Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

Administrator
EPISCOPAL CHURCH HOME THE GARDENS
1860 UNIVERSITY AVENUE WEST
SAINT PAUL, MN 55104

RE: CCN: 245625
Cycle Start Date: March 26, 2025

Dear Administrator:

On May 22, 2025, we notified you a remedy was imposed. On August 6, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 18, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 26, 2025 be discontinued as of July 18, 2025.

In our letter of May 22, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 26, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 10, 2025

Administrator
Episcopal Church Home The Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: March 26, 2025

Dear Administrator:

On May 22, 2025, we informed you of imposed enforcement remedies.

On May 29, 2025, the Minnesota Department of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 26, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 26, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 26, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Episcopal Church Home The Gardens will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975

Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 26, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file

electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/27/25-5/29/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/27/25-5/29/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e)	F 605		7/18/25

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

Electronically Signed | 06/19/2025

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

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F 605	Continued From page 1 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F 605		

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F 605	Continued From page 2 §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 605		

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F 605	Continued From page 3 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure ordered as needed (PRN) psychotropic medications were limited to a 14 day time period for 1 of 2 residents (R25) reviewed for psychotropic use. According to the State Operations Manual, appendix PP, a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant; anti-anxiety; and hypnotic. R25's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated intact cognition, had non-traumatic brain dysfunction, non Alzheimer's dementia, depression, and fibromyalgia, and pain frequently interfered with sleeping at night, and took an antidepressant. R25's Physician's Orders indicated the following order:	F 605	1. Corrective action for those residents was found to have been affected by the deficient practice: The facility reviewed with provider on 5/29/25 and discontinued (DC) ordered as needed (PRN) psychotropic medication for R25. An end date has been added to ensure medications were monitored and evaluated for the appropriateness of continued use. R25 care plan was reviewed and is current. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who have PRN psychotropics could be affected if the nurses do not promptly contact the provider about a stop date for the 14-days time period. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review and update if	

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F 605	Continued From page 4 1/20/25, hydroxyzine HCL (an antihistamine medication used to relieve itching, and is also used as a sedative that decreases activity in the brain) oral tablet 25 milligram (MG) give 1 tablet by mouth every 6 hours as needed (PRN) for itching; anxiousness related to insomnia. The order lacked a stop date. R25's medication administration record (MAR) dated January, February, March, April, and May 2025, was reviewed and indicated R25 received hydroxyzine 25 mg on 2/14/25, 2/26/25, 3/7/25, 5/3/25, and 5/13/25. R25's progress notes dated 2/16/25 at 12:31 p.m., indicated a medication regimen review was completed and the note directed staff to see a communication to nursing regarding psych monitoring. R25's progress notes dated 4/14/25 at 11:02 p.m., indicated a medication regimen review was completed and the note directed staff to see the communication to the provider regarding PRN (as needed) psychotropic. R25's physician visit notes dated 1/27/25, 2/12/25, 3/18/25, 5/26/25, and lacked information the hydroxyzine should be extended beyond 14 days. R25's Consultant Pharmacist Report form dated 2/13/25, and 2/17/25, indicated R25 had a PRN order for Vistaril (hydroxyzine HCL) that required a 14-day stop date. Further, if therapy beyond 14 days was required, the provider could assess and provide a rationale for the extended use, as well as provide a specific duration of therapy. The form had a hand written note that indicated the	F 605	needed the update unnecessary medication and psychoactive medication policy to ensure clarity to nurses and the expectation of reviewing and documenting elder psychotropic medication. Re-educating will occur with nurses promptly following up with the provider and documenting the stop date for the PRN psychotropic medication and if non-antipsychotics are extended, it should be identified on electronic medical record. The consulting pharmacist will continue to review psychotropic medication monthly, and the nurses will follow up on pharmacy recommendations. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON/designee will conduct audits 1x a week if warranted for 4 weeks, then monthly for 3x a month PRN psychotropic medication and the documentation if when the medication needed to be extended beyond 14-day time period. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 605	Continued From page 5 provider was called/faxed by licensed practical nurse (LPN)-A on 5/29/25, and there was no nursing documentation of previous attempts to address the report. R25's Consultant Pharmacist Report form dated 4/13/25, and 4/14/25, indicated R25 had a PRN order for Vistaril that required a 14-day stop date. Further if therapy beyond 14 days was required, the provider could assess and provide a rationale for the extended use, as well as provide a specific duration of therapy. The form had a hand written note that indicated the provider was called/faxed by LPN-A on 5/29/25, and there was no nursing documentation of previous attempts to address with the provider. During interview on 5/29/25 at 9:58 a.m., the covering pharmacist (P)-A stated R25's pharmacy recommendations for 2/16/25, and 4/14/25, were to address a stop date for the PRN hydroxyzine if going past 14 days and verified the medication was still ordered without a stop date and stated PRN psychotropic medications had to be evaluated after 14 days, but non-antipsychotics could be extended but it was not identified in the electronic medical record the medication was extended. During interview on 5/29/25 at 10:23 a.m., the director of nursing, (DON) stated LPN-A was following up on the medication and would have expected follow up sooner. A policy, Unnecessary Medication, dated 1/1/15, indicated the registered nurse (RN) manager or designee reviews each elder's medication regimen in addition to the pharmacist's monthly drug regimen review to assure there are no	F 605		

