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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKMG

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/20/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Capes, HFE NE II — 04/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/21/2016
(L33)

Posted 05/11/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245452
May 2, 2016

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

Dear Ms. Schneider:

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

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

Effective April 21, 2016 the above facility is certified for or recommended for:

131 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 131 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 2, 2016

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

RE: Project Number S5452025

Dear Ms. Schneider:

On March 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 28, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 21, 2016 and therefore remedies outlined in our letter to you dated March 22, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245452 Y1	A. Building B. Wing Y2	4/20/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0309	Correction	ID Prefix F0323	Correction	ID Prefix F0327	Correction
Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(j)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix F0329	Correction	ID Prefix F0334	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.60(c)	Completed
LSC	04/12/2016	LSC	04/12/2016	LSC	04/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/KJ	05/02/2016	22580	04/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245452 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/28/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	03/31/2016	LSC K0046	03/31/2016	LSC K0052	03/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0054	04/21/2016	LSC K0056	03/02/2016	LSC K0062	03/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0144	03/07/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/02/2016	SIGNATURE OF SURVEYOR 37010	DATE 04/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245452 Y1	A. Building 02 - EPISCOPAL CHURCH HOME OF MN B. Wing Y2	4/28/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	03/31/2016	LSC K0052	03/31/2016	LSC K0054	04/21/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	03/31/2016	LSC K0144	03/07/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	05/02/2016	37010	04/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKMG

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 04/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/21/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2878
March 22, 2016

Mr. Marvin Plakut, Administrator
Episcopal Church Home of Minnesota
1879 Feronia Avenue
Saint Paul, Minnesota 55104

RE: Project Number S5452025

Dear Mr. Plakut:

On March 3, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 3, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	03/03/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification	F 000	RECEIVED 4-1-16 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157 4/1/16 SER	R62's representative was notified of the change of condition on 3/2/2016. R62 is no longer in the facility. Representatives of elders with a change of condition have been notified of that change. Nurses were educated on notifying elders' representatives of changes of elder condition and/or making attempt to notify elder representatives within two hours of identifying that change on 3-29-16, 3-30-16 and 3-31-16. Policy and Procedures were reviewed. The policy was revised to show that change of condition notification to elder representative will occur within two hours of identifying that change.	4/12/16

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

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.

Marvin J. Plakut, Administrator, 4/1/16

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to notify the family member with a significant change in health status for 1 of 1 resident (R62) in the sample with a change in condition. Findings include: During an observation of R62 on 2/29/16, at 7:00 p.m. there were audible wheezing sounds with expiration and the tongue of R62 was very dry and cratered in appearance. During an observation of R62 on 3/1/16, at 8:10 a.m. there were audible wheezing sounds with expiration and the tongue of R62 was very dry and cratered in appearance. In reviewing the medical record document, dated, 2/29/16, titled, Nutrition-Fluids, revealed thickened fluid consumed at meals and mighty shake nutritional supplement consumed TID for a 24-hour period documented 580 ml (millimeter). Document review of the form dated 12/18/15, titled, Nutritional Re-Assessment indicated the fluid intake for R62 according to body weight in a	F 157	Continued from page 1 Audits for elders with change of conditions will be completed 5 x week until the QA committee meets in May 2016. Results of audits will be reviewed by the QA committee in May to determine if further audits are required. The DON or designee will be responsible. Date of completion: April 12, 2016	

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F 157	Continued From page 2 24-hour period should be 1400 ml. According to the document titled Physician Orders and dated 2/18/16, indicated R62 had a diet order change to nectar thick liquids and to receive speech therapy to determine oral function for swallowing. In reviewing the form titled, Vitals Summary, indicated on 2/28/16, at 11:18 a.m. a pulse of 110, compared to the general range of 72 beats per minute for R62. The next recorded pulse was on 3/1/16, at 6:26 a.m. at 90 beats per minute. The next documented pulse was on 3/1/16, at 10:27 a.m. at 110 beats per minute and noted as irregular-new onset documented. The respirations recorded on the Vitals Summary indicated on 3/1/16, at 6:26 a.m. R62 was breathing 34 times per minute exceeding the adult medical normal standard of 12-16 breaths per minute. In reviewing the form titled, Vitals Summary, indicated on 3/1/16, at 6:27 a.m., R62 had a tympanic temperature of 99.3 degrees Fahrenheit (F), compared to the average of 96-97 degrees F. recorded for R62. Document review of the form titled, Medication Review Report, indicated R62 receives medication Acetaminophen Tablet 500 mg Give 2 tablet by mouth 4 times a day related to nondisplaced fracture of left tibial spine, initial encounter for closed fracture from 12/2/15. According to the progress notes dated 3/1/16, at 6:53 a.m. RN-A documented, "Elder noted to have wheezing and increased [sic]of breath. Writer assessed elder and vital signs were abnormal, Doctor on call was notified about elder's findings, an order for Albuterol and chest	F 157		

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F 157	Continued From page 3 X RAY was put in." On 3/1/16, at 9:00 a.m. a chest X Ray was completed on R62 and the preliminary results were received by FAX at 9:58 a.m. with the interpretation of no acute findings. The primary physician was given the results by voice mail on 3/1/16, at 10:30 a.m. On 3/1/16, at 11:22 a.m. nurse practitioner (NP) ordered, "monitor elder and update tomorrow am shift, update if elder condition worsens." On 3/2/16, at 10:50 a.m. family was notified of change in condition for R62. The facility policy dated, 1/1/15, titled, Change in Condition, indicated the facility would promptly notify the elder, physician and responsible party of changes in the resident's condition. During an interview with registered nurse RN-(A) on 3/2/16, at 9:32 a.m. verified the family should have been notified of the change of condition for R62 when the physician ordered the chest X Ray and made medication changes on 3/1/16, at 6:53 a.m. and especially when the results were known of the chest X Ray on 3/1/16, at 11:00 a.m.,the family should have been informed.	F 157		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	HOSPICE: R244 is no longer in the facility.	4/12/16

