



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

RE: CCN: 245452
Cycle Start Date: March 6, 2025

Dear Administrator:

On March 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 04/01/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2025
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME OF MINNESOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 3/3/25-3/6/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 3/3/25-3/6/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54528305C(MN00107117), H54528306C(MN00100499) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2025

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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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580			4/7/25

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure provider notification occurred when a skin altercation was identified for 1 of 1 residents (R24) reviewed for surgical incision care. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure, diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a non-adherent dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider			F 580	R24 provider and family were notified on the skin altercation. R24's Electronic Medical Records (EMR) has been updated. R24 care plan was reviewed and is current. All residents could be affected if provider and family notifications are not made aware in a timely manner. The policy titled Change in Condition revised 5/4/22 was reviewed and ensures the documentation and timely notification with providers and POA/family. Nursing staff will be reeducated on the policy titled Change in Condition revised 5/4/22 specifically to ensure the documentation and timely notification with providers and POA/family. DON/designee will audit once a week for 4 weeks, then monthly x 3 months, reviewing the documentation and timely notification with providers and POA/family per facility policy titled Change in Condition revised 5/4/22. The results of the audits will be reviewed in the facility QAPI committee for continued quality		

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F 580	Continued From page 3 notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted to be black, necrotic, and foul smelling. Nurse practitioner (NP)-A assessed and sent R24 to the hospital for further evaluation and R24 had ssurgery for toe amputation. R24's provider order dated 2/21/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. A review of R24's electronic medical record (EMR) from 2/28/25- 3/5/25, lacked indication R24's surgical incision had any changes or R24's provider or surgical team were notified. When interviewed on 3/5/25 at 2:07 p.m., registered nurse (RN)-E stated a nursing assistant (NA) notified them of the toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified on Monday 2/10/25. RN-E stated when first notified, there was a small black area on the side of the toe. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black tissue and the entire top of R24's foot was discolored and dark. When interviewed on 3/5/25 at 3:44 p.m., NP-B stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to bee seen that day and NP-B was asked to assess the toe when they had a chance. NP-B reviewed	F 580	improvement and compliance. The DON or designee will be responsible for compliance.		

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F 580	Continued From page 4 documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. Furthermore, NP-B expected staff to notify the providers when the toe was first noticed so treatment/monitoring orders would be placed or to send R24 in for further evaluation right away. NP-B stated for surgical incisions, the surgical team should be notified of any complications. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified for a resident, staff were expected to at least put a progress note in and update the provider and family. RN-D stated any changes to the surgical incision should also have been documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention. RN-D verified R24's provider and family were not notified at the time the skin was noted or when changes to the surgical incision were noted. When interviewed on 3/6/25 at 11:37 a.m., the Director of Nursing (DON) stated when a skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated, R24's provider should have been notified when the toe was first seen and when changes to the surgical incision were noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound	F 580			

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F 580	Continued From page 5 changes since that appointment until 3/6/25. A facility policy titled Change in Condition revised 5/4/22, directed staff to promptly notify the residents provider or on call provider when there was a need to alter the resident's medical treatments.			F 580			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess a new skin alteration and changes in a surgical incision for 1 of 1 residents (R24) who developed gangrenous toe that required surgical treatment. Furthermore, the facility failed ensure coordination of care for a hospice patient with a change in condition for 1 of 1 residents (R25) reviewed for hospice. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure, required			F 684	R24 had a comprehensive skin assessment completed. R25 Hospice provider and any other provider has been updated on any changes in condition, to include seizure activity R24 and R25 care plans were reviewed and are current. All residents could be affected if Hospice/providers and family notifications were not made aware in a timely manner. The policy titled Change in Condition revised 5/4/22 was reviewed and ensures the documentation and timely notification with providers and POA/family. The facility policy Skin Care January 2015 was reviewed and is current. Nursing staff will be reeducated on the policy titled Change		4/7/25

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F 684	Continued From page 6 dialysis (treatment to filter the blood), diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's care plan revised 11/15/24, indicated R2 had an unstageable right heel ulcer. Staff were directed to follow policies/procedures for prevention and treatment and prevention of wounds. Staff were also directed to monitor, document and report as needed any skin changes. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted to be black, necrotic, and foul smelling. Nurse practitioner (NP)-B assessed and sent R24 to the emergency room (ER) for further evaluation. R24's medical record lacked indication a comprehensive assessment of R24's toe had been completed or documented prior to sending to the ER for further evaluation. R24's hospital progress note dated 2/10/25 at	F 684	in Condition revised 5/4/22 and Skin care was reviewed and ensures the documentation and timely notification with providers and POA/family. The facility policy Skin Care January 2015 was reviewed and is current. DON/designee will audit once a week for 4 weeks, then monthly x 3 months, reviewing the documentation and timely notification with providers and POA/family per facility policy titled Change in Condition revised 5/4/22. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance		

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F 684	Continued From page 7 10:09 a.m., indicated R24 had ischemic (insufficient blood flow) changes to the right 5th toe and had full thickness dry gangrene (condition where decreased blood flow causes tissue death) to the 5th toe that extended over the 5th metatarsal head (top or start if the bone in the midfoot). R24 will require at least a partial foot amputation. R24's hospital progress note dated 2/13/25 at 6:17 a.m., indicated R24 had a metatarsal amputation (procedure to remove the toes and part of the mid-foot) of the right foot. The incision and flap were well healing thus far however R24 was high risk for the surgical flap to fail due to vascular disease. R24's hospital discharge order dated 2/19/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. R24's weekly skin audit dated 2/19/25, indicated R24 had a surgical incision and did not indicate any complications or concerns with the incision. R24's weekly skin audit dated 3/5/25, indicated R24 had a surgical incision on the right foot. The audit did not indicate any complications or concerns with the incision. A review of R24's electronic medical record (EMR) from 2/28/25- 3/4/25, lacked indication R24's surgical incision had any changes or complications. An observation on 3/5/25 at 12:59 p.m., registered nurse (RN)-E entered R24's room to perform wound cares. After performing hand hygiene and donning gloves and gown, RN-E	F 684			

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F 684	Continued From page 8 removed the ace bandage from R24's right foot and cut loose the kerlix wrap. Gauze on the top of the foot was then removed and the surgical incision was visualized. There was scant bloody draining on the gauze removed and sutures in place. The incision did not appear fully approximated was foul smelling. There was dark black tissue along the incision site and R24's foot had a darkening color through the top of it almost to the ankle. RN-E verified the black tissue around the surgical incision and discoloration of R24's foot. When interviewed on 3/5/25 at 2:07 p.m., registered nurse RN-E stated initially, a nursing assistant (NA) notified them of a black area of the 5th toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified the following Monday (2/10/25). RN-E stated when R24's right little toe was first observed, there was a small black area on the side of the toe. RN-E had documented a progress note and verified there was not a discription of size or measurements of the area. RN-E verified the note and stated to monitor for increased size, measurements and location would have been helpful to be able to tell how it was progressing. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black tissue and the entire top of R24's foot was discolored and dark. RN-E was not aware of when R24's surgical incision had started to worsen and verified there was no documentation or assessment of it. When interviewed on 3/5/25 at 3:44 p.m., NP-B	F 684			

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F 684	Continued From page 9 stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to be seen that day and was asked to assess the toe when I had a chance. NP-B reviewed documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. NP-B stated there was a low threshold for sending R24 to the ER for evaluation due to R24 having vascular disease and poor healing for thier heel wounds. NP-B stated for surgical incisions, typically, the surgical team would be notified of any complications or changes. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified was noted for a resident, staff were expected to at least put a progress note in and update the provider and family. An assessment should be completed for anything newly found. RN-D stated any changes to the surgical incision should also be documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and verified there was no documentation of it. RN-D had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention but had forgotten to document the communication. RN-E was not sure if R24's surgical team were notified. When interviewed on 3/6/25 at 11:37 a.m., the Director of Nursing (DON) stated when any skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated with surgical incisions or already identified wounds, staff were expected to document any signs of poor healing,	F 684			

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F 684	Continued From page 10 what it looks like, smells, suture problems, and take measurements if needed. R24's provider should have been notified when the toe was first seen and when changes to the surgical incision was noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound changes since that appointment until today. A facility policy for non-pressure wound care was requested however was not recieved. R25 Hospice Collaboration R25's quarterly Minimum Data Set (MDS) dated 1/14/25, indicated she had severely impaired cognition and was on hospice care. The MDS identified her diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), hemiplegia or hemiparesis (one-sided weakness or paralysis), a seizure disorder, and intellectual disabilities (developmental conditions affecting cognitive functioning and adaptive behavior). Additionally, the MDS reported she was taking an anticonvulsant medication. R25's care plan dated 7/15/24, identified she was on hospice related to a terminal illness and indicated staff would follow the hospice and facility coordinated plan of care. Additionally, the care plan indicated hospice nursing care would coordinate with and supplement facility-provided nursing care, and hospice, family, and providers			F 684			

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F 684	Continued From page 11 would be informed of all R25's changes on condition. A progress note dated 9/9/24, indicated "seizure activity noted this AM". A progress note dated 11/2/24, indicated the hospice nurse was updated about R25's "seizure activity" but that she had "returned to normal without medication". A progress note dated 12/16/24, indicated she had "seizure activity". A progress note dated 12/21/24, indicated R25 "had a seizure while hospice nurse was around, she handled it." A progress note dated 1/3/25, indicated a "seizure noted around 11:25 am this morning." A provider progress note dated 2/6/25, indicated staff reported no concerns during the provider's visit, and under the assessment and plan for R25's seizure disorder, the provider wrote, "chronic. Last reported seizure was in August 2024," with no new orders given. During interview on 3/5/25 at 8:42 a.m., R25's hospice case manager (HCM) verified responsibility over her case management and stated the hospice team was responsible for all her medications "except her Keppra," (an anticonvulsant medication used to treat seizures), "that's the only one we don't cover." HCM stated R25's Keppra was monitored by her primary provider. HCM recalled R25 had a seizure at least once a month and stated she would get a "loading dose of lorazepam" (a rescue medication	F 684			

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F 684	Continued From page 12 used to rapidly stop seizures) before facility staff would update HCM. HCM stated there had been no contact with the hospice providers by R25's primary providers regarding her seizures or medication changes. HCM stated during weekly hospice visits, "I check with the nurses, sometimes I will check with the nurse manager as well," and indicated they also sent weekly reports to the facility with updates to her plan of care. HCM stated, "as far as I am aware, the [primary] provider is updated on her seizure activity and her overall health status." During interview on 3/6/25 at 9:37 a.m., consultant pharmacist (CP) stated for the Keppra medication, therapeutic lab levels were "rarely drawn" because "it is so safe". CP indicated it would be provider-driven that a lab level be drawn and stated, "I would expect if a resident was seizing, I would be making sure the provider was aware, seeing what they're saying; is there a reason the provider wasn't saying anything? I would expect if a resident was having seizures, that the provider would be reviewing the medication and the dose to adjust that." CP was unaware of R25's documented seizure activity and questioned if she had seizures. During subsequent interview on 3/6/25 at 10:31 a.m., CP directed attention to a provider note dated 2/6/25, and stated because the provider wrote in their assessment and plan they were monitoring R25's chronic seizures, "that means they are looking at it and reviewing" and stated historically, providers would only do labs if there was a negative outcome. However, if there were no seizures or negative outcomes, "the lab isn't really required."			F 684			