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EPISCOPAL CHURCH HOME THE GARDENS	1860 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104

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F 605	Continued From page 6 excessive dosages, duplicative therapy, excessive durations, inadequate monitoring for side effects or other parameters or inadequate indications for use. A policy, Psychoactive Medication revised on 3/1/18, indicated medications will be necessary with an appropriate diagnosis for use, and the med will not be given in excessive dose or for excessive duration. Further, PRN orders for psychotropic drugs are limited to 14 days. Once the attending physician or prescribing practitioner feels that it is appropriate to extend the PRN beyond 14 days, the practitioner must document their rationale for the extension and indicate the duration for the PRN order in the medical record.	F 605		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares i.e. nail care was provided for 1 of 1 resident (R46) reviewed for activities of daily living (ADLs) and who was dependent on staff for such cares. Findings include: R46's Optional State Assessment (OSA) dated 2/17/25, indicated moderate cognitive impairment, and required extensive assistance with bed mobility, transfers, and toilet use.	F 677	1. Corrective action for those residents was found to have been affected by the deficient practice: R46 nails were trimmed by a nurse and will continue to be trimmed on bath day as necessary and document refusal of nail care. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who are diabetic and rely on assistance for personal care could be	7/18/25

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	245625	A. BUILDING _____ B. WING _____	05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7 R46's admission minimum data set (MDS) dated 2/17/25, indicated moderate cognitive impairment, rejected care one to three days, and had impairment in range of motion to both lower extremities. R46's admission care area assessment (CAA) worksheet indicated R46 required assist with ADLs and used a mechanical lift for all transfers and contributing factors in ADL dependence included, changing cognitive status, mood decline, history of falls, history of stroke, diagnoses of diabetes, glaucoma, and pain. R46's Medical Diagnosis form indicated the following diagnoses: type two diabetes mellitus, Parkinsonism (a neurological condition that causes movement disorders), muscle weakness, primary open-angle glaucoma to the left eye, long term (current) use of anticoagulants, and unspecified disorientation. R46's Physician's Orders form indicated the following orders: 5/20/25, weekly skin checks on bath or shower day, trim nails and shave facial hairs every evening shift every Tuesday for health maintenance. R46's treatment administration record (TAR), dated 5/2025, indicated R46 required weekly skin checks on bath and shower day, trim nails and shave facial hairs every evening shift every Tuesday for health maintenance. The TAR indicated R46 received nail care on 5/20/25, and 5/27/25. R46's care sheet provided on 5/27/25 at 12:13	F 677	affected by not receiving routine nail care, including cleaning under the fingernails and trimming nails when there is approximately an inch of growth. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review, and update as needed with the Standard of Care/Elder Rights policy to ensure clarity to nurses on the expectation of nail care for residents who are diabetic. Re-educate nursing staff on the importance of providing appropriate nail care to diabetic residents, ensuring nails are clean, properly trimmed, and any refusals are accurately documented. The MAR/TAR will be updated as needed to reflect when nursing staff are responsible for completing nail care for diabetic residents. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON/designee will audit 3 random residents 1x a week for 4 weeks, then monthly 3x a month reviewing residents who are dietetic and dependent on staff for routine nail care. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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	245625	A. BUILDING _____ B. WING _____	05/29/2025

