, Rt Hand Curved Utensils, Soup in mug with meals. Provide Elder with adaptive equipment items at meals." During observation on 3/21/22, at 5:28 p.m. R52 was seated at the dining table next to an unidentified visitor for a different resident. R52 had a regular plate and regular silverware. R52 constantly tried to push chair back and stand up. An unidentified nursing assistant (NA) encouraged R52 to eat and pushed her chair back to the table. The unidentified visitor reached over and took a spoonful of R52's food and assisted R52 with a bite. During observation on 3/22/22, at 1:07 p.m. R52 was seated at the dining table eating lunch independently. R52 had a regular plate and regular utensils. During interview on 3/22/22, at 1:25 p.m. NA-E	F 810		

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	245625	A. BUILDING _____ B. WING _____	C 03/24/2022

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

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F 810	Continued From page 20	F 810		

stated there was a binder on the unit that indicated instructions for special diets and adaptive equipment for each resident. NA-E looked in the book and confirmed R52 required food to be cut in bite sized pieces, soup in a cup and curved utensils. NA-E further confirmed R52 did not have curved utensils. NA-E opened the utensil drawer and stated, "They do not even store them on this unit."

During observation on 3/23/22, at 12:50 p.m. R52 was seated at the dining table eating soup from a small bowl and an open-faced egg salad sandwich with regular utensils on a regular plate. R52 was having difficulty loading her spoon with some of the egg salad. Much of the soup was on the table and on R52's lap.

During interview on 3/23/22, at 12:54 p.m. NA-F stated R52's family wanted R52 to be independent with eating. NA-F reviewed the NCS and confirmed R52 should receive her soup in a mug. NA-F confirmed and stated R52 did not have her soup in a mug.

During interview on 3/24/22, at 8:53 a.m. dietary technician (DT)-A stated being involved in the initial ordering for adaptive equipment for R52 and that she expected the staff to provide the appropriate ordered adaptive equipment for every meal.

During interview on 3/24/22, at 9:14 a.m. registered nurse (RN)-B stated the expectation was to have appropriate adaptive equipment available and provided when ordered. RN-B further stated R52 should have soup in a handled mug and food on a lipped plate.

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F 810	Continued From page 21 During interview on 3/24/22, at 10:52 a.m. director of nursing (DON) stated if an elder (resident) had an order for adaptive equipment the expectation was that the equipment was available and provided at each meal. A facility policy on adaptive equipment was requested but not provided.	F 810		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/23/2022. At the time of this survey, Episcopal Church Home Gardens was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		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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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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K 000	Continued From page 2 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 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3 through 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/23/2022 at 09:15 AM, it was revealed by a review of available documentation that there is no documentation on the last time the smoke detector sensitivity test was completed. An interview with the Facility Maintenance	K 345	K345 □ Fire Alarm System □ Testing and Maintenance 1. Integrated Fire and Security was contacted to inspect the smoke detectors. The inspection was completed on 4/19/2022 and a copy of the report has been placed in the LSC book. No additional concerns noted at this time. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. A policy/procedure around smoke detector maintenance will be developed. The smoke detector sensitivity report will be added to the preventative maintenance schedule through our building management system, TELS. 4. Maintenance Director or designee will audit to ensure smoke detector sensitivity	5/20/22

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K 345	Continued From page 3 Director verified this deficiency finding at the time of discovery.	K 345	report is complete within the required timeframe. Progress on plan of correction will be reported and reviewed at the facilities quality assurance committee and safety committee. 5. Deficient practice was corrected on 4/18/2022. Plan of correction to be completed by May 20th 2022.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition) section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/23/2014 at 9:35 AM, it was revealed by a review of available documentation that the fire alarm out of service policy was not complete with the hours of out of service time before implementing the fire watch protocol. An interview with the Facility Maintenance	K 346	K346 Fire Alarm System - Out of Service 1. The fire watch log and protocol will be completed for any future outages. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. The fire watch procedure will be reviewed and updated. The fire watch log will be added to the preventative maintenance schedule through our building management system, TELS. 4. Maintenance Director or designee will audit to ensure the policy is followed and fire watch log is completed within the required timeframe. Progress on plan of correction will be reported and reviewed at the facilities quality assurance committee	5/20/22