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F 684	Continued From page 13 During interview on 3/6/25 at 10:44 a.m., registered nurse (RN)-A stated when a resident was on hospice, "we call them first." RN-A stated for R25, "most of her medications were managed by hospice except for her Keppra". RN-A explained when R25 had a seizure, they first assessed her and ensured her safety, then administered her lorazepam medication and updated her hospice team. RN-A stated there was not a liaison between the hospice team and R25's primary care provider who managed her Keppra medication. RN-A stated the floor nursing staff communicated with the nurse manager and "it would go up from there." RN-A stated the hospice team was good at communicating with the floor staff if there were concerns or changes to her plan of care and "we communicate that with our team." Per interview on 3/6/25 at 11:32 a.m., RN-B expected staff to update hospice first with any change in condition for a hospice resident and "if it is anything they are not covering, hospice would refer that back to the providers here." RN-B stated "because our providers are here so often, we do update them" but stated it may be a more informal, verbal report. RN-B reviewed R25's progress notes and confirmed the documented seizure activity on the dates 9/9/24, 11/2/24, 12/6/24, 12/21/24, and 1/3/25. RN-B reviewed the provider progress note on 2/6/25, and confirmed the provider's documentation that R25 had no seizure activity since August 2024. RN-B was unsure why the provider note did not include the documented seizure activity from the progress notes. Per interview on 3/6/25 at 1:46 p.m., the director of nursing (DON) expected hospice to collaborate			F 684			

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F 684	Continued From page 14 with the nurse manager immediately to determine a resident's plan of care once signed onto hospice. The DON stated the communication between the hospice team and primary providers should be going through the nurse managers, but stated there could be problems with that since the nurse managers are not always available. The DON expected nursing staff to communicate changes of condition with the hospice providers and if the hospice team was not managing that aspect of a resident's care, they should defer to the attending provider. The DON stated, "we would encourage our nurses to be updating the providers," and the hospice team should also remind the nurses to update the primary provider. The DON reviewed R25's progress notes and confirmed the documented seizure activity and the provider progress note dated 2/6/25. The DON stated, "this does seem tricky with the shared management." The DON stated although nurses were encouraged to update the primary providers, "sometimes they would believe if they updated hospice, the work is done." During interview on 3/6/25 at 3:03 p.m., R25's nurse practitioner (NP)-A verified responsibility for the provider note dated 2/6/25, and stated there had been no updates from the facility regarding the seizure activity documented in her progress notes. NP-A stated, "If I had been notified of the seizures, and they had been true seizures, I would have notified my MD [medical doctor]," due to being new in the field. Furthermore, NP-A expected staff to provide verbal updates when on-site, "then I could go back and review the notes. We rely heavily on those progress notes." Per interview on 3/7/25 at 7:47 a.m., with R25's medical doctor (MD)-B, there were no updates	F 684			

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F 684	Continued From page 15 received about her seizure activity. MD-B stated, "I am not typically involved in the hospice IDG communications. I don't believe we were updated" about her seizure activity. MD-B expected an update from facility staff, however, stated "I don't know that I would have changed anything" with her care. MD-B denied concerns for her safety and stated her care was being managed fine. MD-B stated, "I think we should have been updated and I think maybe this is a learning point for staff there." Per Nursing Facility Services Agreement for Routine Hospice Care dated 3/20/23, the facility should ensure that all facility services are provided competently and efficiently in a timely manner. Facility services should meet or exceed the standards of care for providers of such services and should be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements. The agreement indicated hospice and facility should communicate with one another regularly and as needed for each particular hospice patient and each party was responsible for documenting such communications in its respective clinical records to ensure the needs of hospice patients were met 24 hours per day. Furthermore, the agreement indicated the facility should designate a member of the facility's interdisciplinary team who would be responsible for working with hospice to coordinate care provided by facility staff and hospice staff. The policy directed that team member to collaborate with hospice and coordinate with facility staff participating in the care planning process; communicate with hospice and other healthcare providers participating in the provision of care for the terminal illness and other conditions to ensure	F 684			

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F 684	Continued From page 16	F 684			
F 689 SS=D	quality of care; and to ensure the facility communicates with the hospice medical director, the hospice patient's attending physician, and other practitioners participating in the provision of care to the hospice patient as needed to coordinate care provided by other physicians. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe smoking environment was provided for 2 of 2 residents (R50 and R55) reviewed for smoking. Findings include: R50's annual Minimum Data Set (MDS) dated 12/19/24, identified intact cognition, no rejection of care, and independent with eating and oral hygiene. Manual wheelchair was used independently. R50's Selfcare/Mobility Care Area Assessment (CAA) dated 12/19/24 identified a diagnosis of tobacco use. E50 has no impairment to extremities and was able to voice needs and used call light appropriately. The resident was often independent with ADLs (activities of daily	F 689			4/7/25
			R50 and R55 residents have been reassessed for safe smoking. All residents who desire to smoke off campus grounds will have an initial resident safe smoking assessment and thereafter quarterly assessments. The facility policy titled Smoking Policy was reviewed and is current. Resident Smoking Policy contract was reviewed and revised 3/21/25. Facility will ensure all smoking waste and materials will be cleaned up and disposed of in receptacles. Staff will be reeducated on The facility policy titled Smoking Policy that will include description of safe disposal of smoking materials and resident safe smoking assessments; and Resident Smoking Policy contract.		

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F 689	Continued From page 17 living) and received assist as needed. R50's care plan dated 11/20/19, identified current smoking status. The care plan identified he was able to light his own cigarette, keep his lighter at the bedside, and smoke independently with use of a smoking apron. Staff were directed to encourage him to use his smoking apron. The plan of care lacked description of safe disposal of smoking materials. R50's Smoking Safety Screen dated 12/18/24, identified he smoked in the morning, afternoon and evening, could light own cigarettes, and a smoking apron was used for adaptive equipment. Plan of care included assure resident was safe while smoking. The safety screen lacked description of safe disposal of smoking materials. During an observation on 3/3/25 at 9:41 a.m., R50 self-propelled his wheelchair toward his room with his smoking apron on. R50 stated he was a smoker, but the ashtray (smoking materials disposal receptacle) kept being "messed with" so he had to put his cigarette butts out on the ground by stomping them with his foot. He said it had occurred for a month or so, off and on. During a tour of the designated smoking area and interview on 3/03/25 at 9:48 a.m., with maintenance staff (M)-A, there was no ashtray or container to dispose of smoking materials. Approximately 20 cigarette butts of various brands and colors were laying on the ground and on the dried grass and leaves about 15 feet from the facility entrance. M-A stated it was an ongoing problem where people would mess with or steal the ashtray. M-A stated the cigarette butts should be disposed of in an approved container for fire			F 689	Admin or designee will audit x2 week x4 weeks, then monthly x 3 months, to ensure the receptacle is available off campus for disposal of smoking waste. Admin or designee will audit smokers x2 a week x4 weeks to ensure use of smoking apron and disposal of smoking waste. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. Admin or designee will be responsible for compliance.		

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F 689	Continued From page 18 safety purposes. During an observation on 3/3/25 at 10:54 a.m., R50 was in his room getting ready to go outside for a cigarette. He removed two cigarettes from a full pack and put those two into an empty pack. R50 left his room with his smoking apron still on the bed. During an observation on 3/3/25 at 10:56 a.m., R50 told nursing assistant (NA)-A he was going outside for a smoke. NA-A did not remind R50 to put on his smoking apron. During an observation and interview on 3/3/25 at 11:02 a.m., R50 reached the designated smoking area and started a cigarette. at 11:20 a.m., he extinguished the cigarette by rolling the butt between his fingers until the ash fell out on the ground. His pants had several small holes that resembled old burn holes in the groin area of his pants. R50 had not ashed on himself during this smoking observation. There continued to be no smoking material disposal receptacle available. During an interview together on 3/3/25 at 11:24 a.m., NA-C stated R50 needed a smoking apron on, he had it on earlier in the morning but she did not check if he had it on for his 11:02 a.m., cigarette. NA-A stated he needed the apron on because ash would fall off and burn his clothing, and R50 was independent with managing his smoking apron. She also agreed she did not check if he had his smoking apron on for his 11:02 a.m., cigarette. During an interview on 3/3/25 at 11:29 a.m., the assistant director of nursing (ADON) said lack of a smoking receptacle was a fire hazard and he	F 689			

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F 689	Continued From page 19 would go speak to maintenance now. During a follow up interview on 3/3/25 at 1:47 p.m., the ADON stated he talked to the administrator and was told the smoking materials disposal receptacles by the designated smoking area kept getting stolen . The ADON stated a new smoking disposal receptacle was ordered. R55 R55's quartely Minimum Data Set (MDS) dated 1/13/25, indicated intact cognition and diagnoses of type II diabetes, chronic obstructive pulmonary disease (COPD), and tobacco use. It further indicated R55 required set up assistance with most activities of daily living (ADLs) and was independent with mobility. During interview on 3/4/25 at 3:29 p.m., R55 stated he was on smoking restrictions because of dental surgery, but he didn't always follow it. He further stated he put his cigarette butts out on the sidewalk or on the side of the garbage can outside and threw them away in the trash can. He stated they (facility) just got a smoking receptacle yesterday but they hadn't had one in a while before then. During an interview on 3/6/25 at 8:05 a.m., the administrator stated maintenance was here on the weekends and should have checked to see if the smoking area was in safe condition during daily rounds. Additionally, nursing should ensure smoking aprons were in place if that was what the smoking safety screen identified. During an interview on 3/6/25 at 8:52 a.m., the	F 689			

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F 689	Continued From page 20 director of maintenance services (DMS) stated every morning staff would do a walk through and clean up the grounds. He said checking for a smoking materials disposal receptacle was also part of their process but not documented. The facility's smoking policy dated 5/28/24, identified no smoking of any kind allowed on campus grounds, all smoking at least 25 feet from entrance on city sidewalk, smoking waste and materials must be cleaned up and kept free from sight from others. The Life Safety Code, state fire code, and MN (Minnesota) clean indoor air act would be followed.	F 689			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a dialysis fistula site was maintained according to professional standards of care for 1 of 2 residents (R24) reviewed for dialysis. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure, diabetes, and vascular disease. Furthermore, R24 required dialysis (treatment to filter the blood	F 698	R24 care plan was reviewed and updated to clarify the restrictions for taking blood pressure on the arm of the fistula site for dialysis. All residents on dialysis will have their care plans reviewed and updated to ensure it clearly states the residents the arm of the fistula site to assure blood pressure is taken on the correct arm. Facility policy titled Dialysis dated 1/1/15 was reviewed. It is standard care to not		4/7/25