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F 677	Continued From page 8 p.m., indicated R46 had a Tuesday p.m. bath and preferred a whirlpool bath, and further staff were to trim nails and clean facial hair. R46's care plan dated 2/17/25, indicated R46 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations. R46's care plan dated 2/10/25, indicated R46 had an ADL self-care deficit and interventions included, "BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse." Additionally, R46 required assist of one for personal hygiene and oral cares. R46's progress notes were reviewed and lacked documentation R46 refused nail care on 5/27/25. R46's task form, Monitor Behavior Symptoms, dated 4/30/25, to 5/29/25, was reviewed and R46 had one behavior of repeating movement on 5/22/25, otherwise had no documented refusals. During observation on 5/27/25 at 1:32 p.m., R46's fingernails were long and had a brownish black debris under the nails. During observation on 5/28/25 at 9:13 a.m., R46's fingernails were long with gray debris. R46's right thumb nail was long and his fingernails on the right hand were long with debris underneath the nails. During interview and observation on 5/28/25 between 10:14 a.m., and 10:19 a.m., nursing assistant (NA)-A stated they looked to the care sheet to know what cares a resident required and	F 677		

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F 677	Continued From page 9 if a resident refused cares it was reported to the nurse and documented in the care tracker. NA-A stated the NA trimmed nails if a resident was not diabetic, but if a resident was diabetic, the nurse trimmed the resident's nails. At 10:19 a.m., NA-A viewed R46's nails and stated they looked really long and R46 needed his nails cleaned and further stated it did not look like R46's nails were trimmed the day prior, or staff would have seen R46's nails needed to be cleaned. During interview on 5/28/25 at 10:21 a.m., licensed practical nurse (LPN)-A stated staff used care sheets and looked on the care plan and medication administration record and TAR to know what cares a resident required and refusals were documented in a progress note. LPN-A stated nurses were responsible for trimming nails on bath days if a resident was diabetic. LPN-A viewed R46's fingernails and stated R46 definitely needed to have his nails trimmed and further stated it did not look like R46 had his nails trimmed on 5/27/25 and further stated R46's nails needed to be cleaned under the fingernails as well and stated R46's nails had approximately a ½ inch of growth and verified R46 had a shower on the p.m. shift the night before. During interview on 5/29/25 at 10:13 a.m., the director of nursing stated nail care was typically completed on bath day and nurses take care of the nails and further stated LPN-A took care of R46's nails. A policy, Standard of Care/Elder Rights, dated 4/2022, indicated elders would be provided with the necessary care and services per policies and procedures to attain or maintain the highest practicable, physical, mental and psychosocial	F 677		

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F 677	Continued From page 10 wellbeing in accordance with their comprehensive assessments, elder rights, needs, preferences, and plan of care. Minimal requirements included nail care to ensure they are clean and trimmed.	F 677		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		7/18/25

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F 756	Continued From page 11 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to act upon the consultant pharmacist's recommendation for 1 of 1 residents (R25) reviewed for unnecessary medications. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated intact cognition, had non-traumatic brain dysfunction, non Alzheimer's dementia, depression, and fibromyalgia, and pain frequently interfered with sleeping at night, and took an antidepressant. R25's Physician's Orders indicated the following order: 1/20/25, hydroxyzine HCL (an antihistamine medication used to relieve itching, and is also used as a sedative that decreases activity in the brain) oral tablet 25 milligram (MG) give 1 tablet by mouth every 6 hours as needed (PRN) for itching; anxiousness related to insomnia. R25's medication administration record (MAR) dated January, February, March, April, and May 2025, was reviewed and indicated R25 received hydroxyzine 25 mg on 2/14/25, 2/26/25, 3/7/25, 5/3/25, and 5/13/25. R25's progress notes dated 2/16/25 at 12:31	F 756	1. Corrective action for those residents was found to have been affected by the deficient practice: The facility reviewed with provider on 5/29/25 and discontinued (DC) ordered as needed (PRN) psychotropic medication for R25. An end date has been added to ensure medications were monitored and evaluated for the appropriateness of continued use. R25 care plan was reviewed and is current. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who are affected by psychotropic medication will be reviewed by a consulting pharmacist. The facility will notify all admissions and complete monthly regimen review and will be documented in the medical records. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review, and update as needed for the Pharmacy Policies and Procedures and Drug Regimen Review policy. Nurses will be re-educated on the importance of promptly correcting and	