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F 279	Continued From page 4 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan related to hospice for 1 of 1 resident (R244) in the sample identified receiving hospice services, failed to develop a care plan for 1 of 3 residents (R199) in the sample reviewed for activities of daily living and failed to develop a care plan for 2 of 5 residents (R2, R47) reviewed for unnecessary medications. Findings include: A comprehensive and individualized care plan was not developed for R244 regarding hospice care. Record review revealed a Team Care Plan from a hospice provider showing that R244 had been admitted to hospice care on 8/24/15 with diagnoses of malignant neoplasm of biliary tract and secondary malignant neoplasm of bone.	F 279	Continued from page 4 All elders who utilize hospice services will have both hospice and facility care plans completed by a representative of the hospice and the facility for coordination of care within 24 hours of being admitted to hospice. Each entity will specify what each entity will provide for the elder. A hospice schedule will be provided to the facility outlining schedules for hospice nurse, social worker, chaplain and HHA with specified duties and will be updated with changes. A meeting with hospice providers was completed on 3-29-16 and outlined the above changes and requirements for individualized and coordinated care plans and service. Nurse Managers and MDS nurses were educated on hospice care planning requirements and need for care plan coordination, individualization, and hospice schedules on 3-30-16. Audits of new hospice clients in facility will be completed after 24 hours on hospice care. Results of audits will be reviewed by the QA committee in May to schedule for further audits.	

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F 279	Continued From page 5 The facility's current plan of care, dated 2/15/16, did not contain a Focus related to hospice. The facility's care plan did contain a Focus that read, "The resident has a terminal prognosis r/t stage IV bile duct cancer with mets to bone liver [sic]," with an intervention that read, "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met." No further Focus was present in the care plan with details specific to this resident's psychosocial, activity, or spiritual needs related hospice care. R244's record did include a care plan from the hospice provider, but this care plan was generic and contained only a few details specific to R244. When interviewed on 3/3/16, at 10:16 a.m. registered nurse (RN)-G stated that the facility mainly used the hospice provider's care plan and the facility's care plan basically referred to the hospice provider's care plan. He also explained that the facility's care plan directed staff to coordinate care with the hospice provider. R2's plan of care had not been developed to include activities, mood, diabetes, esophageal reflux and any side effects or effectiveness of scheduled medications. R2 was admitted on 7/2/15 with diagnosis including major depressive disorder,single episode, essential hypertension, gastro-esophageal reflux, and diabetes mellitus. R2's physician orders dated March 2, 2016, included the following medications: Metformin HCL Tablet 500 mg (milligrams)	F 279	Continued from page 5 CARE PLAN DEVELOPMENT: R199's care plan was revised to include: Activities, Fall Risk, Bladder Incontinence and Social Services with individualized approaches. R2's care plan was revised to include: Activities, Mood, Diabetes Mellitus, Reflux Disease, and medication side effects and monitoring. R 2's and R 47's care plans were revised to include: elder symptoms to monitor, and psychoactive medication monitoring including orthostatic BP and non-pharmacological approaches to use. Target behaviors/symptoms were identified. All elder care plans were reviewed and revised as needed to ensure inclusion of active disease processes, Fall Risk, Activities, Bladder Incontinence, Mood, Social Services, medication monitoring and non-pharmacological approaches for mood and behavior.	

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F 279	Continued From page 6 (diabetic medication) Give 0.5 tablet by mouth one time a day related to Diabetes Mellitus, Omeprazole Capsule Delayed Release 20 mg Give 1 Capsule by mouth one time a day related to Esophageal Reflux (medication for esophageal reflux), Paxil Tablet 20 mg Give 20 mg by mouth one time a day related to Major Depressive Disorder, Single Episode, Unspecified, Triamterene-HCTZ Capsule 37.5-25 mg Give 1 capsule by mouth one time a day related to Unspecified Essential Hypertension. R2 physician orders also included an order to complete an accucheck (test to check blood glucose) before breakfast one time a day every Mon, Wed, Fri related to Diabetes Mellitus. Interview with Registered Nurse (RN)-B, who was the Nurse Manager where R2 resided, verified on 3/3/16 at noon, that R2's care plan lacked any focus on activities, mood, diabetes and medication monitoring. RN-B verified that R2 received medications for mood, diabetes, high blood pressure and esophageal reflux and the care plan lacked any indication of their use and any side effects from the medication use, and that the care plan should have included those issues. R199's plan of care was not comprehensively developed to include activities, falls risk, bladder incontinence, and social services. Review of R199's plan of care received on 3/2/16 directed the following : - the resident is (SPECIFY High, Moderate, Low) risk for fall r/t [related to] decreased mobility, use	F 279	Continued from page 6 Department Managers, Nurse Managers and MDS nurses were educated on CAAs, Care Planning, Care Plan Reviews, Dashboard and Reports on 3-21-16. Department Managers, Nurse Managers and MDS nurses were educated on providing individualized care plans that include: Activities, Hospice Coordination requirements, Depression care planning requirements, Mood, Social Service, Disease Management, medications side effects and to include monitoring, non-pharmacological approaches to be used, Fall Risk to include identifying High, Moderate and Low risk, and Bladder Incontinence on 3-30-16. Policy and Procedures for Comprehensive Care Plans was reviewed and revised as needed. Care Plan Audits will be completed 3 x week on random elders. Results of audits will be reviewed by the QA committee in May to determine schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	

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F 279	Continued From page 7 of Hoyer lift, wheelchair. interventions were listed as: Ensure that the resident is wearing appropriate footwear (SPECIFY and describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in w/c, - The resident needs a safe environment with (SPECIFY: even floors free from spills and/or clutter; adequate, glare-free light, a working and reachable call light, the bed in low position at night, handrails on walls, personal items within reach. - The resident has (SPECIFY:URGE, STRESS, FUNCTIONAL, MIXED) bladder incontinence r/t impaired mobility. Interventions include: INCONTINENT: Check (SPECIFY FREQ) and as required for incontinence. Nurse Practitioner (NP) progress notes dated 2/15/16 indicated the resident remains in her room the entire day, including eating all of her meals. Social worker in visiting with patient. Interview with RN-B on 3/3/16, verified the plan of care was not complete regarding falls and bladder incontinence and did not include any focus for activities and social services. R47 received an antidepressant medication and did not have identification of target behaviors, accurate monitoring of depression, and an individualized plan of care including non-pharmacological interventions for depression. On 3/2/16 at 10:05 a.m. R47 was sitting in her room, A breakfast tray was in the room near the lounge chair. R47 indicated she preferred to eat	F 279		