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F 698	Continued From page 21 when in kidney failure). R24's provider and nursing orders reviewed on 3/5/25, lacked indication of where R24's fistula was located or if R24 had restrictions for blood pressure on their left arm. R24's care plan revised 9/20/24, indicated R24 required dialysis 3 times a week. R24's care plan lacked indication R24 had restrictions for blood pressure on their left arm. An observation on 3/5/25 at 10:23 a.m., trained medication assistant (TMA)-A entered R24's room to provide medication. R24 was sitting in their wheelchair and was very sleepy. Registered nurse (RN)-E requested vital signs. TMA-A obtained a vital sign machine and re-entered R24's room. TMA-A placed a blood pressure cuff on R24's left arm above the elbow and obtained a blood pressure. When interviewed on 3/5/25 at 2:03 p.m., TMA-A verified the blood pressure was taken on the left arm and was not aware of any restrictions for taking blood pressures for R24. TMA-A was not sure if a blood pressure could be taken on the same arm as a dialysis fistula site and would need to verify with the nurse. When interviewed on 3/5/24 at 2:07 p.m., RN-E stated TMA-A should not have taken the blood pressure on R24's left arm. RN-E further stated R24 was wearing a sweatshirt and TMA-A may not have noticed it. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated blood pressures should not be taken over the fistula site or on the arm of the fistula site.			F 698	take the blood pressure reading on the same arm as the fistula site. Facility will educate nurses, TMAs, and NARs about facility policy titled Dialysis dated 1/1/15 education will also cover residents on dialysis should not have their blood pressure taken on the same side as the fistula site and instead on the opposite arm per standards of care. DON/designee will audit three residents who are on dialysis, care plans once a week x4 weeks, then monthly x 3 months, to ensure nurses have correct orders on their charts and communicate to nurses and TMAs. DON/designee will audit 3 dialysis residents x1 a week for x4 weeks, then monthly x 3 months, for proper placement of blood pressure cuff. The results of these audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.		

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F 698	Continued From page 22 RN-D further stated the order for blood pressures had not been ordered for R24 but was now placed. RN-D stated care sheets were not used on the short term stay unit as residents discharged and admitted frequently. However, the information was included on the nurse 24-hour sheet which nurse and TMA's have access to. RN-D stated there was only a verbal process for nursing assistants and a better process of communication may be needed. When interviewed on 3/6/25 at 11:43 a.m., the Director of Nursing (DON) expected staff to take blood pressures on the opposite arm of the fistula for residents with dialysis. This should be included in the orders, included on the 24-hour sheet for the nurses and TMAs, and reported to the NAs.	F 698			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757			4/7/25

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F 757	Continued From page 23 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure antifungal medications without an end date were monitored and evaluated for the appropriateness of continued use for 2 of 2 residents (R17, R27) reviewed who were prescribed antifungal medications. Findings include: R17 R17's quarterly Minimum Data Set dated 12/4/24, identified intact cognition, no rejection of care, diagnoses of type two diabetes mellitus with diabetic chronic kidney disease and candidiasis (fungal infection) of skin and nail. Skin interventions included application of ointments/medication other than to feet. R17 was dependent on staff for toileting hygiene and required substantial to maximal assistance for showering and bathing. R17's annual Care Area Assessment (CAA) dated 9/5/24, triggered for potential for pressure ulcers, however identified no current skin issues were present, staff were directed to observe for changes and update MD (medical doctor) PRN (as needed).	F 757	R17 and R27 medication reviews were completed. Any unnecessary medications have been discontinued. As necessary an end date has been added to ensure medications were monitored and evaluated for the appropriateness of continued use. R17 and R27 care plans were reviewed and are current. Current residents' orders have been reviewed by consulting pharmacist (CP) for appropriateness of continued use and requested end dates as necessary. The facility policy for Unnecessary Medications dated 8/7/12 was reviewed and is current. Facility will educate nurse managers/nurses on the facility policy titled Unnecessary Medications dated 8/7/12, including getting a stop date to ensure medications were monitored and evaluated for the appropriateness DON/designee will audit 3 random residents orders per week for 4 weeks, then monthly x 3 months, for appropriateness of continued use and		

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F 757	Continued From page 24 R17's care plan dated 9/15/23, identified a potential for alteration in skin integrity related to immobility, diabetes, morbid obesity, bowel and bladder incontinence. Nursing staff were directed to monitor skin with cares and report changes and monitor/document/report signs/symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. The care plan lacked instructions for care to fungal infections of the skin. R17's active Order Summary dated 3/6/25 identified: effective 6/24/24, clotrimazole external cream 1% (antifungal medication). Apply to affected area topically two times a day related to candidiasis of skin and nail. The order had no end date. The Clotrimazole Product Monograph Dosing Considerations dated 9/16/22, identified clinical improvement with relief of pruritus, usually occurred within the first week of treatment. The symptoms of jock itch, ringworm and diaper rash usually resolved within two to four weeks. If the signs and symptoms of the infection were not resolved after four weeks of treatment with clotrimazole topical, a physician should be consulted. If a cure is not mycologically confirmed, treatment should, as a rule, be continued for two weeks after all clinical symptoms have disappeared. Candida infections are generally treated for only two weeks. R17's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified clotrimazole cream was documented as applied twice daily over the past year to the groin area	F 757	requested end dates as necessary; Audit will check if orders for appropriateness of continued use and requested end dates as necessary. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.		

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F 757	Continued From page 25 while resident was in the facility. The original start date of the medication was identified as 12/29/23. R17 had received the medication routinely for one year and approximately two months. R17's weekly skin assessments dated 11/23/24 through 3/1/25, identified no candidiasis or skin deficits. R17's primary care provider visit notes dated 1/30/25, 1/6/25, 11/18/24, 11/4/24, 9/9/24, 8/1/24, 7/22/24, 6/10/24, 4/4/24, 3/5/24, 3/14/24 and 1/3/24, lacked a review for continued use of clotrimazole and lacked mention of any candidiasis skin concerns. During an observation on 3/3/25 at 8:55 a.m., R17 was in bed with a hospital gown on. Feet, nails, and other exposed skin shows no signs of fungal infection. During a phone call to nurse practitioner (NP)-A's office (R17's primary care provider) on 3/5/25 at 3:13 p.m., registered nurse (RN)-C, who was NP-A's primary nurse, stated antifungal medications should always have an indication for use and length of time to use. Typically, clotrimazole was prescribed twice daily for a 14-day course and then reassessed. RN-C reviewed medications on R17's chart and stated clotrimazole was not on their medication list, even though it was on the facility's medication list, apparently had not been reconciled. RN-C stated she would leave instructions for NP-A to review clotrimazole and ensure it was still appropriate as an active order. R17's telephone order (TO) to nursing dated 3/5/25, identified discontinue clotrimazole cream			F 757			

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F 757	Continued From page 26 if resident having no more rash. The medication was documented as discontinued from the active orders. During an interview on 3/6/25 at 8:30 a.m., nursing assistant (NA)-A stated R17 had no current skin conditions. R27 R27's quarterly MDS dated 2/20/25, identified severely impaired cognition, no rejection of care, and diagnoses of dementia with agitation. Skin concerns included two venous/arterial ulcers and MASD (moisture associated skin damage). Application of ointments/ medications other than to feet were used and R17 was on hospice care. Substantial/maximal assistance was provided from staff for bathing and showering and R17 was dependent on staff for lower body dressing and hygiene. R27's significant change CAA dated 11/22/24, identified actual pressure ulcers (PU) one unstageable PU, one stage 2, and one vascular ulcer. R27 was newly enrolled in hospice and had additional diagnoses of type two diabetes mellitus and PVD (peripheral vascular disease). R27 was incontinent, staff performed pericare after each incontinent episode and changed product PRN to keep skin clean and dry. Staff were directed to continue to treat and observe for changes and update MD PRN. There was no documentation of fungal infections of the skin. R27's care plan dated 5/20/24, identified a potential/actual impairment to skin integrity related to impaired mobility, bowel/bladder incontinence and chronic vascular injury to their left lower leg. R27 refused to lay in a bed. The			F 757			

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F 757	Continued From page 27 care plan indicated they refused to have a bed in their room for wound treatments and brief changes. Nursing staff were directed to monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD/NP. The care plan lacked instructions for care to fungal infections of the skin. R27's active Order Summary dated 3/6/25, identified three different orders for antifungal medication application: 1. Effective 4/19/22, apply nystatin powder twice daily to reddened areas under breast and groin. Nursing assistant may apply during cares. The order had no end date. 2. Effective 4/15/23, left to right abdominal folds, dust area between folds with nystatin powder and lightly rub in one time a day for preventing abdominal breakdown. Brush off extra. The order had no end date. 3. Effective 2/17/25, Zeasorb-AF external powder 2 % (miconazole nitrate topical). Apply to pannus folds topically two times a day for rash. The order had no end date. The undated Nystatin Topical Powder package insert identified indications for use included skin infections caused by candida albicans and other susceptible candida species. Patients were directed to apply to candidal lesions two or three times daily until healing was complete. R27's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified nystatin powder was documented as applied as ordered over the past year to the groin area while resident was in the facility. The original start date	F 757			

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F 757	Continued From page 28 of the medication was identified as 12/29/23. R17 had received the medication routinely for two years and approximately eleven months. on 2/17/25, Zeasorb-AF was added and used in conjunction with the nystatin. R17's primary care provider visit notes dated 1/31/25, 11/18/24, 9/3/24, 7/15/24, 5/29/24, and 3/4/24, lacked a review for continued use of nystatin and lacked mention of any candidiasis skin concerns. R27's wound care consults dated 1/23/25 and 12/5/24 lacked mention of ongoing use of nystatin or conditions under breasts or groin. During an interview on 3/04/25 at 4:15 p.m. NA-B stated she worked with R27 routinely. Nystatin powder was in her room and the groin was improving to a pink color only. The resident refused to allow observation of the application site. During an interview on 3/5/25 at 3:47 p.m., NP-B stated nystatin, and antifungals could be used if symptoms were active. NP-B stated there was no clinically significant risk of antimicrobial resistance due to prolonged use. However, NP-B stated they relied on the nurses to let providers know on skin conditions so they could taper down medications as needed. NP-B stated R27's care and topicals were now managed by hospice. During an interview on 3/06/25 at 10:32 a.m. hospice RN case manager (HCM) stated hospice started R17's Zeasorb on 2/17/25, because they nystatin was not effective. The HCM stated the two orders for nystatin should have been discontinued when the Zeasorb powder was	F 757			