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F 756	Continued From page 12 p.m., indicated a medication regimen review was completed and the note directed staff to see a communication to nursing regarding psych monitoring. R25's progress notes dated 4/14/25 at 11:02 p.m., indicated a medication regimen review was completed and the note directed staff to see the communication to the provider regarding PRN (as needed) psychotropic. R25's Consultant Pharmacist Report form dated 2/13/25, and 2/17/25, indicated R25 had a PRN order for Vistaril (hydroxyzine HCL) that required a 14-day stop date. Further, if therapy beyond 14 days was required, the provider could assess and provide a rationale for the extended use, as well as provide a specific duration of therapy. The form had a hand written note that indicated the provider was called/faxed by licensed practical nurse (LPN)-A on 5/29/25, and there was no nursing documentation of previous attempts to address the report. R25's Consultant Pharmacist Report form dated 4/13/25, and 4/14/25, indicated R25 had a PRN order for Vistaril that required a 14-day stop date. Further if therapy beyond 14 days was required, the provider could assess and provide a rationale for the extended use, as well as provide a specific duration of therapy. The form had a hand written note that indicated the provider was called/faxed by LPN-A on 5/29/25, and there was no nursing documentation of previous attempts to address with the provider. During interview on 5/29/25 at 9:58 a.m., the covering pharmacist (P)-A stated R25's pharmacy recommendations for 2/16/25, and 4/14/25, were	F 756	following up with providers as needed. Any incomplete items will be readdressed during the following month□s pharmacy review. They will also review pharmacy notes and concerns for all residents, ensuring that consulting pharmacist recommendations are addressed by the next monthly review. The pharmacist will be expected to provide consultation on all aspects of pharmacy services and conduct a thorough review of each resident□s drug regimen. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will audit the past three months of pharmacy reviews and conduct an additional audit once the June review is completed. Monthly audits will continue for 3x a month. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 756	Continued From page 13 to address a stop date for the PRN hydroxyzine if going past 14 days and verified the medication was still ordered without a stop date and stated PRN psychotropic medications had to be evaluated after 14 days, but non-antipsychotics could be extended but it was not identified in the electronic medical record the medication was extended. During interview on 5/29/25 at 10:17 a.m., the DON stated pharmacy recommendations went to the clinical leader and if a resident was admitted, the pharmacist consultant would review the medications and then on a monthly basis for the nurse to correct or to follow up with the providers and further stated the pharmacist expected pharmacist recommendations be followed up on by their next monthly review and further if the provider is asked to address something and the provider documents they will address at the next visit, then they will wait until that visit. During interview on 5/29/25 at 10:23 a.m., the director of nursing, (DON) stated LPN-A was following up on the medication and would have expected follow up sooner. A policy, Pharmacy Policies and Procedures and Drug Regimen Review, dated 2/20/18, indicated the pharmacist provides consultation on all aspects of the provision of pharmacy services and reviews each elder's drug regimen at least monthly. The consulting pharmacist will be notified of all admissions and complete a monthly regimen review (MRR) that will be documented in the medical record and irregularities will be communicated and addressed as outlined. Any irregularities noted in the individual MRR are reported to the DON, medical director and	F 756		

