DEPARTMENT O	F HEALTH AND	HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	CAID SERVICES
						AND TRANSMITTAL		ID: HPDI
	1	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	T	Facility ID: 00486
1. MEDICARE/MEDICA (L1) <b>245452</b>	AID PROVIDER NO.		3. NAME AND AL (L3) <b>EPISCOPAL</b>	CHURCH H	IOME OF 1	MINNESOTA	<ol> <li>TYPE OF ACTION</li> <li>Initial</li> </ol>	DN: <u>7(</u> L8) 2. Recertification
2.STATE VENDOR OR 1 (L2) <b>419042400</b>	MEDICAID NO.		(L4) 1879 FERON (L5) SAINT PAU			(L6) <b>55104</b>	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE C (L9)	CHANGE OF OWNER	SHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	GORY <b>09 ESRD</b>	<u>03</u> (L7) 13 PTIP 22 CLIA	<ol> <li>8. Full Survey Afte</li> </ol>	
<ol> <li>DATE OF SURVEY</li> <li>ACCREDITATION S<sup>7</sup> 0 Unaccredited 2 AOA</li> </ol>	<b>05/04/201</b> TATUS: 1 TJC 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDI 12/31	NG DATE: (L35)
11LTC PERIOD OF CE	RTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):			X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirem	nents:
To (b):				equirements e Based On:		2. Technical Personnel		
12. Total Facility Beds	131	(L18)	-	cceptable POC		<ul> <li>3. 24 Hour RN</li> <li>4. 7-Day RN (Rural SN</li> <li>5. Life Safety Code</li> </ul>	<ul> <li>7. Medical Di</li> <li>8. Patient Roo</li> <li>9. Beds/Room</li> </ul>	m Size
13.Total Certified Beds	131	(L17)		pliance with Pro ents and/or Appl		* Code: <b>A</b> *	(L12)	
14. LTC CERTIFIED BE	D BREAKDOWN					15. FACILITY MEETS		
18 SNF	18/19 SNF 81	19 SNF 50	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AC	GENCY REMARKS (I	FAPPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNA	ATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Sue Reuss, Supe	ervisor		0	5/05/2015	(L19)	Anne Kleppe, Enforcer	ment Specialist	05/05/2015 (L20)
	PART II -	TO BE	COMPLETED I	BY HCFA RI	EGIONAI	<b>COFFICE OR SINGLE S</b>	TATE AGENCY	
19. DETERMINATION          _X_       1. Facility          2. Facility	is Eligible to Participate	;		IPLIANCE WIT ITS ACT:	H CIVIL	<ol> <li>Statement of Fina</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt	
2. Pacinity	is not Eligible	(L21)						
22. ORIGINAL DATE	23. LT	C AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATIO 04/01/1987	N B	EGINNINC	G DATE	ENDING DA	TE	VOLUNTARY         00           01-Merger, Closure         00		<u>NTARY</u> Meet Health/Safety
(L24)	(I	A1)		(L25)		02-Dissatisfaction W/ Reimburs	00141110	Meet Agreement
25. LTC EXTENSION 1	DATE: 27. Al	TERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
	A.	Suspension	n of Admissions:			04-Other Reason for Withdrawal		er Status Change
	(L27) B.	Rescind S	uspension Date:	(L44)			00-Active	
				(L45)				
28. TERMINATION DA	TE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
			03001					
	(L28	3)			(L31)			
31. RO RECEIPT OF CM	AS-1539	32	2. DETERMINATION	OF APPROVAL	LDATE			
	(L32	2)	04/17/2015		(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5452

Electronically Delivered: May 5, 2015

Ms. Andrea Krebs, Administrator Episcopal Church Home of Minnesota 1879 Feronia Avenue Saint Paul, Minnesota 55104

Dear Ms. Krebs:

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

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

Effective April 17, 2015 the above facility is certified for:

- 81 Skilled Nursing Facility/Nursing Facility Beds
- 50 Nursing Facility II Beds

Your facility's Medicare approved area consists of 81 skilled nursing facility beds.

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Ane Klagse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 5, 2015

Ms. Andrea Krebs, Administrator Episcopal Church Home of Minnesota 1879 Feronia Avenue Saint Paul, Minnesota 55104

RE: Project Number S5452024

Dear Ms. Krebs:

On March 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2015, effective April 17, 2015 and therefore remedies outlined in our letter to you dated March 25, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please contact me if you have any questions about this electronic notice.

Sincerely,

Ame Klagse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245452	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/4/2015
Name of Facility		Street Address, City, State, Zip Code	
EPISCOPAL CHURCH HOME (	OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104	

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

(Y4) Item		(Y5) E	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483	Con 04/1 3.10(k)(2)	rection npleted <b>0/2015</b>	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 04/10/2015		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 04/10/2015
ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Con	rection npleted 0/2015	ID Prefix Reg. # LSC	483.25(d)		Correction Completed 04/10/2015		ID Prefix Reg. # LSC	F0318 483.25(e)(2)		Correction Completed 04/10/2015
	F0323 483.25(h)	Con 04/1	rection npleted 0/2015	ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 04/10/2015			F0441 483.65		Correction Completed 04/10/2015
ID Prefix Reg. # LSC		Con	rection npleted	ID Prefix Reg. # LSC					Reg. #			
ID Prefix Reg. # LSC		Con	rection npleted	ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	cy Si	viewed By R/AK viewed By		Date: 05/05/20 Date:	Signature 15 Signature		-	160	)22		Date: 05/( Date:	04/2015
Followup	o Survey Comple 3/12/20				Check for any Uncorrected					Summary of the Facility?	YES	NO

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245452	( <b>Y2) Multiple Con</b> A. Building B. Wing	(Y3) Date of Revisit 4/24/2015		
Nam	e of Facility			Street Address, City, State, Zip Code	
EPISCOPAL CHURCH HOME OF MINNESOTA				1879 FERONIA AVENUE SAINT PAUL, MN 55104	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction				Correction					Correction
ID Prefix			Completed 04/10/2015	ID Prefix			Completed 04/10/2015		ID Prefix			Completed 04/17/2015
-	NFPA 101			-	NFPA 101				-	NFPA 101		
LSC	K0025			LSC	K0029				LSC	K0038		
			Correction				Correction					Correction
ID Prefix			Completed 04/10/2015	ID Prefix			Completed		ID Prefix			Completed
	NFPA 101		04/10/2010	Reg. #					<b>D</b> "			
-	K0062								LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix												
Reg. #				Reg. #					Reg. #			
									200			
			Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					Reg. #			
			Correction				Correction					Correction
			Completed				Completed					Completed
Reg. # LSC				Reg. # LSC					Reg. # LSC			
Reviewed I	Ву	Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
State Agen		PS/AK		05/05/20	-		-		12424		04/2	24/2015
Reviewed I CMS RO	Ву	Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
	to Survey Co	mplotod or										
Followup 1		2/2015			Check for an Uncorrecte					Summary of the Facility?	YES	NO
				1								

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245452	(Y2) Multiple Con A. Building B. Wing	° 02 - EPISCOPAL CHURCH HOME OF MN			
Name of Facility			Street Address, City, State, Zip Code		
EPISCOPAL CHURCH HOME OF MI	NNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 04/10/2015	ID Prefix		Correction Completed	ID Prefix		Correction Completed
-	NFPA 101		Reg. #			Reg. #		
LSC	K0062		LSC			LSC _		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Dec #		
						LSC		
		Correction			Correction			Correction
ID Drofiv		Completed	ID Brofiv		Completed	ID Drofiv		Completed
ID Prefix								
Reg. # LSC			Reg. # LSC			LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
LSC			LSC			LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #			Reg. #			Dog #		
LSC			LSC			LSC _		
Reviewed B	By Revie	ewed By	Date:	Signature of Sur	veyor:		Date	
State Agen	cy PS	/AK	05/05/2015			12424	04	4/24/2015
Reviewed E CMS RO	3y Revie	ewed By	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Complete 3/12/2015		c	heck for any Uncor Uncorrected Defic				NO

DEPARTMENT OF HEALTH AND HUM	AN SERVICES	C	ENTERS FOR MED	DICARE & MEDICAID SERVICES	
MEDI	CARE/MEDICAID CERTIFIC	ATION AND 7	FRANSMITTAL	ID: HPDI	
PART I	- TO BE COMPLETED BY T	HE STATE SU	JRVEY AGENCY	Facility ID: 00486	
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FAC			4. TYPE OF ACTION: <u>2</u> (L8)	
(L1) <b>245452</b>	(L3) EPISCOPAL CHURCH HO	DME OF MINN	ESOTA	1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID NO. (L2) <b>419042400</b>	(L4) 1879 FERONIA AVENUE		(L6) <b>55104</b>	3. Termination 4. CHOW	
	(L5) SAINT PAUL, MN		(L0) 33104	5. Validation6. Complaint7. On-Site Visit9. Other	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGO			8. Full Survey After Complaint	
(L9)	01 Hospital 05 HHA		PTIP 22 CLIA		
6. DATE OF SURVEY 03/12/2015 (L34)	02 SNF/NF/Dual 06 PRTF		CORF	FISCAL YEAR ENDING DATE: (L35)	
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray	11 ICF/IID 15 A		12/31	
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP	12 RHC 16 H	HOSPICE	12/51	
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED A	AS:		'	
From (a):	X A. In Compliance With	And	d/Or Approved Waivers Of	The Following Requirements:	
To (b):	Program Requirements		2. Technical Personnel	6. Scope of Services Limit	
10 T-4-1 E	Compliance Based On:	_	3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director	
12. Total Facility Beds <b>131</b> (L18)	1. Acceptable POC	_	5. Life Safety Code	<ul> <li>F) <u>8</u>. Patient Room Size</li> <li>9. Beds/Room</li> </ul>	
13.Total Certified Beds <b>131</b> (L17)	▲ B. Not in Compliance with Progr Requirements and/or Applie	ram		(L12)	
	Requirements and/or Applic	I	D	(E12)	
14. LTC CERTIFIED BED BREAKDOWN		15. FA	CILITY MEETS		
18 SNF 18/19 SNF 19 SNF	ICF IID	186	1 (e) (1) or 1861 (j) (1):	(L15)	
81 50					
(L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	CABLE SHOW LTC CANCELLATION D	DATE):			
17. SURVEYOR SIGNATURE	Date :	18. S	TATE SURVEY AGENCY	APPROVAL Date:	
Fatty Momodou, HFE NE II	04/03/2015	An	ne Kleppe, Enforcei	ment Specialist 04/16/201	5
		(L19)			(L20)
PART II - TO BE	COMPLETED BY HCFA RE	GIONAL OFF	FICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH	CIVIL		ncial Solvency (HCFA-2572)	
1. Facility is Eligible to Participate	RIGHTS ACT:		3. Both of the Above	Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible					
(L21)					
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEM	ENT 26. 7	TERMINATION ACTION:	(L30)	
OF PARTICIPATION BEGINNIN	IG DATE ENDING DAT	E <u>VOLU</u>	UNTARY 00	INVOLUNTARY	
04/01/1987		01-Me	erger, Closure	05-Fail to Meet Health/Safety	
(L24) (L41)	(L25)	02-Di	ssatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNA	TIVE SANCTIONS		sk of Involuntary Terminatio	n <u>OTHER</u>	
A. Suspens	on of Admissions:	04-Ot	her Reason for Withdrawal	07-Provider Status Change	
(L27) B Bessind	(L44)			00-Active	
(L27) B. Rescind	Suspension Date:				
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. R	EMARKS		
	03001				
(L28)		(L31)			

	(L28)	(L31)	
31. RO RECEIPT OF CMS-1539		32. DETERMINATION OF APPROVAL DATE	
	(L32)	(L33)	DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 25, 2015

Ms. Andrea Krebs, Administrator Episcopal Church Home of Minnesota 1879 Feronia Avenue Saint Paul, Minnesota 55104

RE: Project Number S5452024

Dear Ms. Krebs:

On March 12, 2015, a Focused Survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

## DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: <u>susanne.reuss@state.mn.us</u> Telephone: (651) 201-3793 Fax: (651) 201-3790

### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 21, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 21, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

# ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Episcopal Church Home of Minnesota March 25, 2015 Page 4

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 12, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

Episcopal Church Home of Minnesota March 25, 2015 Page 5

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: <u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Episcopal Church Home of Minnesota March 25, 2015 Page 6

Sincerely,

Ame Klagge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		<u> </u>	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245452	B. WING			03/	/12/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
EPISCO	PAL CHURCH HOME	OF MINNESOTA			1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the otance. Your signature at the bage of the CMS-2567 form will tion of compliance.					
F 280	revisit of your facilit that substantial con has been attained i verification. 483.20(d)(3), 483.1	acceptable POC an on-site y will be conducted to validate npliance with the regulations n accordance with your 0(k)(2) RIGHT TO	F 2	280			4/10/15
SS=D	The resident has th incompetent or othe incapacitated under	r the laws of the State, to ing care and treatment or					
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					
		NT is not met as evidenced					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 03/31/2015

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.