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F 279	Continued From page 8 in her room. A review of R47's medical record revealed a physician order for duloxetine hcl 60 milligrams every day for depression. The annual MDS dated 10/20/15 indicated R47 was cognitively intact, had a diagnoses of depression but no mood or depression symptoms. A review of the care plan, revised 11/30/15 indicated R47 was taking an antidepressant, but the care plan lacked any indication of what symptoms should be monitored. The care plan indicated the resident was to be allowed to verbalize feelings. but did not identify other individualized non pharmacological interventions that would provide direction to staff. The clinical nurse manager (RN)-C on 3/3/16 at 11:30 a.m. indicated she was not aware of any collective monitoring for symptoms of depression for R47 and verified the care plan did not identify individualized interventions for R47. On 3/4/16 at 2:30 p.m. the director of nursing verified the care plan lacked individualized non pharmacological interventions for R47. Review of "Episcopal Church Home/Policy and Procedure Comprehensive Care Plan" dated 8/9/2012, directed the following: 2. A complete comprehensive plan of care will be initiated no longer than 7 days after the comprehensive assessment for admission. 4. The care plan is to remain current and up to date; changing as the needs of the resident changes, in an effort to guide all cares in a timely	F 279		

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F 279	Continued From page 9 and quality driven manner to meet the needs and expressed wishes of the resident and /or responsible party. 5. The plan of care will address real and potential risks to ensure that the highest level of practicable function is being maintained or attained.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R62) to include fluid intake to be thickened and the number of milliliters per	F 280	R62's care plan was revised on 3-1-16, to include the appropriate thickness of liquids and the amount of fluid needed per body weight. All elders requiring thickened liquids have had their care plans updated to include the appropriate thickness of the liquids and the amount of fluids needed per body weight. Dietary and nursing care planners were educated on care planning the fluid thickness and amount of required fluids per body weight of elders requiring thickened fluids on 3-30-16. Audits of care plans for elders with thickened fluids will be completed on all elders with fluid thickness changes for identification of fluid thickness and amount of fluids required per body weight daily.	4/12/16

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F 280	Continued From page 10 body weight required to prevent dehydration and failed to revise the plan of care for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include: During an observation on 3/1/16, at 10:01 a.m. R62 was being spoon fed nectar thick consistency thickened liquid by nursing assistant (NA)-A who indicated typically R62 did better at taking fluids but was breathing heavier and not as alert as usual today. Document review of the form titled, Plan of Care, dated 12/18/15, addressed intake decline in ability to feed self. The goal was to be free from signs and symptoms of dehydration. The interventions addressed to monitor for increased difficulty with chewing/swallowing. Offer fluids in between meals and push fluids. Resident to continue on the regular/puree/ thin liquids. According to the document titled, Physician Orders and dated 2/18/16, indicated R62 had a diet order change to nectar thick liquids and to receive speech therapy to determine oral function for swallowing. Document review of the form dated 12/18/15, titled, Nutritional Re-Assessment, indicated the fluid intake for R62 according to body weight in a 24-hour period should be 1400 ml.(milliliter) When interviewed on 3/3/16, at 11:00 a.m., registered nurse (RN)-C and nursing assistant (NA)-A did not know how many milliliter's of fluid R62 was supposed to have in a 24 hour period and did not know where to find the information	F 280	Continued from page 10 Policy and procedure for Intake and Output was revised to include identifying on the care plan fluid thicknesses and calculating the amount of fluids needed per body weight for elders who require thickened liquids. R 19's and R 47's care plans were revised to include: elder symptoms to monitor, psychoactive medication monitoring including orthostatic BP and non-pharmacological approaches to use. Target behaviors/symptoms were identified. Daily monitoring of behaviors, symptoms and medication side effects were put into place for these elders. All elders who use psychoactive medications have had their care plan reviewed and revised to include symptoms to monitor, medication monitoring including Orthostatic BPs and non-pharmacological approaches to use. Target behaviors/ symptoms were identified. Daily monitoring of behaviors, symptoms and medication side effects were put into place for these elders.	

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F 280	Continued From page 11 but would check and find out. R19 received psychophamalogical medications and the facility failed to revise the plan of care to identify the specific behaviors to monitor, and develop specific interventions that included nonpharmalogical interventions. R19 had current physician order for lorazepam 0.5 mg every 8 hours as needed for prophylaxis related to anxiety and Olanzapine tablet 2.5 mg twice a day related to psychotic disorder with delusions and fluoxetine 20 mg every day related to major depressive disorder. Although R19 had a diagnosis of anxiety disorder and psychotic disorder with delusions, the medical record did not identify what behaviors were specifically displayed by R19 for anxiety or psychotic disorder. The medical record lacked any monitoring of such behaviors and what interventions were attempted when behaviors were evident. The medical record lacked documentation of a monthly orthostatic blood pressure monitoring. The electronic monthly medication administration record (MAR) for February and March were reviewed. The February MAR indicated the as needed lorazepam .5 mg had been given the evening of 2/28 and 2/29/2016. The progress note for 2/28/16 indicated the resident was trying to get out of bed, and on 2/29/16 the note indicated the resident wanted to stand up. The current care plan identified the use of an anti anxiety medication and a psychotropic medication but lacked specific behaviors R19 may display and lacked individualized interventions.	F 280		

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F 280	Continued From page 12 On 3/3/16 at 11:30 a.m. the clinical nurse manager (RN)-C verified the findings and indicated the original order for the olanzapine was ordered for nausea. The original order was dated 8/28/14, and was written for nausea. However the current order, written 8/9/15 indicated psychotic disorder with delusions. RN-C indicated the practice at the facility was to document by exception. The monitoring would just be check off marks that indicated the monitoring occurred, but did not indicate what behaviors might have been displayed. On 3/4/16 at 2:30 p.m. the director of nursing verified the lack of symptom/behavior monitoring and orthostatic blood pressure monitoring and agreed the care plan needed to include individualized interventions for the use of these medications.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive, coordinated, and individualized plan of care for 1 of 1 resident (R244) reviewed for hospice.	F 309	R244 is no longer at the facility. All elders who utilize hospice services will have both hospice and facility care plans completed by a representative of the hospice and the facility for coordination of care within 24 hours of being admitted to hospice. Each entity will specify what each entity will provide for the elder. A hospice schedule will be provided to the facility outlining schedules for hospice nurse, social worker, chaplain and HHA with specified duties and will be updated with changes.	4/12/16