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F 756	Continued From page 14 attending physician and are to be acted on by the time of the next physician visit or sooner if indicated by the pharmacist. Any noted irregularities will be noted on the consultant pharmacy communication form and sent to the DON electronically. The DON will print the communication form and route to the nurse manager/licensed nurse to address nursing concerns. The nurse manager/licensed nurse will address physician concerns with the attending physician. The communication form and any changes to the plan of care will be maintained in the medical record. The DON will address all irregularities with the medical director via the consulting pharmacist administrative report on a monthly basis.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). 2 medication errors occurred out of 34 opportunities resulting in a 5.88% medication error rate for 2 of 3 residents (R32, R38). Findings include: R32's Medical Diagnosis form indicated the following diagnoses: pain unspecified, spinal stenosis (a narrow space in the spine), lumbar	F 759	1. Corrective action for those residents was found to have been affected by the deficient practice: R32 received lidocaine cream 4% was applied to the right heel and toes of both feet at bedtime. R38 received the correct dosage of Acetaminophen Oral Tablet 1,000 mg by mouth three times a day for pain. R32 and R38 treatment administration records (TAR) were reviewed and updated.	7/18/25

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F 759	Continued From page 15 region with neurogenic claudication (leg pain or weakness), polyneuropathy unspecified (damaged nerves). R32's Physician Orders form indicated the following order: 5/6/22, lidocaine cream 4% cream apply to the right heel topically two times a day for neuropathic pain related to pain per the podiatrist and apply to toes of both feet topically at bedtime for neuropathic pain for 14 days. R32's medication administration record (MAR) dated May 2025, indicated R32 required lidocaine cream 4% apply to the right heel topically two times a day for neuropathic pain related to pain. During observation on 5/28/25 at 8:17 a.m., licensed practical nurse (LPN)-A stated he had to bring R32 to his room to apply cream for R32's foot. At 8:21 a.m., LPN-A brought R32 to his room and at 8:26 a.m., after sanitizing hands and donning gloves applied Aspercreme with lidocaine to both of R32's feet. During interview on 5/28/25 at 8:51 a.m., LPN-A verified the lidocaine cream 4% was applied to both feet and reviewed R32's orders that indicated the lidocaine cream 4% was to be applied to the right heel and saw the order also indicated to apply to the toes of both feet at bedtime and verified the order for application to the toes was at bedtime and stated he would have to recheck the order. During interview on 5/29/25 at 10:13 a.m., the director of nursing (DON) stated staff should be looking at the MAR and treatment administration record (TAR) and dosage and should compare	F 759	2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility will review and update the MAR and TARs for residents who have medication for lidocaine cream 4% and 1,000 mg Acetaminophen Oral Tablets. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review, and update as needed with the Administration of Medications policy to ensure clarity to nurses and Trained Medication Assistant (TMA)s that medications must be administered in a timely manner and in accordance with the prescribed orders. Re-education to the nurses and TMAs of administering the right medications, right dose, right time and right method of administration before the medication is administered. As well as staff should be looking at the MAR and treatment administration record (TAR) and dosage and should compare the order. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON/Designee will audit 6 random observations of med passing weekly for 4 weeks, then 6 random observations monthly 3x a month to ensure nurses and TMAs are administering the correct medications. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and	

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F 759	Continued From page 16 the order. R38 R38's quarterly MDS dated 5/5/25, indicated moderately impaired cognition and diagnoses of osteoporosis, wedge compression fracture, and low back pain. It further indicated R38 had pain almost constantly rated at an 8 out of 10, and received scheduled pain medication. R38's care plan dated 5/5/25, indicated R38 was at risk for alteration in comfort related to a history of falls with fracture, osteoporosis, and degenerative joints. It further indicated the following interventions: -Complete pain evaluation upon admission and as needed -Give pain medications as ordered -Monitor/document effectiveness of all pain interventions -Provide appropriate non-pharmacological measures such as TV, activities to stimulate mind or divert focus on pain, back rub, and changing positions. -Report unrelieved pain and change of condition to primary care provider R38's physician's orders dated 12/13/24, indicated Acetaminophen Oral Tablet. Give 1,000 mg by mouth three times a day for pain. During observation on 5/28/25 at 7:40 a.m., Trained Medication Assistant (TMA)-A was administering medications to R38. TMA-A administered 3 tablets of acetaminophen (325 mg) which was a total of 975 mg.	F 759	compliance. The DON or designee will be responsible for compliance.	