PRINTED: 04/16/2015

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED
		245452	B. WING _			12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 1	F 28	30		
	review the facility fit to identify the reco- healing and prever related dermatitis fit reviewed for non-p Findings include: On 03/11/2015 at 1 nurse, (RN)-D was care on R25, revea R25's buttocks, on the bottom right. On 3/12/15 at 10:3 changed the type of buttocks from a sta- zinc based ointment denuded areas on RN-D reported sta- zinc based ointment incontinence cares bottom since 2/24/ On 3/12/15 at 10:4 (NA)-D and floor no creams and ointment bottom. NA-D poin protectant, not zince showed surveyor po ointments which in corticosteroid, and creams and ointment medication supply recommended by to NA-D reported sheet	6 a.m. R25's nursing assistant, urse, (LPN)-C identified which ents were used on R25's ted out a standard skin based product and LPN-D prescription creams and		It is the policy of ECH that care remain current and up to date t the care and services provided residents. Plan of correction for residents this survey: (R25) had their plan of care up reflect the care and services pr attain or maintain the highest le practicable function. Plan to address/prevent this de other residents: All residents with non-pressure skin conditions had a care plan with updates as warranted to e compliance. Measures put in place to preve recurrence: The policy and procedure for re care plan has been reviewed a current. The staff have been in on the policy and procedure. Plan to monitor: A random 10% audit of residen plans with known skin condition conducted the next 3 months to compliance. The results of the be reported on at the QA meeti audits continuing as warranted Responsible for maintaining co RN Managers, DON and Certif Nurse	o reflect to our cited with dated to ovided to evel of ficiency for related review nsure nt evising the nd remains serviced t care ns will be o ensure audit will ng with mpliance:	

If continuation sheet Page 2 of 34

		AND HUMAN SERVICES				FORM	: 04/16/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245452	B. WING			03/	/12/2015
	PROVIDER OR SUPPLIER PAL CHURCH HOME	OF MINNESOTA		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	standard skin prote ointment. On 3/12/15 at 10:5 (RN)-B reviewed R the care plan was r denuded areas on explained the floor which cream to app from the wound car reported she becar areas on 3/9/15. RI was not able to find RN-D recommende buttocks. RN-B cor would not be exped a zinc based cream licensed nurse. R25's care area as noted "Elder was a ulcer on coccyx." (S thickness tissue los visible but bone, te exposed. Slough m obscure the depth undermining and tu assessment did no of skin on buttocks R25's skin and wou revealed no problet the denuded areas 3/12/15. Review of undated, provided zinc based ointmer Review of the Skin	Actant, not a zinc based 1 a.m. the nurse manager, 25's care plan and confirmed not updated to include the R25's buttocks. RN-B nursing staff would know oly based on recommendations re specialist, RN-D. RN-B me aware of the denuded N-B searched R25's room and d the zinc based ointment ed to be applied to R25's infirmed the nursing assistants oted to know when to switch to n, without guidance from a sessment, dated 2/16/15, dmitted with stage III pressure Stage 3 pressure ulcer - Full ss. Subcutaneous fat may be ndon, or muscle is not hay be present but does not of tissue loss. May include inneling.) The care area t note R25 had denuded areas , at that point of time. und care plan, dated 2/18/15, m or intervention focused on on R25's buttocks until the nursing assistant guide, no direction to staff regarding	F 2	280			

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	<b>IPLETED</b>
		245452	B. WING		03	/12/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 280	2/24/15 "Present o moisture associate denuded skin on rig zinc-barrier cream the skin site on the as healed. On 3/9/ moisture associate lower buttocks and buttocks. The prog [sic] been having d low grade temp [te Will continue incom barrier cream appli "Elder's diarrhea ha skin noted." for bot on R25's buttocks. R25's orders inclue nurse practitioner o ointment (a zinc ba daily to R25's buttocks. R25's buttocks. R25's orders inclue nurse practitioner o ointment (a zinc ba daily to R25's buttocks. The Wound Care M and Treatment Pro directed staff "Red or change schedule (i.e. Thera Calzinc; prn." The form was and concern. The S manual, updated 4. "Remember: stand hours. Standing or short term or a a si better than nothing [medical doctor] m as possible] and de are appropriate for	n the right lower buttocks is d skin dmg [damage]." "Noted ght lower buttocks. Will use BID [twice daily]." On 3/4/15, right lower buttocks was noted 15, RN-D noted R25 again had d skin damage on her right a new area on her left lower ress notes indicated "Elder ahs iarrhea since yesterday. Has mperature] this am [morning]. tinence care. Zinc based ed." On 3/11/15, RN-D noted ave improved. Less denuded h the right and left lower area	F 2	80		

Facility ID: 00486

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION (X3) DA	D. 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G CO	MPLETED
		245452	B. WING	03	8/12/2015
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE	
EPISCOF	PAL CHURCH HOME	OF MINNESOTA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 280	Continued From pa	age 4	F 28		
	procedure further of found after admiss (paper one kept in interventions per o	directed staff regarding wounds ion "Update working care plan binder) with all treatments & rders." and "RN [registered kin Impairment" care plan			
F 282 SS=D		RVICES BY QUALIFIED ARE PLAN	F 28	2	4/10/15
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of			
	This REQUIREME	NT is not met as evidenced			
	Based on observative review, the facility was followed for 1 for falls and for 1 controls for 1 controls and	tion, interview and document failed to ensure the care plan of 3 residents (R155) reviewed f 3 residents (R19) who n oral care and application of a		It is the policy of ECH that care plans remain current and up to date to and are followed to reflect the care and services provided to our residents. Plan of correction for residents cited with this survey: (R155) had their care plan reviewed for falls; (R19) had their care plan reviewed	
	R155's care plan dated 4/28/14, identified a risk for falls, with a goal of being free from falls. The care plan directed staff of the following interventions: ensure call light is within reach, fall risk per protocol, evaluate the risks vs. benefits and side effects of psychotropic medications, verbal reminders to not transfer or ambulate without assistance, assess for environmental			<ul> <li>for hand splint application and oral cares per speech recommendations. Updates and revisions were made if deemed necessary to reflect the care and services provided.</li> <li>Plan to address/prevent this deficiency fo other residents:</li> <li>An audit of the care plans for all residents that have had a fall in the last 3 months,</li> </ul>	r
	balance and ambu falling to resident/f	r unmet needs, assess gait, lation, staff to explain risk of amily, and nursing to respond istance as soon as possible.		for those with splints, braces or like adaptive equipment and for residents with speech recommended oral cares has been done with revisions made as	ו

Facility ID: 00486

If continuation sheet Page 5 of 34

	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	OMB NO. (X3) DATE	0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· /	PLETED
		245452	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE
F 282		-	F 28	2		
	Falls indicated the f added: educate res within reach (10/5/1 (2/10/15), and low f On 3/11/15, at 2:04 laying in bed sleepi reach and the bed a On 3/12/15, at 8:33 and stated she has she falls, but thoug times. On 3/12/15 at 9:47 was interviewed, ar with assistance of c asked what was be falling, NA-C replied close to the bed be bed and keeps her stated they keep th remind her to call fo On 3/12/15, at 9:59 was interviewed an the night, and has f stated R155 has a might get up at night tubing. RN-B furthe prevent falls for R1 within reach, and e also stated the falls department head m any new interventio	p.m. R155 was observed ng, with the call light within at a regular height. a.m. R155 was interviewed, fallen, she wasn't sure why ht she just lost her balance at a.m. nursing assistant (NA)-C nd stated R155 transferred one staff and a walker. When ing done to prevent R155 from d they keep the bedside table cause R115 likes to read in books on the table. NA-C also e call light close to R115, and		warranted to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for the comprehensive care plan has be reviewed and revised. The staff f been in-serviced on the revised p procedure. Plan to monitor: A random audit of resident care p falls, splints, braces or like adapt equipment and oral cares will be conducted and compared to obse of care delivered on the househo the next 3 months to ensure care compliance. The results of the au be reported on at the QA meeting audits continuing as warranted. Responsible for maintaining com RN Managers, DON and ADON	en bave policy and plans for ive ervations lds over plan udit will g with	

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		AND HUMAN SERVICES				FORM	04/16/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245452	B. WING _			03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA		-	379 FERONIA AVENUE AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa Interventions to Add	dress Falls form).	F 28	82			
	(DON) was intervie expect staff to asse	p.m. the director of nursing wed, and verified she would ess for reasons for fall, and to tions into the care plan.					
	need total assist for hygiene because of arthritis." Intervention assist in the morning and personal hygien	tted 3/27/14 directed staff "I r grooming and personal f hand contractures and ons included: "I receive total ng and evening with grooming ne needs" and "I am at risk for y function d/t [due to] hx oneumonia."					
		House nursing assistant care ected staff "Brush teeth after e aspiration."					
	R19's nursing assis oral cares, including brought her to brea 7:41 a.m. to 8:47 a. dining room eating 9:00 a.m. R19 sat r waiting to go to an a left for an appointm	a.m., during observations, stant, NA-E assisted R19 with g brushing her teeth and then kfast in the dining room. From .m. R19 was observed in the breakfast. From 8:47 a.m. to hear the door to the household appointment. At 9:00 a.m. R19 hent. R19 was not approached fast with an offer to perform					
	NA-E and NA-D con R19 with oral cares	n 3/11/15 at 1:08 p.m. the working with R19 for the day, nfirmed they did not assist after breakfast. NA-E assisted R19 with oral cares					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 04/16/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245452	B. WING			03/	12/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA			879 FERONIA AVENUE AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	On 3/11/15 at 2:25 RN-B and the hous confirmed the nursi assist R19 with ora On 3/11/15 at 2:51 offered to assist he breakfast or lunch. On 3/12/15 at 9:35 pathologist (SLP) e coughing and requi make sure food res R19's care plan, da staff "I have contrace stiffness r/t [related Interventions includ hand splint daily." On 3/11/15 at 7:41 R19's hand splint w for breakfast. From was observed in the and was not wearin 8:47 a.m. to 9:00 a. the household waiti 9:00 a.m. R19 left fi not approached by offer to apply her so During interview, or nursing assistants of NA-E and NA-D rep soft hand splint toda	<ul> <li>p.m. the nurse manager, sehold coordinator (HC)-A ing assistants should offer to a cares after breakfast.</li> <li>p.m. R19 reported no one or with oral cares after</li> <li>a.m. the speech language explained R19 had issues with ired oral cares after meals to sidue was out of her mouth.</li> <li>ated 3/27/14, further directed cture of my hands and to] Arthritis and Parkinson's".</li> <li>ded "Staff will apply my soft</li> <li>a.m., during observations, vas not applied prior to leaving in 7:41 a.m. to 8:47 a.m. R19 e dining room eating breakfast ng a soft hand splint. From .m. R19 sat near the door to ing to go to an appointment. At for an appointment. R19 was staff after breakfast with an oft hand splint.</li> <li>n 3/11/15 at 1:08 p.m. the working with R19 for the day, ported they did not apply the ay because it was only applied ly added R19 refused to wear</li> </ul>	F 2	82			

If continuation sheet Page 8 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245452	B. WING		03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/2010
EPISCOF	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	in her room in her r soft hand splint. Wh apply the soft hand something she had one offered to apply On 3/11/15 at 2:25 RN-B and the hous confirmed the nursi assist R19 with the assistants should ir refused. RN-B, HC- confirmed no one ir refusing to wear he	p.m. R19 was observed sitting ecliner. She was not wearing a nen asked if staff offered to splint, R19 reported it was to request to be done and no y it today. p.m. the nurse manager, ehold coordinator (HC)-A ng assistants should offer to soft hand splint daily. Nursing nform a nurse or HC-A if R19 -A and the floor nurse, LPN-D nformed them today about R19 r soft hand splint.	F 28	2		
F 309 SS=D	offered to put on he 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	p.m. R19 reported no one had er soft hand splint today. CARE/SERVICES FOR EING ary care and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment	F 30	9		4/10/15
	by: Based on interview facility failed to esta interventions for 1 c for dialysis. In addit care and services v	NT is not met as evidenced y and document review, the ablish emergency medical of 1 residents (R74) reviewed ion, the facility did not ensure vere provided for 1 of 1 in a non-pressure related skin		It is the policy of ECH to provide a residents with the care and servic attain or maintain the highest prace physical, mental and psychosocia well-being, in accordance with the comprehensive assessment and p	es to ticable I	

Facility ID: 00486

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		AND HUMAN SERVICES				FORM /	04/16/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED
		245452	B. WING	ì		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA			879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 9	F	309			
	issues.				care	ما المراجع ال	
	Findings include:				Plan of correction for residents cited this survey:	a witti	
	-				Resident (R74) has had emergency		
	R74's care plan dated 5/28/13, directed sta check dialysis site, fistula, bruit, for bleeding				dialysis interventions added to his pl care. Resident (R25) had their plan		
	signs and symptom	is of infection per facility			care updated to reflect the care and		
		plan lacked emergency			services provided for non-pressure skin issues.	related	
			Plan to address/prevent this deficier	ncy for			
	dialysis services.				other residents:		
	B74's Face Sheet i	dentified diagnoses that			All residents receiving dialysis were identified and have had emergency		
	included chronic kid	dney disease. The quarterly			dialysis interventions added to their		
	Minimum Data Set indicated R74 had i	(MDS) dated 12/9/14,			of care. All residents with non-press related skin conditions have had a c		
		quired extensive assistance of			plan review with revisions made as	ale	
	one staff for bed m	obility, transfer, dressing,			needed.		
		nd toileting. The Physician's 3/11/15, directed outpatient			Measures put in place to prevent recurrence:		
		hursday and Saturday.			A policy and procedure for emergen	су	
		······································			dialysis interventions has been crea	ted.	
		ews were held with licensed N)-A at 10:33 a.m. , with			The staff have been in-serviced on t new policy and procedure. The polic		
	registered nurse (R	N)-C at 11:49, and with the			Comprehensive Care Plan has beer	n	
		(DON) at 2:45 p.m., who all			reviewed and remains current. Staff	have	
		an did not address emergency rd to lack of access to the			been re-educated on following the established plan of care to ensure c	are	
	regular dialysis cen				and services are provided.		
	The facility was upo	able to provide a policy and			Plan to monitor: All residents on dialysis will have a c	are	
		gency medical interventions			plan audit done monthly to ensure th		
		ing outpatient dialysis			emergency dialysis interventions are	ə in	
	treatments.				place. A random 10 % audit of resid care plans with known skin condition		
		0:32 a.m. the wound care			be conducted the next 3 months to e	ensure	
		pleted wound care on R25,			compliance. The result of the audits		
		ded areas on R25's buttocks, left and one on the bottom			be reported on at the QA meeting w audits continuing as warranted	แท	
					and the second and a second and the		

Facility ID: 00486

If continuation sheet Page 10 of 34

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY PLETED
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	IPLETED
		245452	B. WING _			12/2015
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
PISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 309	Continued From page 10		F 30	09		
	right.			Responsible for maintain RN Mangers, DON, ADO		
	On 3/12/15 at 10:30 a.m. RN-D explained she changed the type of cream to be used on R25's buttocks from a standard barrier ointment to a zinc based ointment on 2/24/15 due to the denuded area on her right lower buttocks. RN-D reported staff should have been applying a zinc based ointment on R25's buttocks as part of incontinence cares due to the denuded areas on her bottom since 2/24/15.					
On 3/ (NA)-I cream bottor protect survey which vitami ointme were 2 care r with th and th	(NA)-D and floor nu creams and ointme bottom. NA-D show protectant, not zinc surveyor prescriptic which included: ant vitamin creams. No ointments in R25's were zinc based, as care nurse, RN-D. I with the R25 on 3/8	6 a.m. R25's nursing assistant, irse, (LPN)-C identified which nts they used on R25's red surveyor a standard skin based and LPN-D showed on creams and ointments ifungal, corticosteroid, and ne of the creams and room or medication supply s recommended by the wound NA-D reported she worked /15, 3/9/15 and on 3/12/15 d was a standard skin ne based ointment.				
	(RN)-B reviewed R2 the care plan was n denuded areas on I explained the floor which cream to app from the wound car reported she becan areas on 3/9/15. R1 was not able to find	a.m. the nurse manager, 25's care plan and confirmed ot updated to include the R25's buttocks. RN-B nursing staff would know ly based on recommendations e specialist, RN-D. RN-B ne aware of the denuded N-B searched R25's room and the zinc based ointment of be applied to R25's				