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K 346	Continued From page 4 Director verified this deficiency finding at the time of discovery.	K 346	and safety committee. 5. Plan of correction to be completed by May 20th 2022.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 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 and staff interview, the facility failed to implement an automatic fire sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Chapter 15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/23/2014 at 9:35 AM, it was revealed by a review of available documentation that the fire	K 354	K354 □ Sprinkler System - Out of Service 1. The fire watch log and protocol will be completed for any future outages. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. The fire watch procedure will be reviewed and updated. The fire watch log will be added to the preventative maintenance schedule through our building management system, TELS. 4. Maintenance Director or designee will audit to ensure the policy is followed and fire watch log is completed within the required timeframe. Progress on plan of correction will be reported and reviewed at	5/20/22

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K 354	Continued From page 5 sprinkler out of service policy was not complete with the hours of out of service time before implementing the fire watch protocol. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 354	the facilities quality assurance committee and safety committee. 5. Plan of correction to be completed by May 20th 2022.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire and smoke damper systems per NFPA 101 (2012 edition) Life Safety Code, sections 9.2 and 19.5.2.1, NFPA 80 (2010 edition), the Standard for Fire Doors and Other Opening Protectives, sections 19.4.9, 19.4.10 and 19.5.5, NFPA 90A (2012 edition) the Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 105 (2010 edition) the Recommended Practice for the Installation of Smoke-Control Door Assemblies, sections 6.5.11, 6.5.12 and 6.6.6. This deficient finding could have a widespread impact on the residents within the facility.	K 521	K521 □ HVAC 1. Contractor/Vendor was contacted and scheduled to test dampers on 5/2/2022. An inspection report will be reviewed and placed in the LSC book. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. A policy/procedure around smoke damper maintenance will be reviewed and/or developed. The smoke damper report will be added to the preventative maintenance schedule through our building management system, TELS. 4. Maintenance Director or designee will audit to ensure smoke damper report is complete within the required timeframe.	5/20/22

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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. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 521	Progress on plan of correction will be reported and reviewed at the facilities quality assurance committee and safety committee. 5. Deficient practice will be corrected on 5/2/2022. Plan of correction to be completed by May 20th 2022.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections, 19.7.1.4 through 19.7.1.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/23/2022 at 9:15 AM, it was revealed by a	K 712	K712 □ Fire Drills 1. A fire drill was completed on 3/31/2022 at 10pm. Paperwork was added to the LSC book on 3/31/2022. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. The fire drill policy will be reviewed and updated. The fire drill schedule in TELS will be reviewed to ensure all shifts are scheduled for a fire drill throughout the	5/20/22

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K 712	Continued From page 7 review of available documentation that the facility was missing the fire drill for the 3rd quarter night shift. An interview with the Facility Maintenance Director verified this finding at the time of discovery.	K 712	year. 4. Maintenance Director or designee will audit to ensure fire drills are complete within the required timeframe. Progress on plan of correction will be reported and reviewed at the facilities quality assurance committee and safety committee. Copies 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 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		5/20/22

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K 914	Continued From page 8 Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles in resident sleeping rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/23/2022 at 9:30 AM, it was revealed by a review of available documentation that the facility had not completed its outlet testing in all resident rooms for the past two years. The last date recorded was 2/11/2019. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 914	K914 □ Electrical Systems □ Maintenance and Testing 1. Receptacle testing on resident rooms has started. 2. 56/56 residents have the potential to be affected by the deficient practice. 3. A policy for receptacle outlet testing will be developed and added to the LSC book. The receptacle testing schedule will be added to the preventative maintenance schedule in our building management software, TELS. 4. Maintenance Director or designee will audit TELS monthly to ensure receptacle testing is complete within the required timeframe. Progress on plan of correction will be reported and reviewed at the facilities quality assurance committee and safety committee. 5. Plan of correction to be completed by May 20th 2022.	

DEPARTMENT OF HEALTH

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 only a suggestion 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

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****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.	2 000	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.	

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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5625032C (MN81574) and H5625033C (MN81182). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are 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.	