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F 759	Continued From page 17 During interview on 5/28/25 at 8:00 a.m., TMA-A verified administering 975 milligrams (mg) of acetaminophen instead of the prescribed 1,000 mg, because the bottle in the locked medication cabinet in R38's room only contained 325 mg tablets and she would've had to go to the basement to get a bottle with the correct dosage. TMA-A stated R38 "has pain" so she should be receiving the full amount the physician ordered. During interview on 5/29/25 at 10:32 a.m., LPN-B stated TMA-A told her she had made a medication error when administering acetaminophen to R38 and if a resident doesn't have the correct dose for a medication the staff should let a nurse or nurse manager know or go get the stock medication before administering it. Nursing staff can also order the medication if they are out of it. A policy, Administration of Medications dated 11/25/22, indicated medications must be administered timely and in accordance with the prescriber's orders. The person administering medication must ensure that the right medications, right dose, right time and right method of administration are verified before the medication is administered.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		7/18/25

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F 812	Continued From page 18 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure expired foods were removed from service in the main kitchen and 2 of 3 unit kitchens reviewed and to ensure proper dishware sanitization occurred for 2 of 3 unit kitchens reviewed. Furthermore, the facility failed to ensure final temperatures were obtained for 1 of 1 unit kitchen reviewed during breakfast and holding temperatures were obtained before meal service for 1 of 1 unit kitchen reviewed during dinner. Findings include: FOOD STORAGE An observation on 5/27/25 at 11:58 a.m., the main kitchen was observed. A review of the walk-in refrigerator showed the following: -an opened bottle of Ken's Steakhouse ranch with a best by date of 5/13/2025 -an opened bottle of Everyday Essential ranch with a best by date of 5/2025 -an opened container of Glenview Farms buttermilk with a best by date of 5/21/25	F 812	1. Corrective action for those residents was found to have been affected by the deficient practice: Facility ensured expired food was removed from service in the main kitchen, maintain proper dishware sanitization, food temperatures were reviewed and updated during mealtimes. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could be affected by expired food, improper dishware sanitization, and food temperatures. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review, and update as needed for storage of food, dishwashing procedures, and service temperatures policies. Re-education with the nursing and culinary staff working in the unit kitchens	

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	245625	A. BUILDING _____ B. WING _____	05/29/2025

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

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F 812	Continued From page 19 The above items were verified by the Dietary manager (DM). An observation on 5/27/25 at 12:37 p.m., the garage food storage was observed. In the main refrigerator showed 2 half gallons of Glenview Farms whole milk with a best by date of 5/15/25. This was verified by the DM. An observation 5/27/25 at 12:48 p.m., the 7th floor kitchen was observed. A review of the cupboards and refrigerator showed the following: -an opened bottle of Kraft itialian dressing with a best by date of 12/13/24 -an open bottle of Kraft thousand island dressing with a best by date of 2/13/24 -an open bottle of Kraft tarter sauce with a best by date of 2/2/25 -an open bottle of Everyday Essentials blue cheese dressing with a best by date of 5/14/25 -an opened carton of Glenview Farms liquid eggs with a use by date of 5/24/25 -an opened bottle of Thirstier lemon juice with a best by date of 3/23/25 -a bowl of hard boiled eggs covered with plastic wrap with no date. When interviewed on 5/27/25 at 1:02 p.m., nursing assistant (NA)-B verified the above items and removed them. NA-B stated when the cooks deliver stock, they reviewed the dates. Any staff who were going to use items should also be looking. NA-B further stated they worked yesterday and verified the bowl of hard-boiled eggs were made then and they should have been dated. An observation on 5/27/25 at 1:12 p.m., the 5th floor kitchen was reviewed. A review of the	F 812	will be educated on the facility□s disposal of items that are beyond expiration date, proper washing, rinsing and sanitizing procedures, and food temperature safety. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The dietitian/designee will conduct 3 random unit kitchen audits 2x for 4 weeks, then monthly 3x a month, on proper food storage, dishwashing operation, and food temperatures. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 812	Continued From page 20	F 812		

refrigerator and cupboards showed the following:
-an open container of Kraft tarter sauce with a best by date of 11/2/24
-a can of Bush's pinto beans with a best by date of 10/28/22
-a can of Eden's black beans with a best by date of 10/28/22
-three cans of Hunts tomato past with a best by date of 9/11/14

When interviewed on 5/27/25 at 1:24 p.m., NA-C verified the above items and disposed of them. NA-C stated the cooks deliver stock and should be looking at the dates. Furthermore, NA-C was not sure why some of the items were here as only breakfast was cooked on the units.

