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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HPDI
Facility ID: 00486

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245452**
2. STATE VENDOR OR MEDICAID NO. (L2) **419042400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/04/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 05/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/05/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/17/2015
(L33)

DETERMINATION APPROVAL

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
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,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245452	A. Building B. Wing	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) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**04/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**04/10/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**04/10/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**04/10/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**04/10/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	**04/10/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**04/10/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**04/10/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**04/10/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	05/05/2015	16022	05/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/12/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245452	01 - MAIN BUILDING 01	4/24/2015

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) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	04/10/2015	ID Prefix Reg. # NFPA 101 LSC K0029	04/10/2015	ID Prefix Reg. # NFPA 101 LSC K0038	04/17/2015
ID Prefix Reg. # NFPA 101 LSC K0062	04/10/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	05/05/2015	12424	04/24/2015
CMS RO				

Followup to Survey Completed on: 3/12/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245452	02 - EPISCOPAL CHURCH HOME OF MN	4/24/2015

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) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	04/10/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	05/05/2015	12424	04/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/12/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HPDI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00486

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Fatty Momodou, HFE NE II 04/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

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

Email: susanne.reuss@state.mn.us
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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING ______ B. WING ______	03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		4/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | 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.

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F 280	Continued From page 1 by: Based on observation, interview and document review the facility failed to update the plan of care to identify the recommended ointment to promote healing and prevent further worsening of moisture related dermatitis for 1 of 1 resident (R25) reviewed for non-pressure related skin issues. Findings include: On 03/11/2015 at 10:32 a.m. the wound care nurse, (RN)-D was observed to complete wound care on R25, revealing two denuded areas on R25's buttocks, one on the bottom left and one on the bottom right. On 3/12/15 at 10:30 a.m. RN-D explained she changed the type of cream to be applied on R25's buttocks from a standard barrier ointment to a zinc based ointment on 2/24/15 due to the denuded areas on R25's 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 bottom since 2/24/15. On 3/12/15 at 10:46 a.m. R25's nursing assistant, (NA)-D and floor nurse, (LPN)-C identified which creams and ointments were used on R25's bottom. NA-D pointed out a standard skin protectant, not zinc based product and LPN-D showed surveyor prescription creams and ointments which included: antifungal, corticosteroid, and vitamin creams. None of the creams and ointments in R25's room or medication supply were zinc based, as recommended by the wound care nurse, RN-D. NA-D reported she worked with R25 on 3/8/15, 3/9/15 and on 3/12/15 and the cream used was a	F 280	It is the policy of ECH that care plans remain current and up to date to reflect the care and services provided to our residents. Plan of correction for residents cited with this survey: (R25) had their plan of care updated to reflect the care and services provided to attain or maintain the highest level of practicable function. Plan to address/prevent this deficiency for other residents: All residents with non-pressure related skin conditions had a care plan review with updates as warranted to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for revising the care plan has been reviewed and remains current. The staff have been in-serviced on the policy and procedure. Plan to monitor: A random 10% audit of resident care plans with known skin conditions will be conducted the next 3 months to ensure compliance. The results of the audit will be reported on at the QA meeting with audits continuing as warranted. Responsible for maintaining compliance: RN Managers, DON and Certified Wound Nurse	

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F 280	Continued From page 2	F 280		

standard skin protectant, not a zinc based ointment.

On 3/12/15 at 10:51 a.m. the nurse manager, (RN)-B reviewed R25's care plan and confirmed the care plan was not updated to include the denuded areas on R25's buttocks. RN-B explained the floor nursing staff would know which cream to apply based on recommendations from the wound care specialist, RN-D. RN-B reported she became aware of the denuded areas on 3/9/15. RN-B searched R25's room and was not able to find the zinc based ointment RN-D recommended to be applied to R25's buttocks. RN-B confirmed the nursing assistants would not be expected to know when to switch to a zinc based cream, without guidance from a licensed nurse.

R25's care area assessment, dated 2/16/15, noted "Elder was admitted with stage III pressure ulcer on coccyx." (Stage 3 pressure ulcer - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) The care area assessment did not note R25 had denuded areas of skin on buttocks, at that point of time.

R25's skin and wound care plan, dated 2/18/15, revealed no problem or intervention focused on the denuded areas on R25's buttocks until 3/12/15. Review of the nursing assistant guide, undated, provided no direction to staff regarding zinc based ointment.

Review of the Skin Condition/Wound Progression progress notes for R25 revealed a note on

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2/24/15 "Present on the right lower buttocks is moisture associated skin dmg [damage]." "Noted denuded skin on right lower buttocks. Will use zinc-barrier cream BID [twice daily]." On 3/4/15, the skin site on the right lower buttocks was noted as healed. On 3/9/15, RN-D noted R25 again had moisture associated skin damage on her right lower buttocks and a new area on her left lower buttocks. The progress notes indicated "Elder ahs [sic] been having diarrhea since yesterday. Has low grade temp [temperature] this am [morning]. Will continue incontinence care. Zinc based barrier cream applied." On 3/11/15, RN-D noted "Elder's diarrhea have improved. Less denuded skin noted." for both the right and left lower area on R25's buttocks.

R25's orders included an order initiated by the nurse practitioner on 3/11/15 for calmoseptine ointment (a zinc based cream) to be applied twice daily to R25's buttocks related to moisture associated dermatitis.

The Wound Care Management Standard Orders and Treatment Protocols, last revised 2/26/14, directed staff "Red denuded Skin 1. Follow toilet or change schedule. 2. Apply zinc based oint after (i.e. Thera Calzinc; Calmoseptine) 2x/ day and prn." The form was not filled in with R25's name and concern. The Skin & Wound Training manual, updated 4/2014, directed staff "Remember: standing orders are only good for 72 hours. Standing orders are only designed for short term or a a situation where something is better than nothing. The wound nurse and/or MD [medical doctor] must get involved ASAP [as soon as possible] and determine if the standing orders are appropriate for the long term or what should be done instead of the standing order." The

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F 280	Continued From page 4 procedure further directed staff regarding wounds found after admission "Update working care plan (paper one kept in binder) with all treatments & interventions per orders." and "RN [registered nurse] to initiate "Skin Impairment" care plan (paper)."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 3 residents (R155) reviewed for falls and for 1 of 3 residents (R19) who required assist with oral care and application of a hand splint. Findings include: 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 hazards, assess for unmet needs, assess gait, balance and ambulation, staff to explain risk of falling to resident/family, and nursing to respond to requests for assistance as soon as possible.	F 282	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 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. Plan to address/prevent this deficiency for other residents: An audit of the care plans for all residents that have had a fall in the last 3 months, for those with splints, braces or like adaptive equipment and for residents with speech recommended oral cares has been done with revisions made as	4/10/15

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F 282	Continued From page 5 The New Care Plan Interventions to Address Falls indicated the following interventions were added: educate resident on safety, and call light within reach (10/5/14), educate on call light use (2/10/15), and low bed (3/3/15). On 3/11/15, at 2:04 p.m. R155 was observed laying in bed sleeping, with the call light within reach and the bed at a regular height. On 3/12/15, at 8:33 a.m. R155 was interviewed, and stated she has fallen, she wasn't sure why she falls, but thought she just lost her balance at times. On 3/12/15 at 9:47 a.m. nursing assistant (NA)-C was interviewed, and stated R155 transferred with assistance of one staff and a walker. When asked what was being done to prevent R155 from falling, NA-C replied they keep the bedside table close to the bed because R115 likes to read in bed and keeps her books on the table. NA-C also stated they keep the call light close to R115, and remind her to call for assistance. On 3/12/15, at 9:59 a.m. registered nurse (RN)-B was interviewed and stated R155 gets up during the night, and has had some falls. RN-B further stated R155 has a urinary catheter, and feels she might get up at night and trip on the drainage tubing. RN-B further stated interventions to prevent falls for R155 are to have the call light within reach, and encourage her to use it. RN-B also stated the falls are reviewed at the facility department head morning stand up meeting, and any new interventions are communicated to all staff. RN-B stated she did not review R155's care plan following her falls, but did add interventions to the working care plan (New Care Plan	F 282	warranted to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for the comprehensive care plan has been reviewed and revised. The staff have been in-serviced on the revised policy and procedure. Plan to monitor: A random audit of resident care plans for falls, splints, braces or like adaptive equipment and oral cares will be conducted and compared to observations of care delivered on the households over the next 3 months to ensure care plan compliance. The results of the audit will be reported on at the QA meeting with audits continuing as warranted. Responsible for maintaining compliance: RN Managers, DON and ADON	

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Interventions to Address Falls form).

On 3/12/15, at 3:48 p.m. the director of nursing (DON) was interviewed, and verified she would expect staff to assess for reasons for fall, and to update fall interventions into the care plan.

R19's care plan, dated 3/27/14 directed staff "I need total assist for grooming and personal hygiene because of hand contractures and arthritis." Interventions included: "I receive total assist in the morning and evening with grooming and personal hygiene needs" and "I am at risk for impaired respiratory function d/t [due to] hx [history] recurrent pneumonia."

Review of the King House nursing assistant care guide, undated, directed staff "Brush teeth after each meal to reduce aspiration."

On 3/11/15 at 7:41 a.m., during observations, R19's nursing assistant, NA-E assisted R19 with oral cares, including brushing her teeth and then brought her to breakfast in the dining room. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to perform oral cares.

During interview, on 3/11/15 at 1:08 p.m. the nursing assistants working with R19 for the day, NA-E and NA-D confirmed they did not assist R19 with oral cares after breakfast. NA-E confirmed she only assisted R19 with oral cares before breakfast.