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	```	NG		IPLETED
		245452	B. WING _		03/	/12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	age 11 cted to know when to switch to	F 3(	09		
		n, without guidance from a				
	noted "Elder was a ulcer on coccyx." ( thickness tissue los visible but bone, te exposed. Slough m obscure the depth undermining and tu assessment did no	sessment, dated 2/16/15, dmitted with stage III pressure Stage 3 pressure ulcer - Full ss. Subcutaneous fat may be ndon, or muscle is not hay be present but does not of tissue loss. May include unneling.) The care area t note R25 had denuded areas ocks, at that point of time.				
	revealed no proble the denuded areas 3/12/15. Review of	und care plan, dated 2/18/15, m or intervention focused on on R25's buttocks until the nursing assistant guide, no direction to staff regarding nt.				
	progress notes for 2/24/15 "Present of moisture associate denuded skin on rig zinc-barrier cream the skin site on the as healed. On 3/9/" moisture associate	Condition/Wound Progression R25 revealed a note on n the right lower buttocks is d skin dmg [damage]." "Noted ght lower buttocks. Will use BID [twice daily]." On 3/4/15, right lower buttocks was noted 15, RN-D noted R25 again had d skin damage on her right a new area on her left lower				
	buttocks. The prog [sic] been having d low grade temp [ter Will continue incon barrier cream appli "Elder's diarrhea ha	a new area on her left lower ress notes indicated "Elder ahs iarrhea since yesterday. Has mperature] this am [morning]. tinence care. Zinc based ed." On 3/11/15, RN-D noted ave improved. Less denuded h the right and left lower area				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245452	B. WING			<b>03</b> / <sup>.</sup>	12/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME (	OF MINNESOTA			879 FERONIA AVENUE GAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa on R25's buttocks.	ge 12	F 3	09			
	nurse practitioner o ointment (a zinc bas	led an order initiated by the on 3/11/15 for calmoseptine sed cream) to be applied twice cks related to moisture tis.					
	and Treatment Prot directed staff "Red or change schedule (i.e. Thera Calzinc; prn." The form was and skin concern. T manual, updated 4/ "Remember: standi hours. Standing ord short term or a a sit better than nothing. [medical doctor] mu as possible] and de	ing orders are only good for 72 ders are only designed for tuation where something is . The wound nurse and/or MD ust get involved ASAP [as soon etermine if the standing orders					
F 312	be done instead of procedure further d found after admissi (paper one kept in b interventions per or nurse] to initiate "Sk (paper)." 483.25(a)(3) ADL C	the long term or what should the standing order." The lirected staff regarding wounds on "Update working care plan binder) with all treatments & rders." and "RN [registered kin Impairment" care plan	F 3	12			4/10/15
SS=D	A resident who is ur daily living receives	IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal					

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PRINTED: 04/16/2015

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245452	B. WING _		03/	12/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		12/2013	
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 312	Continued From pa	age 13	F 31	2			
	by: Based on observa review, the facility f (R19) reviewed for provided oral cares recommended by s minimize the risk of Findings include: On 3/11/15 at 7:41 NA-E assisted R19 brushing her teeth breakfast in the din 8:47 a.m. R19 was eating breakfast. F R19 sat near the da go to an appointment after breakfast with On 3/11/15 at 1:08 working with R19 for confirmed they did after breakfast. NA R19 with oral cares On 3/11/15 at 2:25 RN-B and the hous confirmed the nurs assist R19 with oral inform a nurse or H could investigate th methods to increas after meal. RN-B, H	a.m. R19's nursing assistant, with oral cares, including and then brought her to ing room. From 7:41 a.m. to observed in the dining room rom 8:47 a.m. to 9:00 a.m. bor to the household waiting to ent. At 9:00 a.m. R19 left for an was not approached by staff an offer to perform oral cares. p.m. the nursing assistants or the day, NA-E and NA-D not assist R19 with oral cares -E confirmed she only assisted		It is the policy of ECH to del services to maintain good nu grooming and personal and Plan of correction for resider this survey: Upon notification of this findi (R19) speech recommendat reviewed and the care plan r reflect care and services pro Plan to address/prevent this with other residents: An audit of 100% of the reside speech recommendations has completed to ensure complia Changes to the care plans h made as deemed necessary compliance. Measures put in place to pre recurrence: The policy and procedure for follow through on therapy recommendations has been staff have been in-serviced of and procedure. Plan to monitor: An audit of the care planned recommendations as compa observations on the househo done over the next 3 months at the quarterly QA meetings continuing as deemed necess Responsible for maintaining RN Managers, DON and AE	trition, brai hygiene. its cited with ng, resident ons were evised to vided. deficiency dents with as been ance. ave been to ensure event r initiation and created. The on the policy speech red to care olds will be and reported with audits sary. compliance:		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/16/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245452	B. WING			03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER		· [	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
EPISCO	PAL CHURCH HOME	OF MINNESOTA			1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 14	F 3	312			
	about R19 refusing	oral cares.					
		p.m. R19 reported no one r with oral cares after					
	pathologist (SLP) e coughing and requi	a.m. the speech language xplained R19 had issues with red oral cares after meals to idue was out of her mouth.					
	and activities of dai dated 6/13/14, reve deformities related	re area assessment for pain ly living and rehabilitation, aled R19 had hand and finger to arthritis, and a diagnosis of					
	grooming tasks. R1 set [MDS], dated 2/ extensive assistance performance of per	mpaired her ability to complete 9's quarterly minimum data 17/15, indicated R19 required ee of two or more staff for sonal hygiene tasks and had					
	assessments and p through 8/7/14 reve	Impairment. herapy progress notes, lan of care, for dates 8/1/14 ealed a diagnosis of yngeal phase (difficulty					
	transferring food fro and esophagus to i swallowing process	) and oral residue and d after completion of swallow					
	during evaluation. F "The patient particip staff assistance to o mild impairment". S	Recommendations included bates in oral cares with nursing decrease risk of aspiration with speech therapy provided					
	follow through inclu to decrease risk of						
	nursing order, date	ician's Order Sheet revealed a d 8/5/14, which directed staff e mouth wash and a pick					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245452	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 312 F 315 SS=D	toothette to clean m day at 0800, 1200, speech" R19's care plan, da need total assist for hygiene because of arthritis." Interventio assist in the mornin and personal hygien impaired respiratory [history] recurrent p Review of the King guides, undated, di each meal to reduc 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servit infections and to re function as possible This REQUIREMEN by: Based on observat review, the facility factors	houth of bacteria 3 times per 1700, Special Instructions: per ted 3/27/14 directed staff "I grooming and personal i hand contractures and ons included: "I receive total grand evening with grooming ne needs" and "I am at risk for y function d/t [due to] hx neumonia." House nursing assistant care rected staff "Brush teeth after e aspiration." HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the pondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder ex. NT is not met as evidenced tion, interview and document ailed to attempt to discontinue catheter for 1 of 3 residents	F 312		as valid as the nically	4/10/15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/16/201 APPROVEI 0938-039	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245452	B. WING			<b>03</b> /1	2/2015	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COL					
EPISCOPAL CHURCH HOME OF MINNESOTA					879 FERONIA AVENUE AINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 315	Continued From pa	ge 16	F 3	15				
	laying in bed sleepin bag attached to her On 3/12/15, at 8:33 and stated she has long time, and she of tried to discontinue urinary catheter offe but denied pain at t also stated she gets infections. R155 de On 3/12/15, at 9:59 was interviewed and urinary catheter sim- further stated R155 discontinued right a had to reinsert it. RI attempts had been urinary catheter, an urologist since her a On 3/12/15, at 3:48 (DON) was intervier admitted to the facil verified R155 had m R155's Face Sheet included neurogenie urine. The quarterly dated 12/23/14, ind intact, required exter with toileting, and h catheter. The Care dated 7/10/14, indic a urinary catheter in	a.m. R155 was interviewed had the urinary catheter for a didn't believe the facility had it. R155 further stated the en feels sore and hurts her, he time of the interview. R155 s occasional bladder enied having seen a urologist. a.m. registered nurse (RN)-B d stated R155 has had the ce she was admitted. RN-B had the urinary catheter fiter her admission, but they N-B verified no further made to discontinue the d R155 had not seen a admission to the facility. p.m. the director of nursing wed, and stated R155 was lity with a urinary catheter, and			this survey: Upon notification of this finding, (R11 has had medical justification obtained from Metro Urology where she has be seen for many years. Plan to address/prevent this deficient other residents: All residents with indwelling catheter a medical records review for present medical justification of their catheter were found to be in compliance with medical justification for their indwelling catheter and where needed had it act to their care plan and diagnosis list. Measures put in place to prevent recurrence: The RN Managers will maintain a log residents on their households with a indwelling catheter and the correspon medical justification for use. At the ti admission or introduction of a new indwelling catheter, for any resident, RN Manager will obtain the necessat medical justification for use or order a plan to discontinue the catheters u soon as clinically warranted. Staff has been in-serviced the systems chang Plan to monitor: The RN Managers will review the indwelling catheter log monthly for completeness and accuracy. A rand audit of the medical record for those residents with an indwelling catheter be done monthly for 3 months to ens that medical justification for use is present. Findings will be reported or the quarterly QA meetings. Based or findings, the QA committee will recommend continuing or discontinu	ed been ncy for rs had ce of r. All the ing dded g of all onding ime of , the ury s and use as ave je. om r will sure n at n the		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		
		245452	B. WING		03/	12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 315	Continued From pa	ge 17	F 31	5		
F 318 SS=D	in the past (8/8/13).			the audits.		
	8/2/13, the progress urinary catheter wa note dated 8/6/13, i retain urine, and dir back in temporarily.			Responsible for maintaining com RN Managers, DON and ADON	pliance:	
	Catheters dated 1/1 condition improves weaning off the catl and referrals to uro necessary by the M	EASE/PREVENT DECREASE	F 318	3		4/10/15
	resident, the facility with a limited range appropriate treatme	ent and services to increase d/or to prevent further				
	by: Based on observat review, the facility fa (R19) reviewed for assistance to apply minimize further wo Findings include: On 3/11/15 at 7:35 NA-E and NA-D ass	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 3 residents range of motion, was offered soft hand splint to prevent or orsening of hand contractures. a.m. R19's nursing assistants, sisted R19 with morning cares er to breakfast in the dining		It is the policy of ECH to provide residents with limited ROM appro treatment and services to increas and/or prevent further decrease i Plan of correction for residents ci this survey: Resident (R19) was reassessed their adaptive equipment and RC program to ensure appropriate tr	opriate se ROM in ROM. ited with by OT for DM	

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ATEMENT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
	245452	B. WING					
IAME OF PROVIDER OR SUPPLIEF		D. WING _	STREET ADDRESS, CITY, STATE, ZIP C		12/2015		
EPISCOPAL CHURCH HOME OF MINNESOTA			1879 FERONIA AVENUE SAINT PAUL, MN 55104				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE		
<ul> <li>leaving for breakfa a.m. R19 was obs breakfast and was splint. From 8:47 a the door to the ho appointment. R19 after breakfast wit splint.</li> <li>On 3/11/15 at 1:08 the soft hand splint because it was on added R19 refuse today.</li> <li>On 3/11/15 at 1:09 in her room in the soft hand splint. W apply her soft han something she ha one offered to app</li> <li>On 3/11/15 at 2:2 RN-B and the hou confirmed the nur apply the soft han should inform a nu intervention. RN-E LPN-D confirmed about R19 refusin</li> <li>On 3/11/15 at 2:5<sup>-1</sup> offered to put on h was again observe hand splint.</li> </ul>	splint was not applied prior to ast. From 7:41 a.m. to 8:47 erved in the dining room eating s not wearing the soft hand a.m. to 9:00 a.m. R19 sat near usehold waiting to go to an :00 a.m. R19 left for an was not approached by staff h an offer to apply the soft hand 8 p.m., NA-E and NA-D reported at was not applied today ly applied at night, and quickly d to wear her soft hand splint 9 p.m. R19 was observed sitting recliner. R19 was not wearing a /hen asked if staff offered to d splint, R19 reported it was d to request to be done and no	F 31	<ul> <li>and services.</li> <li>Plan to address/prevent this other residents:</li> <li>An audit has been conducter residents on a ROM program and revise when needed, the plan of care, services and a equipment needed to increas or prevent a decrease in RC warranted a referral was maturther evaluation and/or recommendations of the prodevice.</li> <li>Measures put in place to programs and any related a equipment used for the residents or grown audit of resident programs will be conducted are wearing adaptive equipment the treatment plan is followed compliance. The results of the be reported on at the QA matudits continuing as warran Responsible for maintaining RN Mangers, DON and AD</li> </ul>	ed for all m to review le treatment idaptive ase ROM and/ DM. If ade to OT for ogram and/or event ucted by the e on the ROM daptive dents on such ouseholds s on ROM to ensure they ment and that ed to ensure the audit will eeting with ted. g compliance:			

Facility ID: 00486

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE		(X3) DATE SURVEY COMPLETED
245452 B. WING		03/12/2015
NAME OF PROVIDER OR SUPPLIER STI	REET ADDRESS, CITY, STATE, ZIP CODE	
FPISCOPAL CHURCH HOME OF MINNESOTA	79 FERONIA AVENUE AINT PAUL, MN 55104	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 318       Continued From page 19 and activities of daily living and rehabilitation, dated 6/13/14, revealed R19 had hand and finger deformities related to arthritis which impaired her ability to complete several activities of daily living and caused pain. The care area assessments did not indicate R19 refused to wear her soft hand splint. R19's quarterly minimum data set [MDS], dated 2/17/15, indicated R19 required extensive assistance of two or more staff for dressing (including application of hand splints), had functional impairment in range of motion on both sides of her upper body and had moderate cognitive impairment. Review of the Physician's Order Sheet revealed an order, dated 4/20/11 which directed staff "Between hand spling [sic] application, apply palm protector. 2 times per day during Day, Evening, For Left hand contracture" R19's care plan, dated 3/27/14 directed staff "1 have contracture of my hands and stiffness r/t [related to] Arthritis and Parkinson's". Interventions included "Staff will apply my soft hand splint daily."         Review of the King House nursing assistant care guides, undated, directed staff "Splint for left hand".       F 323         F 323       483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES       F 323         The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.       F 323		4/10/15