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F 757	Continued From page 29 started, and she would have the hospice physician update the orders. R27's telephone order (TO) to nursing from the hospice physician dated 3/6/25, identified to discontinue nystatin and continue Zeasorb powder to rashes. During an interview on 3/6/25 at 8:46 a.m., licensed practical nurse (LPN)-A stated skin assessments were completed on resident's bath days. If no skin concerns were found, then none were documented. LPN-A stated she would typically notice if an antibiotic did not have an end date, and reach out to the provider, but was not the current practice for topical antifungals. During an interview on 3/06/25 at 9:28 a.m., the facility's consultant pharmacist (CP) stated topical antifungals would typically be discontinued once the skin concerns were healed and expected the facility nurses to update the primary care provider for review of ongoing use. The CP stated there was not a risk for antimicrobial resistance related to ongoing use. During an interview on 3/6/25 at 11:35 a.m., the director of nursing (DON) stated if skin conditions were resolved or not improving regarding topical antifungals, the nurses should notify providers, so the medication was not used if not necessary. The facility policy for Unnecessary Medications dated 8/7/12, identified the RN manager or designee reviews each resident's medication regimen (in addition to the Pharmacist's monthly drug regimen review) to assure there were no excessive dosages, duplicative therapy, excessive durations, inadequate monitoring for			F 757			

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F 757	Continued From page 30			F 757			
F 812 SS=E	side effects or other parameters or inadequate indications for use. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure frozen food items were stored in a manner to prevent cross contamination in 2 of 3 unit kitchenettes reviewed. Findings include: During observation on 3/5/25 at 10:49 a.m., the second-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened plastic bag of frozen, pre-cooked bacon that was not			F 812			4/7/25
					The facility has ensured frozen food items are stored in a manner to prevent cross contamination. Any frozen items not stored properly have been removed. All residents could be affected by frozen food items that were stored improperly. Nursing staff and culinary staff working in the unit kitchenettes will be educated on the facility policy titled Episcopal Homes Refrigerator and Food Storage Policy and Procedure 11/24; including proper food		

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F 812	Continued From page 31 sealed but was dated "3/3". Additionally, there was a resealable gallon-sized bag of frozen, pre-cooked sausage links that was dated "3/3". There was also a sealed plastic bag of frozen, pre-cooked pancakes that had a thick layer of white, ice crystals inside on the pancakes. Nursing assistant (NA)-J reviewed the items in the freezer and confirmed the dates and stated the unit usually went through the food items in 3 days per policy. When asked about the opened bags of bacon and sausage links, NA-J stated someone from the main kitchen came each morning and went through the freezer and removed undated and old food items. During observation on 3/5/25 at 1:32 p.m., the first-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened and unsealed bag of frozen, pre-cooked bacon. The bag was dated "3/4" but not able to be resealed in it's original packaging, leaving the bacon open to air in the freezer. Per interview on 3/5/25 at 1:43 p.m. with culinary supervisor (CS), kitchen staff were expected to remove outdated food items or items that "look bad". CS confirmed kitchen staff rounded on the unit kitchenettes in the morning and looked through the freezers and refrigerators to replenish what the units needed. CS also expected "everything in the fridge and freezer" to be covered or sealed. During follow-up tour and interview on 3/5/25 at 2:41 p.m., CS and culinary manager (CM) verified the opened food packages in the second-floor kitchenette freezer. CM confirmed kitchen staff rounded each morning on the unit kitchenettes to replenish food items and stated someone should	F 812	storage that are not in their original containers would be placed in approved, seamless, tightly sealed containers. Dietitian or designee will audit random unit's refrigerators and freezers x3 a week x4 weeks, then monthly x 3 months, on proper food storage. Results will be brought to QAPI committee meeting for review and discussion. Dietitian/designee will be responsible for compliance.		

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F 812	Continued From page 32 have removed the bacon, sausage links, and pancakes. Additionally, CM stated nursing staff utilized the kitchenettes and were also expected to remove outdated and opened items. CM stated, "the expectation would be if you're seeing something that is unlabeled or opened and you weren't sure how long it had been open or it did not have a bag, you should take it out or call the kitchen at least if you have questions." CM stated food items that were stored improperly posed the risk of cross-contamination and infection control. Per interview on 3/6/25 at 1:41 p.m., the administrator expected food to be labeled and sealed appropriately to prevent cross contamination. Per facility policy titled Episcopal Homes Refrigerator and Food Storage Policy and Procedure dated 11/24, all food products not in their original containers would be placed in approved, seamless, tightly sealed containers. Staff were directed to properly re-seal packages of frozen foods to prevent freezer burn and spoilage.			F 812			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			F 880			4/7/25

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F 880	Continued From page 33 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			F 880			

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F 880	Continued From page 34 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was performed for 2 of 3 residents (R24, R84) observed during personal cares and 1 of 1 residents observed during wound cares. Furthermore, the facility failed to ensure transmission-based precautions (TBP) were followed for 1 of 3 (R24) residents observed for TBP. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure that required dialysis, diabetes, and vascular disease. Furthermore, R24 had a pressure wound, required assistance of two staff for toileting, and was frequently incontinent of bladder.			F 880	R24□s and R84□s Electronic Medical Record (EMR) has been verified to have the correct precautions. R24 and R84 receive all cares with staff following proper infection control practices including proper hand hygiene and transmission based precautions. Facility policy titled Hand Hygiene revised10/2/24 and facility policy titled Enhanced Barrier Precautions revised 10/2/24, both policies were reviewed and are current. Nursing staff will be re-educated on facility policy titled Hand Hygiene revised10/2/24 and facility policy titled Enhanced Barrier Precautions revised 10/2/24, specifically covering hand washing and transmission based precautions. DON/Designee will complete random audits for 3 ADL□s residents on		

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F 880	Continued From page 35 R24's hospital provider note dated 2/18/25 indicated R24 had a history of Methicillin Resistant Staphylococcus aureus (MRSA); a multi-drug resistant bacteria. The note further indicated cultures from R24's right foot infection had MRSA growth. R24's care plan revised 2/20/25, indicated R2 had a right foot surgical incision and directed staff to follow facility policies/procedures for treatment. R24's care plan further indicated R24 required assistance with toileting. R24's Electronic Medical Record (EMR) lacked indication R24 required TBP or enhanced barrier precautions (EBP). An observation on 3/3/25 at 7:54 a.m., R24 was sitting up in their recliner. Outside R24's room on the door frame was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. An observation on 3/5/25 at 7:54 a.m., R24 was sitting up at the edge of their bed. Outside the room was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. At 7:56 a.m., trained medication assistant (TMA)-A entered R24's room without donning a gown or gloves and provided medications. When interviewed on 3/5/25 at 7:59 A.M., TMA-A verified the EBP sticker outside the door and the sign for Enteric Contact Precautions. TMA-A was			F 880	transmission-based precautions each week x 4 weeks, then monthly x 3 months, to ensure proper infection control practices were followed, including hand hygiene and proper use of Personal Protective Equipment (PPE). DON/Designee will audit 3 residents each week x 4 weeks, then monthly x 3 months to verify the EMR records and the resident room signage match. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.		

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F 880	Continued From page 36 not sure which precautions R24 needed and would need to talk to the nurse. TMA-A further stated a gown and gloves were needed when working with R24's wounds or ostomy. TMA-verified with the registered nurse (RN)-E R24 was on EBP. When interviewed on 3/5/35 at 8:05 a.m., RN-D stated R24 required EBP and only required gown and glove for personal cares, wound cares and hygiene. RN-E verified the sign for enteric contact precautions and further stated "I don't even know what that is". An observation on 3/5/25 at 8:10 a.m., nursing assistant (NA)-D entered R24's room to provide morning cares. NA-D performed hand hygiene, donned gown and gloves before entering. A warm basin of soapy water was placed on R24's bedside table. With several washcloths inside the basin. NA-D washed R24's legs and left foot. NA-D placed the washcloth back into the basin of soap and water. R24's brief was unfastened and was wet. NA-D tucked the brief under R24 and then grabbed a washcloth from the basin of soapy water and cleaned R24's peri area. The washcloth used to clean R24's peri area was then placed back into the same basin of soapy water. The basin of soapy water was brought over to R24's bathroom sink. The water was emptied into the sink, leaving the washcloths in the basin. Without glove exchange and hand hygiene, NA-D then refilled the basin with soapy water and took the basin with the same washcloths over and placed on R24's bedside table again. R24 was assisted with turning to the left side and NA-E took a washcloth out of the basin to wash R24's back, right arm and underarm area. The washcloth was placed back into the basin of soapy water. R24 was then assisted to turn to			F 880			

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F 880	Continued From page 37 their right. R24's brief was tucked down and a washcloth was obtained from the soapy basin of water. R24's bottom was cleaned and R24 was assisted to their back. NA-D then took the basin of soapy water and emptied into the sink, this time including the washcloths. NA-D filled the bucket with soapy water and obtained clean washcloths on R4's bathroom sink and brought to the bedside table. Without glove exchange or hand hygiene, NA-D took a washcloth out of the basin and washed R24's chest and abdomen. NA-D put the washcloth into the bathroom sink before obtaining a second one from the basin and assisting in washing R24's face. The bucket was then emptied, and all wet washcloths were then placed into the bucket. NA-D then removed gloves and threw them in the garbage. Without hand hygiene, NA-D took obtained clothing for R24 and guided the legs into the pants. NA-D then obtained a clean brief and placed it next to R24 before assisting with turning to place it on. The soiled brief was still tucked under, however was removed and placed in the garbage. NA-D assisted R24 with a shirt and sweatshirt. NA-D then removed gloves and without performing hand hygiene prepared a lift and wheelchair while waiting for help to transfer R24 to the wheelchair. When interviewed on 3/5/25 at 8:47 a.m., NA-D verified they did not perform hand hygiene after glove removal and was supposed to. NA-D further stated the soiled washcloths were placed back into the basin of water because the sink was farther away and the basin was just closer at that time. NA-D acknowledged the washcloths. NA-D verified the enteric isolation sign outside R24's room and stated R24 was "not infected" and only required EBP.			F 880			

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F 880	Continued From page 38 An observation on 3/5/25 at 1:00 p.m., RN-E was in R24's room donned in a gown and gloves preparing items for R24's dressing change to the right heel and right foot surgical incision. Once set up, RN-E washed hands and donned new gloves. RN-E removed the ace bandage and kerlix from R24's right foot. The gauze over the surgical dressing was removed and an adaptic dressing removed from the heel. RN-E obtained a clean gauze and cleaned R24's heel with wound cleaner. Then took Aquaphor ointment and applied to R24's foot avoiding surgical incision and heel. RN-E then removed their right glove and without hand hygiene, placed donned a new one. R24's heel wound was measured and Adaptec dressing applied. Without hand hygiene or glove exchange, Betadine swabs were then used over R24's surgical incision. The surgical incision was covered with gauze before wrapping R24's foot with kerlix and ace wrap. When interviewed on 3/5/25 at 2:07 p.m., RN-E verified they did not perform hand hygiene in between glove exchanges. RN-E stated that only needed to be done with certain circumstances such as picking up something from the floor. When interviewed on 3/6/25 at 10:05 a.m., RN- D stated when residents were on EBP, just the yellow sticker was outside their door on the frame. This directed staff to gown and glove for direct resident cares. If the resident was in full isolation precautions, the isolation sign would be placed outside their door and staff were expected to follow the directions on the sign. RN-D stated R24 was on contact for MRSA related to R24's surgical incision, but believed the infection was no longer active as R24 had completed the antibiotics. RN-D further stated they did not have			F 880			