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F 309	Continued From page 13 Findings include: Record review revealed a Team Care Plan from a hospice provider showing that R244 had been admitted to hospice care on 8/24/15 with diagnoses of malignant neoplasm of biliary tract and secondary malignant neoplasm of bone. The facility's current plan of care, dated 2/15/16, did not contain a Focus related to hospice. The facility's care plan did contain a Focus that read, "The resident has a terminal prognosis r/t stage IV bile duct cancer with mets to bone liver [sic]," with an intervention that read, "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met." No further Focus was present in the care plan with details specific to this resident's psychosocial, activity, or spiritual needs related hospice care. R244's record did include a care plan from the hospice provider, but this care plan was generic and contained only a few details specific to R244. When interviewed on 3/3/16, at 10:16 a.m. registered nurse (RN)-G stated that the facility mainly used the hospice provider's care plan and the facility's care plan basically referred to the hospice provider's care plan. He also explained that the facility's care plan directed staff to coordinate care with the hospice provider.	F 309	Continued from page 13 A meeting with hospice providers was completed on 3-29-16 and outlined the above changes and requirements for individualized and coordinated care plans and service. Nurse Managers and MDS nurses were educated on hospice care planning requirements and need for care plan coordination, individualization, and hospice schedules on 3-30-16. Policy and Procedures for Comprehensive Care Plans was reviewed and revised to reflect Hospice and facility coordination and identification of services. Audits of new hospice clients in facility will be completed after 24 hours on hospice care. Results of audits will be reviewed by the QAPI committee in May to schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	R19's falls have been investigated to identify a root cause with appropriate interventions directed at the root cause of the falls.	4/12/16

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F 323	Continued From page 14 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly evaluate the root cause for falls for 1 of 2 residents (R19) reviewed for accidents. Findings include: R19's clinical diagnoses information indicated R19 had anxiety disorder, psychotic disorder, anemia, and Parkinson's disease. On 3/2/16 at approximately 8:05 a.m., nursing assistant (NA)-F pivot transferred R19 from the wheelchair into bed. R19 was laid down, repositioned with pillows to ensure comfort, and covered with a blanket. The bed was lowered into the lowest position and a blue floor mat was put in place by R19's bed. The call light was placed near R19's side. R19's annual minimum data set (MDS) dated 12/12/15 indicated R19 needed extensive assist of two staff persons for transferring from one surface to another and walking in her room, Extensive assist was also needed for toileting, dressing and personal grooming. R19 had one upper extremity with limited function and had one fall without injury prior to the assessment date. A fall and safety risk analysis dated 12/10/15	F 323	Continued from page 14 All elders who have fallen since March 1, 2016, have had a review of their falls and a root cause identified with appropriate interventions directed at the root cause. All staff were educated on identification of root cause and interventions for falls on 3-29-16, 3-30-16 and 3-31-16. Fall Policy and Procedure was reviewed and revised as needed to include: IDT team review of each fall to identify the root cause and interventions related to the root cause. Fall audits will occur at IDT meeting 5 x Week. Results of audits will be reviewed by the QA committee in May to schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	

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F 323	Continued From page 15 indicated the resident had a score on the Morse Fall Scale of 75 and did have a history of falls. Risk factors and interventions included unsteady gait, extensive assist of one with transfers, history of self-transferring unsuccessfully, orthostatic hypotension, prescribed diuretics, psychoactives, arthritis, contractures and on hospice. No additional fall and safety risk Analysis had been completed after the additional falls. A review of the incident reports for R19's falls: 10/1/15 Fell when family member was "taking her for a walk and she fell off the chair". R19 obtained a 2.5 cm x 3 cm abrasion near hairline near the forehead. The incident report indicated there was no physiological or redisposing situations factors regarding the fall. 11/19/15, R19 was found sitting on the floor near her bed. Vital signs were noted and resident was alert and oriented to person, place time and situation and documentation indicated resident had gait imbalance. There was no predisposing environmental factors or predisposing situation factors noted. A progress note dated the same time indicated resident was encouraged to use call light and request assist as needed. 11/23/15 at 10:30 a.m. R19 was found face down on her bed with her right hand twisted behind her back. The wheelchair was close beside the bed. Staff was called and they repositioned the resident on to her back to rest. The report indicated R19 was oriented to person, however no other information was on the report. 2/23/16 at 1:15 a.m., R19 was found on the floor after yelling for help. R19's back was against the	F 323		

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F 323	Continued From page 16	F 323		

bed. R19 was found to be oriented to person place and situation, No environmental factors, physiological or situational factors were noted on the incident report. However, the report did indicate it was possible R19 rolled out of bed.

2/25/16 at 1:35 p,m. indicated the resident was found by the nursing assistant sitting on the blue mat by her bed. The form indicated the resident was oriented to person and situation but was confused. There were no environmental or situational factors that contributed to the fall.

2/28/16 at 2:30 p.m. R19 was found lying diagonal on the mat on the floor with head towards the bottom of the bed. The progress note reads: "Bed was lowered to lowest position and nursing assistant was sitting with elder. Elder stated "I was trying to go sit in my chair" Elder did not use call light, When asked about it she stated she couldn't find it, Call light noted on bed", The incident report indicated R19 was oriented to person, place time and situation. It also indicated no environmental factors, or situation factors contributed to the fall. The report identified the resident as confused. A statement indicated R19 thought she could get up on her own.

There was no indication on the incident reports or in the progress note, that a thorough review was conducted of the falls with the intent to determine the contributing factors such as toileting, or hunger and the prevention of further falls.