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		AND HUMAN SERVICES				FORM	04/16/2015 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245452	B. WING	i		03/1	12/2015	
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-		
EPISCOF	EPISCOPAL CHURCH HOME OF MINNESOTA				879 FERONIA AVENUE SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG				IX i	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 20	F:	323				
	This REQUIREMEN by: Based on observat documentation revi evaluate/re-assess multiple falls for 1 of for accidents. Findings include: R155'S Incident De falls: On 3/3/15, at 3:00 a screaming help, up resident was sitting stated she was goir visible injuries. Res bed with two, and w Corrective measure placed in low position within reach, and no access for a head in On 2/10/15, at 5:00 on the floor in a sitt she was trying to ge floor. Resident's lef centimeter (cm) x 2 and bruising were a face. Resident was Corrective measure to use call light, and On 10/5/14, at 5:00	NT is not met as evidenced tion, interview, and ew, the facility failed to potential causative factors for of 3 residents (R155) reviewed tails identified the following a.m. Staff heard resident on going into her room on floor next to bed. Resident ng to the bathroom. There no ident was assisted back to vas toileted with no result. es initiated: R115's bed was on, the call light was placed euro checks were initiated (to			It is the policy of ECH to ensure the environment remains as free of active hazards as is possible and that earesident receives adequate supervand assistance devices to prevent accidents. Plan of correction for residents citet this survey: Resident (R155) had their fall risk reassessed with appropriate intervadded to their plan of care. Plan to address/prevent this deficient other residents: An audit of the care plans for the residents that have had a fall in the months was conducted with revision and/or interventions implemented warranted ensuring compliance. Measures put in place to prevent recurrence: The RN Managers will maintain a son each resident in the working carbook. At the time of a resident fall, intervention(s) will be added and so be educated on the new intervention prevent future falls. Staff have been in-serviced on this system. Plan to monitor: A random audit of the care plans for the residents that have fallen in the moth fall, intervention intervention for a months. The of the audit will be reported on at timeeting with audits continuing as	cident ch vision ed with rentions ency for e last 3 ons as fall log re plan a new taff will on(s) to en		
	when she was putti	ng a book back on the shelf, to bed. Resident received a 1			warranted Responsible for maintaining comp	liance:		

Facility ID: 00486

		& MEDICAID SERVICES			OMB NO		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245452	B. WING		03/12/2015		
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
EPISCOPAL CHURCH HOME OF MINNESOTA			:				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 323	Continued From pa	age 21	F 323	3			
	skin tear to the left 1 cm skin tear to he of pain in the left sl	to her left ear, a 1.5 cm x 2 cm side of her face, and a 2 cm x er left elbow. Also complained houlder. es taken by facility was left		RN Managers, DON and ADON	I		
		p.m. R155 was observed ing, with the call light within at a regular height.					
	and stated she has	a.m. R155 was interviewed, fallen, she wasn't sure why ht she just lost her balance at					
	was interviewed, a with assistance of asked what was be falling, NA-C replie close to the bed be bed and keeps her stated the call ligh	a.m. nursing assistant (NA)-C nd stated R155 transferred one staff and a walker. When sing done to prevent R155 from d they keep the bedside table cause R115 likes to read in books on the table. NA-C also t is kept close to R115, and for R115 to call for assistance.					
	was interviewed ar the night, and has stated R155 has a might get up at nig tubing. RN-B furthe prevent falls for R1 within reach, and e also stated the falls department head n	a.m. registered nurse (RN)-B ad stated R155 gets up during had some falls. RN-B further urinary catheter, and feels she ht and trip on the drainage er stated interventions to 55 are to have the call light ncourage her to use it. RN-B s are reviewed at the facility norning stand up meeting, and ons are communicated to all					

Facility ID: 00486

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		& MEDICAID SERVICES				0		<u>. 0938-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/12/2015		
		245452	B. WING						
NAME OF I	PROVIDER OR SUPPLIER				RESS, CITY, STATE, Z	ZIP CODE			
EPISCOPAL CHURCH HOME OF MINNESOTA			1879 FERONIA AVENUE SAINT PAUL, MN 55104						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	(EAG	ROVIDER'S PLAN OF CH CORRECTIVE AC SS-REFERENCED TO DEFICIENC	TION SHOULD	) BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	-	F 3	23					
	Interventions to Ad	e plan (New Care Plan dress Falls form).							
	(DON) was intervie expect staff to asse	B p.m. the director of nursing wed, and verified she would less for reasons for fall, and to tions into the care plan.							
	included hypertens diabetes. The quar dated 12/23/14, inc intact, and required	t identified diagnoses that ion, osteoporosis and terly Minimum Data Set (MDS) licated R155 was cognitively I extensive assistance of one							
	toileting. The Care 7/10/14, indicated I to unsteady gait, ne assistance/guidanc ambulation, forgetf incontinence, and r								
	place and remind r	ated 4/28/14, identified a risk							
	for falls, with a goa care plan included ensure call light is	I of being free from falls. The the following interventions: within reach, fall risk per the risks vs. benefits and side							
	effects of psychotro reminders to not tra assistance, assess	opic medications, verbal ansfer or ambulate without for environmental hazards,							
	and ambulation, sta resident/family, and requests for assista	eeds, assess gait, balance aff to explain risk of falling to d nursing to respond to ance as soon as possible. The							
	New Care Plan Inte indicated the follow educate resident or	erventions to Address Falls ring interventions were added: n safety, and call light within lucate on call light use							

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	MB NO. (X3) DATE	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		245452			03/	12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 323	Continued From pa (2/10/15), and low b	-	F 323			
F 371 SS=F	Assessment dated assess resident for process or sign of in contributed to the fa may contribute to fa footwear and clothin the environment to colored tape on cal fall alarms, furniture The policy and proc care plan fall and fa document any fall in time of fall. 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and	SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 371			4/10/15
	by: Based on observat review, the facility fa 6 households review sanitized at appropriate appropriate to assure that	NT is not met as evidenced ion, interview and document ailed to ensure dishes on 1 of wed were washed and riate water temperatures and t food was stored in areas that d contamination in the main		It is the policy of ECH to procure for from sources approved or consider satisfactory by Federal, State or loc authorities and to store, prepare, distribute and service food under s conditions.	red cal	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED
		245452	B. WING _	·····	03/12/2015
NAME OF I	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP	CODE
EPISCOPAL CHURCH HOME OF MINNESOTA				1879 FERONIA AVENUE SAINT PAUL, MN 55104	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLÉTIO E APPROPRIATE DATE
F 371	Continued From pa	lge 24	F 37	71	
	<ul> <li>kitchen. This had the potential to impact 122 out of 123 residents residing at the facility.</li> <li>Findings include:</li> <li>The facility failed to ensure dishes on 1 of 6 households were washed and sanitized at appropriate water temperatures.</li> <li>On 3/9/15 at 7:05 p.m. a homemaker on the King Unit, (H)-A was observed to place a rack of silverware into the dishwasher. Dish machine wash and temperatures did not rise above 125 F [Fahrenheit]. Surveyor alerted H-A. H-A again ran the silverware through the dishwasher. Wash and</li> </ul>			Plan of correction for resid this survey: No residents were harmed	
				practice. Plan to address/prevent th other residents:	
				All homemaking and food were re-educated on dishv procedures and proper sto	vashing
				Measures put in place to p recurrence: Homemakers will notify the	e household
	F. A sign on the dis wash temperatures	again did not rise above 125 h machine directed staff that must reach a minimum of 150 atures must reach a minimum		coordinator if the temperat where they need to be imm Weekly, dishwasher tempe be checked by the Househ to ensure each household at required temperatures.	nediately. erature logs will nold Coordinator dishwasher is
	King Unit (H)-B was silverware in plastic dishwasher. Wash above 130 F and rin above 140 F. At 11	7 a.m. a homemaker on the s observed placing a load of c silverware holders into the temperatures did not rise nse temperatures did not rise :16 a.m. H-B reported the		staff will notify maintenance they notice ceiling tiles are Monthly the FSD will make the maintenance supervise environment is free of uns conditions.	e immediately if not intact. orounds with or to ensure
	dishwasher rack. H plastic silverware c	n soaked before placing in the I-B was observed to put the ontainers into the dish ne last time. H-B reported she vare away.		Plan to monitor: Weekly, d temperature logs will be ch Household Coordinator to household dishwasher is a temperatures. Monthly the	necked by the ensure each at required FSD will make
	(DM) demonstrated worked by running cycle the rinse tem	5 p.m. the dietary manager, how the dish machine it three times. On the first dish perature went above 150 F for		rounds with the maintenan to ensure environment is f unsanitary conditions.	nce supervisor ree of
		r rinse. On the second and n and rinse temperatures did		Responsible for maintainir Household Coordinators, F	

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	CON	IPLETED
		245452	B. WING		03/12/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	)E	
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 371	observation. DM ra machine. DM expla the racks were at I turn black. The tes confirmed this indi- at the racks were r explained the hom supervisor if dish r reaching minimum wash dishes in the dishes were not wa water temperature DM reported he m- temperatures throu in the monitoring lo On 3/10/15 at 12:5 not aware why wat reach a minimum she continued to w dishwasher, instea water temperature H-B reported the h unit, (HC)-A about temperatures not k 12:40 p.m. on 3/10 The Dishwashing I 12/11/08, directed water shall be main the washing cycle sanitizing cycle (16 point.). The flow pr between 15 and 25 Corrective Action: minimum standard	F. DM confirmed this an a test strip through the dish ained if water temperatures at east 170 F the test strip would t strip turned light brown. DM cated the water temperatures not at least 170 F. DM emakers should notify a nachine temperatures were not levels and then proceed to main kitchen. DM explained if ashed and rinsed at minimum , they were not fully sanitized. onitored dish machine ugh the temperatures recorded ogs. 6 p.m. H-B reported she was er temperatures needed to remperature. H-B confirmed rash dishes in the household d of the main kitchen, despite s not meeting minimum levels. ousehold coordinator on her the dishwasher water peing hot enough at about	F 371			

	TOF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CONSTRU	JCTION			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	245452		B. WING				03/12/2015	
NAME OF	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIF	P CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERON SAINT PAU	IL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAG	PROVIDER'S PLAN OF C CH CORRECTIVE ACTION SS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETIC DATE
F 371	Continued From pa	age 26	F 3	71				
	or temperature stri contact point is at operation of the dis be notified and all soon as the proble	I using a holding thermometer ps to test that the surface 160 F to ensure proper sh machine. Maintenance will dishwashing will be halted as m is identified. If necessary, re and/or hand sanitizing of						
	dishes will be done soon as standard t maintained."	e. Dishwashing may resume as emperatures are again being						
	March 2015 reveal were recorded at n	washer Temperatures log for led dish machine temperatures ninimum levels for 3/9/15. orded for 3/10/15 were illegible.						
		o ensure food was prepared in I the risk of contamination.						
	3/9/15 water was n ceiling onto the floo on it was a few incl time the ceiling wa was told it was from 6:30 p.m. a new ce	our of the kitchen at noon on noted to be dripping from the or. A cart with trays of bread hes away. Cook-A reported last s leaking into the kitchen she m a tub room. On 3/9/15 at eiling tile was placed and water ping. A cart with several trays						
	of entrees and side new ceiling tile. On with several trays of new ceiling tile. Th have a darkened a leak. DM confirmed should not be store	e dishes was located under the a 3/12/15 at 3:31 p.m. a cart of cookies was noted under the e ceiling tile was observed to area, indicating potential water d findings and reported food ed in areas of potential e maintenance supervisor, MS,						
	reported she repair floor above the kito leaking into the kito	red a mop room sink on the chen on 3/9/15 as it was chen from the ceiling. MS g tile was currently dry, but						

Facility ID: 00486

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		MPLETED
		245452	B. WING _		03	/12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	)E	
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 371	Continued From pa	ge 27	F 37	71		
	5	idual moisture that leaked the mop room sink.				
F 441 SS=E	indicated the mop s water had leaked d sealed and the ceili 483.65 INFECTION	Work Order, dated 3/9/15, sink caulking was cracked and own to kitchen. The crack was ng tile was replaced. I CONTROL, PREVENT	F 44	11		4/10/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a reprevent the spread isolate the resident. (2) The facility musicommunicable dise from direct contact direct contact will tr (3) The facility musical	ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which				

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		AND HUMAN SERVICES				FORM	04/16/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		E SURVEY PLETED
		245452	B. WING			03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCO	EPISCOPAL CHURCH HOME OF MINNESOTA				879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441		-	F ·	441			
	by: Based on observative review, the facility for control practices were hygiene for 3 of 4 re- observed for activition of 1 resident (R25) Findings include: R4 did not receive prappropriate hand were On 3/11/15 at 7:40 to assist with mornin (without washing here retrieved R4's leg brattaches to a reside NA-B cleaned the ere alcohol wipe, unattathe end of the cather wipe and attached the drainage bag into the amount of urine in the writer how the cather stored. NA-B askeed toilet and R4 denied warm soapy water,				It is the policy of ECH to establish a maintain an infection control program provide a safe, sanitary and comfort environment and to help prevent the development and transmission of dia and infection. Plan of correction for residents cited this survey: (R4), (R25), (R123) and (R19) had t medical condition reviewed and rem infection free as a result of this prac Plan to address/prevent this deficien other residents: All staff assisting with ADLs or perfo wound care had mandatory hand hy in-services conducted. Measures put in place to prevent recurrence: The policy and procedure for hand hygiene and the infection control pla have been reviewed and remain cur The staff have been re-educated on policy and procedures. Plan to monitor: RN Managers or designee will condu- random audits of ADLs and wound of to ensure that proper hand hygiene a infection control practices are being	m to table sease d with their nain trice. ncy for orming ygiene an rrent. the uct cares and	

Facility ID: 00486

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STATEMEN	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	CON		
		245452	B. WING _			03/12/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	E	
EPISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 441	incontinent product bowel movement ( pericares, NA-B ap NA-B was observe to attach the cathe applied R4's pants into the wheelchair washed hands. Interview with RN indicated she woul changed and hand leg bag, after clear movement and after Interview with the of 2:50 p.m., indicated the nursing assistant gloves after perical incontinent bowel r the catheter. The facility failed to individual cares with On 3/11/15, at 10:5 (NA)-B and NA-C w R123 with bed batt lying in bed, entirel explained giving R resident refused tu defecation and woo movement (BM) in washed hands and checked the water with R123, obtaine	<ul> <li>After completing billing oplied a new incontinent brief.</li> <li>d, with the same gloved hands, ter leg bag to R4's leg and</li> <li>NA-B assisted R4 to transfer</li> <li>NA-B removed gloves and</li> <li>B on 3/11/15 at 10:15 a.m., d have expected gloves to be swashed after changing the hing up the incontinent bowel er pericares.</li> <li>director of nursing on 3/12/15 at d the expectation would be for nt to wash hands and change res, after cleaning up the novement, and after emptying</li> <li>b ensure R123 received the appropriate hand hygiene.</li> <li>a.m., two nursing assistants were observed to be assisting here.</li> <li>a.m., two nursing assistants were observed to be assisting the to urge for rried for having bowel the tub. NA-B and NA-C donned gloves. NA-C temperature and confirmed d a basin of warm soapy water, d advanced to assist R123</li> </ul>			s continuing compliance:		