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F 282	Continued From page 7 On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer to assist R19 with oral cares after breakfast. On 3/11/15 at 2:51 p.m. R19 reported no one offered to assist her with oral cares after breakfast or lunch. On 3/12/15 at 9:35 a.m. the speech language pathologist (SLP) explained R19 had issues with coughing and required oral cares after meals to make sure food residue was out of her mouth. R19's care plan, dated 3/27/14, further directed staff "I 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." On 3/11/15 at 7:41 a.m., during observations, R19's hand splint was not applied prior to leaving for breakfast. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast and was not wearing a soft hand splint. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to apply her soft hand splint. During interview, on 3/11/15 at 1:08 p.m. the nursing assistants working with R19 for the day, NA-E and NA-D reported they did not apply the soft hand splint today because it was only applied at night, then quickly added R19 refused to wear her soft hand splint today.	F 282		

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F 282	Continued From page 8 On 3/11/15 at 1:08 p.m. R19 was observed sitting in her room in her recliner. She was not wearing a soft hand splint. When asked if staff offered to apply the soft hand splint, R19 reported it was something she had to request to be done and no one offered to apply it today. On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer to assist R19 with the soft hand splint daily. Nursing assistants should inform a nurse or HC-A if R19 refused. RN-B, HC-A and the floor nurse, LPN-D confirmed no one informed them today about R19 refusing to wear her soft hand splint. On 3/11/15 at 2:51 p.m. R19 reported no one had offered to put on her soft hand splint today.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish emergency medical interventions for 1 of 1 residents (R74) reviewed for dialysis. In addition, the facility did not ensure care and services were provided for 1 of 1 residents (R25) with a non-pressure related skin	F 309	It is the policy of ECH to provide all residents with the care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of	4/10/15

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F 309	Continued From page 9 issues. Findings include: R74's care plan dated 5/28/13, directed staff to check dialysis site, fistula, bruit, for bleeding, and signs and symptoms of infection per facility protocol. The care plan lacked emergency medical interventions and what the facility would do if R74 was unable to receive outpatient dialysis services. R74's Face Sheet identified diagnoses that included chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 12/9/14, indicated R74 had moderate cognitive impairment, and required extensive assistance of one staff for bed mobility, transfer, dressing, personal hygiene and toileting. The Physician's Order Sheet dated 3/11/15, directed outpatient dialysis Tuesday, Thursday and Saturday. On 3/11/15, interviews were held with licensed practical nurse (LPN)-A at 10:33 a.m. , with registered nurse (RN)-C at 11:49, and with the director of nursing (DON) at 2:45 p.m., who all verified the care plan did not address emergency procedures in regard to lack of access to the regular dialysis center. The facility was unable to provide a policy and procedure on emergency medical interventions for residents receiving outpatient dialysis treatments. On 03/11/2015 at 10:32 a.m. the wound care nurse, (RN)-D completed wound care on R25, revealing two denuded areas on R25's buttocks, one on the bottom left and one on the bottom	F 309	care Plan of correction for residents cited with this survey: Resident (R74) has had emergency dialysis interventions added to his plan of care. Resident (R25) had their plan of care updated to reflect the care and services provided for non-pressure related skin issues. Plan to address/prevent this deficiency for other residents: All residents receiving dialysis were identified and have had emergency dialysis interventions added to their plan of care. All residents with non-pressure related skin conditions have had a care plan review with revisions made as needed. Measures put in place to prevent recurrence: A policy and procedure for emergency dialysis interventions has been created. The staff have been in-serviced on the new policy and procedure. The policy for Comprehensive Care Plan has been reviewed and remains current. Staff have been re-educated on following the established plan of care to ensure care and services are provided. Plan to monitor: All residents on dialysis will have a care plan audit done monthly to ensure that emergency dialysis interventions are in place. A random 10 % audit of resident care plans with known skin conditions will be conducted the next 3 months to ensure compliance. The result of the audits will be reported on at the QA meeting with audits continuing as warranted	

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F 309	Continued From page 10 right. 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 3/12/15 at 10:46 a.m. R25's nursing assistant, (NA)-D and floor nurse, (LPN)-C identified which creams and ointments they used on R25's bottom. NA-D showed surveyor a standard skin protectant, not zinc based and LPN-D showed surveyor prescription creams and ointments which included: antifungal, corticosteroid, and vitamin creams. None of the creams and ointments in R25's room or medication supply were zinc based, as recommended by the wound care nurse, RN-D. NA-D reported she worked with the R25 on 3/8/15, 3/9/15 and on 3/12/15 and the cream used was a standard skin protectant, not a zinc based ointment. On 3/12/15 at 10:51 a.m. the nurse manager, (RN)-B reviewed R25's care plan and confirmed the care plan was not updated to include the denuded areas on R25's buttocks. RN-B explained the floor nursing staff would know which cream to apply based on recommendations from the wound care specialist, RN-D. RN-B reported she became aware of the denuded areas on 3/9/15. RN-B searched R25's room and was not able to find the zinc based ointment RN-D recommended be applied to R25's buttocks. RN-B confirmed the nursing assistants	F 309	Responsible for maintaining compliance: RN Mangers, DON, ADON	

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would not be expected to know when to switch to a zinc based cream, without guidance from a licensed nurse.

R25's care area assessment, dated 2/16/15, noted "Elder was admitted with stage III pressure ulcer on coccyx." (Stage 3 pressure ulcer - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) The care area assessment did not note R25 had denuded areas of skin on her buttocks, at that point of time.

R25's skin and wound care plan, dated 2/18/15, revealed no problem or intervention focused on the denuded areas on R25's buttocks until 3/12/15. Review of the nursing assistant guide, undated, provided no direction to staff regarding zinc based ointment.

Review of the Skin Condition/Wound Progression progress notes for R25 revealed a note on 2/24/15 "Present on the right lower buttocks is moisture associated skin dmg [damage]." "Noted denuded skin on right lower buttocks. Will use zinc-barrier cream BID [twice daily]." On 3/4/15, the skin site on the right lower buttocks was noted as healed. On 3/9/15, RN-D noted R25 again had moisture associated skin damage on her right lower buttocks and a new area on her left lower buttocks. The progress notes indicated "Elder ahs [sic] been having diarrhea since yesterday. Has low grade temp [temperature] this am [morning]. Will continue incontinence care. Zinc based barrier cream applied." On 3/11/15, RN-D noted "Elder's diarrhea have improved. Less denuded skin noted." for both the right and left lower area

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F 309	Continued From page 12 on R25's buttocks. R25's orders included an order initiated by the nurse practitioner on 3/11/15 for calmoseptine ointment (a zinc based cream) to be applied twice daily to R25's buttocks related to moisture associated dermatitis. The Wound Care Management Standard Orders and Treatment Protocols, last revised 2/26/14, directed staff "Red denuded Skin 1. Follow toilet or change schedule. 2. Apply zinc based oint after (i.e. Thera Calzinc; Calmoseptine) 2x/ day and prn." The form was not filled in with R25's name and skin concern. The Skin & Wound Training manual, updated 4/2014, directed staff "Remember: standing orders are only good for 72 hours. Standing orders are only designed for short term or a a situation where something is better than nothing. The wound nurse and/or MD [medical doctor] must get involved ASAP [as soon as possible] and determine if the standing orders are appropriate for the long term or what should be done instead of the standing order." The procedure further directed staff regarding wounds found after admission "Update working care plan (paper one kept in binder) with all treatments & interventions per orders." and "RN [registered nurse] to initiate "Skin Impairment" care plan (paper)."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		4/10/15

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R19) reviewed for activities of daily living, was provided oral cares after meals, as recommended by speech therapy to prevent or minimize the risk of pneumonia and aspiration.

Findings include:

On 3/11/15 at 7:41 a.m. R19's nursing assistant, NA-E assisted R19 with oral cares, including brushing her teeth and then brought her to breakfast in the dining room. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to perform oral cares.

On 3/11/15 at 1:08 p.m. the nursing assistants working with R19 for the day, NA-E and NA-D confirmed they did not assist R19 with oral cares after breakfast. NA-E confirmed she only assisted R19 with oral cares before breakfast.

On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer assist R19 with oral cares after breakfast and inform a nurse or HC-A if R19 refused so they could investigate the reason and attempt methods to increase compliance with oral cares after meal. RN-B, HC-A and the floor nurse, LPN-D confirmed no one informed them today

It is the policy of ECH to deliver care and services to maintain good nutrition, grooming and personal and oral hygiene.
Plan of correction for residents cited with this survey:
Upon notification of this finding, resident (R19) speech recommendations were reviewed and the care plan revised to reflect care and services provided.
Plan to address/prevent this deficiency with other residents:
An audit of 100% of the residents with speech recommendations has been completed to ensure compliance.
Changes to the care plans have been made as deemed necessary to ensure compliance.
Measures put in place to prevent recurrence:
The policy and procedure for initiation and follow through on therapy recommendations has been created. The staff have been in-serviced on the policy and procedure.
Plan to monitor:
An audit of the care planned speech recommendations as compared to care observations on the households will be done over the next 3 months and reported at the quarterly QA meetings with audits continuing as deemed necessary.
Responsible for maintaining compliance:
RN Managers, DON and ADON

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F 312	Continued From page 14 about R19 refusing oral cares. On 3/11/15 at 2:51 p.m. R19 reported no one offered to assist her with oral cares after breakfast or lunch. On 3/12/15 at 9:35 a.m. the speech language pathologist (SLP) explained R19 had issues with coughing and required oral cares after meals to make sure food residue was out of her mouth. Review of R19's care area assessment for pain and activities of daily living and rehabilitation, dated 6/13/14, revealed R19 had hand and finger deformities related to arthritis, and a diagnosis of Parkinson's which impaired her ability to complete grooming tasks. R19's quarterly minimum data set [MDS], dated 2/17/15, indicated R19 required extensive assistance of two or more staff for performance of personal hygiene tasks and had moderate cognitive impairment. Review of speech therapy progress notes, assessments and plan of care, for dates 8/1/14 through 8/7/14 revealed a diagnosis of dysphagia, oropharyngeal phase (difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process) and oral residue and pocketing was noted after completion of swallow during evaluation. Recommendations included "The patient participates in oral cares with nursing staff assistance to decrease risk of aspiration with mild impairment". Speech therapy provided education to nursing staff and recommended follow through include providing regular oral care to decrease risk of pneumonia. Review of the Physician's Order Sheet revealed a nursing order, dated 8/5/14, which directed staff "after each meal use mouth wash and a pick	F 312		

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F 312	Continued From page 15 toothette to clean mouth of bacteria 3 times per day at 0800, 1200, 1700, Special Instructions: per speech" R19's care plan, dated 3/27/14 directed staff "I need total assist for grooming and personal hygiene because of hand contractures and arthritis." Interventions included: "I receive total assist in the morning and evening with grooming and personal hygiene needs" and "I am at risk for impaired respiratory function d/t [due to] hx [history] recurrent pneumonia." Review of the King House nursing assistant care guides, undated, directed staff "Brush teeth after each meal to reduce aspiration."	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt to discontinue the use of a urinary catheter for 1 of 3 residents (R155) reviewed for urinary catheter. Findings include:	F 315	It is the policy of ECH that any resident that has an indwelling catheter has valid medical justification and if not, has the catheter removed as soon as clinically warranted. Plan of correction for residents cited with	4/10/15

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On 3/11/15, at 2:04 p.m. R155 was observed laying in bed sleeping, with a urinary collection bag attached to her leg.