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F 880	Continued From page 39 a contact isolation sign, so enteric contact isolation was similar so that one was placed. RN-D stated staff should be following the isolation signs if in place. When interviewed on 3/6/25 at 11:00 a.m., the infection preventionist/Director of Nursing (DON) expected staff to follow the TBP or contact isolation signs that were placed for the resident. IF they were unsure, they should follow up. DON further expected staff to perform hand hygiene when moving from dirty areas to clean areas and after each glove removal. R84 R84's quarterly Minimum Data Set (MDS) dated 1/17/25, indicated severely impaired cognition and diagnoses of dementia, delirium, and history of urinary tract infections (UTI). It further included R84 was dependent on staff for toileting, mobility, and was always incontinent of bowel and bladder. During observation on 3/5/25 at 1:03 p.m., NA-F and NA-G were transferring R84 from the wheelchair to bed. Once she was laying in bed, they removed the sling from underneath her in order to change her brief. NA-F removed R84's pants, put them in the dirty clothes basket, removed her brief and cleaned her peri area with a wipe while wearing gloves. Then NA-G assisted R84 to roll over and NA-F used a wipe to clean her bottom which had a small amount of bowel movement on it. Then NA-F put a new pair of pants on and proceeded to put R84's neck pillow around her neck, pull her sheet and blanket up to her chin, put a pillow under her head, and used the bed remote to adjust the bed without changing gloves. Once those tasks were complete, NA-F removed her gloves, used hand	F 880			

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F 880	Continued From page 40 sanitizer, and exited the room. During an interview on 3/5/25 at 1:20 p.m., NA-F stated nursing staff should remove their gloves and wash their hands following a brief change. NA-F verified touching R84's blankets, pillow, neck pillow, and bed controller after changing her brief without removing her gloves or washing her hands. During an interview on 3/5/25 at 1:25 p.m., NA-G stated nursing staff should change gloves after a changing a brief, and wash their hands before touching anything else. During interview on 3/6/25 at 7:50 a.m., licensed practical nurse (LPN)-B stated after completing personal cares (specifically changing a brief), nursing assistants should remove their gloves, wash their hands, and apply new gloves before touching anything else. A facility policy titled Hand Hygiene revised 10/2/24, directed staff to perform hand hygiene after touching body fluids or contaminated items whether gloves are worn and immediately before and after glove removal. A facility policy titled Enhanced Barrier Precautions revised 10/2/24, directed staff to implement EBP when residents were infected or colonized with an MDRO, when contact precautions were not otherwise indicated.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883			4/7/25

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F 883	Continued From page 41 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative			F 883			

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NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME OF MINNESOTA				STREET ADDRESS, CITY, STATE, ZIP CODE 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 883	Continued From page 42 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R59, R211) were offered and/or provided updated vaccinations for pneumococcal disease and 1 of 4 residents (R59) were offered and/or provided updated vaccinations for influenza in accordance with the Centers for Disease Control (CDC) vaccinations. Findings include: R59's significant change Minimum Data Set (MDS) dated 1/16/25, indicated R59 was admitted on 12/11/24, was currently 77 years old, had intact cognition and diagnosis of diabetes which put him at higher risk for pneumococcal diseases. It further indicated his influenza and pneumococcal vaccinations were not up to date and had not been offered. R59's immunization report undated, indicated R59 received the pneumococcal conjugate vaccine (PCV13) on 5/24/17. It further indicated R59's most recent influenza vaccination was administered on 10/26/2023.			F 883	R59 and R211 was offered the influenza and pneumococcal immunizations vaccines and educated on risks and benefits of the vaccinations. All residents have been offered the influenza and pneumococcal immunizations vaccines. The policy titled, Vaccination-Residents has been reviewed and is current, specifically for influenza and pneumococcal immunization Vaccination-Residents; updates specifically include all new admissions to both TCU and LTC will be offered the pneumococcal vaccination and then on an annual basis. Facility form, immunization consent form, includes the pneumococcal vaccine and educating the resident on risks and benefits of the vaccinations. Nursing staff re-education will be provided on the requirement to offer the pneumococcal vaccination to all residents upon admission and then on an annual basis per the policy titled,		

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F 883	Continued From page 43 The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 3/5/25, identified based on R29's age and vaccine history: Give one dose of PCV20 or PCV21 at least 1 year after PCV13. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. R59's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a signed declination or documentation of risk and benefits regarding the pneumococcal and/or influenza vaccination. R211 R211's significant change MDS dated 3/2/25, indicated R211 was admitted on 1/22/25, was currently 74 years old, had intact cognition and diagnoses of heart failure and hypertension. It further indicated his infuenza and pneumococcal vaccinations were not up to date. R211's immunization report (undated) lacked documentation of an influenza and pneumococcal vaccination. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 3/5/25, identified based on R211's age and vaccine history: Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 are used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be	F 883	Vaccination-Residents. Education will include the nurse educating the resident on the benefits of the vaccinations. DON/Designee will Audit 3 new admissions a week for 4 weeks, then monthly x 3 months, audit will verify that the influenza and pneumococcal immunizations have been offered, the nurse educating the resident on risks and benefits of the vaccinations. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance		

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F 883	Continued From page 44 considered in adults with immunocompromising condtions such as cochlear implants, or cerebrospinal fluid leaks. R211's medical record lacked documentation he had received any pneumococcal vaccinations, a signed declination, or information regarding risks and benefits regarding the pneumococcal and influenza vaccinations. During interview on 3/6/25 at 10:05 a.m. the director of nursing (DON)/infection preventionist (IP) stated when the facility recieved a new admission, the health unit coordinator (HUC) was responsible for entering the vaccines into point clinck care (computer program). Then the nurse was responsible for ensuring there wasn't any contraindications, offering the resident the vaccines, and then administering them. The DON/IP further stated the facility offered the influenza vaccination to residents from September to April each year and they had a vaccine clinic in October. After that they offered vaccinations to new admits. If a resident refused a vaccination there should be a signed declination form which included the risk and benefits, and it should be documented in the residents medical record. She also verified they didn't have a Minnesota Immunization Information Connection (MIIC) report for R211. The facility's policy on influenza and pneumococcal vaccinations were requested but not received.	F 883			
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The	F 887			4/7/25

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F 887	Continued From page 45 LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or			F 887			

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

PRINTED: 04/01/2025
FORM APPROVED
OMB NO. 0938-0391

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F 887	Continued From page 46 (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide a COVID-19 vaccination timely to 1 of 1 resident (R211) who requested to be vaccinated. Findings include: R211's significant change Minimum Data Set (MDS) dated 3/2/25, indicated R211 was admitted on 1/22/25, had intact cognition and diagnoses of heart failure and hypertension. R211's immunization report (undated) lacked documentation of a COVID-19 vaccination. R211's medical record lacked a signed consent/declination form with risks and benifits for a COVID-19 vaccination. During interview on 3/3/25 at 10:43 a.m. R211 stated he had not been vaccinated "in years." He asked someone (unknown) about getting the flu,			F 887	R211 was offered and received the consent/declination form with risks and benefits for a COVID-19 Vaccination. All residents were offered the COVID-19 vaccination, all residents could be affected if not offered and educated on the COVID 19 vaccinations. The facility policy titled, Vaccination-Residents has been reviewed and is current and covers the COVID-19 vaccinations. Nursing staff re-education will be provided to facility nurses on the requirement to offer the COVID-19 vaccination upon admission and on an annual basis to all residents per the policy titled, Vaccination-Residents. Education will include the nurse education on the consent/declination form and educating residents with risks and benefits for a COVID-19 Vaccination. DON/Designee will Audit 3 new		

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F 887	Continued From page 47 COVID, pneumonia and Tetanus vaccination in the past, but they told him he could only get them at the care center. He still hadn't received any vaccinations. During interview on 3/6/25 at 10:05 a.m., the director of nursing (DON)/infection preventionist (IP) stated when the facility recieved a new admission, the health unit coordinator (HUC) was responsible for entering the vaccines into point click care (computer program). Then the nurse was responsible for ensuring there wasn't any contraindications, offering the resident the vaccine, and then administering them. If a resident refused a vaccination there should be a signed declination form which included the risk and benefits, and it should be documented in the residents medical record. She also verified they didn't have a Minnesota Immunization Information Connection (MIIC) report for R211 and that he hadn't received the COVID-19 vaccination. The facility's policy regarding COVID-19 vaccinations was request but not received.	F 887	admissions a week for 4 weeks, then monthly x 3 months, audit will verify that the COVID-19 Vaccinations immunizations have been offered, the nurse educating the resident on the benefits of the vaccinations. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: EM3711

Dear Administrator:

The above facility was surveyed on March 3, 2025 through March 6, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/06/2025
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/3/25-3/6/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

03/21/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54528305C(MN00107117), H54528306C(MN00100499). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000			

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265			4/7/25

Minnesota Department of Health

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure provider notification occurred when a skin altercation was identified for 1 of 1 residents (R24) reviewed for surgical incision care. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure, diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a non-adherent dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted	2 265	corrected		

Minnesota Department of Health

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2 265	Continued From page 4 to be black, necrotic, and foul smelling. Nurse practitioner (NP)-A assessed and sent R24 to the hospital for further evaluation and R24 had ssurgery for toe amputation. R24's provider order dated 2/21/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. A review of R24's electronic medical record (EMR) from 2/28/25- 3/5/25, lacked indication R24's surgical incision had any changes or R24's provider or surgical team were notified. When interviewed on 3/5/25 at 2:07 p.m., registered nurse (RN)-E stated a nursing assistant (NA) notified them of the toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified on Monday 2/10/25. RN-E stated when first notified, there was a small black area on the side of the toe. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black tissue and the entire top of R24's foot was discolored and dark. When interviewed on 3/5/25 at 3:44 p.m., NP-B stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to bee seen that day and NP-B was asked to assess the toe when they had a chance. NP-B reviewed documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. Furthermore, NP-B expected staff to notify the providers when	2 265			

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2 265	Continued From page 5 the toe was first noticed so treatment/monitoring orders would be placed or to send R24 in for further evaluation right away. NP-B stated for surgical incisions, the surgical team should be notified of any complications. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified for a resident, staff were expected to at least put a progress note in and update the provider and family. RN-D stated any changes to the surgical incision should also have been documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention. RN-D verified R24's provider and family were not notified at the time the skin was noted or when changes to the surgical incision were noted. When interviewed on 3/6/25 at 11:37 a.m., the Director of Nursing (DON) stated when a skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated, R24's provider should have been notified when the toe was first seen and when changes to the surgical incision were noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound changes since that appointment until 3/6/25. A facility policy titled Change in Condition revised 5/4/22, directed staff to promptly notify the residents provider or on call provider when there was a need to alter the resident's medical	2 265			

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2 265	Continued From page 6 treatments. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures related to notification of change in resident health status and who to notify. The Director of Nursing (or designee) could conduct measurable audits on residents health records to verify change in health status is being completed and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess a new skin alteration and changes in a surgical incision for 1 of 1 residents (R24) who developed gangrenous toe that required surgical treatment. Furthermore, the facility failed ensure coordination of care for a hospice patient with a	2 875	corrected		4/7/25