When interviewed on 5/27/25 at 1:57 p.m., cook-A stated the kitchen staff delivers items to the floor kitchens. Cook-A stated whoever was delivering items should be doing a review of the use by or expiration dates of the food on the unit.

SANITIZATION OF DISHWARE

An observation on 5/27/25 at 12:48 p.m., the 7th floor kitchen had one side of a double sink filled with soap and water. On the counter was a rack of plates and cups air drying on the counter. When interviewed on 5/27/25 at 1:12 p.m., NA-B stated the dishwasher had been broken for at least the last two days. When the dishwasher was down, staff would use dish soap and wash them twice in the sink.
An observation on 5/27/25 at 1:24 p.m., the 3rd floor kitchen was reviewed. A double sink was filled with soapy water on one side. NA-D was putting plates away from a dishrack on the counter. A sign on the cupboard stated

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F 812	Continued From page 21 Dishwasher broken, use 2nd or 4th floor machines. An interview on 5/27/25 at 1:32 p.m., NA-D verified the sign and stated the dishes had not been brought to other floors. NA-D further had been trained to just wash by hand with soap and water and let air dry. An observation on 5/28/25 at 1:24 p.m., NA-B and NA-D were washing dishes in a double sink with dish soap and water. The dishes were placed on a dish rack to the right of the sink. At 1:43 p.m., the full rack was moved over to the left side of the sink and a second dishrack was placed to the right of the sink. At 2:28 p.m., the dishes remained on the racks drying. At 2:24 p.m., without taking the plates to another floor for sanitization, NA-D started putting the dishes away. Plates were going into the cupboard just to the left of the sink. Cups and glasses were set on a try and placed on the counter facing the table area. The remainder of the plates and bowls. At 2:27 p.m., NA-E took the glasses and cups from the tray on the counter and started putting away in cupboards next to the dining table. FOOD TEMPRATURES An observation on 5/27/25 at 5:01 p.m., the 3rd floor kitchen's steam table on holding dinner in place. At 5:10 p.m. NA-G obtained plates and set up to start serving dinner. Without obtaining holding temperatures, NA-G opened the steam table cover, placed it aside, and plated two plates with goulash, and broccoli. And the plates were served to residents at the table. At 5:15 the other 3 other plates were made and served to the	F 812		

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F 812	Continued From page 22 residents. When interviewed on 5/27/25 at 6:28 p.m., NA-G verified they had not taken food temperatures from the steam table before serving residents. NA-G stated the kitchen did take them when the food arrives and stated they should be taken before serving residents. An observation on 5/28/25 at 8:28 a.m., NA-B started breakfast on 3rd floor. After hand hygiene, NA-B obtained pans to prepare breakfast. NA-B poured some oil in the pans and removed pasteurized eggs, egg substitute and pre-cooked frozen bacon and sausage from the refrigerator and freezer. NA-B cracked the eggs into the left pan and placed some liquid eggs in the pan. NA-B disposed of eggshells and washed hands. NA-B then placed the pre-cooked bacon and sausage into the pan on the right and washed hands. With a spoon, the eggs were stirred together and scrambled. As items cooked, NA-B offered juice to the residents. Once cooked, the burners were turned off. At 8:51 a.m., without obtaining food temperatures, NA-B then began dishing plates and delivering to residents sitting at the table. When interviewed on 5/28/25 at 10:51 a.m., NA-B verified they did not obtain the food temperature after making breakfast and wasn't sure if a temperature was needed. Also, NA-B stated they do not obtain temperatures before serving the meals from the steam table and stated the cooks take the food temperatures when they deliver the food. NA-B stated there was some discussion a while back about taking food temperatures but wasn't sure if temping food needed to be done. NA- B further stated they didn't think there was a	F 812		