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PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452 OF MINNESOTA	A. BUILDI	TPLE CONSTRUCTION		TE SURVEY MPLETED
PAL CHURCH HOME		B. WING _			
PAL CHURCH HOME	OF MINNESOTA			03	/12/2015
	OF MINNESOTA		STREET ADDRESS, CITY, STATE, ZIP CC	DE	
			1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	-	F 44	41		
hands. NA-C dump and refilled the bas washcloths and pro	ed the dirty water in the toilet in with warm soapy water, and ceeded to assist with pericare.				
BM." At 11:00 a.m., and threw in the ga stepped out and ca	NA-C removed soiled gloves rbage, opened R123's door, me back with five wash				
washing hands in-b grabbed two plastic floor and placed on dirty wash clothes.	etween. At 11:07 a.m., NA-B bags with dirty linens from the R123's bed and added more At 11:15 a.m., NA-B and NA-C				
R123's legs without performing hand hy applied a lift sling u	changing gloves or giene. Both nursing assistants nder R123 and transferred				
(RN)-B explained h wash hands in betw gloves, and when c body fluids. RN-B e appropriately wash "Staff should wash	er expectation was for staff to yeen all cares, before donning oming into contact with any xpected the staff to hands. RN-B further stated hands before, in between and				
not change gloves a movement and veri R123 skin with the she did not perform the soiled gloves ar "We forget to wash	after cleaning up R123's bowel fied she applied lotion on soiled gloves. NA-B verified hand hygiene after removing nd should have. NA-B added, our hands in between glove				
	donned another pai hands. NA-C dump and refilled the bas washcloths and pro Prior to pericare NA BM." At 11:00 a.m., and threw in the ga stepped out and ca clothes and donned washing hands in-b grabbed two plastic floor and placed on dirty wash clothes. proceeded to apply R123's legs without performing hand hy applied a lift sling u him to the wheelcha On 3/11/15, at 11:2 (RN)-B explained h wash hands in betw gloves, and when c body fluids. RN-B e appropriately wash "Staff should wash after removing glov On 3/11/15, at 11:3 not change gloves a movement and veri R123 skin with the she did not perform the soiled gloves ar "We forget to wash change and we just	Continued From page 30 donned another pair of gloves without washing hands. NA-C dumped the dirty water in the toilet and refilled the basin with warm soapy water, and washcloths and proceeded to assist with pericare. Prior to pericare NA-C stated R123 was "having a BM." At 11:00 a.m., NA-C removed soiled gloves and threw in the garbage, opened R123's door, stepped out and came back with five wash clothes and donned another pair of gloves without washing hands in-between. At 11:07 a.m., NA-B grabbed two plastic bags with dirty linens from the floor and placed on R123's bed and added more dirty wash clothes. At 11:15 a.m., NA-B and NA-C proceeded to apply lotion with soiled gloves on R123's legs without changing gloves or performing hand hygiene. Both nursing assistants applied a lift sling under R123 and transferred him to the wheelchair at 11:20 a.m. On 3/11/15, at 11:27 a.m., registered nurse (RN)-B explained her expectation was for staff to wash hands in between all cares, before donning gloves, and when coming into contact with any body fluids. RN-B expected the staff to appropriately wash hands. RN-B further stated "Staff should wash hands before, in between and after removing gloves." On 3/11/15, at 11:38 a.m. NA-B verified she did not change gloves after cleaning up R123's bowel movement and verified she applied lotion on R123 skin with the soiled gloves. NA-B verified she did not perform hand hygiene after removing the soiled gloves and should have. NA-B added, "We forget to wash our hands in between glove change and we just talked about it." NA-C verified she did not wash hands after removing gloves during R123's bed bath and	donned another pair of gloves without washing hands. NA-C dumped the dirty water in the toilet and refilled the basin with warm soapy water, and washcloths and proceeded to assist with pericare. Prior to pericare NA-C stated R123 was "having a BM." At 11:00 a.m., NA-C removed soiled gloves and threw in the garbage, opened R123's door, stepped out and came back with five wash clothes and donned another pair of gloves without washing hands in-between. At 11:07 a.m., NA-B grabbed two plastic bags with dirty linens from the floor and placed on R123's bed and added more dirty wash clothes. At 11:15 a.m., NA-B and NA-C proceeded to apply lotion with soiled gloves on R123's legs without changing gloves or performing hand hygiene. Both nursing assistants applied a lift sling under R123 and transferred him to the wheelchair at 11:20 a.m. On 3/11/15, at 11:27 a.m., registered nurse (RN)-B explained her expectation was for staff to wash hands in between all cares, before donning gloves, and when coming into contact with any body fluids. RN-B expected the staff to appropriately wash hands. RN-B further stated "Staff should wash hands before, in between and after removing gloves." On 3/11/15, at 11:38 a.m. NA-B verified she did not change gloves after cleaning up R123's bowel movement and verified she applied lotion on R123 skin with the soiled gloves. NA-B verified she did not perform hand hygiene after removing the soiled gloves and should have. NA-B added, "We forget to wash our hands in between glove change and we just talked about it." NA-C verified she did not wash hands after	donned another pair of gloves without washing hands. NA-C dumped the dirty water in the toilet and refilled the basin with warm soapy water, and washcloths and proceeded to assist with pericare. Prior to pericare NA-C stated R123 was "having a BM." At 11:00 a.m., NA-C removed soiled gloves and threw in the garbage, opened R123's door, stepped out and came back with five wash clothes and donned another pair of gloves without washing hands in-between. At 11:07 a.m., NA-B grabbed two plastic bags with dirty linens from the floor and placed on R123's bed and added more dirty wash clothes. At 11:15 a.m., NA-B and NA-C proceeded to apply lotion with soiled gloves on R123's legs without changing gloves or performing hand hygiene. Both nursing assistants applied a lift sling under R123 and transferred him to the wheelchair at 11:20 a.m. On 3/11/15, at 11:27 a.m., registered nurse (RN)-B explained her expectation was for staff to wash hands in between all cares, before donning gloves, and when coming into contact with any body fluids. RN-B expected the staff to appropriately wash hands. RN-B further stated "Staff should wash hands before, in between and after removing gloves." On 3/11/15, at 11:38 a.m. NA-B verified she did not change gloves after cleaning up R123's bowel movement and verified she applied lotion on R123 skin with the soiled gloves. NA-B verified she did not perform hand hygiene after removing the soiled gloves and should have. NA-B added, "We forget to wash our hands in between glove change and we just talked about it." NA-C verified she did not wash hands after	donned another pair of gloves without washing hands. NA-C dumped the dirty water in the toilet and refiled the basin with warm soapy water, and washcloths and proceeded to assist with pericare. Prior to pericare NA-C stated R123 was "having a BM." At 11:00 a.m., NA-C removed solied gloves and threw in the garbage, opened R123's door, stepped out and came back with five wash clothes and donned another pair of gloves without washing hands in-between. At 11:07 a.m., NA-B grabbed two plastic bags with dirty linens from the floor and placed on R123's bed and added more dirty wash clothes. At 11:15 a.m., NA-B and NA-C proceeded to apply lotion with soiled gloves on R123's legs without changing gloves or performing hand hygiene. Both nursing assistants applied a lift sling under R123 and transferred him to the wheelchair at 11:20 a.m. On 3/11/15, at 11:27 a.m., registered nurse (RN)-B explained her expectation was for staff to wash hands in between all cares, before donning gloves, and when coming into contact with any body fluids. RN-B expected the staff to appropriately wash hands. RN-B further stated "Staff should wash hands before, in between and after removing gloves." On 3/11/15, at 11:38 a.m. NA-B verified she did not change gloves and should have. NA-B verified she did not perform hand hygiene after removing the soiled gloves. NA-B verified she added, "We forget to wash our hands in between glove change and we just talked about it." NA-C verified she did not wash hands after

If continuation sheet Page 31 of 34

		AND HUMAN SERVICES				FORM	: 04/16/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		245452	B. WING	i		03	/12/2015
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
EPISCOPAL CHURCH HOME OF MINNESOTA					1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	R123 stated she sh between. Further si The Standard Prec directed, "Hands ar work, breaks, after secretions, excretion whether or not glow washed before and removed, between situation involving p infectious organism indicated. In addition and procedures on cross contamination addition, "Gloves a with blood, body fluc contaminated items non-sterile gloves a after washing hand mucous membrane gloves will be applie procedures on the cross-contamination be removed immediate The facility failed to protocols were follo R19. On 3/11/15 at 7:41 (NA)-E was observent the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commode and the commod	o go get more wash clothes. nould have washed hands in tated, "I was nervous." autions policy, undated, re washed before and after touching blood, body fluids, ons and contaminated items, res are worn. Hands will be immediately after gloves are elder contact, after any possible contamination with its and when otherwise on, wash hands between tasks the same elder to prevent n of different body sites." In re to be worn when contact ids, secretions and s is possible. New clean are to be worn immediately s and just prior to touching es and nonintact skin. New ed when performing tasks and same elder when n is possible. Gloves are to liately after use, and before	F	441			

If continuation sheet Page 32 of 34

		AND HUMAN SERVICES			FORM	04/16/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245452	B. WING		<b>03</b> / <sup>.</sup>	12/2015
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
EPISCOF	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F 441			
		ng or sanitizing hands. NA-E with brushing her teeth.				
	not wash or sanitize gloves soiled from a	p.m. NA-E confirmed she did e her hands after removing assisting R19 with using the pleting perineal care. NA-E				
	reported she donne	a new pair of gloves to help n, but did not wash or sanitize				
	nursing (ADON) rep nursing assistants t completing toileting	p.m. the assistant director of ported he would expect to wash or sanitize hands after and perineal cares and prior even if gloves were changed				
	was followed during 3 pressure ulcer. (A thickness tissue los visible but bone, ter exposed. Slough m	ensure hand hygiene protocol g wound care for R25's stage A stage 3 pressure ulcer is full ss. Subcutaneous fat may be ndon, or muscle is not ay be present but does not of tissue loss. May include inneling.)				
	specialist, (RN)-D v 3 pressure ulcer on preparation solutior and applied a foam wound. RN-D did no removing her pair of	2 a.m. the wound care vas observed cleaning a stage R25's coccyx with skin h. RN-D then changed gloves dressing over R25's coccyx ot wash or sanitize hands after of gloves, soiled from cleaning er, and donning new gloves oam dressing.				
		2 a.m. RN-D confirmed she did e her hands between changing				

Facility ID: 00486

If continuation sheet Page 33 of 34

		AND HUMAN SERVICES				FORM	): 04/16/2015 1 APPROVED ). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA COI	TE SURVEY MPLETED
		245452	B. WING			03	/12/2015
NAME OF	PROVIDER OR SUPPLIER	·	-		TREET ADDRESS, CITY, STATE, ZIP CODE		
EPISCOPAL CHURCH HOME OF MINNESOTA					879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	prior to applying a f pressure ulcer. RN for her to carry alco	age 33 ng R25's pressure ulcer and coam dressing over the -D reported it would be helpful ohol based hand sanitizer to ene during wound cares.	F	441			

Facility ID: 00486

If continuation sheet Page 34 of 34

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
<b>CENTERS FOR MEDICARE &amp; MEDICAID</b>	SERVICES

### F6452023

PRINTED: 04/03/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			01501 / 0	INB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		e survey Ipleted
		245452	B: WING			03/	12/2015
	PROVIDER OR SUPPLIER	OF MINNESOTA		1	TREET ADDRESS, CITY, STATE, ZIP CODE 879 FERONIA AVENUE AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH CMS-2567 FORM Y VERIFICATION OF UPON RECEIPT O ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W A Life Safety Code Minnesota Departm time of this survey, MN was found not it the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN CORRECTION FO DEFICIENCIES TO HEALTHCARE FIR STATE FIRE MARS	F COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOU VERIFICATION. Survey was conducted by the nent of Public Safety. At the Episcopal Church Home of in substantial compliance with or participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. THE PLAN OF R THE FIRE SAFETY D: E INSPECTIONS SHAL DIVISION STREET, SUITE 145			EPOC		
	Or by email to:						
		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically Signed						03/30/2015

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.

#### PRINTED: 04/03/2015 FORM APPROVED OMB NO. 0938-0391

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

ULNILI	101 MILDIOAIL	& MEDICAID SERVICES			0	10 110.	0000-0001
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245452	B. WING	-		<b>0</b> 3/	12/2015
	PROVIDER OR SUPPLIER	OF MINNESOTA		18	TREET ADDRESS, CITY, STATE, ZIP CODE 379 FERONIA AVENUE AINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficient 2. The actual, or pro- 3. The name and/our responsible for corre- prevent a reoccurred The Episcopal Chur building with a parti- constructed at 2 dif- building was constru- determined to be of 1971, an addition w side of the building Type II(222) constru- was constructed to that was determined construction. Beca- the addition meet the for existing building surveyed as one bu- be surveyed as a set The building is fully facility has a fire allow smoke detection in to the corridor that it	tate.mn.us and @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. posed, completion date. r title of the person ection and monitoring to ence of the deficiency. rch Home of MN is a 3-story al basement. The building was ferent times. The original ucted in 1960 and was Type II(222) construction. In ras constructed to the south that was determined to be of uction. In 2008, an addition the north side of the building d to be of Type II(222) use the original building and he construction type allowed s, the 2 buildings will be finding. The 2008 building will eparate building fire sprinkler protected. The arm system with full corridor the corridors and areas open s monitored for automatic fire tion. There are smoke alarms	κo	000			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00486

If continuation sheet Page 2 of 6

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

PRINTED: 04/03/2015 FORM APPROVED OMB NO. 0938-0391

CENTER					OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRU NG <b>01 - MAIN E</b>			E SURVEY IPLETED
		245452	B. WING			03/	12/2015
NAME OF F	ROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE		
EPISCOF	AL CHURCH HOME	OF MINNESOTA		1879 FERON SAINT PAU	IA AVENUE L, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOL S-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 000	Continued From page 2 The facility has a licensed capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD		КO	00			
K 025 SS=D	NOT MET as evide NFPA 101 LIFE SA Smoke barriers are least a one half hou accordance with 8.3 terminate at an atriu protected by fire-rat panels and steel fra	nced by:	КO	25			4/10/15
	floor. Dampers are penetrations of smo heating, ventilating, 19.3.7.3, 19.3.7.5,	not required in duct oke barriers in fully ducted and air conditioning systems.					
	Based on observat failed to maintain su accordance with the 2000 edition, Section and 8.3.6. This de	ion and interview, the facility moke barrier walls in e requirements of NFPA 101 - ons 19.3.7, 19.3.7.3, 8.3, 8.3.2 ficient practice could affect all visitors within the smoke		door on been se 4/10/14. houseke	Ill ensure that the smoke the 1st floor by room 12 aled in an approved mar . The maintenance and eeping director and Admi esponsible for ensuring nce.	2 has ìner by	
	on 03/12/2015, it was above the smoke b	veen 09:00 AM and 02:00 PM as observed that the wall arrier doors on the 1st floor by petrations that had not been ved manner.			r.		