The current care plan, last revised on 2/23/16 indicated the resident was a high risk for falls and had interventions that included anticipate and meet the residents needs, ensure call light is

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F 323	Continued From page 17 within reach and encourage the resident to use it for assistance as needed., blue mat placed on floor when in bed, and ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Staff was directed to not leave resident alone in bathroom and to check on staff every 30 minutes when in bed. On 3/2/16 at 8:30 a.m. NA-F indicated the resident was a fall risk and needed the floor mat to prevent injury. NA-F indicated she would check on R19 every hour and added that R19 did not have any negative behaviors. On 3/2/16 at 10:50 a.m., the clinical nurse manager (RN)-C indicated the falls were reviewed and the care plans were updated, but there was no documentation of a review of causal factors for any of the falls. A Fall and Safety Risk Anaylsis form had not been completed after the last three falls. On 3/3/16 at 3:00 p.m. the director of nursing verified the Incident reports did not indicate a review of contributing factors of why R19 continued to have falls. The Fall Risk Assessment Policy and Procedure, dated 9/9/2012, indicated a Fall Risk Assessment will be completed upon admission, quarterly in conjunction with the MDS schedule, upon significant change in status and after 3 falls have occurred. Point 6. indicated a post fall huddle will occur after a fall to review contributing factors and prevent recurrence of falls.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327	R62's care plan was revised on 3-1-16, to include the appropriate thickness of liquids and the amount of fluid needed per body weight.	4/12/16

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F 327	Continued From page 18 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to adequately assess fluid intake for 1 of 1 resident (R62) in the sample reviewed for hydration with a change of condition to nectar thick consistency due to aspiration. Findings include: During an observation on 3/1/16, at 10:01 a.m. R62 was being spoon fed nectar thick consistency thickened liquid by nursing assistant (NA)-A who indicated typically R62 did better at taking fluids but was breathing heavier and not as alert as usual today. R62 was observed with a dry appearing, cratered tongue. On 3/1/16, at 11:22 a.m. nurse practitioner (NP) ordered, "monitor elder and update tomorrow am shift, update if elder condition worsens." Document review on 3/2/16, at 8:00 a.m. of the vital sign section for temperature, pulse, respiration, blood pressure and oxymeter for the evening, 3/1/16, and night shift 3/2/16, was absent. There were no progress notes to indicate food or fluid intake and the shift report read "ok" for communication between the shifts. There were no documents to indicate if nectar thick fluids were offered between meals or if hydration status was assessed. When interviewed on 3/2/16, at 8:30 a.m. RN-A	F 327	Continued from page 18 All elders requiring thickened liquids have had their care plans updated to include the appropriate thickness of the liquids and the amount of fluids needed per body weight. Dietary and nursing care planners were educated on care planning the fluid thickness and amount of required fluids per body weight of elders requiring thickened fluids on 3-30-16. Audits of care plans for elders with thickened fluids will be completed on all elders with fluid thickness changes for identification of fluid thickness and amount of fluids required per body weight daily. Policy and procedure for Intake and Output was revised to include identifying on the care plan fluid thicknesses and calculating the amount of fluids needed per body weight for elders who require thickened liquids. Results of audits will be reviewed by the QA committee in May to determine schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	

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F 327	Continued From page 19 verified the prior night and evening shift did not provide information on R62's hydration status and did not obtain vital signs to report to the physician as ordered and as would be expected for a standard of care. Document review of the form titled, Plan of Care, dated 12/18/15, addressed intake decline in ability to feed self. The goal was to be free from signs and symptoms of dehydration. The interventions addressed to monitor for increased difficulty with chewing/swallowing. Offer fluids in between meals and push fluids. Resident to continue on the regular/puree/ thin liquids. According to the document titled, Physician Orders and dated 2/18/16, indicated R62 had a diet order change to nectar thick liquids and to receive speech therapy to determine oral function for swallowing. Document review of the form dated 12/18/15, titled, Nutritional Re-Assessment indicated the fluid intake for R62 according to body weight in a 24-hour period should be 1400 ml.(milliliter) Document review of the nursing assistant assignment sheet did not address nectar thickened liquids and did not address the individualized number of milliliters of fluid needs in a 24-hour time period for R62. When interviewed on 3/3/16, at 11:00 a.m., registered nurse (RN)-C and nursing assistant (NA)-A did not know how many milliliter's of fluid R62 was supposed to have in a 24 hour period and did not know where to find the information but would check and find out.	F 327		

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F 329	Continued From page 20	F 329		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess and monitor clinical indicators for the continual use of psychopharmacological medications for 2 of 5 residents (R19, R47) reviewed for unnecessary medications. Findings include:	F 329	R 19's and R 47's care plans were revised to include: elder symptoms to monitor, psychoactive medication monitoring including orthostatic BP and non-pharmacological approaches to use. Target behaviors/symptoms were identified. Daily monitoring of behaviors, symptoms and medication side effects were put into place for these elders. All elders who use psychoactive medications have had their care plan reviewed and revised to include symptoms to monitor, medication monitoring including Orthostatic BPs and non-pharmacological approaches to use. Target behaviors/symptoms were identified. Daily monitoring of behaviors, symptoms and medication side effects were put into place for these elders. All nursing staff were educated on monitoring for medication effects and side effects related to psychoactive medications, orthostatic BPs related to these medications, target behaviors and symptoms and trying non-pharmacological approaches before utilizing PRN psychoactive medication on 3-29-16, 3-30-16 and 3-31-16. The policy and procedure for Psychoactive Medications was reviewed and revised as needed.	4/12/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	03/03/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 On 3/2/16 from 7:15 a.m. to 8:03 a.m., R19 was sitting in a wheelchair at a dining room table eating breakfast. R19 could feed self. At approximately 8:15 a.,m, R19 appeared to push away from the table indicating she was done eating. Nurse assistant (NA)-F wheeled R19 back to her room and proceeded to transfer R19 to the bed. During this time, NA-F spoke to R19 told her what she was doing, and asked R19 if she wanted to watch the sports channel when comfortable in bed. During this time, R19 indicated no negative behaviors of anxiety or indicated any delusions. R19 had current physician order for lorazepam 0.5 mg every 8 hours as needed for prophylaxis related to anxiety and Olanzapine tablet 2.5 mg twice a day related to psychotic disorder with delusions and fluoxetine 20 mg every day related to major depressive disorder. The annual minimum data set (MDS) dated 12/15/15 indicated R19 was cognitively impaired and had mild depression. The MDS indicated R19 showed no symptoms of hallucinations or delusions and had not displayed physical, verbal or other behavioral symptoms. Although R19 had a diagnosis of anxiety disorder and psychotic disorder with delusions, the medical record did not identify what behaviors were specifically displayed by R19 for anxiety or psychotic disorder. The medical record lacked any monitoring of such behaviors and what interventions were attempted when behaviors were evident. The medical record lacked documentation of monthly orthostatic blood pressure monitoring,	F 329	Continued from page 21 Audits of monitoring for behaviors, effects and side effects of psychoactive medications, orthostatic BPs as needed, and non-pharmacological interventions used for PRN psychoactive medications will be done 5 x week randomly. Results of audits will be reviewed by the QA committee in May to determine schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	