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 830	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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility staff failed to follow the interventions for 3 of 4 residents (R8, R12, and R45) and the facility failed to implement appropriate fall interventions for 1 of 4 residents (R45) reviewed for falls. Findings Include: R8's diagnoses obtained from the admission recorded printed 3/24/22, included Alzheimer's	2 830	corrected.	5/20/22

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2 830	Continued From page 3 disease, dementia, delirium and depression. R8's admission Minimum Data Set (MDS) dated 12/27/21, indicated R8 had severe cognitive impairment and required supervision during transfers. The admission MDS's Care Area Assessment indicated R8 was at risk for falling due to wandering, unsteadiness, medications and diagnoses. 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 observation; On 3/21/22, at 6:24 p.m. R8 observed seated in a chair located outside of her room at the head of the hallway. R8 did not have walker or a wheelchair next to her. -at 6:32 p.m. nursing assistant (NA)-B states to R8 "you are just fine, you can sit right there, I will be right back." R8 observed sitting in a chair outside of her room in the hallway. NA-B did not get R8's walker or wheelchair at this time, but walked down the hallway into another resident's room. -at 6:34 p.m. R8 stood up from the chair she was sitting in and walks back into her room, without using a walker or wheelchair and closes	2 830		

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2 830	Continued From page 4 the door to her room. During another continuous observation; On 3/22/22, at 1:47 p.m. R8 observed standing next to the bed with her left shoe on, and no shoe or sock on her right foot. R8's walker or wheelchair was not within reach at this time. During observation R8 sat back down on the edge of her bed. -at 2:05 p.m. R8 was observed bent over the edge of the bed placing her socks and shoes on her feet. At this time, NA-A and another staff member walked pass R8's room, however neither staff member observed what R8 was doing and kept walking down the hallway. During an observation on 3/23/22, at 9:40 a.m. NA-A asked R8 if she could help R8 into the bathroom. During transfer into the bathroom, R8 was observed to only have one nonskid sock on, the other foot had no shoe or nonskid sock on, and NA-A had R8 walk into the bathroom without a walker or a transfer belt. During transfer NA-A stated R8 normally does not walk with a walker. NA-A further stated, "I don't ever see her [R8] walk with a walker." During this time, NA-A proceeded to get R8's walker after R8 was seated on the toilet and placed the walker next to R8. NA-A then stated R8 will leave her walker in other resident's rooms. R8's Fall Risk Evaluation dated 12/20/21, indicated R8 had a history of falls, and was at risk for falls. R8's undated nursing assistant care sheet indicated R8 was a high fall risk, used a walker and staff were to give R8 her walker if she was not using it.	2 830		

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2 830	Continued From page 5 During an interview on 3/23/22, at 9:22 a.m. NA-A indicated she had never heard anything about R8 being a fall risk. NA-A further indicated R8 wanders around the unit. During an interview on 3/23/22, at 10:08 a.m. RN-A indicated R8 was a fall risk, and staff are to monitor R8's whereabouts. RN-A further indicated R8 will walk off without using her walker and staff was to reminder R8 to use her walker and to ensure R8 was using her walker when ambulating. 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. R12's quarterly MDS dated 1/3/22, indicated R12 had severe cognitive impairment and required extensive assist of one person for transferring and required supervision of one staff when ambulating in her room or on the unit. R12's annual MDS dated 7/7/21, Care Area Assessment indicated being at risk for falls due to wandering, unsteadiness with transitions, history of falls, diagnoses, medications and has had multiple falls due to self transferring. R12's Fall Risk Evaluation dated 12/29/21, indicated R12 was at risk for falls and self ambulation and transferring without calling for help contributed to previous falls. The Fall Risk Evaluation indicated R12 was to wear a right foot brace, ask staff for assistance and to use her call light.	2 830		

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2 830	Continued From page 6 R12's care plan with an initiated date of 6/30/21, indicated R12 had activity of daily living deficit due to vertigo, impaired balance, gait disorder and right foot drop. The care plan further indicated R12 was a high fall risk and staff were to ensure her call light was within reach, anticipate her needs and her right foot drop had caused falls. R12's care plan did not provide instructions for a leg 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 walking in her room, no staff present in the room. -at 7:41 a.m. RN-C and NA-C observed entering R12's room, RN-C gave R12 medications and NA-C gathered garbage and linens.	2 830		