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2 875	Continued From page 7 change in condition for 1 of 1 residents (R25) reviewed for hospice. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure, required dialysis (treatment to filter the blood), diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's care plan revised 11/15/24, indicated R2 had an unstageable right heel ulcer. Staff were directed to follow policies/procedures for prevention and treatment and prevention of wounds. Staff were also directed to monitor, document and report as needed any skin changes. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted to be black, necrotic, and foul smelling. Nurse	2 875			

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2 875	Continued From page 8 practitioner (NP)-B assessed and sent R24 to the emergency room (ER) for further evaluation. R24's medical record lacked indication a comprehensive assessment of R24's toe had been completed or documented prior to sending to the ER for further evaluation. R24's hospital progress note dated 2/10/25 at 10:09 a.m., indicated R24 had ischemic (insufficient blood flow) changes to the right 5th toe and had full thickness dry gangrene (condition where decreased blood flow causes tissue death) to the 5th toe that extended over the 5th metatarsal head (top or start if the bone in the midfoot). R24 will require at least a partial foot amputation. R24's hospital progress note dated 2/13/25 at 6:17 a.m., indicated R24 had a metatarsal amputation (procedure to remove the toes and part of the mid-foot) of the right foot. The incision and flap were well healing thus far however R24 was high risk for the surgical flap to fail due to vascular disease. R24's hospital discharge order dated 2/19/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. R24's weekly skin audit dated 2/19/25, indicated R24 had a surgical incision and did not indicate any complications or concerns with the incision. R24's weekly skin audit dated 3/5/25, indicated R24 had a surgical incision on the right foot. The audit did not indicate any complications or concerns with the incision. A review of R24's electronic medical record	2 875			

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2 875	Continued From page 9 (EMR) from 2/28/25- 3/4/25, lacked indication R24's surgical incision had any changes or complications. An observation on 3/5/25 at 12:59 p.m., registered nurse (RN)-E entered R24's room to perform wound cares. After performing hand hygiene and donning gloves and gown, RN-E removed the ace bandage from R24's right foot and cut loose the kerlix wrap. Gauze on the top of the foot was then removed and the surgical incision was visualized. There was scant bloody draining on the gauze removed and sutures in place. The incision did not appear fully approximated was foul smelling. There was dark black tissue along the incision site and R24's foot had a darkening color through the top of it almost to the ankle. RN-E verified the black tissue around the surgical incision and discoloration of R24's foot. When interviewed on 3/5/25 at 2:07 p.m., registered nurse RN-E stated initially, a nursing assistant (NA) notified them of a black area of the 5th toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified the following Monday (2/10/25). RN-E stated when R24's right little toe was first observed, there was a small black area on the side of the toe. RN-E had documented a progress note and verified there was not a discription of size or measurements of the area. RN-E verified the note and stated to monitor for increased size, measurements and location would have been helpful to be able to tell how it was progressing. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black	2 875			

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2 875	Continued From page 10 tissue and the entire top of R24's foot was discolored and dark. RN-E was not aware of when R24's surgical incision had started to worsen and verified there was no documentation or assessment of it. When interviewed on 3/5/25 at 3:44 p.m., NP-B stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to be seen that day and was asked to assess the toe when I had a chance. NP-B reviewed documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. NP-B stated there was a low threshold for sending R24 to the ER for evaluation due to R24 having vascular disease and poor healing for thier heel wounds. NP-B stated for surgical incisions, typically, the surgical team would be notified of any complications or changes. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified was noted for a resident, staff were expected to at least put a progress note in and update the provider and family. An assessment should be completed for anything newly found. RN-D stated any changes to the surgical incision should also be documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and verified there was no documentation of it. RN-D had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention but had forgotten to document the communication. RN-E was not sure if R24's surgical team were notified. When interviewed on 3/6/25 at 11:37 a.m., the	2 875			

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2 875	Continued From page 11 Director of Nursing (DON) stated when any skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated with surgical incisions or already identified wounds, staff were expected to document any signs of poor healing, what it looks like, smells, suture problems, and take measurements if needed. R24's provider should have been notified when the toe was first seen and when changes to the surgical incision was noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound changes since that appointment until today. A facility policy for non-pressure wound care was requested however was not recieved. R25 Hospice Collaboration R25's quarterly Minimum Data Set (MDS) dated 1/14/25, indicated she had severely impaired cognition and was on hospice care. The MDS identified her diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), hemiplegia or hemiparesis (one-sided weakness or paralysis), a seizure disorder, and intellectual disabilities (developmental conditions affecting cognitive functioning and adaptive behavior). Additionally, the MDS reported she was taking an anticonvulsant medication. R25's care plan dated 7/15/24, identified she was on hospice related to a terminal illness and indicated staff would follow the hospice and facility coordinated plan of care. Additionally, the	2 875			

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2 875	Continued From page 12 care plan indicated hospice nursing care would coordinate with and supplement facility-provided nursing care, and hospice, family, and providers would be informed of all R25's changes on condition. A progress note dated 9/9/24, indicated "seizure activity noted this AM". A progress note dated 11/2/24, indicated the hospice nurse was updated about R25's "seizure activity" but that she had "returned to normal without medication". A progress note dated 12/16/24, indicated she had "seizure activity". A progress note dated 12/21/24, indicated R25 "had a seizure while hospice nurse was around, she handled it." A progress note dated 1/3/25, indicated a "seizure noted around 11:25 am this morning." A provider progress note dated 2/6/25, indicated staff reported no concerns during the provider's visit, and under the assessment and plan for R25's seizure disorder, the provider wrote, "chronic. Last reported seizure was in August 2024," with no new orders given. During interview on 3/5/25 at 8:42 a.m., R25's hospice case manager (HCM) verified responsibility over her case management and stated the hospice team was responsible for all her medications "except her Keppra," (an anticonvulsant medication used to treat seizures), "that's the only one we don't cover." HCM stated R25's Keppra was monitored by her primary provider. HCM recalled R25 had a seizure at least	2 875			

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2 875	Continued From page 13 once a month and stated she would get a "loading dose of lorazepam" (a rescue medication used to rapidly stop seizures) before facility staff would update HCM. HCM stated there had been no contact with the hospice providers by R25's primary providers regarding her seizures or medication changes. HCM stated during weekly hospice visits, "I check with the nurses, sometimes I will check with the nurse manager as well," and indicated they also sent weekly reports to the facility with updates to her plan of care. HCM stated, "as far as I am aware, the [primary] provider is updated on her seizure activity and her overall health status." During interview on 3/6/25 at 9:37 a.m., consultant pharmacist (CP) stated for the Keppra medication, therapeutic lab levels were "rarely drawn" because "it is so safe". CP indicated it would be provider-driven that a lab level be drawn and stated, "I would expect if a resident was seizing, I would be making sure the provider was aware, seeing what they're saying; is there a reason the provider wasn't saying anything? I would expect if a resident was having seizures, that the provider would be reviewing the medication and the dose to adjust that." CP was unaware of R25's documented seizure activity and questioned if she had seizures. During subsequent interview on 3/6/25 at 10:31 a.m., CP directed attention to a provider note dated 2/6/25, and stated because the provider wrote in their assessment and plan they were monitoring R25's chronic seizures, "that means they are looking at it and reviewing" and stated historically, providers would only do labs if there was a negative outcome. However, if there were no seizures or negative outcomes, "the lab isn't really required."	2 875			

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2 875	Continued From page 14 During interview on 3/6/25 at 10:44 a.m., registered nurse (RN)-A stated when a resident was on hospice, "we call them first." RN-A stated for R25, "most of her medications were managed by hospice except for her Keppra". RN-A explained when R25 had a seizure, they first assessed her and ensured her safety, then administered her lorazepam medication and updated her hospice team. RN-A stated there was not a liaison between the hospice team and R25's primary care provider who managed her Keppra medication. RN-A stated the floor nursing staff communicated with the nurse manager and "it would go up from there." RN-A stated the hospice team was good at communicating with the floor staff if there were concerns or changes to her plan of care and "we communicate that with our team." Per interview on 3/6/25 at 11:32 a.m., RN-B expected staff to update hospice first with any change in condition for a hospice resident and "if it is anything they are not covering, hospice would refer that back to the providers here." RN-B stated "because our providers are here so often, we do update them" but stated it may be a more informal, verbal report. RN-B reviewed R25's progress notes and confirmed the documented seizure activity on the dates 9/9/24, 11/2/24, 12/6/24, 12/21/24, and 1/3/25. RN-B reviewed the provider progress note on 2/6/25, and confirmed the provider's documentation that R25 had no seizure activity since August 2024. RN-B was unsure why the provider note did not include the documented seizure activity from the progress notes. Per interview on 3/6/25 at 1:46 p.m., the director of nursing (DON) expected hospice to collaborate	2 875			

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2 875	Continued From page 15 with the nurse manager immediately to determine a resident's plan of care once signed onto hospice. The DON stated the communication between the hospice team and primary providers should be going through the nurse managers, but stated there could be problems with that since the nurse managers are not always available. The DON expected nursing staff to communicate changes of condition with the hospice providers and if the hospice team was not managing that aspect of a resident's care, they should defer to the attending provider. The DON stated, "we would encourage our nurses to be updating the providers," and the hospice team should also remind the nurses to update the primary provider. The DON reviewed R25's progress notes and confirmed the documented seizure activity and the provider progress note dated 2/6/25. The DON stated, "this does seem tricky with the shared management." The DON stated although nurses were encouraged to update the primary providers, "sometimes they would believe if they updated hospice, the work is done." During interview on 3/6/25 at 3:03 p.m., R25's nurse practitioner (NP)-A verified responsibility for the provider note dated 2/6/25, and stated there had been no updates from the facility regarding the seizure activity documented in her progress notes. NP-A stated, "If I had been notified of the seizures, and they had been true seizures, I would have notified my MD [medical doctor]," due to being new in the field. Furthermore, NP-A expected staff to provide verbal updates when on-site, "then I could go back and review the notes. We rely heavily on those progress notes." Per interview on 3/7/25 at 7:47 a.m., with R25's medical doctor (MD)-B, there were no updates received about her seizure activity. MD-B stated,	2 875			

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2 875	Continued From page 16 "I am not typically involved in the hospice IDG communications. I don't believe we were updated" about her seizure activity. MD-B expected an update from facility staff, however, stated "I don't know that I would have changed anything" with her care. MD-B denied concerns for her safety and stated her care was being managed fine. MD-B stated, "I think we should have been updated and I think maybe this is a learning point for staff there." Per Nursing Facility Services Agreement for Routine Hospice Care dated 3/20/23, the facility should ensure that all facility services are provided competently and efficiently in a timely manner. Facility services should meet or exceed the standards of care for providers of such services and should be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements. The agreement indicated hospice and facility should communicate with one another regularly and as needed for each particular hospice patient and each party was responsible for documenting such communications in its respective clinical records to ensure the needs of hospice patients were met 24 hours per day. Furthermore, the agreement indicated the facility should designate a member of the facility's interdisciplinary team who would be responsible for working with hospice to coordinate care provided by facility staff and hospice staff. The policy directed that team member to collaborate with hospice and coordinate with facility staff participating in the care planning process; communicate with hospice and other healthcare providers participating in the provision of care for the terminal illness and other conditions to ensure quality of care; and to ensure the facility communicates with the hospice medical director,	2 875			