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	246452	A. BUILDING _____ B. WING _____	03/03/2016

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

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F 329	Continued From page 22 The electronic monthly medication administration record (MAR) for February and March were reviewed. The February MAR indicated the as needed lorazepam .5 mg had been given the evening of 2/28 and 2/29/16. The progress note for 2/28/16 indicated the resident was trying to get out of bed, and on 2/29/16 the note indicated the resident wanted to stand up. There was no indication any non pharmalogical interventions were attempted prior to the administration of the antianxiety medication. The current care plan identified the use of an anti anxiety medication and a psychotropic medication but lacked specific behaviors R19 displayed and did not identify individualized interventions. On 3/3/16 at 11:30 a.m., the clinical nurse manager (RN)-C verified the findings and indicated the original order for the olanzapine was ordered for nausea. The original order was dated 8/28/14, and was written for nausea. However the current order, written 8/9/15 indicated psychotic disorder with delusions. RN-C indicated the practice at the facility was to document by exception. The monitoring would just be check off marks that indicated the monitoring occurred, but did not indicate what behaviors might have been displayed. On 3/4/16 at 2:30 p.m. the director of nursing verified the lack of symptom/behavior monitoring and orthostatic blood pressure monitoring and agreed the care plan needed to include individualized interventions, including non pharmacological interventions, for the use of these medications.	F 329		

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

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F 329	Continued From page 23 R47 received an antidepressant medication and did not have identification of target behaviors, accurate monitoring of depression, and lacked a care plan that included non-pharmacological interventions for depression. On 3/2/16 at 10:05 a.m., R47 was sitting in her room, A breakfast tray was in the room near the lounge chair. R47 indicated she preferred to eat in her room. A review of R47's medical record revealed a physician order for duloxetine hcl 60 milligrams every day for depression. The annual MDS dated 10/20/15 indicated R47 was cognitively intact, had no mood or depression symptoms but did have a diagnosis of depression. A review of the care plan, revised 11/30/15 indicated R47 was taking an antidepressant, but the care plan lacked any indication of what symptoms should be monitored. The care plan indicated the resident was to be allowed to verbalize feelings, but did not identify other individualized non pharmacological interventions that would provide direction to staff. The clinical nurse manager (RN)-C on 3/3/16 at 11:30 a.m. indicated she was not aware of any collective monitoring for symptoms of depression for R47 and verified the care plan did not identify individualized interventions for R47. On 3/4/16 at 2:30 p.m. the director of nursing verified the care plan lacked individualized non pharmacological interventions for R47.	F 329		

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F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	R40 was offered the influenza vaccination on 3-23-16. All elders' records were reviewed to ensure each was offered influenza vaccination. All elders each year will be offered an influenza vaccination and will be documented in the medical record. All nurses were educated on offering influenza vaccination to each elder in residence from September through March each year and documenting acceptance or refusal in the record and were educated on offering all new admissions the vaccine within the first 7 days after admission from September through March each year. This education occurred on 3-29-16, 3-30-16 and 3-31-16. Policy and Procedure for Vaccinations was reviewed revised as needed. Audit of all elders currently in residence and within 48 hours of admission for all newly admitted elders will be completed to ensure the Influenza Vaccination was offered and refusals documented with each newly admitted elder during the months of September – March. Results of audits will be reviewed by the QA committee in May to determine schedule for further audits. The DON or designee will be responsible. Date of completion: April 12, 2016	4/12/16

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F 334	Continued From page 25 already been immunized; (III) The resident or the resident's legal representative has the opportunity to refuse immunization; and (IV) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not have documentation of influenza vaccination for 1 of 5 residents (R40) reviewed for immunization. Findings include: Record review revealed an admission record showing R40 was admitted 1/15/16. This record also included documentation of Pneumovax vaccination on 12/15/06, but no documentation of	F 334		

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F 334	Continued From page 26 influenza immunization for this year could be located. When interviewed on 3/3/16, at 1:31 p.m. the director of nursing stated that there was no documentation that the resident had the influenza vaccination or refused the vaccination during this influenza season. The facility's Influenza Vaccinations-Resident policy, dated 4/12/13, read, "1. The vaccine will be offered from September of each year through the end of March the following year...5. Residents have the right to refuse the vaccination,. Vaccination refusal and reason why will be documented in the designated spot on the consent form and the progress notes,..7. The vaccine will be given IM in the deltoid and documented per policy in the MAR [medication administration record]..."	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 428	The consultant pharmacist has reviewed R19 and R47 to ensure all irregularities were reported to attending physician and the director of nursing, and to ensure these reports were acted upon. These include: monitoring for target behaviors, presence of monitoring for orthostatic BP and documentation of effectiveness of non-pharmacological interventions.	4/12/16