On 3/12/15, at 8:33 a.m. R155 was interviewed and stated she has had the urinary catheter for a long time, and she didn't believe the facility had tried to discontinue it. R155 further stated the urinary catheter often feels sore and hurts her, but denied pain at the time of the interview. R155 also stated she gets occasional bladder infections. R155 denied having seen a urologist.

On 3/12/15, at 9:59 a.m. registered nurse (RN)-B was interviewed and stated R155 has had the urinary catheter since she was admitted. RN-B further stated R155 had the urinary catheter discontinued right after her admission, but they had to reinsert it. RN-B verified no further attempts had been made to discontinue the urinary catheter, and R155 had not seen a urologist since her admission to the facility.

On 3/12/15, at 3:48 p.m. the director of nursing (DON) was interviewed, and stated R155 was admitted to the facility with a urinary catheter, and verified R155 had not seen a urologist.

R155's Face Sheet identified diagnoses that included neurogenic bladder, and retention of urine. The quarterly Minimum Data Set (MDS) dated 12/23/14, indicated R155 was cognitively intact, required extensive assistance of one staff with toileting, and had an indwelling urinary catheter. The Care Area Assessment (CAA) dated 7/10/14, indicated R155 continued to have a urinary catheter in her bladder due to urinary retention and had an unsuccessful trial to remove

F 315

this survey:
Upon notification of this finding, (R155) has had medical justification obtained from Metro Urology where she has been seen for many years.
Plan to address/prevent this deficiency for other residents:
All residents with indwelling catheters had a medical records review for presence of medical justification of their catheter. All were found to be in compliance with the medical justification for their indwelling catheter and where needed had it added to their care plan and diagnosis list.
Measures put in place to prevent recurrence:
The RN Managers will maintain a log of all residents on their households with an indwelling catheter and the corresponding medical justification for use. At the time of admission or introduction of a new indwelling catheter, for any resident, the RN Manager will obtain the necessary medical justification for use or orders and a plan to discontinue the catheters use as soon as clinically warranted. Staff have been in-serviced the systems change.
Plan to monitor:
The RN Managers will review the indwelling catheter log monthly for completeness and accuracy. A random audit of the medical record for those residents with an indwelling catheter will be done monthly for 3 months to ensure that medical justification for use is present. Findings will be reported on at the quarterly QA meetings. Based on the findings, the QA committee will recommend continuing or discontinuing

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F 315	Continued From page 17 in the past (8/8/13). R155 was admitted to the facility on 7/31/13. On 8/2/13, the progress notes indicated R155's urinary catheter was discontinued. A physician's note dated 8/6/13, indicated R155 continued to retain urine, and directed to insert the catheter back in temporarily. The facility policy and procedure on Indwelling Catheters dated 1/15/15, directed as soon as the condition improves attempts should be made at weaning off the catheter and for discontinuation, and referrals to urology will be made as deemed necessary by the M.D.	F 315	the audits. Responsible for maintaining compliance: RN Managers, DON and ADON	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R19) reviewed for range of motion, was offered assistance to apply soft hand splint to prevent or minimize further worsening of hand contractures. Findings include: On 3/11/15 at 7:35 a.m. R19's nursing assistants, NA-E and NA-D assisted R19 with morning cares and then brought her to breakfast in the dining	F 318	It is the policy of ECH to provide all residents with limited ROM appropriate treatment and services to increase ROM and/or prevent further decrease in ROM. Plan of correction for residents cited with this survey: Resident (R19) was reassessed by OT for their adaptive equipment and ROM program to ensure appropriate treatment	4/10/15

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room. R19's hand splint was not applied prior to leaving for breakfast. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast and was not wearing the soft hand splint. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to apply the soft hand splint.

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.

On 3/11/15 at 1:09 p.m. R19 was observed sitting in her room in the recliner. R19 was not wearing a soft hand splint. When asked if staff offered to apply her soft hand splint, R19 reported it was something she had to request to be done and no one offered to apply it today.

On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer to apply the soft hand splint daily. Nursing assistants should inform a nurse or HC-A if R19 refused this intervention. RN-B, HC-A and the floor nurse, LPN-D confirmed no one informed them today about R19 refusing to wear her soft hand splint.

On 3/11/15 at 2:51 p.m. R19 reported no one offered to put on her soft hand splint today and was again observed to not be wearing the soft hand splint.

Review of R19's care area assessment for pain

and services.
Plan to address/prevent this deficiency for other residents:
An audit has been conducted for all residents on a ROM program to review and revise when needed, the treatment plan of care, services and adaptive equipment needed to increase ROM and/ or prevent a decrease in ROM. If warranted a referral was made to OT for further evaluation and/or recommendations of the program and/or device.
Measures put in place to prevent recurrence:
Learning circles were conducted by the RN Managers to re-educate on the ROM programs and any related adaptive equipment used for the residents on such programs residing in their households
Plan to monitor:
A random audit of resident s on ROM programs will be conducted to ensure they are wearing adaptive equipment and that the treatment plan is followed to ensure compliance. The results of the audit will be reported on at the QA meeting with audits continuing as warranted.
Responsible for maintaining compliance:
RN Mangers, DON and ADON

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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 "I 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 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/10/15

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and documentation review, the facility failed to evaluate/re-assess potential causative factors for multiple falls for 1 of 3 residents (R155) reviewed for accidents.

Findings include:

R155'S Incident Details identified the following falls:

On 3/3/15, at 3:00 a.m. Staff heard resident screaming help, upon going into her room resident was sitting on floor next to bed. Resident stated she was going to the bathroom. There no visible injuries. Resident was assisted back to bed with two, and was toileted with no result. Corrective measures initiated: R115's bed was placed in low position, the call light was placed within reach, and neuro checks were initiated (to access for a head injury).

On 2/10/15, at 5:00 a.m. Resident was observed on the floor in a sitting position. Resident stated she was trying to get out of bed and fell on the floor. Resident's left arm was bleeding from a 5 centimeter (cm) x 2 cm skin tear. Some bleeding and bruising were also identified to resident's face. Resident was transferred back to bed. Corrective measures initiated: frequent reminders to use call light, and neuro checks were initiated.

On 10/5/14, at 5:00 p.m. Resident was lying on bed and rang the call light. She said she had a fall when she was putting a book back on the shelf, then she crawled into bed. Resident received a 1

It is the policy of ECH to ensure that the environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.
Plan of correction for residents cited with this survey:
Resident (R155) had their fall risk reassessed with appropriate interventions added to their plan of care.
Plan to address/prevent this deficiency for other residents:
An audit of the care plans for the residents that have had a fall in the last 3 months was conducted with revisions and/or interventions implemented as warranted ensuring compliance.
Measures put in place to prevent recurrence:
The RN Managers will maintain a fall log on each resident in the working care plan book. At the time of a resident fall, a new intervention(s) will be added and staff will be educated on the new intervention(s) to prevent future falls. Staff have been in-serviced on this system.

Plan to monitor:
A random audit of the care plans for residents that have fallen in the month will be done monthly for 3 months. The results of the audit will be reported on at the QA meeting with audits continuing as warranted
Responsible for maintaining compliance:

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F 323	Continued From page 21 x 0.2 cm skin tear to her left ear, a 1.5 cm x 2 cm skin tear to the left side of her face, and a 2 cm x 1 cm skin tear to her left elbow. Also complained of pain in the left shoulder. Corrective measures taken by facility was left blank. On 3/11/15, at 2:04 p.m. R155 was observed laying in bed sleeping, with the call light within reach and the bed at a regular height. On 3/12/15, at 8:33 a.m. R155 was interviewed, and stated she has fallen, she wasn't sure why she falls, but thought she just lost her balance at times. On 3/12/15 at 9:47 a.m. nursing assistant (NA)-C was interviewed, and stated R155 transferred with assistance of one staff and a walker. When asked what was being done to prevent R155 from falling, NA-C replied they keep the bedside table close to the bed because R115 likes to read in bed and keeps her books on the table. NA-C also stated the call light is kept close to R115, and reminder are given for R115 to call for assistance. On 3/12/15, at 9:59 a.m. registered nurse (RN)-B was interviewed and stated R155 gets up during the night, and has had some falls. RN-B further stated R155 has a urinary catheter, and feels she might get up at night and trip on the drainage tubing. RN-B further stated interventions to prevent falls for R155 are to have the call light within reach, and encourage her to use it. RN-B also stated the falls are reviewed at the facility department head morning stand up meeting, and any new interventions are communicated to all staff. RN-B stated she did not review R155's care plan following the falls, but did add interventions	F 323	RN Managers, DON and ADON	

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to the working care plan (New Care Plan Interventions to Address Falls form).

On 3/12/15, at 3:48 p.m. the director of nursing (DON) was interviewed, and verified she would expect staff to assess for reasons for fall, and to update fall interventions into the care plan.

R155's Face Sheet identified diagnoses that included hypertension, osteoporosis and diabetes. The quarterly Minimum Data Set (MDS) dated 12/23/14, indicated R155 was cognitively intact, and required extensive assistance of one staff with bed mobility, transfers, ambulation and toileting. The Care Area Assessment (CAA) dated 7/10/14, indicated R155 was at risk for falls due to unsteady gait, need of standby assistance/guidance for transfers and ambulation, forgetfulness, episodes of bowel incontinence, and receives pain medications. The CAA further directed staff to keep call light in place and remind resident to use it for assistance.