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2 830	Continued From page 7 -at 7:44 a.m. both RN-C and NA-C exited the room, R12 was observed seated in a recliner chair with no shoes on and neither staff attempted to apply R12's leg brace which was observed under the lamp stand. -at 7:52 a.m. NA-C brought R12 breakfast and left the room, NA-C did not offer to apply socks, leg brace or ensured R12's call light was within reach. R12's progress note dated 3/13/22, at 9:29 p.m. indicated R12 had a fall and was found on the floor. The progress note indicated previous intervention for R12 was to call for help when transferring. R12's progress note indicated approaches to prevent reoccurrences was R12 was reorient to call light and was advised to use call light for help. R12's progress note dated 1/20/22, at 10:21 p.m. indicated R12 had a fall and was found on the floor. The progress note indicated interventions for R12 was reminder signs were put on the wall and walker which indicated R12 to ask for help prior to ambulating or transferring. A follow up progress note dated 1/21/22, indicated R12 was not using her right leg brace, and walker prior to the fall on 1/20/22. R12's progress note dated 12/22/21, at 7:49 p.m. indicated R12 had a fall, and interventions included R12 was to wear nonskid socks. R12's progress note dated 12/3/21, at 3:05 p.m. indicated R12 had a fall, and interventions included R12 forgot to wear right leg brace and staff were to offer to put it on for her. R12's progress note dated 9/25/21, at 12:30 p.m. indicated R12 had a fall, and interventions	2 830		

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2 830	Continued From page 8 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 nursing care sheets indicated R12 was a high fall risk, had fallen many times due to vertigo (dizziness) and R12 was to have a right leg brace on when ambulating. 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 on 3/23/22, at 8:37 a.m. RN-C indicated R12 had a leg brace that was to be applied in the mornings. During an interview on 3/24/22, at 11:09 a.m. director of nursing (DON) indicated her expectation was staff to follow the interventions such as keeping the doors open, the use of shoes or nonskid socks, encouraging residents to use their walkers, keeping walkers and call lights within reach and staff should be offering to apply the leg brace if the resident allows to prevent falls. R45's quarterly Minimum Data Set (MDS) dated 2/14/22, indicated diagnoses which included Parkinson's disease, extrapyramidal and movement disorder, abnormalities of gait and mobility, muscle weakness, dementia with behavioral disturbance, lack of coordination, and neuromuscular scoliosis. It further indicated R45 required extensive assistance with transfers, limited assistance with ambulation, and a fall	2 830		

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2 830	Continued From page 9 history of two or more falls without injury, and one fall with injury. R45's care plan last revised on 2/28/22, included R45 had an activities of daily living (ADL) self-care performance deficit with an intervention of extensive assist of one with transfers. R45's care plan further included R45 was at high risk for falls with interventions to ensure walker and call light were within reach at all times. R45's nursing assistant care sheet (undated) included a section on safety which indicated R45 was a fall risk and to place his call light and walker within reach at all times. R45's fall risk assessment dated 2/9/22, indicated R45 was a fall risk, had a history of multiple falls, and had risk factors which included: decline in functional status, Parkinson's disease, dizziness/lightheadedness, uses a walker, decline in decision making skills, dementia, and impaired judgement. R45's care area assessment (CAA) dated 8/25/21, indicated CAA triggered as R45 was at risk for falling. "Risk factors include: wandering behaviors, unsteadiness with transitions, orders for scheduled antidepressant and cardiovascular medications. Incontinence of bowel and bladder, cognitive impairment, inattention, and disorganized thinking related to dementia. Report of pain, and diagnoses of Parkinson's disease, psychosis, depression, movement disorder/dyskinesia, and hypertension. Per Physical Device review (8/23/21) R45 shuffles when walks and leans to the left. Uses walker to go to and from destinations. Does need constant reminders and monitoring for safety as will walk away without his walker. Alteration in safety	2 830		