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: HPDI21

Facility ID: 00486

If continuation sheet Page 3 of 6

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION (X3)	DATE SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	· ·		COMPLETED
		245452	B. WING		03/12/2015
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PISCOF	PAL CHURCH HOME	OF MINNESOTA	· ·	879 FERONIA AVENUE SAINT PAUL, MN 55104	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 025	Continued From pa	ge 3	K 025		
		verified by the facility ervisor (MS) at the time of			
K 029 SS=F	NFPA 101 LIFE SA	FETY CODE STANDARD	K 029		4/10/15
	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autom option is used, the other spaces by sm doors. Doors are s field-applied protec	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from hoke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are			
	Based on observation observation failed to provide pro- accordance with the -2000 edition, Section deficient practice content of the section	s not met as evidenced by: tion and interview, the facility otection of hazardous areas in e requirements of NFPA 101 ion 19.3.2.1 and 8.4.1 This ould affect all residents, guests smoke compartments.		In the areas affected by the cable TV installation and other areas identified, f caulking will be applied to ensure prope protection to hazardous areas. This wil completed by 4/10/14. The maintenance/housekeeping supervisor and Administrator will be responsible for	er I be
	on 03/12/2015, it w in the corridor wall Where the fire stop	ween 09:00 AM and 02:00 PM as observed that penetrations around conduit and wires ping has been removed, fallen V installation in the following		ensuring compliance.	

Facility ID: 00486

If continuation sheet Page 4 of 6

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		SURVEY
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	01 - MAIN BUILDING 01	COMI	PLETED
		245452	B, WING		03/1	2/2015
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PISCO	PAL CHURCH HOME	OF MINNESOTA		1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 029	<ul> <li>2) 2nd floor Homen penetrations in corr</li> <li>3) 2nd floor Server penetrations in the</li> <li>3) 1st floor Mechan penetrations in corr</li> <li>This deficiency was Environmental Sup</li> </ul>	haker Closet by room 202 had idor wall and ceiling. Room Isabella House had corridor wall. ical Room By room 122 had	K 029			
K 038 SS=D	Exit access is arrar	FETY CODE STANDARD nged so that exits are readily nes in accordance with section	K 038	3		4/17/15
	Based on observat has failed to provide This deficient practi- rapid evacuation of in the event of an e- quick evacuation in 19.2.1 Findings include: On facility tour betw on 03/12/2015, it w House Feronia Exit because of loose w	s not met as evidenced by: tion and interview, the facility e a proper exit to the outside. ice could affect the safe and all residents, visitors and staff mergency that may require accordance with section 7.1. veen 09:00 AM and 02:00 PM as observed that the Cook door was difficult to open reather stripping and had a 6" ard surface with loose bricks to		The exit located in Cooke House g out to Feronia Ave will have new we stripping installed. We will also repa concrete so there is a smooth trans between the door and sidewalk. Thi be completed by 4/17/14. The maintenance/housekeeping supervi and Administrator will be responsible compliance.	eather ave the ition is will isor	i X

Facility ID: 00486

If continuation sheet Page 5 of 6

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
				01 - MAIN BUILDING 01		
		245452	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	12/2015
	PROVIDER OR SUPPLIER	OF MINNESOTA	1	1879 FERONIA AVENUE SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 038	Continued From pa Environmental Sup discovery.	ge 5 ervisor (MS) at the time of	K 038			
K 062 SS=F		FETY CODE STANDARD	K 062	r .		4/10/15
	continuously mainta condition and are in	c sprinkler systems are ained in reliable operating spected and tested .6, 4.6.12, NFPA 13, NFPA 25,			4	
	Based on record re facility has failed to sprinkler system. T affect all occupants visitors.	s not met as evidenced by: eview and interview, the properly maintain the fire his deficient practice could including patients, staff and		ECH will document all quarterly s flow tests beginning immediate. The maintenance technicians, supervise Administrator will be responsible for ensuring compliance. The safety committee will review quarterly.	ne sor and	
	on 03/12/15, it was available document	veen 9:00 AM and 02:00 PM discovered, during review of tation, that the facility did not re sprinkler testing as required as.		₹KC		
		verified by the facility ervisor (MS) at the time of				

Event ID: HPDI21

Facility ID: 00486

If continuation sheet Page 6 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES	1	75452023 01		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG 02 - EPISCOPAL CHURCH HOME OF MN		E SURVEY PLETED
		245452	B. WING _		03/ <sup>.</sup>	12/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA		SAINT PAUL, MN 55104	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF O			2	9	
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOU VERIFICATION.				
	Minnesota Departm time of this survey, MN was found not i the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		EPOC	-	
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY				
	HEALTHCARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145				
	Or by email to:					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/30/2015

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.

PRINTED: 04/03/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		E SURVEY
ID PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 02 - EPISCOPAL CHURCH HOME OF MN		
		245452	B. WING		03/	12/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1879 FERONIA AVENUE		
PISCOP	PAL CHURCH HOME	OF MINNESOTA		SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	Continued From pa	ge 1	КO	00		
	Marian.Whitney@s Angela.Kappenmar	tate.mn.us and				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defici	what has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	building with a parti constructed at 2 dif building was constr determined to be of 1971, an addition was side of the building Type II(222) constr was constructed to that was determine construction. Beca the addition meet th for existing building	rch Home of MN is a 3-story al basement. The building was ferent times. The original aucted in 1960 and was f Type II(222) construction. In vas constructed to the south that was determined to be of auction. In 2008, an addition the north side of the building d to be of Type II(222) suse the original building and he construction type allowed ps, the 2 buildings will be uilding. The 2008 building will eparate building.				
	facility has a fire all smoke detection in to the corridor that	fire sprinkler protected. The arm system with full corridor the corridors and areas open is monitored for automatic fire tion. There are smoke alarms s.				

Facility ID: 00486

If continuation sheet Page 2 of 3

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SUF COMPLET	
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02 - EPISCOPAL CHURCH HOME OF MN		_0
		245452	B. WING		03/12/2	015
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 879 FERONIA AVENUE		
PISCOF	PAL CHURCH HOME	OF MINNESOTA		SAINT PAUL, MN 55104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) /IPLETIC DATE
K 000	The facility has a lic	age 2 censed capacity of 131 beds of 123 at the time of the	K 000			
K 062 SS=F	NOT MET as evide NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	42 CFR Subpart 483.70(a) is enced by: FETY CODE STANDARD c sprinkler systems are ained in reliable operating nspected and tested 6, 4.6.12, NFPA 13, NFPA 25,	K 062		4/1	0/15
	Based on record re facility has failed to sprinkler system. T affect all occupants visitors. Findings include: On facility tour betw on 03/12/15, it was available documen conduct quarterly fi in the last 12 month This deficiency was	s not met as evidenced by: eview and interview, the properly maintain the fire his deficient practice could including patients, staff and veen 9:00 AM and 02:00 PM discovered, during review of tation, that the facility did not ire sprinkler testing as required ns. s verified by the facility pervisor (MS) at the time of		ECH will document all quarterly spri flow tests beginning immediate. The maintenance technicians, superviso Administrator will be responsible for ensuring compliance. The safety committee will review quarterly.	r and	

Event ID: HPDI21

Facility ID: 00486

If continuation sheet Page 3 of 3



Protecting, Maintaining and Improving the Health of Minnesotans Electronically Delivered: March 25, 2015

Ms. Andrea Krebs, Administrator Episcopal Church Home of Minnesota 1879 Feronia Avenue Saint Paul, Minnesota 55104

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5452024

Dear Ms. Krebs:

The above facility was surveyed on March 9, 2015 through March 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Episcopal Church Home of Minnesota March 25, 2015 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.

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 me.

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Ane Klasse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

Minneso	ta Department of He	alth				INOVED
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUI COMPLET	
		00486	B. WING		03/12/2	2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	ONIA AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BEC	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	surveyors of this De above provider and licensing orders we are completed, plea copy of these order Minnesota Departm	TS: hrough March 12, 2015, epartment's staff visited the the following Nursing Home re issued. When corrections ase sign and date, make a s and return the original to the hent of Health, Health		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	oftware. to	
	epartment of Health	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6)	) DATE

Electronically Signed

03/31/15

6899

If continuation sheet 1 of 6

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
			B. WING	•		
		00486			03/1	2/2015
		1879 FFF	RONIA AVEN	STATE, ZIP CODE UE		
PISCO	PAL CHURCH HOME	OF MINNESOTA SAINT PA	AUL, MN 55	104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
2 000	Continued From pa	ige 1	2 000			
		, Licensing and Certification 64900, St. Paul, MN		The assigned tag number app far left column entitled "ID Pr The state statute/rule number corresponding text of the state out of compliance is listed in t "Summary Statement of Defic column and replaces the "To o portion of the correction order column also includes the find are in violation of the state state statement, "This Rule is not m evidenced by." Following the findings are the Suggested M Correction and the Time Peric Correction. PLEASE DISREGARD THE F THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAI CORRECTION." THIS APPLI FEDERAL DEFICIENCIES OF WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE VIOLATIONS OF MINNESO STATUTES/RULES.	efix Tag." and the e statute/rule he ciencies" Comply" This dings which tute after the net as surveyors ethod of od For ICH N OF ES TO NLY. THIS GE. NT TO CTION FOR	
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			4/10/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED	
	00486		B. WING		03/12/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PISCOP	PAL CHURCH HOME	OF MINNESOTA	ONIA AVEN UL, MN 55 <sup>-</sup>	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
2 830	Continued From pa	age 2	2 830			
		the attending physician that the ain in bed or the resident n bed.				
	by: Based on interview facility failed to esta	ent is not met as evidenced and document review, the ablish emergency medical of 1 residents (R74) reviewed		POC not required.		
	Findings include:					
	check dialysis site, signs and symptom protocol. The care medical interventio	ted 5/28/13, directed staff to fistula, bruit, for bleeding, and ns of infection per facility plan lacked emergency ns and what the facility would ble to receive outpatient				
	included chronic ki Minimum Data Set indicated R74 had impairment, and re one staff for bed m personal hygiene a Order Sheet dated	identified diagnoses that dney disease. The quarterly (MDS) dated 12/9/14, moderate cognitive quired extensive assistance of obility, transfer, dressing, and toileting. The Physician's 3/11/15, directed outpatient Thursday and Saturday.				
	practical nurse (LP registered nurse (F director of nursing verified the care pla	iews were held with licensed N)-A at 10:33 a.m., with RN)-C at 11:49, and with the (DON) at 2:45 p.m., who all an did not address emergency rd to lack of access to the				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00486		B. WING		03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME		RONIA AVEN AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 3	2 830			
	regular dialysis cer	iter.				
	procedure on emer	able to provide a policy and gency medical interventions ring outpatient dialysis				
	The director of nurs and revise policies an emergency plan who require dialysis necessary. The dire	THOD FOR CORRECTION: sing or designee could review and procedures for ensuring is developed for residents s. Staff could be educated as ector of nursing or designee regular basis to ensure nce.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
21100	MN Rule 4658.065 Storage of Perisha	0 Subp. 5 Food Supplies; ble food	21100			4/10/15
	perishable food mu washable, corrosio	of perishable food. All ist be stored off the floor on n-resistant shelving under , and at temperatures which spoilage.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure that food was t reduced risk of food e main kitchen.		POC not required.		
	Findings include:					

Minnesota Department of Health STATE FORM

6899

HPDI11

If continuation sheet 4 of 6

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00486		B. WING	B. WING		12/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
PISCOP	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUE AUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21100	Continued From pa	ge 4	21100			
		ensure food was prepared in the risk of contamination.				
areas that reduced the risk of contamination. During the initial tour of the kitchen at noon on 3/9/15 water was noted to be dripping from the ceiling onto the floor. A cart with trays of bread on it was a few inches away. Cook-A reported last time the ceiling was leaking into the kitchen she was told it was from a tub room. On 3/9/15 at 6:30 p.m. a new ceiling tile was placed and water was no longer dripping. A cart with several trays of entrees and side dishes was located under the new ceiling tile. On 3/12/15 at 3:31 p.m. a cart with several trays of cookies was noted under the new ceiling tile. The ceiling tile was observed to have a darkened area, indicating potential water leak. DM confirmed findings and reported food should not be stored in areas of potential contamination. The maintenance supervisor, MS, reported she repaired a mop room sink above the kitchen from the ceiling. MS reported the ceiling tile was currently dry, but there was likely residual moisture that leaked down after repair of the mop room sink.						
	water had leaked d sealed and the ceili SUGGESTED MET The director of culir revise policies relat of potential contam	sink caulking was cracked and own to kitchen. The crack was ng tile was replaced. THOD FOR CORRECTION: nary services could review and ed to storage of food in areas ination. The director of				
		ould provide education to all naking staff and monitor for ice.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00486		B. WING	B. WING		12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
PISCOP	PAL CHURCH HOME		ONIA AVENUI UL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21100	Continued From pa	age 5	21100			
		R CORRECTION: Twenty-one				



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 25, 2015

Ms. Andrea Krebs, Administrator Episcopal Church Home of Minnesota 1879 Feronia Avenue Saint Paul, Minnesota 55104

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number S5452024

Dear Ms. Krebs:

The above facility survey was completed on March 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

Episcopal Church Home of Minnesota March 25, 2015 Page 2

When all orders are corrected, the order form should be acknowledged electronically and submitted to:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: <u>susanne.reuss@state.mn.us</u> Telephone: (651) 201-3793 Fax: (651) 201-3790

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 Sue Reuss.