R155's care plan dated 4/28/14, identified a risk for falls, with a goal of being free from falls. The care plan included 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 hazards, assess for unmet needs, assess gait, balance and ambulation, staff to explain risk of falling to resident/family, and nursing to respond to requests for assistance as soon as possible. The New Care Plan Interventions to Address Falls indicated the following interventions were added: educate resident on safety, and call light within reach (10/5/14), educate on call light use

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F 323	Continued From page 23 (2/10/15), and low bed (3/3/15). The facility policy and procedure on Fall (Post) Assessment dated 1/5/15, directed staff to assess resident for any underlying disease process or sign of infection that may have contributed to the fall, review medications that may contribute to falls, assess for proper footwear and clothing, and consider changes to the environment to prevent further falls (such as colored tape on call light, colored tape on floor, fall alarms, furniture arrangement and lighting). The policy and procedure further directed staff to care plan fall and fall prevention measures, and document any fall interventions put into place at time of fall.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishes on 1 of 6 households reviewed were washed and sanitized at appropriate water temperatures and failed to assure that food was stored in areas that reduced risk of food contamination in the main	F 371	It is the policy of ECH to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute and service food under sanitary conditions.	4/10/15

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F 371	Continued From page 24 kitchen. This had the potential to impact 122 out of 123 residents residing at the facility. Findings include: The facility failed to ensure dishes on 1 of 6 households were washed and sanitized at appropriate water temperatures. 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 rinse temperatures again did not rise above 125 F. A sign on the dish machine directed staff that wash temperatures must reach a minimum of 150 F and rinse temperatures must reach a minimum of 180 F. On 3/10/15 at 10:47 a.m. a homemaker on the King Unit (H)-B was observed placing a load of silverware in plastic silverware holders into the dishwasher. Wash temperatures did not rise above 130 F and rinse temperatures did not rise above 140 F. At 11:16 a.m. H-B reported the silverware had been soaked before placing in the 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. On 3/10/15 at 12:25 p.m. the dietary manager, (DM) demonstrated how the dish machine worked by running it three times. On the first dish cycle the rinse temperature went above 150 F for wash and 180 F for rinse. On the second and third cycle the wash and rinse temperatures did	F 371	Plan of correction for residents cited with this survey: No residents were harmed by this practice. Plan to address/prevent this deficiency for other residents: All homemaking and food service staff were re-educated on dishwashing procedures and proper storage for food. Measures put in place to prevent recurrence: Homemakers will notify the household coordinator if the temperatures are not where they need to be immediately. Weekly, dishwasher temperature logs will be checked by the Household Coordinator to ensure each household dishwasher is at required temperatures. Food service staff will notify maintenance immediately if they notice ceiling tiles are not intact. Monthly the FSD will make rounds with the maintenance supervisor to ensure environment is free of unsanitary conditions. Plan to monitor: Weekly, dishwasher temperature logs will be checked by the Household Coordinator to ensure each household dishwasher is at required temperatures. Monthly the FSD will make rounds with the maintenance supervisor to ensure environment is free of unsanitary conditions. Responsible for maintaining compliance: Household Coordinators, Food Service	

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not rise above 130 F. DM confirmed this observation. DM ran a test strip through the dish machine. DM explained if water temperatures at the racks were at least 170 F the test strip would turn black. The test strip turned light brown. DM confirmed this indicated the water temperatures at the racks were not at least 170 F. DM explained the homemakers should notify a supervisor if dish machine temperatures were not reaching minimum levels and then proceed to wash dishes in the main kitchen. DM explained if dishes were not washed and rinsed at minimum water temperature, they were not fully sanitized. DM reported he monitored dish machine temperatures through the temperatures recorded in the monitoring logs.

On 3/10/15 at 12:56 p.m. H-B reported she was not aware why water temperatures needed to reach a minimum temperature. H-B confirmed she continued to wash dishes in the household dishwasher, instead of the main kitchen, despite water temperatures not meeting minimum levels. H-B reported the household coordinator on her unit, (HC)-A about the dishwasher water temperatures not being hot enough at about 12:40 p.m. on 3/10/15.

The Dishwashing Procedures policy, dated 12/11/08, directed staff "The temperature of the water shall be maintained at 150 F or above for the washing cycle and at 180 F for the rinsing and sanitizing cycle (160 F at the surface contact point.). The flow pressure shall be maintained between 15 and 25 pounds per square inch (PSI). Corrective Action: if temperatures are below the minimum standard, immediate action will be taken. If the final rinse temperature on the dish machine reads below 180 F, the temperature

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F 371	Continued From page 26 should be checked using a holding thermometer or temperature strips to test that the surface contact point is at 160 F to ensure proper operation of the dish machine. Maintenance will be notified and all dishwashing will be halted as soon as the problem is identified. If necessary, disposable dishware and/or hand sanitizing of dishes will be done. Dishwashing may resume as soon as standard temperatures are again being maintained." Review of the Dishwasher Temperatures log for March 2015 revealed dish machine temperatures were recorded at minimum levels for 3/9/15. Temperatures recorded for 3/10/15 were illegible. The facility failed to ensure food was prepared in 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 on the floor above the kitchen on 3/9/15 as it was leaking into the kitchen from the ceiling. MS reported the ceiling tile was currently dry, but	F 371		

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F 371	Continued From page 27 there was likely residual moisture that leaked down after repair of the mop room sink. The Maintenance Work Order, dated 3/9/15, indicated the mop sink caulking was cracked and water had leaked down to kitchen. The crack was sealed and the ceiling tile was replaced.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		4/10/15

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F 441	Continued From page 28 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were implemented for hand hygiene for 3 of 4 residents (R4, R123, R19) observed for activities of daily living (ADLs) and 1 of 1 resident (R25) observed for wound care. Findings include: R4 did not receive personal cares with appropriate hand washing On 3/11/15 at 7:40 a.m., NA-B entered R4's room to assist with morning cares. NA-B donned gloves (without washing her hands) raised R4's bed and retrieved R4's leg bag (drainage bag that attaches to a resident's leg) from the bathroom. NA-B cleaned the end of the leg bag with an alcohol wipe, unattached the drainage bag, wiped the end of the catheter tubing with an alcohol wipe and attached the leg bag. NA-B took the drainage bag into the bathroom, measured the amount of urine in the bag and informed this writer how the catheter bag is cleaned and stored. NA-B asked R4 if she needed to sit on the toilet and R4 denied. NA-B retrieved a basin of warm soapy water, and washcloths and proceeded to assist R4. NA-B removed R4's	F 441	It is the policy of ECH to establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction for residents cited with this survey: (R4), (R25), (R123) and (R19) had their medical condition reviewed and remain infection free as a result of this practice. Plan to address/prevent this deficiency for other residents: All staff assisting with ADLs or performing wound care had mandatory hand hygiene in-services conducted. Measures put in place to prevent recurrence: The policy and procedure for hand hygiene and the infection control plan have been reviewed and remain current. The staff have been re-educated on the policy and procedures. Plan to monitor: RN Managers or designee will conduct random audits of ADLs and wound cares to ensure that proper hand hygiene and infection control practices are being	

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F 441	Continued From page 29 incontinent product. R4 was incontinent of a bowel movement (BM). After completing pericares, NA-B applied a new incontinent brief. NA-B was observed, with the same gloved hands, to attach the catheter leg bag to R4's leg and applied R4's pants. NA-B assisted R4 to transfer into the wheelchair. NA-B removed gloves and washed hands. Interview with RN -B on 3/11/15 at 10:15 a.m., indicated she would have expected gloves to be changed and hands washed after changing the leg bag, after cleaning up the incontinent bowel movement and after pericares. Interview with the director of nursing on 3/12/15 at 2:50 p.m., indicated the expectation would be for the nursing assistant to wash hands and change gloves after pericares, after cleaning up the incontinent bowel movement, and after emptying the catheter. The facility failed to ensure R123 received individual cares with appropriate hand hygiene. On 3/11/15, at 10:51 a.m., two nursing assistants (NA)-B and NA-C were observed to be assisting R123 with bed bath. R123 was observed to be lying in bed, entirely covered with bed linen. NA-B explained giving R123 a bed bath because resident refused tub bath due to urge for defecation and worried for having bowel movement (BM) in the tub. NA-B and NA-C washed hands and donned gloves. NA-C checked the water temperature and confirmed with R123, obtained a basin of warm soapy water, and washcloths and advanced to assist R123 with bed bath. At 10:56 a.m., NA-C removed soiled gloves and threw in the garbage and	F 441	followed. Audit results will be reported on at the QA meeting with audits continuing as warranted Responsible for maintaining compliance: RN Managers, DON, Wound Nurse, and ADON	

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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

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opening the door to go get more wash clothes. R123 stated she should have washed hands in between. Further stated, "I was nervous."

The Standard Precautions policy, undated, directed, "Hands are washed before and after work, breaks, after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Hands will be washed before and immediately after gloves are removed, between elder contact, after any situation involving possible contamination with infectious organisms and when otherwise indicated. In addition, wash hands between tasks and procedures on the same elder to prevent cross contamination of different body sites." In addition, "Gloves are to be worn when contact with blood, body fluids, secretions and contaminated items is possible. New clean non-sterile gloves are to be worn immediately after washing hands and just prior to touching mucous membranes and nonintact skin. New gloves will be applied when performing tasks and procedures on the same elder when cross-contamination is possible. Gloves are to be removed immediately after use, and before touching non-contaminated items and environmental surfaces and before going to another elder or different task. Hands are to be washed immediately after gloves are removed."

The facility failed to ensure hand hygiene protocols were followed during morning cares for R19.

On 3/11/15 at 7:41 a.m. a nursing assistant, (NA)-E was observed assisting R19 with using the commode and completing perineal care. NA-E then removed gloves and donned a new

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pair, without washing or sanitizing hands. NA-E then assisted R19 with brushing her teeth.