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F 812	Continued From page 23 thermometer in the unit kitchens to do so. When interviewed on 5/28/25 at 12:02 p.m., stated the NAs should be temping the steam table before serving to ensure the temps are holding. Cook-B further stated the food in the steam table usually sat about 30-40 minutes before serving. When interviewed on 5/28/25 at 2:31 p.m., the CD stated a couple of years back, the NAs started to cook breakfast in the kitchen and the cooks no longer are doing any cooking on the units. More responsibility had been shifted to the NAs including reviewing expiration and best by dates of food. However, it was not getting done consistently, so the kitchen staff took that back over about 6-8 months ago. CD expected staff to review kitchen storage and kitchen refrigerators for expired items and if found dispose of them. CD further expected the nursing staff to be obtaining temperature of breakfast items cooked and holding temperatures before serving food from the steam tables. CD was aware of the dishwashers not working on 3 and she had been working with ecolab on a rental. CD was out for most of May and would have to check with maintenance on why it was not working and what had happened to fix/replace it. When a dishwasher was down on a unit, the CD expected staff to take the dishes to another unit to use the dishwasher. This was the best way to ensure sanitization occurred properly. When interviewed on 5/29/25, the interim Administrator stated the facility was in the process of replacing both dishwashers for 3 and 7. If the dishwashers were not working, staff would use a three compartmental sink to sanitize or bring them to the other floors to sanitize. The	F 812		

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F 812	Continued From page 24 interim administrator further stated staff were expected to check and remove expired items according to policy and ensure cooking and holding temperatures were monitored in the steam tables. A facility policy titled Storage of Food, do date, directed to store all food in a manner that ensures quality and maximizes safety of the food served. Furthermore, the policy directed staff to dispose of items that are beyond their spiration date or use by dates. A facility policy titled Dishwashing Procedures, revised 2/11/08, directed staff to ensure the dishwashing operation will provide proper washing, rinsing and sanitizing procedures according to federal regulations. The policy further directed staff will use disposable dishware or ensure proper hand sanitization of the dishes would be completed. A facility policy titled Service Temperatures revised 7/2019, directed staff to take temperatures of all hot and cold foods prior to service to ensure foods are maintained and ensure the safety of food served. The policy further directs NAs were responsible to record and document temperatures in their designated areas.	F 812		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/28/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Episcopal Church Home The Gardens was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2025

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: EPISCOPAL CHURCH HOME GARDENS is a 7-story building with a lower-level parking garage. The original building was constructed in 2012 and was determined to be of Type I (332) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. There are single station smoke alarms in all resident rooms. The facility has a capacity of 60 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/28/2025 at 9:43 AM , it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested annually for 90 minutes within the last year. This deficient finding was confirmed by the Maintenance Manager and Regulatory	K 291	" The annual testing of emergency lighting will be documented and completed displaying the emergency lighting has been tested annually. " The task in TELS will be updated to ensure ongoing compliance with the annual inspection of emergency lighting annually. " Completion will be audited monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. " The Director of Facilities or designee will be responsible for compliance.	7/18/25

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K 291	Continued From page 3 Maintenance Technician at the time of discovery.	K 291		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 05/28/2025 between at 10:20 AM, it was revealed by observation that there were wires and	K 353	"The zip ties were cut and removed. The wire was secure and ensured it was not connected to the sprinkler system. "Re-educate Maintenance and IT about the placement of the wires when completing a project. "Completion will be audited 1x a week for 4 weeks, then monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. "The Director of Facilities or designee will be responsible for compliance.	7/18/25

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K 353	Continued From page 4 conduit resting on the sprinkler pipe above the ceiling on the third floor.. An interview with the Maintenance Manager and Regulatory Maintenance Technician verified this deficient finding at the time of discovery.	K 353		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/28/2025 at 10:14 AM, it was revealed by observation that there was a penetration in the smoke barrier on the fourth and seventh floor.	K 372	"Fire caulk was used for the wall and closed the penetrations for the fourth and seventh floor. "Re-educate Maintenance and IT departments about the requirements when penetrating a wall for projects. "Completion will be audited x1 a week for 4 weeks, then monthly x3 months and results will be brought to QAPI committee meeting for review and discussion. "The Director of Facilities or designee will be responsible for compliance.	7/18/25

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K 372	Continued From page 5 An interview with the Maintenance Manager and Regulatory Maintenance Technician verified this deficient finding at the time of discovery.	K 372		