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F 428	Continued From page 27 facility consultant pharmacist failed to identify drug regimen irregularities including lack of monitoring of specific behaviors, lack of monitoring of orthostatic blood pressures and development of and documentation of the effectiveness of non-pharmacological interventions for 2 of 5 residents (R19, R47) reviewed for unnecessary medications. Findings include: R19 had current physician order for lorazepam 0.5 mg every 8 hours as needed for prophylaxis related to anxiety and Olanzapine tablet 2.5 mg twice a day related to psychotic disorder with delusions and fluoxetine 20 mg every day related to major depressive disorder. The annual minimum data set (MDS) dated 12/15/15 indicated R19 was cognitively impaired, and had mild depression. The MDS indicated R19 showed no symptoms of hallucinations or delusions and had did not display physical, verbal or other behavioral symptoms. Although R19 had a diagnosis of anxiety disorder and psychotic disorder with delusions, the medical record did not identify what behaviors were specifically displayed by R19 for anxiety or psychotic disorder. The medical record lacked any monitoring of such behaviors and what interventions were attempted when behaviors were evident. The medical record also lacked documentation of a monthly orthostatic blood pressure monitoring for January and February 2016. The electronic monthly medication administration record (MAR) for February and March were	F 428	Continued from page 27 The consultant pharmacy has completed a review of all other residents on psychoactive medications to ensure all irregularities were found and reported to the attending physician and director of nursing. These include: monitoring for target behaviors, presence of monitoring for orthostatic BP and documentation of effectiveness of non-pharmacological interventions. The consultant pharmacist was educated on reporting all irregularities related to psychoactive medications to the attending physicians and director of nursing on 3-29-16. A representative from the consulting pharmacy will complete an audit on 5 random records each month x 3 months after the consultant pharmacist has completed their review. The results of these audits will be reported to QA and recommendations for further audits after three months will come from this committee. The DON or designee will be responsible. Date of completion April 12, 2016.	

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F 428	Continued From page 28 reviewed. The February MAR indicated the as needed lorazepam .5 mg had been given the evening of 2/28 and 2/29/16. The progress note for 2/28/16 indicated the resident was trying to get out of bed, and on 2/29/16 the note indicated the resident wanted to stand up. The current care plan identified the use of an anti anxiety medication and a psychotropic medication but lacked specific behaviors R19 may display and did not identify individualized interventions. On 3/3/16 at 11:30 a.m. the clinical nurse manager (RN)-C verified the findings and indicated the original order for the olanzapine was ordered for nausea. The original order was dated 8/28/14, and was written for nausea. However the current order, written 8/9/15 indicated psychotic disorder with delusions. RN-C indicated the practice at the facility was to document by exception. The monitoring would just be check off marks that indicated the monitoring occurred, but did not indicate what behaviors might have been displayed. On 3/4/16 at 2:30 p.m., the director of nursing verified the lack of symptom/behavior monitoring and orthostatic blood pressure monitoring and agreed the care plan needed to include individualized interventions for the use of these medications. R47 received an antidepressant medication and did not have identification of target behaviors, accurate monitoring of depression, and individualized plan of care related to depression and non-pharmacological interventions for depression incorporated into the plan of care.	F 428		

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	245452	A. BUILDING _____ B. WING _____	03/03/2016

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

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F 428	Continued From page 29 On 3/2/16 at 10:05 a.m. R47 was sitting in her room. A breakfast tray was in the room near the lounge chair. R47 indicated she preferred to eat in her room. A review of R47's medical record revealed a physician order for duloxetine hcl 60 milligrams every day for depression. The annual MDS dated 10/20/15 indicated R47 was cognitively intact, had no mood or depression symptoms R47 's care plan identified the use of an antidepressant medication but lacked documentation of individualized non pharmacological interventions. A review of the care plan, revised 11/30/15 indicated R47 was taking an antidepressant, but the care plan lacked any indication of what symptoms should be monitored. The care plan indicated the resident was to be allowed to verbalize feelings, but did not identify other individualized non pharmacological interventions that would provide direction to staff. The clinical nurse manager (RN)-C on 3/3/16 at 11:30 a.m. indicated she was not aware of any collective monitoring for symptoms of depression for R47 and verified the care plan did not identify individualized nonpharmacological interventions for R47. On 3/4/16 at 2:30 p.m. the director of nursing verified the care plan lacked individualized non pharmacological interventions for R47. On 3/4/16 at 3:30 p.m. an attempt to contact the consulting pharmacist was made but	F 428		

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

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F 428	Continued From page 30 unsuccessful.	F 428		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	APPROVED Tom Linhoff By Tom Linhoff at 11:37 am, Apr 01, 2016 RECEIVED APR - 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Mark McKinney | Plant Operations Director | 4/1/16

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building.. 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.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a licensed capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of the 8 smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 52 of the 131 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0930 and 1400 on 3/01/2016 observations revealed that the smoke barrier on the 2nd floor leading into the TCU had penetrations from wiring above the ceiling tiles. The deficient practice was observed by the Maintenance Supervisor (DL).	K 025	A. Smoke barrier penetrations – Areas specified in the k-tag have been sealed with appropriate fire stop caulk. B. Re-trained all maintenance staff on the proper use of fire stop caulk and the need to seal any smoke barrier penetrations that they create in the course of their duties. C. Will re-enforce to any outside contractors, the requirement to seal any smoke barrier penetration that they create with fire stop caulk. D. Compliance will be monitored by Plant Operations Director.	3/31/2016
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.	K 046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 3 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could effect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 0930 to 1400 on 03/01/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (DL) revealed that the facility could not provide any documentation verifying that the battery backup emergency lights had been tested monthly or annually. This deficient practices were confirmed by the Maintenance Supervisor (DL) at the time of discovery.	K 046	A. Monthly Inspection – A 30-second functional test has been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required test and provide appropriate documentation. B. Annual Inspection – A 90 minute functional test has been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required test and provide appropriate documentation. C. Compliance with K046 will be monitored by the Plant Operations Director.	3/31/2016
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in	K 052	A. Obtain documentation from Fire Alarm Monitoring company each month, in the form of a digital alarm communicator transmitter (DACT) report to reference and confirm all incidents of the fire alarm system being activated have been received. Generally, this report will be requested after each fire drill, in order to confirm proper operation of DACT. B. Compliance with K052 will be monitored by the Plant Operations Director.	3/31/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 4 accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 131 of 131 residents. FINDINGS INCLUDE: On 03/01/2016 between 0930 and 1400, while reviewing the facility's fire alarm inspection and testing reports, the Plant Operations Director (ML) failed to produce documentation verifying that the facility's digital alarm communicator transmitter (DACT) was being tested monthly. This finding was confirmed with the Maintenance Supervisor (DL).	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and documentation review it was revealed that the facility failed to provide documentation for sensitivity testing of smoke detectors in accordance with NFPA 72 and LSC (00) Section 9.6.2.10. This deficiency could affect 131 residents. Findings Include: 1. During the documentation review and staff interview between 0930 and 1400 on 03/01/2016 it was revealed that there was no documentation for smoke detector sensitivity testing.	K 054	A. Sensitivity testing has been scheduled for April 21, 2016 B. This testing will be completed every five (5) years. C. Compliance will be monitored by the Plant Operations Director	4/21/2016