On 3/11/15 at 1:08 p.m. NA-E confirmed she did not wash or sanitize her hands after removing gloves soiled from assisting R19 with using the commode and completing perineal care. NA-E reported she donned a new pair of gloves to help R19 brush her teeth, but did not wash or sanitize her hands first.

On 3/11/15 at 1:26 p.m. the assistant director of nursing (ADON) reported he would expect nursing assistants to wash or sanitize hands after completing toileting and perineal cares and prior to brushing teeth, even if gloves were changed between tasks.

The facility failed to ensure hand hygiene protocol was followed during wound care for R25's stage 3 pressure ulcer. (A stage 3 pressure ulcer is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.)

On 3/11/15 at 10:32 a.m. the wound care specialist, (RN)-D was observed cleaning a stage 3 pressure ulcer on R25's coccyx with skin preparation solution. RN-D then changed gloves and applied a foam dressing over R25's coccyx wound. RN-D did not wash or sanitize hands after removing her pair of gloves, soiled from cleaning R25's pressure ulcer, and donning new gloves prior to applying a foam dressing.

On 3/11/15 at 10:32 a.m. RN-D confirmed she did not wash or sanitize her hands between changing

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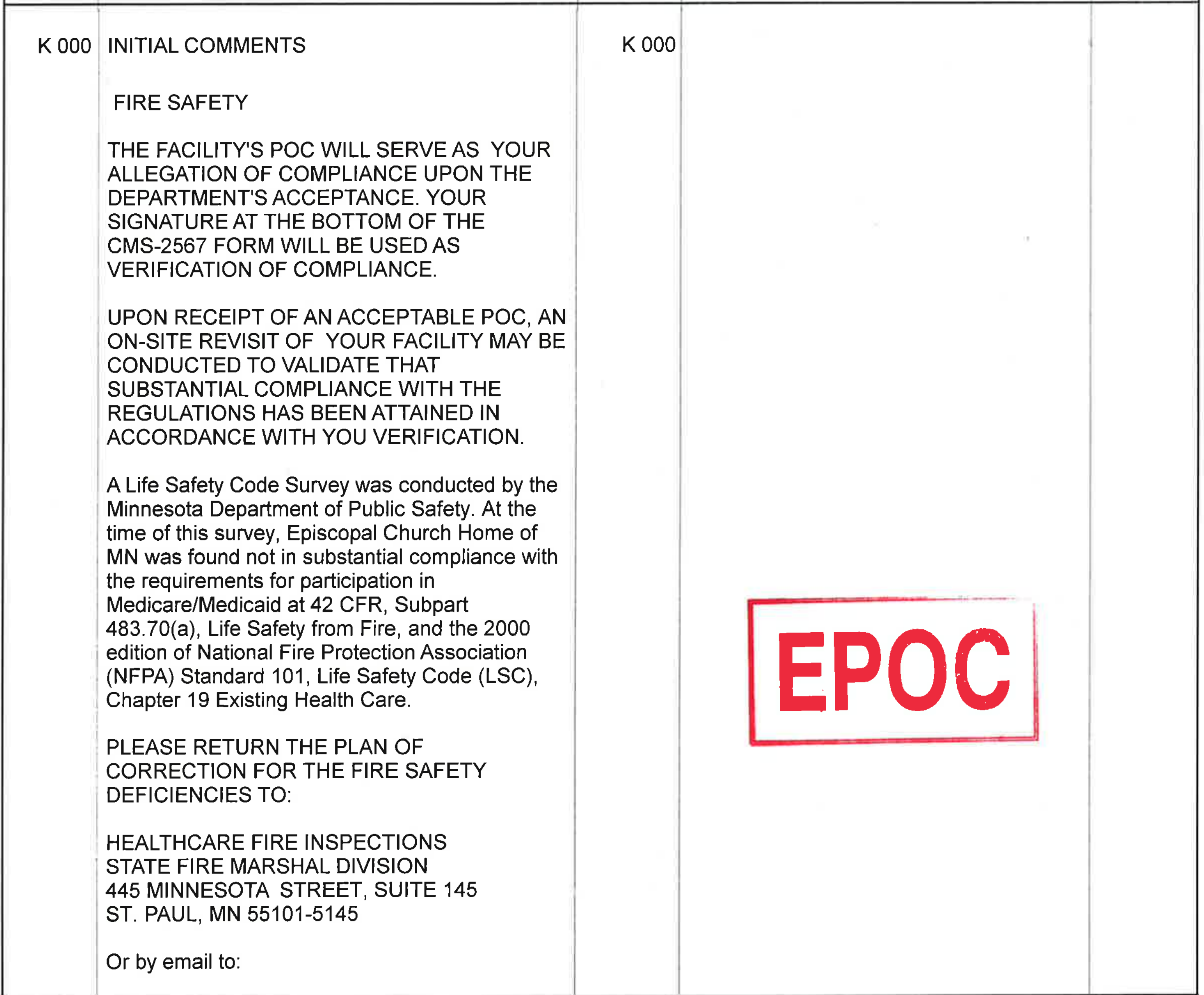
F 441	Continued From page 33 gloves; after cleaning R25's pressure ulcer and prior to applying a foam dressing over the pressure ulcer. RN-D reported it would be helpful for her to carry alcohol based hand sanitizer to promote hand hygiene during wound cares.	F 441		

F5452023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	03/12/2015

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



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building.. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a licensed capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors within the smoke compartments. Findings include: On facility tour between 09:00 AM and 02:00 PM on 03/12/2015, it was observed that the wall above the smoke barrier doors on the 1st floor by room 122, had penetrations that had not been sealed in an approved manner.	K 025	ECH will ensure that the smoke barrier door on the 1st floor by room 122 has been sealed in an approved manner by 4/10/14. The maintenance and housekeeping director and Administrator will be responsible for ensuring compliance.	4/10/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/12/2015

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

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K 025	Continued From page 3 This deficiency was verified by the facility Environmental Supervisor (MS) at the time of discovery.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect all residents, guests and staff within the smoke compartments. Findings include: On facility tour between 09:00 AM and 02:00 PM on 03/12/2015, it was observed that penetrations in the corridor wall around conduit and wires Where the fire stopping has been removed, fallen out or from cable TV installation in the following areas: 1) 3rd floor Mechanical Room next to room 304, 2" hole in ceiling from cable tv instalation.	K 029	In the areas affected by the cable TV installation and other areas identified, fire caulking will be applied to ensure proper protection to hazardous areas. This will be completed by 4/10/14. The maintenance/housekeeping supervisor and Administrator will be responsible for ensuring compliance.	4/10/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/12/2015**

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

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K 029	Continued From page 4 2) 2nd floor Homemaker Closet by room 202 had penetrations in corridor wall and ceiling. 3) 2nd floor Server Room Isabella House had penetrations in the corridor wall. 3) 1st floor Mechanical Room By room 122 had penetrations in corridor wall This deficiency was verified by the facility Environmental Supervisor (MS) at the time of discovery.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all residents, visitors and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 09:00 AM and 02:00 PM on 03/12/2015, it was observed that the Cook House Feronia Exit door was difficult to open because of loose weather stripping and had a 6" step down to the hard surface with loose bricks to step on to the exit. This deficiency was verified by the facility	K 038	The exit located in Cooke House going out to Feronia Ave will have new weather stripping installed. We will also repave the concrete so there is a smooth transition between the door and sidewalk. This will be completed by 4/17/14. The maintenance/housekeeping supervisor and Administrator will be responsible for compliance.	4/17/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**03/12/2015**

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

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K 038	Continued From page 5 Environmental Supervisor (MS) at the time of discovery.	K 038		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to properly maintain the fire sprinkler system. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 02:00 PM on 03/12/15, it was discovered, during review of available documentation, that the facility did not conduct quarterly fire sprinkler testing as required in the last 12 months. This deficiency was verified by the facility Environmental Supervisor (MS) at the time of discovery.	K 062	ECH will document all quarterly sprinkler flow tests beginning immediate. The maintenance technicians, supervisor and Administrator will be responsible for ensuring compliance. The safety committee will review quarterly.	4/10/15

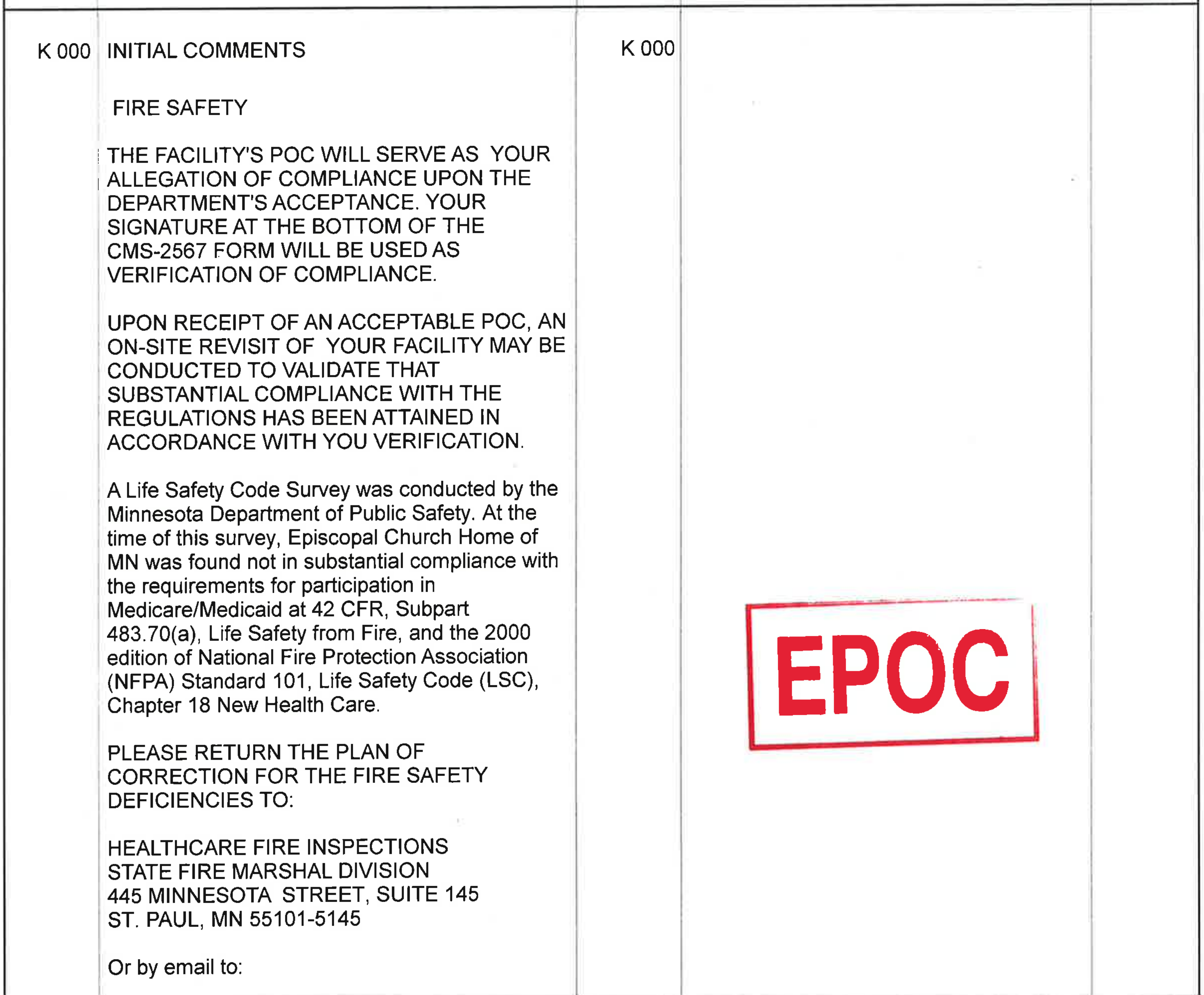
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5452023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **02 - EPISCOPAL CHURCH HOME OF MN** B. WING ______	**03/12/2015**