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Ane Klagge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

Minneso	ta Department of He	alth		FORI	MAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY MPLETED
		00486	B. WING	03	/12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
EPISCOP	PAL CHURCH HOME	OF MINNESOTA	NONIA AVEN AUL, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENT	ГS	3 000		
	*****ATTENTIC	DN*****			
	BOARDING CAP LICENSING CORP				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon uny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	surveyors of this De above provider and licensing orders we are completed, plea	TS: chrough March 12, 2015, epartment's staff visited the the following Boarding Care re issued. When corrections ase sign and date, make a rs and return the original to 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 Boarding Care Homes.	
	epartment of Health / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
Electron	ically Signed				03/31/15

STATE FORM

6899 HPDI11

If continuation sheet 1 of 25

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
	00486		B. WING	03/	/12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	ONIA AVENI UL, MN 551	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
3 000	Continued From pa	age 1	3 000		
	Regulation Divisior	nent of Health, Health h, Licensing and Certification x 64900, St. Paul, MN		The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after th statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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 FOF VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	e F
3 945	MN Rule 4655.640 Care in General	0 Subp. 1 Adequate Care;	3 945		4/10/15
	resident shall recei and custodial care individual needs. F encouraged to be a for self-help, and to interests. Nursing out of bed as much	e in general. Each patient or ve nursing care or personal and supervision based on Patients and residents shall be active, to develop techniques o develop hobbies and home patients shall be up and as possible unless the a states in writing on the patient			

HPDI11

If continuation sheet 2 of 25

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/12/2015	
		00486	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
PISCOP	PAL CHURCH HOME	OF MINNESOTA	RONIA AVEN AUL, MN 55 <sup>.</sup>	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
3 945	Continued From pa	lge 2	3 945			
	' s medical record t bed.	hat the patient must remain in				
	by: Based on observat review the facility fa to identify the recor healing and failed t to prevent further w dermatitis for 1 of 1 non pressure relate	ent is not met as evidenced ion, interview and document ailed to update the plan of care nmended ointment to promote o provide the correct ointment vorsening of moisture related resident (R25) reviewed for ed skin issues.		POC not required		
	Findings include:					
	progress notes for 2/24/15 "Present or moisture associate denuded skin on rig zinc-barrier cream the skin site on the as healed. On 3/9/- moisture associate lower buttocks and buttocks. The prog [sic] been having di low grade temp [ter Will continue incon barrier cream appli "Elder's diarrhea ha	Condition/Wound Progression R25 revealed a note on In the right lower buttocks is d skin dmg [damage]." "Noted ght lower buttocks. Will use BID [twice daily]." On 3/4/15, right lower buttocks was noted 15, RN-D noted R25 again had d skin damage on her right a new area on her left lower ress notes indicated "Elder ans iarrhea since yesterday. Has mperature] this am [morning]. tinence care. Zinc based ed." On 3/11/15, RN-D noted ave improved. Less denuded h the right and left lower area	3			
		led an order initiated by the on 3/11/15 for calmoseptine				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00486		B. WING	B. WING		03/12/2015	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
PISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUE AUL, MN 55104				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
3 945	Continued From pa	age 3	3 945				
		used cream) to be applied twice tocks related to moisture itis.	9				
	nurse, (RN)-D was care on R25, revea	0:32 a.m. the wound care observed to complete wound aling two denuded areas on e on the bottom left and one or					
	changed the type o buttocks from a sta zinc based ointmer denuded area on F RN-D reported staf zinc based ointmer	0 a.m. RN-D explained she of cream to be applied on R25's andard barrier ointment to a nt on 2/24/15 due to the R25's right lower buttocks. If should have been applying a nt on R25's buttocks as part of due to the denuded areas on 15					
	(NA)-D and floor nu creams and ointme bottom. NA-D show protectant, not zinc surveyor prescriptio which included: ant vitamin creams. No ointments in R25's were zinc based, a care nurse, RN-D. with R25 on 3/8/15	6 a.m. R25's nursing assistant urse, (LPN)-C showed which ents were used on R25's ved surveyor a standard skin based. LPN-D showed on creams and ointments tifungal, corticosteroid, and one of the creams and room or medication supply s recommended by the wound NA-D reported she worked , 3/9/15 and on 3/12/15 and as a standard skin protectant, ntment.					
	(RN)-B reviewed R the care plan was r denuded areas on	1 a.m. the nurse manager, 25's care plan and confirmed not updated to include the R25's buttocks. RN-B nursing staff would know					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00486		B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUE AUL, MN 55104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 945	which cream to app from the wound can reported she becar areas on 3/9/15. RI was not able to find RN-D recommended buttocks. RN-B cor would not be expect a zinc based cream licensed nurse. R25's care area as noted "Elder was an ulcer on coccyx." T not note R25 had d buttocks, at that po ulcer - Full thickness fat may be visible b not exposed. Sloug obscure the depth undermining and tu R25's skin and wou revealed no problet the denuded areas 3/12/15. Review of undated, provided n zinc based ointmen The Wound Care M and Treatment Pro- directed staff "Red or change schedule (i.e. Thera Calzinc; prn." The form was and concern. The S manual, updated 4/ "Remember: stand	oly based on recommendations re specialist, RN-D. RN-B ne aware of the denuded N-B searched R25's room and d the zinc based ointment ed be applied to R25's nfirmed the nursing assistants sted to know when to switch to n, without guidance from a sessment, dated 2/16/15, dmitted with stage III pressure he care area assessment did lenuded areas of skin on int of time. (Stage 3 pressure as tissue loss. Subcutaneous but bone, tendon, or muscle is ph may be present but does not of tissue loss. May include unneling.) und care plan, dated 2/18/15, m or intervention focused on on R25's buttocks until the nursing assistant guide, no direction to staff regarding				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00486		B. WING	B. WING		12/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
3 945	better than nothing [medical doctor] mi as possible] and de are appropriate for be done instead of procedure further of found after admissi (paper one kept in interventions per on	age 5 . The wound nurse and/or MD ust get involved ASAP [as soor etermine if the standing orders the long term or what should the standing order." The lirected staff regarding wounds ion "Update working care plan binder) with all treatments & rders." and "RN [registered kin Impairment" care plan			,	
	review, the facility f was implemented f reviewed for range offered assistance prevent or minimize contractures. Findings include:	ion, interview and document ailed to ensure the care plan or 1 of 3 residents (R19) of motion. R19 was not to apply soft hand splint to e further worsening of hand				
	staff "I have contra stiffness r/t [related	ated 3/27/14, further directed cture of my hands and I to] Arthritis and Parkinson's". ded "Staff will apply my soft				
	NA-E and NA-D as and then brought h room. R19's hand s leaving for breakfas a.m. R19 was obse breakfast and was splint. From 8:47 a the door to the hou	a.m. R19's nursing assistants, sisted R19 with morning cares er to breakfast in the dining splint was not applied prior to st. From 7:41 a.m. to 8:47 erved in the dining room eating not wearing the soft hand .m. to 9:00 a.m. R19 sat near sehold waiting to go to an 00 a.m. R19 left for an				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00486	B. WING	B. WING		03/12/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
PISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUI AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
3 945	Continued From pa	age 6	3 945				
		was not approached by staff a an offer to apply the soft hanc	1				
	On 3/11/15 at 1:08 p.m., NA-E and NA-D reported the soft hand splint was not applied today because it was only applied at night, and quickly added R19 refused to wear her soft hand splint today.		ŀ				
	in her room in the r soft hand splint. W apply her soft hand	p.m. R19 was observed sitting ecliner. R19 was not wearing a hen asked if staff offered to I splint, R19 reported it was I to request to be done and no y it today.					
	RN-B and the hous confirmed the nurs apply the soft hand should inform a nur intervention. RN-B, LPN-D confirmed r	5 p.m. the nurse manager, schold coordinator (HC)-A ing assistants should offer to I splint daily. Nursing assistants rse or HC-A if R19 refused this HC-A and the floor nurse, to one informed them today to wear her soft hand splint.					
	offered to put on he	p.m. R19 reported no one er soft hand splint today. R19 d to not be wearing the soft					
	and activities of da dated 6/13/14, reve deformities related ability to complete a and caused pain. T not indicate R19 re splint. R19's quarter	are area assessment for pain ily living and rehabilitation, ealed R19 had hand and finger to arthritis which impaired her several activities of daily living The care area assessments did fused to wear her soft hand erly minimum data set [MDS], cated R19 required extensive					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED				
		00486	B. WING	B. WING		03/12/2015				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE						
EPISCOPAL CHURCH HOME OF MINNESOTA 1879 FERONIA AVENUE SAINT PAUL, MN 55104										
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
3 945	Continued From pa	age 7	3 945							
	functional impairm sides of her upper cognitive impairme Review of the Phys an order, dated 4/2 "Between hand spl protector. 2 times p For Left hand cont Review of the King	sician's Order Sheet revealed 20/11 which directed staff ing [sic] application, apply paln per day during Day, Evening,	1							
	review, the facility	tion, interview and document failed to attempt to discontinue y catheter for 1 of 3 residents or urinary catheter.								
	Findings include:									
		p.m. R155 was observed ing, with a urinary collection r leg.								
	and stated she has long time, and she tried to discontinue urinary catheter off but denied pain at also stated she get	8 a.m. R155 was interviewed s had the urinary catheter for a didn't believe the facility had e it. R155 further stated the ten feels sore and hurts her, the time of the interview. R155 ts occasional bladder enied having seen a urologist.								
	was interviewed ar urinary catheter sir	9 a.m. registered nurse (RN)-B nd stated R155 has had the nce she was admitted. RN-B 5 had the urinary catheter								