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2 830	Continued From page 10 awareness due to cognitive impairments." During observation on 3/22/22, at 10:26 a.m. R45 sat in a chair in his room. His walker and call light were not within reach. During observation on 3/22/22, at 2:39 p.m. R45 sat in a chair in his room. He stood up and took a few steps forward without using his walker. There was a book on the floor in front of him, he stepped on it and his feet started to slip on the pages. The surveyor intervened (in fear of him falling), placed his walker in front of him, and looked for the call light to request assistance. The call light was laying on the floor under his bed, not within reach. During observation on 3/23/22, at 9:27 a.m. R45 sat at the table in the dining room. His walker was not within reach. During observation on 3/23/22, at 10:55 a.m. R45 sat in the recliner in the common area. His walker was pushed up against the wall on the other side of the end table, not within reach. During observation on 3/24/22, at 10:47 a.m. R45 sat in a chair in his room. His walker was in the middle of the room, not within reach. R45's incident note dated 10/31/21, indicated R45 was found sitting in his bedroom on the floor next to two leather chairs. A follow up incident report dated 11/1/21, indicated the following interventions: staff will continue frequent visual checks, offer to toilet, anticipate needs, place call light within reach, and encourage elder to use it for assistance. R45's incident note dated 11/10/21, indicated R45	2 830		

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2 830	Continued From page 11 was found sitting on the floor in his bedroom, with his head lying on the bed frame. A follow up incident report dated 11/11/21, indicated "elder is impulsive and does not use the call light for assistance." It further indicated the following interventions: "staff will continue to monitor elder frequently and ensure walker is in front of him at all times. Remind elder to use his walker every shift." R45's incident note dated 12/5/21, indicated "elder was found sitting on the floor in front of room 439." A follow up incident report dated 12/7/21, indicated R45 "has a walker but forgets to use it almost all day." It lacked any new interventions. R45's incident note dated 12/21/21, indicated "elder was walking without his walker and fell to the floor. When elder was found his head was under the bed. He has no inward or outward rotation of extremities. He does have a scrape on his left shoulder. He denies pain. He often walks around the unit leaving his walker behind. Called nurse practioner (NP) and she ordered to monitor resident and update as needed. Also spoke with R45's wife. She will be here to see him tomorrow. Spoke with her about the need for elder to be in a wheel chair. She agreed and will talk to family and get back to us next week. She is concerned about his falls and the frequency of falls." A follow up incident report dated 12/22/21, indicated "elder doesn't use call light for assistance due to cognitive impairment. Elder is independent with transfer and ambulation." It lacked any new interventions. R45's incident note dated 1/30/22, indicated "Elder was assisted with dressing when he became agitated and stepped back into the bed	2 830		

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2 830	Continued From page 12 and then slid down the bed landing onto his buttocks." A follow up incident report dated 1/31/22, lacked any new interventions. R45's incident note dated 3/13/22, indicated "found elder sitting on the floor leaning to the left side but was not laying on the floor. Laid him down and put a pillow for comfort until assessed by am nurse. This nurse found no s/s (signs and symptoms) injuries. ROM (range of motion) intact all extremeties. VSS (vital signs). Will monitor." 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	2 830		

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2 830	Continued From page 13 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 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 light, but we are available to check on him often 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. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could	2 830		

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2 830	Continued From page 14 review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by:	2 945		5/20/22

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2 945	Continued From page 15 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. Findings include: R52's quarterly Minimal Data Set (MDS) dated 3/2/22, indicated R52 was moderately cognitively impaired and required 1-person extensive assistance with eating. R52's diagnoses included Alzheimer's disease, dementia, and generalized muscle weakness. 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." R52's care plan (CP) revised 12/27/21, indicated R52 had inadequate oral intake r/t poor cognition. R52's CP directed staff to provide adaptive equipment: Serve soups and hot cereal in a mug. Lipped plate, R [right] hand curved utensils. R52's nursing care sheet (NCS) instructed staff to provide cueing/encouragement to improve intake. Assist of 1 as needed. MUGS for soups and hot cereal. R52's progress note dated 12/22/21, at 15:33 (3:33 p.m.) indicated, "Adaptive plate and silverware brought to unit for Elder to try. Dtr [daughter] expressed concerns that Elder seems to be having diminished ability to get food from	2 945	corrected.	