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



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **02 - EPISCOPAL CHURCH HOME OF MN** B. WING ______	**03/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building..

The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 02 - EPISCOPAL CHURCH HOME OF MN B. WING ______	03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a licensed capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to properly maintain the fire sprinkler system. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 02:00 PM on 03/12/15, it was discovered, during review of available documentation, that the facility did not conduct quarterly fire sprinkler testing as required in the last 12 months. This deficiency was verified by the facility Environmental Supervisor (MS) at the time of discovery.	K 062	ECH will document all quarterly sprinkler flow tests beginning immediate. The maintenance technicians, supervisor and Administrator will be responsible for ensuring compliance. The safety committee will review quarterly.	4/10/15

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 9, 2015 through March 12, 2015, surveyors of this Department's staff visited the above provider and the following Nursing Home licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Health	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 03/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	**1879 FERONIA AVENUE SAINT PAUL, MN 55104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Regulation Division, Licensing and Certification Program; P.O. Box 64900, St. Paul, MN 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		4/10/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	03/12/2015

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish emergency medical interventions for 1 of 1 residents (R74) reviewed for dialysis. Findings include: R74's care plan dated 5/28/13, directed staff to check dialysis site, fistula, bruit, for bleeding, and signs and symptoms of infection per facility protocol. The care plan lacked emergency medical interventions and what the facility would do if R74 was unable to receive outpatient dialysis services. R74's Face Sheet identified diagnoses that included chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 12/9/14, indicated R74 had moderate cognitive impairment, and required extensive assistance of one staff for bed mobility, transfer, dressing, personal hygiene and toileting. The Physician's Order Sheet dated 3/11/15, directed outpatient dialysis Tuesday, Thursday and Saturday. On 3/11/15, interviews were held with licensed practical nurse (LPN)-A at 10:33 a.m. , with registered nurse (RN)-C at 11:49, and with the director of nursing (DON) at 2:45 p.m., who all verified the care plan did not address emergency procedures in regard to lack of access to the	2 830	POC not required.	

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2 830	Continued From page 3 regular dialysis center. The facility was unable to provide a policy and procedure on emergency medical interventions for residents receiving outpatient dialysis treatments. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review and revise policies and procedures for ensuring an emergency plan is developed for residents who require dialysis. Staff could be educated as necessary. The director of nursing or designee could monitor on a regular basis to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that food was stored in areas that reduced risk of food contamination in the main kitchen. Findings include:	21100	POC not required.	4/10/15

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21100	Continued From page 4	21100		

The facility failed to ensure food was prepared in 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 on 3/9/15 as it was leaking into 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.

The Maintenance Work Order, dated 3/9/15, indicated the mop sink caulking was cracked and water had leaked down to kitchen. The crack was sealed and the ceiling tile was replaced.

SUGGESTED METHOD FOR CORRECTION:
The director of culinary services could review and revise policies related to storage of food in areas of potential contamination. The director of culinary services could provide education to all culinary and homemaking staff and monitor for continued compliance.

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21100	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		

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.

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: susanne.reuss@state.mn.us
> 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,

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

Minnesota Department of Health

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 9, 2015 through March 12, 2015, surveyors of this Department's staff visited the above provider and the following Boarding Care licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/15

Minnesota Department of Health

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3 000	Continued From page 1 Minnesota Department of Health, Health Regulation Division, Licensing and Certification Program; P.O. Box 64900, St. Paul, MN 55164-0900.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings 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 FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient	3 945		4/10/15

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3 945	Continued From page 2	3 945		
	' s medical record that the patient must remain in bed.			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to update the plan of care to identify the recommended ointment to promote healing and failed to provide the correct ointment to prevent further worsening of moisture related dermatitis for 1 of 1 resident (R25) reviewed for non pressure related skin issues.		POC not required	
	Findings include:			
	Review of the Skin Condition/Wound Progression progress notes for R25 revealed a note on 2/24/15 "Present on the right lower buttocks is moisture associated skin dmg [damage]." "Noted denuded skin on right lower buttocks. Will use zinc-barrier cream BID [twice daily]." On 3/4/15, the skin site on the right lower buttocks was noted as healed. On 3/9/15, RN-D noted R25 again had moisture associated skin damage on her right lower buttocks and a new area on her left lower buttocks. The progress notes indicated "Elder ahs [sic] been having diarrhea since yesterday. Has low grade temp [temperature] this am [morning]. Will continue incontinence care. Zinc based barrier cream applied." On 3/11/15, RN-D noted "Elder's diarrhea have improved. Less denuded skin noted." for both the right and left lower area on R25's buttocks.			
	R25's orders included an order initiated by the nurse practitioner on 3/11/15 for calmoseptine			

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3 945	Continued From page 3	3 945		

ointment (a zinc based cream) to be applied twice daily to R25's buttocks related to moisture associated dermatitis.

On 03/11/2015 at 10:32 a.m. the wound care nurse, (RN)-D was observed to complete wound care on R25, revealing two denuded areas on R25's buttocks, one on the bottom left and one on the bottom right.

On 3/12/15 at 10:30 a.m. RN-D explained she changed the type of cream to be applied on R25's buttocks from a standard barrier ointment to a zinc based ointment on 2/24/15 due to the denuded area on R25's 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 bottom since 2/24/15

On 3/12/15 at 10:46 a.m. R25's nursing assistant, (NA)-D and floor nurse, (LPN)-C showed which creams and ointments were used on R25's bottom. NA-D showed surveyor a standard skin protectant, not zinc based. LPN-D showed surveyor prescription creams and ointments which included: antifungal, corticosteroid, and vitamin creams. None of the creams and ointments in R25's room or medication supply were zinc based, as recommended by the wound care nurse, RN-D. NA-D reported she worked with R25 on 3/8/15, 3/9/15 and on 3/12/15 and the cream used was a standard skin protectant, not a zinc based ointment.

On 3/12/15 at 10:51 a.m. the nurse manager, (RN)-B reviewed R25's care plan and confirmed the care plan was not updated to include the denuded areas on R25's buttocks. RN-B explained the floor nursing staff would know

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3 945	Continued From page 4	3 945		

which cream to apply based on recommendations from the wound care specialist, RN-D. RN-B reported she became aware of the denuded areas on 3/9/15. RN-B searched R25's room and was not able to find the zinc based ointment RN-D recommended be applied to R25's buttocks. RN-B confirmed the nursing assistants would not be expected to know when to switch to a zinc based cream, without guidance from a licensed nurse.

R25's care area assessment, dated 2/16/15, noted "Elder was admitted with stage III pressure ulcer on coccyx." The care area assessment did not note R25 had denuded areas of skin on buttocks, at that point of time. (Stage 3 pressure ulcer - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.)

R25's skin and wound care plan, dated 2/18/15, revealed no problem or intervention focused on the denuded areas on R25's buttocks until 3/12/15. Review of the nursing assistant guide, undated, provided no direction to staff regarding zinc based ointment.

The Wound Care Management Standard Orders and Treatment Protocols, last revised 2/26/14, directed staff "Red denuded Skin 1. Follow toilet or change schedule. 2. Apply zinc based oint after (i.e. Thera Calzinc; Calmoseptine) 2x/ day and prn." The form was not filled in with R25's name and concern. The Skin & Wound Training manual, updated 4/2014, directed staff "Remember: standing orders are only good for 72 hours. Standing orders are only designed for short term or a a situation where something is

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3 945	Continued From page 5	3 945		

better than nothing. The wound nurse and/or MD [medical doctor] must get involved ASAP [as soon as possible] and determine if the standing orders are appropriate for the long term or what should be done instead of the standing order." The procedure further directed staff regarding wounds found after admission "Update working care plan (paper one kept in binder) with all treatments & interventions per orders." and "RN [registered nurse] to initiate "Skin Impairment" care plan (paper)."

Based on observation, interview and document review, the facility failed to ensure the care plan was implemented for 1 of 3 residents (R19) reviewed for range of motion. R19 was not offered assistance to apply soft hand splint to prevent or minimize further worsening of hand contractures.
Findings include:

R19's care plan, dated 3/27/14, further directed staff "I 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."