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	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2016

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K 054	Continued From page 5 The deficient practice was observed by the Maintenance Supervisor (DL).	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6 of the 2000 Life Safety code Health care faclities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7 On the facility tour between 0930 and 1400 on 03/01/2016 observations revealed that the sprinkler branch in the maintenance room was being used to hang water lines, wires, and belts for storage. The deficient practice was observed by the Maintenance Supervisor (DL) .	K 056	A. As specified in the k-tag, staff has discontinued use of the sprinkler branch as a place to hang or store items. B. Compliance will be monitored by Plant Operations Director.	3/2/2016
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/01/2016

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K 062	Continued From page 6 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff, and visitors. Findings include: On 03/01/2016 between 0930 and 1400, while reviewing the facility's fire sprinkler inspection and testing reports, the Maintenance Supervisor (DL) failed to produce documentation verifying that the facility's sprinkler system was being tested quarterly. This deficient practice was confirmed by the Maintenance Supervisor (DL) at the time of discovery.	K 062	A. Monthly Inspection – these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. B. Quarterly Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to schedule the "fire sprinkler company" to perform the required inspections and provide appropriate documentation. D. Long Term – Be aware the current age of the equipment and the appropriate requirement of both wet and dry systems. E. Staff and "Contractor" are to use the "Fire Sprinkler System Historical Log" to document each event. F. Compliance with K062 will be monitored by the Plant Operations Director.	3/31/2016
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 7 facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:30 and 1400 on 03/01/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. b. Weekly visual inspections of the generator. This deficient practice was verified by the Maintenance Supervisor (DL).	K 144	A. Weekly Inspection – these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. Staff is to use the "Generator Weekly Inspection Checklist" to document each inspection. B. Monthly Inspection – these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Testing – these duties have been added to our Preventative Maintenance software. Contractor will perform required annual maintenance and inspection. D. Compliance with K144 will be monitored by the Plant Operations Director.	3/7/2016

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	245452	A. BUILDING 02 - EPISCOPAL CHURCH HOME OF MN B. WING	03/01/2016

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	APPROVED By Tom Linhoff at 11:29 am, Apr 01, 2016 RECEIVED APR - 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark M Ladwig

TITLE: Plant Operations Director

(X6) DATE: 4/1/2016

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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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building.. 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.	K 000		

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K 000	Continued From page 2 The facility has a licensed capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could effect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 0930 to 1400 on 03/01/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (DL) revealed that the facility could not provide any documentation verifying that the battery backup emergency lights had been tested monthly or annually. This deficient practices were confirmed by the Maintenance Supervisor (DL) at the time of discovery.	K 046	A. Monthly Inspection – A 30-second functional test has been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required test and provide appropriate documentation. B. Annual Inspection – A 90-minute functional test has been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required test and provide appropriate documentation. C. Compliance with K046 will be monitored by the Plant Operations Director.	3/31/2016
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall	K 052		

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K 052	Continued From page 3 be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 131 of 131 residents. FINDINGS INCLUDE: On 03/01/2016 between 0930 and 1400, while reviewing the facility's fire alarm inspection and testing reports, the Plant Operations Director (ML) failed to produce documentation verifying that the facility's digital alarm communicator transmitter (DACT) was being tested monthly. This finding was confirmed with the Maintenance Supervisor (DL).	K 052	A. Obtain documentation from Fire Alarm Monitoring company each month, in the form of a digital alarm communicator transmitter (DACT) report to reference and confirm all incidents of the fire alarm system being activated have been received. Generally, this report will be requested after each fire drill, in order to confirm proper operation of DACT. B. Compliance with K052 will be monitored by the Plant Operations Director.	3/31/2016
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and documentation review it was revealed that the facility failed to provide documentation for sensitivity testing of smoke	K 054		

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K 054	Continued From page 4 detectors in accordance with NFPA 72 and LSC (00) Section 9.6.2.10. This deficiency could affect 131 residents. Findings Include: 1. During the documentation review and staff interview between 0930 and 1400 on 03/01/2016 it was revealed that there was no documentation for smoke detector sensitivity testing. The deficient practice was observed by the Maintenance Supervisor (DL).	K 054	A. Sensitivity testing has been scheduled for April 21, 2016 B. This testing will be completed every five (5) years. C. Compliance will be monitored by the Plant Operations Director	4/21/2016
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff, and visitors. Findings include: On 03/01/2016 between 0930 and 1400, while	K 062	A. Monthly Inspection -- these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. B. Quarterly Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to schedule the "fire sprinkler company" to perform the required inspections and provide appropriate documentation. D. Long Term – Be aware the current age of the equipment and the appropriate requirement of both wet and dry systems. E. Staff and "Contractor" are to use the "Fire Sprinkler System Historical Log" to document each event. F. Compliance with K062 will be monitored by the Plant Operations Director.	3/31/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 02 - EPISCOPAL CHURCH HOME OF MN B. WING	03/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5 reviewing the facility's fire sprinkler inspection and testing reports, the Maintenance Supervisor (DL) failed to produce documentation verifying that the facility's sprinkler system was being tested quarterly. This deficient practice was confirmed by the Maintenance Supervisor (DL) at the time of discovery.	K 062		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:30 and 1400 on 03/01/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. b. Weekly visual inspections of the generator. This deficient practice was verified by the Maintenance Supervisor (DL).	K 144	A. Weekly Inspection – these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. Staff is to use the "Generator Weekly Inspection Checklist" to document each inspection. B. Monthly Inspection – these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Testing – these duties have been added to our Preventative Maintenance software. Contractor will perform required annual maintenance and inspection. D. Compliance with K144 will be monitored by the Plant Operations Director.	3/7/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **02 - EPISCOPAL CHURCH HOME OF MN** B. WING _____	**03/01/2016**

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

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