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00486	B. WING		03/12/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			12/2013
-		1879 FF	RONIA AVENU			
PISCOR	PAL CHURCH HOME	SAINT P	AUL, MN 5510	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 945	Continued From pa	age 8	3 945			
	had to reinsert it. R attempts had been urinary catheter, ar urologist since her On 3/12/15, at 3:48 (DON) was intervie admitted to the fac verified R155 had r R155's Face Sheet included neurogen urine. The quarterly dated 12/23/14, ind intact, required ext with toileting, and h catheter. The Care dated 7/10/14, india a urinary catheter i	after her admission, but they N-B verified no further made to discontinue the nd R155 had not seen a admission to the facility. B p.m. the director of nursing ewed, and stated R155 was ility with a urinary catheter, and not seen a urologist. t identified diagnoses that ic bladder, and retention of y Minimum Data Set (MDS) dicated R155 was cognitively ensive assistance of one staff had an indwelling urinary Area Assessment (CAA) cated R155 continued to have n her bladder due to urinary an unsuccessful trial to remove				
	8/2/13, the progress urinary catheter was note dated 8/6/13,	d to the facility on 7/31/13. On as notes indicated R155's as discontinued. A physician's indicated R155 continued to rected to insert the catheter 7.				
	Catheters dated 1/ condition improves weaning off the cat	and procedure on Indwelling 15/15, directed as soon as the a attempts should be made at theter and for discontinuation, plogy will be made as deemed <i>I</i> .D.				
		tion, interview and document failed to ensure infection				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00486	B. WING		03/12/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
3 945	Continued From pa	age 9	3 945			
	hygiene for 3 of 4 r observed for activit	rere implemented for hand residents (R4, R123, R19) ties of daily living (ADLs) and 1 observed for wound care.				
	-	personal cares with vashing				
	to assist with morn (without washing h retrieved R4's leg k attaches to a resid NA-B cleaned the alcohol wipe, unatt the end of the cath wipe and attached drainage bag into t amount of urine in writer how the cath stored. NA-B asket toilet and R4 denie warm soapy water, proceeded to assis incontinent produc bowel movement ( pericares, NA-B ap NA-B was observe to attach the cathe applied R4's pants	a.m., NA-B entered R4's room ing cares. NA-B donned gloves er hands) raised R4's bed and bag (drainage bag that ent's leg) from the bathroom. end of the leg bag with an ached the drainage bag, wiped eter tubing with an alcohol the leg bag. NA-B took the he bathroom, measured the the bag and informed this neter bag is cleaned and d R4 if she needed to sit on the d. NA-B retrieved a basin of , and washcloths and st R4. NA-B removed R4's t. R4 was incontinent of a BM). After completing polied a new incontinent brief. d, with the same gloved hands ter leg bag to R4's leg and . NA-B removed gloves and	5			
	indicated she woul changed and hand	B on 3/11/15 at 10:15 a.m., d have expected gloves to be s washed after changing the ning up the incontinent bowel				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00486	B. WING	B. WING		03/12/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUE AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
3 945	Continued From pa	age 10	3 945				
	2:50 p.m., indicated the nursing assista gloves after perical	director of nursing on 3/12/15 a d the expectation would be for nt to wash hands and change res, after cleaning up the novement, and after emptying					
	individual cares wit On 3/11/15, at 10:5 (NA)-B and NA-C w R123 with bed bath lying in bed, entirel stated giving R123 refused tub bath du worried for having	o ensure R123 received th appropriate hand hygiene. 51 a.m., two nursing assistants were observed to be assisting n. R123 was observed to be y covered with bed linen. NA-E a bed bath because resident ue to urge for defecation and bowel movement (BM) in the d NA-C wash hands and					
	donned gloves. NA temperature and co basin of warm soan advanced to assist a.m., NA-C remove the garbage and do without washing ha	INA-C wash hands and I-C checked the water onfirmed with R123, obtained a py water, and washcloths and R123 with bed bath. At 10:56 ed soiled gloves and threw in onned another pair of gloves ands. NA-C dumped the dirty and refilled the basin with warm					
	soapy water, and w assist with pericare R123 was "having removed soiled glo opened R123's doo	vashcloths and proceeded to e. Prior to pericare NA-C stated a BM." At 11:00 a.m., NA-C oves and threw in the garbage, or, stepped out and came back					
	gloves without was 11:07 a.m., NA-B g dirty linens from the	nes and donned another pair of hing hands in-between. At grabbed two plastic bags with e floor and placed on R123's re dirty wash clothes. At 11:15					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00486	B. WING		03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EPISCOP	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
3 945	Continued From pa	age 11	3 945			
	changing gloves or Both nursing assist	on R123's legs without performing hand hygiene. tants applied a lift sling under red him to the wheelchair at				
	(RN)-B explained h wash hands in betw gloves, and when o bodily fluids. RN-B appropriately wash	7 a.m., registered nurse her expectation was for staff to ween all cares, before donning coming into contact with any expected the staff to hands. RN-B further stated hands before, in between and yes."				
	not change gloves movement and ver R123 skin with the she did not perform the soiled gloves a	8 a.m. NA-B verified she did after cleaning up R123's bowe ified she applied lotion on soiled gloves. NA-B verified n hand hygiene after removing nd should have. NA-B added, n our hands in between gloves t talked about it."				
	removing gloves du opening the door to NA-C verified she o after removing the door knob and grat outside the room. F	did not wash hands after uring R123's bed bath and o go get more wash clothes. did not perform hand hygiene soiled gloves and touched bbed more wash cloths form R123 stated she should have ween. Further stated, "I was				
	directed, "Hands at work, breaks, after secretions, excretion whether or not glow	cautions policy, undated, re washed before and after touching blood, body fluids, ons and contaminated items, ves are worn. Hands will be d immediately after gloves are				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00486	B. WING	B. WING		12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUI AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
3 945	removed, between situation involving p infectious organism indicated. In additio and procedures on cross contamination addition, "Gloves an with blood, body flu contaminated items non-sterile gloves a after washing hand mucous membrane gloves will be applie procedures on the cross-contaminatio be removed immediated touching non-conta environmental surfa another elder or diff washed immediated The facility failed to protocols were follo R19. On 3/11/15 at 7:41 (NA)-E was observe the commode and on NA-E then removed pair, without washir then assisted R19 v On 3/11/15 at 1:08 not wash or sanitize gloves soiled from a commode and com	elder contact, after any possible contamination with is and when otherwise in, wash hands between tasks the same elder to prevent in of different body sites." In re to be worn when contact ids, secretions and is possible. New clean are to be worn immediately s and just prior to touching es and nonintact skin. New ed when performing tasks and same elder when in is possible. Gloves are to liately after use, and before				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		E SURVEY PLETED	
		00486	B. WING		03/12/2015		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			5/1 <i>2/2</i> 010	
		1879 FFI	RONIA AVENUE				
PISCOP	PAL CHURCH HOME	OF MINNESOTA SAINT PA	AUL, MN 5510	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
3 945	Continued From pa	age 13	3 945				
	nursing (ADON) re nursing assistants completing toileting to brushing teeth, e between tasks.	p.m. the assistant director of ported he would expect to wash or sanitize hands after g and perineal cares and prior even if gloves were changed					
	was followed during 3 pressure ulcer. (A thickness tissue los visible but bone, te exposed. Slough m	b ensure hand hygiene protoco g wound care for R25's stage A stage 3 pressure ulcer is full ss. Subcutaneous fat may be ndon, or muscle is not hay be present but does not of tissue loss. May include unneling.)					
	specialist, (RN)-D v 3 pressure ulcer or preparation solution and applied a foam wound. RN-D did n removing her pair of	2 a.m. the wound care was observed cleaning a stage n R25's coccyx with skin n. RN-D then changed gloves n dressing over R25's coccyx not wash or sanitize hands after of gloves, soiled from cleaning er, and donning new gloves foam dressing.					
	not wash or sanitiz gloves; after cleani prior to applying a t pressure ulcer. RN for her to carry alco	2 a.m. RN-D confirmed she did e her hands between changing ng R25's pressure ulcer and foam dressing over the -D reported it would be helpful phol based hand sanitizer to ene during wound cares.					
	review, the facility f was followed for 1 for falls and for 1 o	ion, interview and document failed to ensure the care plan of 3 residents (R155) reviewed f 3 residents (R19) who n oral care to assure care was					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00486	B. WING		03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	ONIA AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
3 945	Continued From pa	age 14	3 945			
	provided based on	individual needs.				
	Findings include:					
	for falls, with a goa care plan directed interventions: ensu risk per protocol, e and side effects of verbal reminders to without assistance hazards, assess fo balance and ambu falling to resident/fa to requests for ass The New Care Plan Falls indicated the added: educate res within reach (10/5/ (2/10/15), and low On 3/11/15, at 2:04	p.m. R155 was observed				
	reach and the bed On 3/12/15, at 8:33 and stated she has	ing, with the call light within at a regular height. 3 a.m. R155 was interviewed, 5 fallen, she wasn't sure why ht she just lost her balance at				
	was interviewed, a with assistance of asked what was be falling, NA-C replie close to the bed be bed and keeps her	a.m. nursing assistant (NA)-C nd stated R155 transferred one staff and a walker. When sing done to prevent R155 from d they keep the bedside table ecause R115 likes to read in books on the table. NA-C also he call light close to R115, and or assistance.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00486	B. WING	B. WING		03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
EPISCO	PAL CHURCH HOME		RONIA AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
3 945	Continued From pa	age 15	3 945				
	was interviewed an the night, and has I stated R155 has a might get up at night tubing. RN-B further prevent falls for R1 within reach, and e also stated the falls department head m any new intervention staff. RN-B stated as plan following her f to the working care Interventions to Add On 3/12/15, at 3:48 (DON) was intervie expect staff to asse update fall intervention R19's care plan, da need total assist fo hygiene because o arthritis." Intervention	<ul> <li>a.m. registered nurse (RN)-B ad stated R155 gets up during had some falls. RN-B further urinary catheter, and feels she ht and trip on the drainage er stated interventions to 55 are to have the call light ncourage her to use it. RN-B are reviewed at the facility norning stand up meeting, and ons are communicated to all she did not review R155's care alls, but did add interventions e plan (New Care Plan dress Falls form).</li> <li>B.p.m. the director of nursing swed, and verified she would ess for reasons for fall, and to tions into the care plan.</li> <li>ated 3/27/14 directed staff "I r grooming and personal f hand contractures and ons included: "I receive total ng and evening with grooming ne needs" and "I am at risk for</li> </ul>					
	impaired respirator [history] recurrent p	y function d/t [due to] hx pneumonia."					
		House nursing assistant care ected staff "Brush teeth after ce aspiration."					
	R19's nursing assist oral cares, includin brought her to brea	a.m., during observations, stant, NA-E assisted R19 with g brushing her teeth and then kfast in the dining room. From .m. R19 was observed in the					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00486	B. WING		03/12/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	ONIA AVENU UL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 945	Continued From pa	age 16	3 945			
	9:00 a.m. R19 sat i waiting to go to an left for an appointm by staff after break oral cares. During interview, of nursing assistants	breakfast. From 8:47 a.m. to near the door to the household appointment. At 9:00 a.m. R19 nent. R19 was not approached fast with an offer to perform n 3/11/15 at 1:08 p.m. the working with R19 for the day,				
	R19 with oral cares confirmed she only before breakfast. On 3/11/15 at 2:25	p.m. the nurse manager,				
	confirmed the nurs	sehold coordinator (HC)-A ing assistants should offer to Il cares after breakfast.				
		p.m. R19 reported no one er with oral cares after				
	pathologist (SLP) e coughing and requ	a.m. the speech language explained R19 had issues with ired oral cares after meals to sidue was out of her mouth.				
	The administrator a designee could rev procedures regardi compliance with re care plans, use of residents assistance	THOD FOR CORRECTION: and director of nursing or riew and revise policies and ing infection control, sident care plans, revision of urinary catheters and providing ce required for skin health and he director of nursing or				
anocota D	designee could pro	not an order of marching of a point of a poi				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00486	B. WING	03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVEN AUL, MN 55 <sup>.</sup>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
3 945	Continued From pa	ge 17	3 945		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
3 970	MN Rule 4655.6400 Assist with Oral hyg	0 Subp. 2E Adequate Care; giene	3 970		4/10/15
		for determining adequate etermining adequate and clude:			
	keep the mouth, tee	as needed with oral hygiene to eth, or dentures clean. used to prevent dry, cracked			
	by: Based on observati review, the facility fareviewed for activiti provided oral cares recommended by s	ent is not met as evidenced on, interview and document ailed to ensure 1 of 3 residents es of daily living, R19 was after meals, as peech therapy, to prevent or pneumonia and/or aspiration.		POC not required.	
	Findings include:				
	NA-E assisted R19 brushing her teeth a breakfast in the din 8:47 a.m. R19 was eating breakfast. Fr R19 sat near the do go to an appointme appointment. R19 v	a.m. R19's nursing assistant, with oral cares, including and then brought her to ing room. From 7:41 a.m. to observed in the dining room rom 8:47 a.m. to 9:00 a.m. por to the household waiting to nt. At 9:00 a.m. R19 left for an was not approached by staff an offer to perform oral cares.			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00486	B. WING		03/	12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
3 970	Continued From pa	age 18	3 970			
	working with R19 f confirmed they did after breakfast. NA R19 with oral cares On 3/11/15 at 2:25 RN-B and the hous confirmed the nurs assist R19 with ora inform a nurse or H could investigate the methods to increas after meal. RN-B, H LPN-D confirmed r about R19 refusing On 3/11/15 at 2:51	5 p.m. the nurse manager, sehold coordinator (HC)-A sing assistants should offer al cares after breakfast and HC-A if R19 refused so they he reason and attempt se compliance with oral cares HC-A and the floor nurse, no one informed them today g oral cares.				
	breakfast or lunch. On 3/12/15 at 9:35 pathologist (SLP) e coughing and requ	er with oral cares after a.m. the speech language explained R19 had issues with ired oral cares after meals to sidue was out of her mouth.				
	and activities of da dated 6/13/14, reve deformities related Parkinson's which grooming tasks. R set [MDS], dated 2 extensive assistan	are area assessment for pain ily living and rehabilitation, ealed R19 had hand and finger to arthritis, and a diagnosis of impaired her ability to complet 19's quarterly minimum data 2/17/15, indicated R19 required ce of two or more staff for rsonal hygiene tasks and had	e			
	moderate cognitive Review of speech assessments and					

Minneso	ta Department of He	alth			FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00486	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENU AUL, MN 5510			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETE DATE
TAG	HEGGEATORT ON E		TAG	DEFICIENCY)		DALE
3 970	Continued From pa	ge 19	3 970			
	transferring food fro and esophagus to i swallowing process pocketing was note during evaluation. F "The patient particing staff assistance to of mild impairment". S education to nursin follow through inclu to decrease risk of Review of the Phys nursing order, date "after each meal us toothette to clean m day at 0800, 1200, speech" R19's care plan, da need total assist for hygiene because of arthritis." Intervention assist in the mornin and personal hygie impaired respiratory [history] recurrent p Review of the King guides, undated, di each meal to reduct SUGGESTED MET The director of nursing of	ician's Order Sheet revealed a d 8/5/14, which directed staff a mouth wash and a pick nouth of bacteria 3 times per 1700, Special Instructions: per ted 3/27/14 directed staff "I r grooming and personal f hand contractures and ons included: "I receive total ng and evening with grooming ne needs" and "I am at risk for y function d/t [due to] hx oneumonia." House nursing assistant care rected staff "Brush teeth after te aspiration."	r			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		00486	B. WING		03/12/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
EPISCOF	PAL CHURCH HOME	OF MINNESOTA	ONIA AVENI UL, MN 551	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
3 970	Continued From pa	ge 20	3 970		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
31320	MN Rule 4655.8670 Storage of perishab	) Subp. 4 Food Supplies; ble foods	31320		4/10/15
	Subp. 4. Storage of perishable food. All perishable food shall be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. Meat and dairy products shall be stored at 40 degrees Fahrenheit or below, and fruit and vegetables at 50 degrees Fahrenheit or below. When stored together, the lower temperature shall apply. Temperatures shall be monitored by an accurate thermometer.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure food was reduced risk of food e main kitchen.		POC not required.	
		ensure food was prepared in the risk of contamination.			
	3/9/15 water was no ceiling onto the floo on it was a few inch time the ceiling was was told it was from 6:30 p.m. a new cei was no longer dripp of entrees and side	ur of the kitchen at noon on oted to be dripping from the r. A cart with trays of bread nes away. Cook-A reported last is leaking into the kitchen she in a tub room. On 3/9/15 at iling tile was placed and water ping. A cart with several trays dishes was located under the 3/12/15 at 3:31 p.m. a cart			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00486	B. WING		03/	12/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVENUI AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
31320		age 21 of cookies was noted under the	31320			
	new ceiling tile. The have a darkened at leak. DM confirmed should not be store contamination. The reported she repair kitchen on 3/9/15 a kitchen from the ce tile was currently de moisture that leake room sink. The Maintenance indicated the mop s water had leaked d	e ceiling tile was observed to rea, indicating potential water d findings and reported food ed in areas of potential e maintenance supervisor, MS, red a mop room sink above the sit was leaking into the eiling. MS reported the ceiling ry, but there was likely residual ed down after repair of the mop Work Order, dated 3/9/15, sink caulking was cracked and lown to kitchen. The crack was ing tile was replaced.				
	SUGGESTED MET The director of culi revise policies relat of potential contam culinary services co culinary and homer continued compliar	THOD FOR CORRECTION: nary services could review and ted to storage of food in areas ination. The director of buld provide education to all making staff and monitor for				
31380	The dishwashing accordance with th which shall be post 4660.8000, subpar maintained betwee square inch (psi) at	0 Hot Water Sanitizing g machine shall be operated in e manufacturer's instructions red nearby; see part t 9. The flow pressure shall be n 15 and 25 pounds per t the dishwasher. The e water shall be maintained at	31380			4/10/15

Minnesota Department of Health STATE FORM

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HPDI11

If continuation sheet 22 of 25

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00486	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
EPISCO	PAL CHURCH HOME	OF MINNESOTA	RONIA AVEN AUL, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
31380	Continued From pa	age 22	31380			
	cycle, and at 170 d rinsing and sanitizin measured at tray le handles both soiled shall wash his or he Dishes and utensils This MN Requirem by: Based on observat review, the facility f 6 households revie sanitized at approp Findings include: The facility failed to households were w appropriate water t On 3/9/15 at 7:05 p Unit, (H)-A was obs silverware into the wash and tempera [Fahrenheit]. Surve the silverware throu- rinse temperatures F. A sign on the dis wash temperatures F and rinse temper of 180 F. On 3/10/15 at 10:4 King Unit (H)-B wa silverware in plastic dishwasher. Wash above 130 F and ri above 140 F. At 11	ent is not met as evidenced ion, interview and document failed to ensure dishes on 1 of ewed were washed and priate water temperatures.		POC not required.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00486	B. WING	B. WING		03/12/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	•		
PISCOP	AL CHURCH HOME		RONIA AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
31380	Continued From pa	age 23	31380				
	dishwasher rack. H-B was observed to put the plastic silverware containers into the dish machine to wash one last time. H-B reported she then put the silverware away.						
	(DM) demonstrated worked by running cycle the rinse tem wash and 180 F for third cycle the wash not rise above 130 observation. DM ra machine. DM expla the racks were at le turn black. The tes confirmed this indic at the racks were n explained the home supervisor if dish m reaching minimum wash dishes in the dishes were not wa water temperature, DM reported he more	25 p.m. the dietary manager, d how the dish machine it three times. On the first dish perature went above 150 F for r rinse. On the second and h and rinse temperatures did F. DM confirmed this an a test strip through the dish ained if water temperatures at east 170 F the test strip would t strip turned light brown. DM cated the water temperatures not at least 170 F. DM emakers should notify a nachine temperatures were not levels and then proceed to main kitchen. DM explained if ashed and rinsed at minimum , they were not fully sanitized. onitored dish machine ugh the temperatures recorded ogs.					
	not aware why water reach a minimum to she continued to we dishwasher, instead water temperatures H-B reported the he unit, (HC)-A about	6 p.m. H-B reported she was er temperatures needed to emperature. H-B confirmed rash dishes in the household d of the main kitchen, despite s not meeting minimum levels. ousehold coordinator on her the dishwasher water being hot enough at about /15.					
	The Disburgships [	Procedures policy, dated					

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00486	B. WING		03/12/2015					
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE						
EPISCOPAL CHURCH HOME OF MINNESOTA 1879 FERONIA AVENUE SAINT PAUL, MN 55104										
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
31380	water shall be main the washing cycle a sanitizing cycle (16 point.). The flow pro- between 15 and 25 Corrective Action: if minimum standard, taken. If the final rin machine reads belo should be checked or temperature strip contact point is at 1 operation of the dis be notified and all of soon as the probler disposable dishwar dishes will be done soon as standard to maintained." Review of the Dish March 2015 revealed were recorded at m Temperatures reco SUGGESTED MET The director of culin could review and re washing and sanitiz culinary services or homemaking and c related to washing monitor for continue	staff "The temperature of the nationed at 150 F or above for and at 180 F for the rinsing and 0 F at the surface contact essure shall be maintained pounds per square inch (PSI). If temperatures are below the immediate action will be nose temperature on the dish ow 180 F, the temperature using a holding thermometer os to test that the surface 60 F to ensure proper th machine. Maintenance will dishwashing will be halted as m is identified. If necessary, re and/or hand sanitizing of . Dishwashing may resume as emperatures are again being washer Temperatures log for ed dish machine temperatures ninimum levels for 3/9/15. rded for 3/10/15 were illegible.								