On 3/11/15 at 7:35 a.m. R19's nursing assistants, NA-E and NA-D assisted R19 with morning cares and then brought her to breakfast in the dining room. R19's hand splint was not applied prior to leaving for breakfast. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast and was not wearing the soft hand splint. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an

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3 945	Continued From page 6	3 945		

appointment. R19 was not approached by staff after breakfast with an offer to apply the soft hand splint.

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.

On 3/11/15 at 1:09 p.m. R19 was observed sitting in her room in the recliner. R19 was not wearing a soft hand splint. When asked if staff offered to apply her soft hand splint, R19 reported it was something she had to request to be done and no one offered to apply it today.

On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer to apply the soft hand splint daily. Nursing assistants should inform a nurse or HC-A if R19 refused this intervention. RN-B, HC-A and the floor nurse, LPN-D confirmed no one informed them today about R19 refusing to wear her soft hand splint.

On 3/11/15 at 2:51 p.m. R19 reported no one offered to put on her soft hand splint today. R19 was again observed to not be wearing the soft hand splint.

Review of R19's care area assessment for pain 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

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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"
Review of the King House nursing assistant care guides, undated, directed staff "Splint for left hand".

Based on observation, interview and document review, the facility failed to attempt to discontinue the use of a urinary catheter for 1 of 3 residents (R155) reviewed for urinary catheter.

Findings include:

On 3/11/15, at 2:04 p.m. R155 was observed laying in bed sleeping, with a urinary collection bag attached to her leg.

On 3/12/15, at 8:33 a.m. R155 was interviewed and stated she has had the urinary catheter for a long time, and she didn't believe the facility had tried to discontinue it. R155 further stated the urinary catheter often feels sore and hurts her, but denied pain at the time of the interview. R155 also stated she gets occasional bladder infections. R155 denied having seen a urologist.

On 3/12/15, at 9:59 a.m. registered nurse (RN)-B was interviewed and stated R155 has had the urinary catheter since she was admitted. RN-B further stated R155 had the urinary catheter

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discontinued right after her admission, but they had to reinsert it. RN-B verified no further attempts had been made to discontinue the urinary catheter, and R155 had not seen a urologist since her admission to the facility.

On 3/12/15, at 3:48 p.m. the director of nursing (DON) was interviewed, and stated R155 was admitted to the facility with a urinary catheter, and verified R155 had not seen a urologist.

R155's Face Sheet identified diagnoses that included neurogenic bladder, and retention of urine. The quarterly Minimum Data Set (MDS) dated 12/23/14, indicated R155 was cognitively intact, required extensive assistance of one staff with toileting, and had an indwelling urinary catheter. The Care Area Assessment (CAA) dated 7/10/14, indicated R155 continued to have a urinary catheter in her bladder due to urinary retention and had an unsuccessful trial to remove in the past (8/8/13).

R155 was admitted to the facility on 7/31/13. On 8/2/13, the progress notes indicated R155's urinary catheter was discontinued. A physician's note dated 8/6/13, indicated R155 continued to retain urine, and directed to insert the catheter back in temporarily.

The facility policy and procedure on Indwelling Catheters dated 1/15/15, directed as soon as the condition improves attempts should be made at weaning off the catheter and for discontinuation, and referrals to urology will be made as deemed necessary by the M.D.

Based on observation, interview and document review, the facility failed to ensure infection

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control practices were implemented for hand hygiene for 3 of 4 residents (R4, R123, R19) observed for activities of daily living (ADLs) and 1 of 1 resident (R25) observed for wound care.

Findings include:

R4 did not receive personal cares with appropriate hand washing

On 3/11/15 at 7:40 a.m., NA-B entered R4's room to assist with morning cares. NA-B donned gloves (without washing her hands) raised R4's bed and retrieved R4's leg bag (drainage bag that attaches to a resident's leg) from the bathroom. NA-B cleaned the end of the leg bag with an alcohol wipe, unattached the drainage bag, wiped the end of the catheter tubing with an alcohol wipe and attached the leg bag. NA-B took the drainage bag into the bathroom, measured the amount of urine in the bag and informed this writer how the catheter bag is cleaned and stored. NA-B asked R4 if she needed to sit on the toilet and R4 denied. NA-B retrieved a basin of warm soapy water, and washcloths and proceeded to assist R4. NA-B removed R4's incontinent product. R4 was incontinent of a bowel movement (BM). After completing pericares, NA-B applied a new incontinent brief. NA-B was observed, with the same gloved hands, to attach the catheter leg bag to R4's leg and applied R4's pants. NA-B assisted R4 to transfer into the wheelchair. NA-B removed gloves and washed hands.

Interview with RN -B on 3/11/15 at 10:15 a.m., indicated she would have expected gloves to be changed and hands washed after changing the leg bag, after cleaning up the incontinent bowel movement and after pericares.

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3 945	Continued From page 10 Interview with the director of nursing on 3/12/15 at 2:50 p.m., indicated the expectation would be for the nursing assistant to wash hands and change gloves after pericares, after cleaning up the incontinent bowel movement, and after emptying the catheter. The facility failed to ensure R123 received individual cares with appropriate hand hygiene. On 3/11/15, at 10:51 a.m., two nursing assistants (NA)-B and NA-C were observed to be assisting R123 with bed bath. R123 was observed to be lying in bed, entirely covered with bed linen. NA-B stated giving R123 a bed bath because resident refused tub bath due to urge for defecation and worried for having bowel movement (BM) in the tub bath. NA-B and NA-C wash hands and donned gloves. NA-C checked the water temperature and confirmed with R123, obtained a basin of warm soapy water, and washcloths and advanced to assist R123 with bed bath. At 10:56 a.m., NA-C removed soiled gloves and threw in the garbage 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	3 945		

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3 945	Continued From page 11 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 bodily 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 gloves change and we just talked about it." NA-C verified she did not wash hands after removing gloves during R123's bed bath and opening the door to go get more wash clothes. NA-C verified she did not perform hand hygiene after removing the soiled gloves and touched door knob and grabbed more wash cloths form outside the room. R123 stated she should have wash hands in between. Further stated, "I was nervous." The Standard Precautions policy, undated, directed, "Hands are washed before and after work, breaks, after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Hands will be washed before and immediately after gloves are	3 945		

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3 945	Continued From page 12 removed, between elder contact, after any situation involving possible contamination with infectious organisms and when otherwise indicated. In addition, wash hands between tasks and procedures on the same elder to prevent cross contamination of different body sites." In addition, "Gloves are to be worn when contact with blood, body fluids, secretions and contaminated items is possible. New clean non-sterile gloves are to be worn immediately after washing hands and just prior to touching mucous membranes and nonintact skin. New gloves will be applied when performing tasks and procedures on the same elder when cross-contamination is possible. Gloves are to be removed immediately after use, and before touching non-contaminated items and environmental surfaces and before going to another elder or different task. Hands are to be washed immediately after gloves are removed." The facility failed to ensure hand hygiene protocols were followed during morning cares for R19. On 3/11/15 at 7:41 a.m. a nursing assistant, (NA)-E was observed assisting R19 with using the commode and completing perineal care. NA-E then removed gloves and donned a new pair, without washing or sanitizing hands. NA-E then assisted R19 with brushing her teeth. On 3/11/15 at 1:08 p.m. NA-E confirmed she did not wash or sanitize her hands after removing gloves soiled from assisting R19 with using the commode and completing perineal care. NA-E reported she donned a new pair of gloves to help R19 brush her teeth, but did not wash or sanitize her hands first.	3 945		

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3 945	Continued From page 13 On 3/11/15 at 1:26 p.m. the assistant director of nursing (ADON) reported he would expect nursing assistants to wash or sanitize hands after completing toileting and perineal cares and prior to brushing teeth, even if gloves were changed between tasks. The facility failed to ensure hand hygiene protocol was followed during wound care for R25's stage 3 pressure ulcer. (A stage 3 pressure ulcer is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) On 3/11/15 at 10:32 a.m. the wound care specialist, (RN)-D was observed cleaning a stage 3 pressure ulcer on R25's coccyx with skin preparation solution. RN-D then changed gloves and applied a foam dressing over R25's coccyx wound. RN-D did not wash or sanitize hands after removing her pair of gloves, soiled from cleaning R25's pressure ulcer, and donning new gloves prior to applying a foam dressing. On 3/11/15 at 10:32 a.m. RN-D confirmed she did not wash or sanitize her hands between changing gloves; after cleaning R25's pressure ulcer and prior to applying a foam dressing over the pressure ulcer. RN-D reported it would be helpful for her to carry alcohol based hand sanitizer to promote hand hygiene during wound cares. Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 3 residents (R155) reviewed for falls and for 1 of 3 residents (R19) who required assist with oral care to assure care was	3 945		

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provided based on individual needs.

Findings include:

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 hazards, assess for unmet needs, assess gait, balance and ambulation, staff to explain risk of falling to resident/family, and nursing to respond to requests for assistance as soon as possible. The New Care Plan Interventions to Address Falls indicated the following interventions were added: educate resident on safety, and call light within reach (10/5/14), educate on call light use (2/10/15), and low bed (3/3/15).

On 3/11/15, at 2:04 p.m. R155 was observed laying in bed sleeping, with the call light within reach and the bed at a regular height.

On 3/12/15, at 8:33 a.m. R155 was interviewed, and stated she has fallen, she wasn't sure why she falls, but thought she just lost her balance at times.

On 3/12/15 at 9:47 a.m. nursing assistant (NA)-C was interviewed, and stated R155 transferred with assistance of one staff and a walker. When asked what was being done to prevent R155 from falling, NA-C replied they keep the bedside table close to the bed because R115 likes to read in bed and keeps her books on the table. NA-C also stated they keep the call light close to R115, and remind her to call for assistance.

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On 3/12/15, at 9:59 a.m. registered nurse (RN)-B was interviewed and stated R155 gets up during the night, and has had some falls. RN-B further stated R155 has a urinary catheter, and feels she might get up at night and trip on the drainage tubing. RN-B further stated interventions to prevent falls for R155 are to have the call light within reach, and encourage her to use it. RN-B also stated the falls are reviewed at the facility department head morning stand up meeting, and any new interventions are communicated to all staff. RN-B stated she did not review R155's care plan following her falls, but did add interventions to the working care plan (New Care Plan Interventions to Address Falls form).