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2 945	Continued From page 16 plate to mouth. Floor staff update on trial." R52's progress note dated 12/27/21, at 10:45 p.m. indicated, "Dtr [daughter], updated writer that she observed Elder using the curved silverware at a meal and it significantly decreased the amount of food that spilled. Will add it and the lipped plate to POC [Plan of Care]." R52's progress note dated 3/15/22, at 16:35 (4:35 p.m.) indicated, " ...Reviewed the care plan expectations with dtr [daughter] including staff providing redirection and allowing Elder to feed herself prior to providing assistance." R52's physician order dated 12/27/21, indicated, "ADAPTIVE EQUIPMENT: Lipped Plate, Rt Hand Curved Utensils, Soup in mug with meals. Provide Elder with adaptive equipment items at meals." During observation on 3/21/22, at 5:28 p.m. R52 was seated at the dining table next to an unidentified visitor for a different resident. R52 had a regular plate and regular silverware. R52 constantly tried to push chair back and stand up. An unidentified nursing assistant (NA) encouraged R52 to eat and pushed her chair back to the table. The unidentified visitor reached over and took a spoonful of R52's food and assisted R52 with a bite. During observation on 3/22/22, at 1:07 p.m. R52 was seated at the dining table eating lunch independently. R52 had a regular plate and regular utensils. During interview on 3/22/22, at 1:25 p.m. NA-E stated there was a binder on the unit that indicated instructions for special diets and	2 945		

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2 945	Continued From page 17 adaptive equipment for each resident. NA-E looked in the book and confirmed R52 required food to be cut in bite sized pieces, soup in a cup and curved utensils. NA-E further confirmed R52 did not have curved utensils. NA-E opened the utensil drawer and stated, "They do not even store them on this unit." During observation on 3/23/22, at 12:50 p.m. R52 was seated at the dining table eating soup from a small bowl and an open-faced egg salad sandwich with regular utensils on a regular plate. R52 was having difficulty loading her spoon with some of the egg salad. Much of the soup was on the table and on R52's lap. During interview on 3/23/22, at 12:54 p.m. NA-F stated R52's family wanted R52 to be independent with eating. NA-F reviewed the NCS and confirmed R52 should receive her soup in a mug. NA-F confirmed and stated R52 did not have her soup in a mug. During interview on 3/24/22, at 8:53 a.m. dietary technician (DT)-A stated being involved in the initial ordering for adaptive equipment for R52 and that she expected the staff to provide the appropriate ordered adaptive equipment for every meal. During interview on 3/24/22, at 9:14 a.m. registered nurse (RN)-B stated the expectation was to have appropriate adaptive equipment available and provided when ordered. RN-B further stated R52 should have soup in a handled mug and food on a lipped plate. During interview on 3/24/22, at 10:52 a.m. director of nursing (DON) stated if an elder (resident) had an order for adaptive equipment	2 945		

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2 945	Continued From page 18 the expectation was that the equipment was available and provided at each meal. A facility policy on adaptive equipment was requested but not 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.	2 945		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain dignity during assistance with dressing for 1 of 1 residents (R41) reviewed for dignity.	21805	corrected.	5/20/22

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21805	Continued From page 19 Findings include: R41's quarterly Minimal Data Set (MDS) dated 2/7/22, indicated R41 was moderately cognitively impaired and required 1 or 2-person extensive assistance for all activities of daily living (ADLs). R41's diagnoses included history of stroke, ataxia (a degenerative disease of the nervous system affecting muscle control or coordination of voluntary movements), dementia, depression, and psychotic disorder. R41's cognitive loss/dementia care area assessment (CAA) dated 8/9/21, indicted R41 had cognitive impairment related to (r/t) diagnosis of dementia. R41's care plan (CP) dated 5/26/20, indicated R41 had an ADL self-care deficit related to dementia, impaired mobility, and ataxia. R41's CP further indicated R41 required extensive assistance by 1 staff to dress and assist of 2 staff as needed for weakness and behaviors. R41's CP further indicated R41 required extensive assistance by 2 staff with transfers using an EZ stand lift. R41's CP instructed caregivers to provide opportunities for positive interaction, stop and talk with R41 when passing by and ensure call light was within reach. R41's nursing care sheet (NCS) instructed staff to place call light within reach and perform frequent visual checks. R41's NCS indicated R41 required extensive assist of 1 for dressing. During continuous observation the following was observed: On 3/23/22, at 8:41 a.m. nursing assistant (NA)-D was in R41's room assisting with completion of	21805		

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21805	Continued From page 20	21805		

morning cares. R41 appeared receptive of cares at this time.