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2 875	Continued From page 17 the hospice patient's attending physician, and other practitioners participating in the provision of care to the hospice patient as needed to coordinate care provided by other physicians. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could create policies or review and/or revise existing policies and procedures pertaining to resident health status or a change of condition, including hospice residents. The DON or designee could educate or re-educate nursing staff to those policies and procedures and conduct measurable audits to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee could bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 875			
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure frozen food	21100	corrected		4/7/25

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21100	Continued From page 18 items were stored in a manner to prevent cross contamination in 2 of 3 unit kitchenettes reviewed. Findings include: During observation on 3/5/25 at 10:49 a.m., the second-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened plastic bag of frozen, pre-cooked bacon that was not sealed but was dated "3/3". Additionally, there was a resealable gallon-sized bag of frozen, pre-cooked sausage links that was dated "3/3". There was also a sealed plastic bag of frozen, pre-cooked pancakes that had a thick layer of white, ice crystals inside on the pancakes. Nursing assistant (NA)-J reviewed the items in the freezer and confirmed the dates and stated the unit usually went through the food items in 3 days per policy. When asked about the opened bags of bacon and sausage links, NA-J stated someone from the main kitchen came each morning and went through the freezer and removed undated and old food items. During observation on 3/5/25 at 1:32 p.m., the first-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened and unsealed bag of frozen, pre-cooked bacon. The bag was dated "3/4" but not able to be resealed in it's original packaging, leaving the bacon open to air in the freezer. Per interview on 3/5/25 at 1:43 p.m. with culinary supervisor (CS), kitchen staff were expected to remove outdated food items or items that "look bad". CS confirmed kitchen staff rounded on the unit kitchenettes in the morning and looked through the freezers and refrigerators to replenish what the units needed. CS also expected	21100			

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21100	Continued From page 19 "everything in the fridge and freezer" to be covered or sealed. During follow-up tour and interview on 3/5/25 at 2:41 p.m., CS and culinary manager (CM) verified the opened food packages in the second-floor kitchenette freezer. CM confirmed kitchen staff rounded each morning on the unit kitchenettes to replenish food items and stated someone should have removed the bacon, sausage links, and pancakes. Additionally, CM stated nursing staff utilized the kitchenettes and were also expected to remove outdated and opened items. CM stated, "the expectation would be if you're seeing something that is unlabeled or opened and you weren't sure how long it had been open or it did not have a bag, you should take it out or call the kitchen at least if you have questions." CM stated food items that were stored improperly posed the risk of cross-contamination and infection control. Per interview on 3/6/25 at 1:41 p.m., the administrator expected food to be labeled and sealed appropriately to prevent cross contamination. Per facility policy titled Episcopal Homes Refrigerator and Food Storage Policy and Procedure dated 11/24, all food products not in their original containers would be placed in approved, seamless, tightly sealed containers. Staff were directed to properly re-seal packages of frozen foods to prevent freezer burn and spoilage. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded	21100			

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21100	Continued From page 20 food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure hand hygiene was performed for 2 of 3 residents (R24, R84) observed during personal cares and 1 of 1 residents observed during wound cares. Furthermore, the facility failed to ensure transmission-based precautions (TBP) were followed for 1 of 3 (R24) residents observed for TBP.	21385	corrected		4/7/25

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21385	Continued From page 21 Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated 12/19/24, indicated R24 was cognitively intact and had diagnoses of kidney failure that required dialysis, diabetes, and vascular disease. Furthermore, R24 had a pressure wound, required assistance of two staff for toileting, and was frequently incontinent of bladder. R24's hospital provider note dated 2/18/25 indicated R24 had a history of Methicillin Resistant Staphylococcus aureus (MRSA); a multi-drug resistant bacteria. The note further indicated cultures from R24's right foot infection had MRSA growth. R24's care plan revised 2/20/25, indicated R2 had a right foot surgical incision and directed staff to follow facility policies/procedures for treatment. R24's care plan further indicated R24 required assistance with toileting. R24's Electronic Medical Record (EMR) lacked indication R24 required TBP or enhanced barrier precautions (EBP). An observation on 3/3/25 at 7:54 a.m., R24 was sitting up in their recliner. Outside R24's room on the door frame was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. An observation on 3/5/25 at 7:54 a.m., R24 was sitting up at the edge of their bed. Outside the	21385			

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21385	Continued From page 22 room was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. At 7:56 a.m., trained medication assistant (TMA)-A entered R24's room without donning a gown or gloves and provided medications. When interviewed on 3/5/25 at 7:59 A.M., TMA-A verified the EBP sticker outside the door and the sign for Enteric Contact Precautions. TMA-A was not sure which precautions R24 needed and would need to talk to the nurse. TMA-A further stated a gown and gloves were needed when working with R24's wounds or ostomy. TMA-verified with the registered nurse (RN)-E R24 was on EBP. When interviewed on 3/5/35 at 8:05 a.m., RN-D stated R24 required EBP and only required gown and glove for personal cares, wound cares and hygiene. RN-E verified the sign for enteric contact precautions and further stated "I don't even know what that is". An observation on 3/5/25 at 8:10 a.m., nursing assistant (NA)-D entered R24's room to provide morning cares. NA-D performed hand hygiene, donned gown and gloves before entering. A warm basin of soapy water was placed on R24's bedside table. With several washcloths inside the basin. NA-D washed R24's legs and left foot. NA-D placed the washcloth back into the basin of soap and water. R24's brief was unfastened and was wet. NA-D tucked the brief under R24 and then grabbed a washcloth from the basin of soapy water and cleaned R24's peri area. The washcloth used to clean R24's peri area was then placed back into the same basin of soapy water. The basin of soapy water was brought over to	21385			

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21385	Continued From page 23 R24's bathroom sink. The water was emptied into the sink, leaving the washcloths in the basin. Without glove exchange and hand hygiene, NA-D then refilled the basin with soapy water and took the basin with the same washcloths over and placed on R24's bedside table again. R24 was assisted with turning to the left side and NA-E took a washcloth out of the basin to wash R24's back, right arm and underarm area. The washcloth was placed back into the basin of soapy water. R24 was then assisted to turn to their right. R24's brief was tucked down and a washcloth was obtained from the soapy basin of water. R24's bottom was cleaned and R24 was assisted to their back. NA-D then took the basin of soapy water and emptied into the sink, this time including the washcloths. NA-D filled the bucket with soapy water and obtained clean washcloths on R4's bathroom sink and brought to the bedside table. Without glove exchange or hand hygiene, NA-D took a washcloth out of the basin and washed R24's chest and abdomen. NA-D put the washcloth into the bathroom sink before obtaining a second one from the basin and assisting in washing R24's face. The bucket was then emptied, and all wet washcloths were then placed into the bucket. NA-D then removed gloves and threw them in the garbage. Without hand hygiene, NA-D took obtained clothing for R24 and guided the legs into the pants. NA-D then obtained a clean brief and placed it next to R24 before assisting with turning to place it on. The soiled brief was still tucked under, however was removed and placed in the garbage. NA-D assisted R24 with a shirt and sweatshirt. NA-D then removed gloves and without performing hand hygiene prepared a lift and wheelchair while waiting for help to transfer R24 to the wheelchair. When interviewed on 3/5/25 at 8:47 a.m., NA-D	21385			

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21385	Continued From page 24 verified they did not perform hand hygiene after glove removal and was supposed to. NA-D further stated the soiled washcloths were placed back into the basin of water because the sink was farther away and the basin was just closer at that time. NA-D acknowledged the washcloths. NA-D verified the enteric isolation sign outside R24's room and stated R24 was "not infected" and only required EBP. An observation on 3/5/25 at 1:00 p.m., RN-E was in R24's room donned in a gown and gloves preparing items for R24's dressing change to the right heel and right foot surgical incision. Once set up, RN-E washed hands and donned new gloves. RN-E removed the ace bandage and kerlix from R24's right foot. The gauze over the surgical dressing was removed and an adaptic dressing removed from the heel. RN-E obtained a clean gauze and cleaned R24's heel with wound cleaner. Then took Aquaphor ointment and applied to R24's foot avoiding surgical incision and heel. RN-E then removed their right glove and without hand hygiene, placed donned a new one. R24's heel wound was measured and Adaptec dressing applied. Without hand hygiene or glove exchange, Betadine swabs were then used over R24's surgical incision. The surgical incision was covered with gauze before wrapping R24's foot with kerlix and ace wrap. When interviewed on 3/5/25 at 2:07 p.m., RN-E verified they did not perform hand hygiene in between glove exchanges. RN-E stated that only needed to be done with certain circumstances such as picking up something from the floor. When interviewed on 3/6/25 at 10:05 a.m., RN- D stated when residents were on EBP, just the yellow sticker was outside their door on the	21385			

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21385	Continued From page 25 frame. This directed staff to gown and glove for direct resident cares. If the resident was in full isolation precautions, the isolation sign would be placed outside their door and staff were expected to follow the directions on the sign. RN-D stated R24 was on contact for MRSA related to R24's surgical incision, but believed the infection was no longer active as R24 had completed the antibiotics. RN-D further stated they did not have a contact isolation sign, so enteric contact isolation was similar so that one was placed. RN-D stated staff should be following the isolation signs if in place. When interviewed on 3/6/25 at 11:00 a.m., the infection preventionist/Director of Nursing (DON) expected staff to follow the TBP or contact isolation signs that were placed for the resident. IF they were unsure, they should follow up. DON further expected staff to perform hand hygiene when moving from dirty areas to clean areas and after each glove removal. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards and when to use EBP versus TBP and hand hygiene. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426			4/7/25

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21426	Continued From page 26 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents received a Tuberculosis (TB) test within 72 hours of admission for 1 of 1 resident (R59) reviewed for TB screening and testing. R59's significant change Minimum Data Set (MDS) dated 1/16/25, indicated R59 was admitted on 12/11/24, had intact cognition and diagnoses of coronary heart disease, heart failure, and diabetes. R59's immunization data sheet (undated) indicated R59 was admitted on 12/11/24, and had	21426	corrected		

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21426	Continued From page 27 completed the first dose of a 2-step TB skin test on 12/21/24, and the second dose on 2/7/24. During interview on 3/6/25 at 10:05 a.m., the director of nursing (DON)/infection preventionist (IP) stated the nurse managers were responsible for administering the TB skin test and it should be completed within 72 hours of admission. The DON/IP verified R59's TB skin test had not been completed within 72 hours of admission and it should have been. The facility policy regarding TB testing was requested but not received. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426			
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	21540			4/7/25