On 3/12/15, at 3:48 p.m. the director of nursing (DON) was interviewed, and verified she would expect staff to assess for reasons for fall, and to update fall interventions into the care plan.

R19's care plan, dated 3/27/14 directed staff "I need total assist for grooming and personal hygiene because of hand contractures and arthritis." Interventions included: "I receive total assist in the morning and evening with grooming and personal hygiene needs" and "I am at risk for impaired respiratory function d/t [due to] hx [history] recurrent pneumonia."

Review of the King House nursing assistant care guide, undated, directed staff "Brush teeth after each meal to reduce aspiration."

On 3/11/15 at 7:41 a.m., during observations, R19's nursing assistant, NA-E assisted R19 with oral cares, including brushing her teeth and then brought her to breakfast in the dining room. From 7:41 a.m. to 8:47 a.m. R19 was observed in the

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dining room eating breakfast. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to perform oral cares.

During interview, on 3/11/15 at 1:08 p.m. the nursing assistants working with R19 for the day, NA-E and NA-D confirmed they did not assist R19 with oral cares after breakfast. NA-E confirmed she only assisted R19 with oral cares before breakfast.

On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer to assist R19 with oral cares after breakfast.

On 3/11/15 at 2:51 p.m. R19 reported no one offered to assist her with oral cares after breakfast or lunch.

On 3/12/15 at 9:35 a.m. the speech language pathologist (SLP) explained R19 had issues with coughing and required oral cares after meals to make sure food residue was out of her mouth.

SUGGESTED METHOD FOR CORRECTION: The administrator and director of nursing or designee could review and revise policies and procedures regarding infection control, compliance with resident care plans, revision of care plans, use of urinary catheters and providing residents assistance required for skin health and range of motion. The director of nursing or designee could provide education to all nursing and medical staff and monitor compliance at regular intervals.

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3 945	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 945		
3 970	MN Rule 4655.6400 Subp. 2E Adequate Care; Assist with Oral hygiene Subp. 2. Criteria for determining adequate care. Criteria for determining adequate and proper care shall include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents reviewed for activities of daily living, R19 was provided oral cares after meals, as recommended by speech therapy, to prevent or minimize the risk of pneumonia and/or aspiration. Findings include: On 3/11/15 at 7:41 a.m. R19's nursing assistant, NA-E assisted R19 with oral cares, including brushing her teeth and then brought her to breakfast in the dining room. From 7:41 a.m. to 8:47 a.m. R19 was observed in the dining room eating breakfast. From 8:47 a.m. to 9:00 a.m. R19 sat near the door to the household waiting to go to an appointment. At 9:00 a.m. R19 left for an appointment. R19 was not approached by staff after breakfast with an offer to perform oral cares.	3 970	POC not required.	4/10/15

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On 3/11/15 at 1:08 p.m. the nursing assistants working with R19 for the day, NA-E and NA-D confirmed they did not assist R19 with oral cares after breakfast. NA-E confirmed she only assisted R19 with oral cares before breakfast.

On 3/11/15 at 2:25 p.m. the nurse manager, RN-B and the household coordinator (HC)-A confirmed the nursing assistants should offer assist R19 with oral cares after breakfast and inform a nurse or HC-A if R19 refused so they could investigate the reason and attempt methods to increase compliance with oral cares after meal. RN-B, HC-A and the floor nurse, LPN-D confirmed no one informed them today about R19 refusing oral cares.

On 3/11/15 at 2:51 p.m. R19 reported no one offered to assist her with oral cares after breakfast or lunch.

On 3/12/15 at 9:35 a.m. the speech language pathologist (SLP) explained R19 had issues with coughing and required oral cares after meals to make sure food residue was out of her mouth.

Review of R19's care area assessment for pain and activities of daily living and rehabilitation, dated 6/13/14, revealed R19 had hand and finger deformities related to arthritis, and a diagnosis of Parkinson's which impaired her ability to complete grooming tasks. R19's quarterly minimum data set [MDS], dated 2/17/15, indicated R19 required extensive assistance of two or more staff for performance of personal hygiene tasks and had moderate cognitive impairment.
Review of speech therapy progress notes, assessments and plan of care, for dates 8/1/14 through 8/7/14 revealed a diagnosis of

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dysphagia, oropharyngeal phase (difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process) and oral residue and pocketing was noted after completion of swallow during evaluation. Recommendations included "The patient participates in oral cares with nursing staff assistance to decrease risk of aspiration with mild impairment". Speech therapy provided education to nursing staff and recommended follow through include providing regular oral care to decrease risk of pneumonia.
Review of the Physician's Order Sheet revealed a nursing order, dated 8/5/14, which directed staff "after each meal use mouth wash and a pick toothette to clean mouth of bacteria 3 times per day at 0800, 1200, 1700, Special Instructions: per speech"
R19's care plan, dated 3/27/14 directed staff "I need total assist for grooming and personal hygiene because of hand contractures and arthritis." Interventions included: "I receive total assist in the morning and evening with grooming and personal hygiene needs" and "I am at risk for impaired respiratory function d/t [due to] hx [history] recurrent pneumonia."

Review of the King House nursing assistant care guides, undated, directed staff "Brush teeth after each meal to reduce aspiration."

SUGGESTED METHOD FOR CORRECTION:
The director of nursing or designee could review and revise policies and procedures to ensure residents receive the necessary oral care. The director of nursing or designee could provide education to all nursing staff and monitor for continued compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	03/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 970	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 970		
31320	MN Rule 4655.8670 Subp. 4 Food Supplies; Storage of perishable foods 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored in areas that reduced risk of food contamination in the main kitchen. The facility failed to ensure food was prepared in 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	31320	POC not required.	4/10/15

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31320	Continued From page 21 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 on 3/9/15 as it was leaking into 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. The Maintenance Work Order, dated 3/9/15, indicated the mop sink caulking was cracked and water had leaked down to kitchen. The crack was sealed and the ceiling tile was replaced. SUGGESTED METHOD FOR CORRECTION: The director of culinary services could review and revise policies related to storage of food in areas of potential contamination. The director of culinary services could provide education to all culinary and homemaking staff and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31320		
31380	MN Rule 4655.8810 Hot Water Sanitizing The dishwashing machine shall be operated in accordance with the manufacturer's instructions which shall be posted nearby; see part 4660.8000, subpart 9. The flow pressure shall be maintained between 15 and 25 pounds per square inch (psi) at the dishwasher. The temperatures of the water shall be maintained at	31380		4/10/15

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31380	Continued From page 22	31380		

140 to 160 degrees Fahrenheit for the washing cycle, and at 170 degrees Fahrenheit for the rinsing and sanitizing cycle, both temperatures measured at tray level. If the same person handles both soiled and clean dishes, the person shall wash his or her hands between operations. Dishes and utensils shall be air dried.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure dishes on 1 of 6 households reviewed were washed and sanitized at appropriate water temperatures.

POC not required.

Findings include:

The facility failed to ensure dishes on 1 of 6 households were washed and sanitized at appropriate water temperatures.

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 rinse temperatures again did not rise above 125 F. A sign on the dish machine directed staff that wash temperatures must reach a minimum of 150 F and rinse temperatures must reach a minimum of 180 F.

On 3/10/15 at 10:47 a.m. a homemaker on the King Unit (H)-B was observed placing a load of silverware in plastic silverware holders into the dishwasher. Wash temperatures did not rise above 130 F and rinse temperatures did not rise above 140 F. At 11:16 a.m. H-B reported the silverware had been soaked before placing in the

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31380	Continued From page 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.

On 3/10/15 at 12:25 p.m. the dietary manager, (DM) demonstrated how the dish machine worked by running it three times. On the first dish cycle the rinse temperature went above 150 F for wash and 180 F for rinse. On the second and third cycle the wash and rinse temperatures did not rise above 130 F. DM confirmed this observation. DM ran a test strip through the dish machine. DM explained if water temperatures at the racks were at least 170 F the test strip would turn black. The test strip turned light brown. DM confirmed this indicated the water temperatures at the racks were not at least 170 F. DM explained the homemakers should notify a supervisor if dish machine temperatures were not reaching minimum levels and then proceed to wash dishes in the main kitchen. DM explained if dishes were not washed and rinsed at minimum water temperature, they were not fully sanitized. DM reported he monitored dish machine temperatures through the temperatures recorded in the monitoring logs.

On 3/10/15 at 12:56 p.m. H-B reported she was not aware why water temperatures needed to reach a minimum temperature. H-B confirmed she continued to wash dishes in the household dishwasher, instead of the main kitchen, despite water temperatures not meeting minimum levels. H-B reported the household coordinator on her unit, (HC)-A about the dishwasher water temperatures not being hot enough at about 12:40 p.m. on 3/10/15.

The Dishwashing Procedures policy, dated

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31380	Continued From page 24 12/11/08, directed staff "The temperature of the water shall be maintained at 150 F or above for the washing cycle and at 180 F for the rinsing and sanitizing cycle (160 F at the surface contact point.). The flow pressure shall be maintained between 15 and 25 pounds per square inch (PSI). Corrective Action: if temperatures are below the minimum standard, immediate action will be taken. If the final rinse temperature on the dish machine reads below 180 F, the temperature should be checked using a holding thermometer or temperature strips to test that the surface contact point is at 160 F to ensure proper operation of the dish machine. Maintenance will be notified and all dishwashing will be halted as soon as the problem is identified. If necessary, disposable dishware and/or hand sanitizing of dishes will be done. Dishwashing may resume as soon as standard temperatures are again being maintained." Review of the Dishwasher Temperatures log for March 2015 revealed dish machine temperatures were recorded at minimum levels for 3/9/15. Temperatures recorded for 3/10/15 were illegible. SUGGESTED METHOD FOR CORRECTION: The director of culinary services or designee could review and revise policies related to washing and sanitizing dishes. The director of culinary services or designee could educate all homemaking and culinary staff on procedures related to washing and sanitizing dishes and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31380		