-at 8:49 a.m. NA-D left R41's room and went in and out of a different resident's room (R13) and then into another resident's room (R11).

-at 8:55 a.m. R41 was sitting in wheelchair facing the halfway open door. R41 had on a shirt, and pants pulled up to just above the knees. R41's incontinent brief was visible at her crotch. A blanket was on the floor next to the wheelchair on R41's right. R41 was tugging at her pants attempting to pull them up over her legs. R41's call light was on the bed and not in R41's immediate reach.

-at 9:00 a.m. R41 stated, "I wish she [NA-D] would have come right back." R41 further stated it did not feel good sitting like that and that she felt embarrassed. R41 stated, "I wonder what she [NA-D] is doing. What is she [NA-D] thinking of?"

-at 9:03 a.m. NA-E walked by R41's room without looking into her room.

-at 9:05 a.m. R41 stated, "I don't like this." R41 was observed with pants still at knee level attempting to pull them up further. R41 attempted to self-propel toward door and then backward and toward bed but was unsuccessful. R41 again stated, "What is she [NA-D] doing?"

-at 9:07 a.m. NA-D came out of R11's room but did not walk toward R41's room. NA-E came out of R44's room and walked by R41's room without looking into R41's room.

-at 9:09 a.m. R41 was still sitting in full view from hallway with pants half on and continued to attempt to pull them up herself but was unsuccessful.

-at 9:14 a.m. NA-D came out of R11's room.

-at 9:15 a.m. NA-D re-entered R11's room while R41 still tugged on her pants attempting to pull them up on her own.

-at 9:16 a.m. NA-D came out of R11's room.

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21805	Continued From page 21 R41 was heard saying, "I want to go." -at 9:17 a.m. NA-D walked by R41's room without looking into R41's room. -at 9:18 a.m. R41 still sitting within view from the hallway with her pants only to her knees. R41's thighs were exposed, and she attempted to cover them with the top of her pants. -at 9:24 a.m. an unidentified male maintenance staff walked past R41's room. -at 9:26 a.m. R41 still sitting in full view from hallway with her pants to her knees. R41 attempted to self-propel in wheelchair with her hands on the wheels of the wheelchair. R41's pants dropped below her knees, and she moved her hands from the wheels back to her pants and pulled them back up to just above her knees. -at 9:37 a.m. NA-D and NA-E both came out of R11's room and entered R41's room. -at 9:40 a.m. NA-D and NA-E used the EZ stand to assist R41 to a standing position while they pulled up her pants and then lowered her back to a seated position in her wheelchair. During interview on 3/23/22, at 9:37 a.m. NA-D stated R41 was a 2 person assist and required the use of the EZ stand. NA-D further stated she (NA-D) and (NA-E) had been tied up with other residents. NA-D acknowledged R41 was sitting with her pants halfway up and that her call light was not within reach. During interview on 3/23/22, at 11:23 a.m. registered nurse (RN)-B stated R41 should not have had to wait 48 minutes for someone to return to assist pulling up her pants. RN-B further stated no elder (resident) should ever wait that long and should not be exposed to the hallway. During interview on 3/23/22, 1:35 p.m. family member (FM)-A stated if (R41) was aware she	21805		

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21805	Continued From page 22 was exposed to the hallway, she would hate it. FM-A further stated (R41) would get frustrated if she tried to do something herself and was unsuccessful. During interview on 3/23/22, at 2:48 p.m. director of nursing (DON) stated the expectation was R41 should have been covered up. DON further stated NA-D should have returned to check on R41 and should have let her know she would be further delayed. DON stated the expectation was that staff provide care in such a way as to protect the elders' dignity. A facility policy on dignity was requested but not provided. Review of the facility annual training on resident rights indicated every elder had rights and those rights included the right to dignity. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts, are offered and assisted to appropriately cover their exposed skin and to ensure personal hygiene is maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		