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21540	Continued From page 28 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure antifungal medications without an end date were monitored and evaluated for the appropriateness of continued use for 2 of 2 residents (R17, R27) reviewed who were prescribed antifungal medications. Findings include: R17 R17's quarterly Minimum Data Set dated 12/4/24, identified intact cognition, no rejection of care, diagnoses of type two diabetes mellitus with	21540	corrected		

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21540	Continued From page 29 diabetic chronic kidney disease and candidiasis (fungal infection) of skin and nail. Skin interventions included application of ointments/medication other than to feet. R17 was dependent on staff for toileting hygiene and required substantial to maximal assistance for showering and bathing. R17's annual Care Area Assessment (CAA) dated 9/5/24, triggered for potential for pressure ulcers, however identified no current skin issues were present, staff were directed to observe for changes and update MD (medical doctor) PRN (as needed). R17's care plan dated 9/15/23, identified a potential for alteration in skin integrity related to immobility, diabetes, morbid obesity, bowel and bladder incontinence. Nursing staff were directed to monitor skin with cares and report changes and monitor/document/report signs/symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. The care plan lacked instructions for care to fungal infections of the skin. R17's active Order Summary dated 3/6/25 identified: effective 6/24/24, clotrimazole external cream 1% (antifungal medication). Apply to affected area topically two times a day related to candidiasis of skin and nail. The order had no end date. The Clotrimazole Product Monograph Dosing Considerations dated 9/16/22, identified clinical improvement with relief of pruritus, usually occurred within the first week of treatment. The symptoms of jock itch, ringworm and diaper rash usually resolved within two to four weeks. If the signs and symptoms of the infection were not	21540			

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21540	Continued From page 30 resolved after four weeks of treatment with clotrimazole topical, a physician should be consulted. If a cure is not mycologically confirmed, treatment should, as a rule, be continued for two weeks after all clinical symptoms have disappeared. Candida infections are generally treated for only two weeks. R17's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified clotrimazole cream was documented as applied twice daily over the past year to the groin area while resident was in the facility. The original start date of the medication was identified as 12/29/23. R17 had received the medication routinely for one year and approximately two months. R17's weekly skin assessments dated 11/23/24 through 3/1/25, identified no candidiasis or skin deficits. R17's primary care provider visit notes dated 1/30/25, 1/6/25, 11/18/24, 11/4/24, 9/9/24, 8/1/24, 7/22/24, 6/10/24, 4/4/24, 3/5/24, 3/14/24 and 1/3/24, lacked a review for continued use of clotrimazole and lacked mention of any candidiasis skin concerns. During an observation on 3/3/25 at 8:55 a.m., R17 was in bed with a hospital gown on. Feet, nails, and other exposed skin shows no signs of fungal infection. During a phone call to nurse practitioner (NP)-A's office (R17's primary care provider) on 3/5/25 at 3:13 p.m., registered nurse (RN)-C, who was NP-A's primary nurse, stated antifungal medications should always have an indication for use and length of time to use. Typically,	21540			

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21540	Continued From page 31 clotrimazole was prescribed twice daily for a 14-day course and then reassessed. RN-C reviewed medications on R17's chart and stated clotrimazole was not on their medication list, even though it was on the facility's medication list, apparently had not been reconciled. RN-C stated she would leave instructions for NP-A to review clotrimazole and ensure it was still appropriate as an active order. R17's telephone order (TO) to nursing dated 3/5/25, identified discontinue clotrimazole cream if resident having no more rash. The medication was documented as discontinued from the active orders. During an interview on 3/6/25 at 8:30 a.m., nursing assistant (NA)-A stated R17 had no current skin conditions. R27 R27's quarterly MDS dated 2/20/25, identified severely impaired cognition, no rejection of care, and diagnoses of dementia with agitation. Skin concerns included two venous/arterial ulcers and MASD (moisture associated skin damage). Application of ointments/ medications other than to feet were used and R17 was on hospice care. Substantial/maximal assistance was provided from staff for bathing and showering and R17 was dependent on staff for lower body dressing and hygiene. R27's significant change CAA dated 11/22/24, identified actual pressure ulcers (PU) one unstageable PU, one stage 2, and one vascular ulcer. R27 was newly enrolled in hospice and had additional diagnoses of type two diabetes mellitus and PVD (peripheral vascular disease). R27 was incontinent, staff performed pericare after each	21540			

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21540	Continued From page 32 incontinent episode and changed product PRN to keep skin clean and dry. Staff were directed to continue to treat and observe for changes and update MD PRN. There was no documentation of fungal infections of the skin. R27's care plan dated 5/20/24, identified a potential/actual impairment to skin integrity related to impaired mobility, bowel/bladder incontinence and chronic vascular injury to their left lower leg. R27 refused to lay in a bed. The care plan indicated they refused to have a bed in their room for wound treatments and brief changes. Nursing staff were directed to monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD/NP. The care plan lacked instructions for care to fungal infections of the skin. R27's active Order Summary dated 3/6/25, identified three different orders for antifungal medication application: 1. Effective 4/19/22, apply nystatin powder twice daily to reddened areas under breast and groin. Nursing assistant may apply during cares. The order had no end date. 2. Effective 4/15/23, left to right abdominal folds, dust area between folds with nystatin powder and lightly rub in one time a day for preventing abdominal breakdown. Brush off extra. The order had no end date. 3. Effective 2/17/25, Zeasorb-AF external powder 2 % (miconazole nitrate topical). Apply to pannus folds topically two times a day for rash. The order had no end date. The undated Nystatin Topical Powder package insert identified indications for use included skin infections caused by candida albicans and other	21540			

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21540	Continued From page 33 susceptible candida species. Patients were directed to apply to candidal lesions two or three times daily until healing was complete. R27's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified nystatin powder was documented as applied as ordered over the past year to the groin area while resident was in the facility. The original start date of the medication was identified as 12/29/23. R17 had received the medication routinely for two years and approximately eleven months. on 2/17/25, Zeasorb-AF was added and used in conjunction with the nystatin. R17's primary care provider visit notes dated 1/31/25, 11/18/24, 9/3/24, 7/15/24, 5/29/24, and 3/4/24, lacked a review for continued use of nystatin and lacked mention of any candidiasis skin concerns. R27's wound care consults dated 1/23/25 and 12/5/24 lacked mention of ongoing use of nystatin or conditions under breasts or groin. During an interview on 3/04/25 at 4:15 p.m. NA-B stated she worked with R27 routinely. Nystatin powder was in her room and the groin was improving to a pink color only. The resident refused to allow observation of the application site. During an interview on 3/5/25 at 3:47 p.m., NP-B stated nystatin, and antifungals could be used if symptoms were active. NP-B stated there was no clinically significant risk of antimicrobial resistance due to prolonged use. However, NP-B stated they relied on the nurses to let providers know on skin conditions so they could taper down	21540			

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21540	Continued From page 34 medications as needed. NP-B stated R27's care and topicals were now managed by hospice. During an interview on 3/06/25 at 10:32 a.m. hospice RN case manager (HCM) stated hospice started R17's Zeasorb on 2/17/25, because they nystatin was not effective. The HCM stated the two orders for nystatin should have been discontinued when the Zeasorb powder was started, and she would have the hospice physician update the orders. R27's telephone order (TO) to nursing from the hospice physician dated 3/6/25, identified to discontinue nystatin and continue Zeasorb powder to rashes. During an interview on 3/6/25 at 8:46 a.m., licensed practical nurse (LPN)-A stated skin assessments were completed on resident's bath days. If no skin concerns were found, then none were documented. LPN-A stated she would typically notice if an antibiotic did not have an end date, and reach out to the provider, but was not the current practice for topical antifungals. During an interview on 3/06/25 at 9:28 a.m., the facility's consultant pharmacist (CP) stated topical antifungals would typically be discontinued once the skin concerns were healed and expected the facility nurses to update the primary care provider for review of ongoing use. The CP stated there was not a risk for antimicrobial resistance related to ongoing use. During an interview on 3/6/25 at 11:35 a.m., the director of nursing (DON) stated if skin conditions were resolved or not improving regarding topical antifungals, the nurses should notify providers, so the medication was not used if not necessary.	21540			

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21540	Continued From page 35 The facility policy for Unnecessary Medications dated 8/7/12, identified the RN manager or designee reviews each resident's medication regimen (in addition to the Pharmacist's monthly drug regimen review) to assure there were no excessive dosages, duplicative therapy, excessive durations, inadequate monitoring for side effects or other parameters or inadequate indications for use. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consultant pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on March 4, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Episcopal Church Home of Minnesota, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Episcopal Church 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 type II (222) construction. In 2008 an addition was constructed to the north side of the building that was determined to be type II (222) construction.	K 000			

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K 000	Continued From page 2 Because the original building and addition ' s meet the same construction type allowed for existing buildings all 3 buildings will be surveyed as one building. A complete fire sprinkler system protects the building. The facility has a fire alarm system with entire corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 131 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include:			K 293	" A new exit sign that can viewed from both hallway directions on the 2nd floor of the Sister Annette House has been installed " The Facilities Director will create a task in TELS for checking exit signs		4/7/25

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K 293	Continued From page 3 On 03/04/2025, between 10:00 AM and 12:30 PM, it was revealed by observation that there were no exit signs on the 2nd floor of the Sister Annette House space to direct persons to an exit in the event of an emergency. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 293	" Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 10:00 AM and 12:30 PM,	K 345			4/7/25

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K 345	Continued From page 4 it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for the smoke detector sensitivity report for 2024.	K 345			
K 353 SS=F	An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery. Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire	K 353			4/7/25
			" The Annual and quarterly sprinkler tests has been completed by contractor. Annual and quarterly sprinkler tests will be scheduled for future completion. A task has been created to ensure compliance.		

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K 353	Continued From page 5 Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 10:00 AM and 12:30 PM, it was revealed by observation and documentation available at the time of the survey, the following: 1. There was no documentation of the testing of the sprinkler system available. 2. There was no inspecting documentation available for the sprinkler system available for 2 of the 4 quarters for 2024. 3. There was storage within 18" of the sprinkler system in the Kitchen. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.			K 353	" Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the			K 362			4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME OF MINNESOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 362	Continued From page 6 underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that there were two penetrations at the cross corridor doors of the Sister Annette House section. This wall serves as a smoke wall for this space. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 362	" The penetration in the smoke barrier above the smoke barrier doors at the cross corridor doors of the Sister Annette House Section have been filled to complete the smoke barrier " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code,	K 511			4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME OF MINNESOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 511	Continued From page 7 electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that in the housekeeping closets on floors 1, 2 and 3, there were combustible carts being stored in front of the electric panels. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 511	" The housekeeping carts on floors 1, 2 and 3 have been relocated to another part of the building that complies with the NFPA 101 (2012 edition) Life Safety Codes, NFPA 99 codes and NFPA 70 and National Electrical Code. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Administrator or designee will be responsible for compliance.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 25, 2025

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

RE: CCN: 245452
Cycle Start Date: March 6, 2025

Dear Administrator:

On April 21, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 25, 2025

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

Re: Reinspection Results
Event ID: EM3712

Dear Administrator:

On April 21, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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