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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7KD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 30004

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245625**

2.STATE VENDOR OR MEDICAID NO.
(L2) **777662100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EPISCOPAL CHURCH HOME GARDENS**
(L4) **1860 UNIVERSITY AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (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 **60** (L18)

13.Total Certified Beds **60** (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
	60			
(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 :
Susanne Reuss, Unit Supervisor 03/30/2016 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/15/2015
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/26/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245625
May 2, 2016

Mr. Keanan Franco, Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, Minnesota 55104

Dear Mr. Franco:

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 12, 2016, the above facility is certified for or recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds .

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 2, 2016

Mr. Keanan Franco, Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5625001

Dear Mr. Franco:

On March 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 12, 2016 and therefore remedies outlined in our letter to you dated March 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245625 Y1	A. Building B. Wing Y2	4/21/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0279	Correction	ID Prefix	F0282	Correction	ID Prefix	F0309	Correction
Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed
LSC		04/12/2016	LSC		04/12/2016	LSC		04/12/2016
ID Prefix	F0315	Correction	ID Prefix	F0318	Correction	ID Prefix	F0329	Correction
Reg. #	483.25(d)	Completed	Reg. #	483.25(e)(2)	Completed	Reg. #	483.25(l)	Completed
LSC		04/12/2016	LSC		04/12/2016	LSC		04/12/2016
ID Prefix	F0371	Correction	ID Prefix	F0428	Correction	ID Prefix		Correction
Reg. #	483.35(i)	Completed	Reg. #	483.60(c)	Completed	Reg. #		Completed
LSC		04/12/2016	LSC		04/12/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 05/02/2016	SIGNATURE OF SURVEYOR 16022	DATE 04/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
3/3/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245625 Y1	A. Building 01 - EPISCOPAL CHURCH HOME GARDENS B. Wing Y2	4/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	04/12/2016	LSC K0050	04/12/2016	LSC K0052	04/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	04/12/2016	LSC K0144	04/12/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/02/2016	SIGNATURE OF SURVEYOR 37010	DATE 04/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7KD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 30004

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245625**

2.STATE VENDOR OR MEDICAID NO.
(L2) **777662100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EPISCOPAL CHURCH HOME GARDENS**
(L4) **1860 UNIVERSITY AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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

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

7. PROVIDER/SUPPLIER CATEGORY **02** (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 **60** (L18)
13.Total Certified Beds **60** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Heim, HPR Social Work Specialist 03/30/2016 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/15/2015
(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.
06201
(L31)

30. REMARKS
Posted 04/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

Mr. Keanan Franco, Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5625001

Dear Mr. Franco:

On March 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- State Monitoring. (42 CFR 488.422)

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME 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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2016

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 _____	03/03/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to maintain range of motion of the upper extremities for 1 of 1 resident reviewed for range of motion, R61. Findings include: R61's medical diagnosis list revealed R61 had a diagnosis of hand contracture. On 3/1/16 at 12:00 p.m. R61 was observed with limited range of motion in her left hand, fingers and wrist and no splint device was in place. A review of R61's care plan, last revised 2/29/16, did not include problems, goals or interventions related to limited range of motion in her left upper extremities. A review of the March 2016 medication and treatment administration record did not include interventions related to limited range of motion in her left upper extremities. On 3/03/16 at 1:34 p.m. the registered nurse manager, RN-D reviewed the care plan with surveyor and reported she could not find the limited range of motion addressed in the care plan. RN-D reported she had limited knowledge of R61's limited range of motion as she was very new to the facility.	F 279	Plan of correction for the Elders cited with this survey: upon notification of this finding (R61) comprehensive assessment reviewed, therapy discharge plan reviewed and comprehensive care plan was updated to include objectives to maintain current range of motion in upper extremity and prevent further declines in range of motion. Deficiency with other elders: An audit of 100% of the Elder comprehensive assessments will be reviewed to identify any Elder with contractures and develop comprehensive care plan with objectives to maintain and/or prevent further decline. Measures to prevent reoccurrence: have completed staff education with therapy to place Functional Maintenance Plan in chart and flag for nurse to review and add to the comprehensive care plan. Therapy staff to continue to educate nursing staff on the carry through of the Functional Maintenance Plan. Nurse manager to ensure that all Functional Maintenance Plans are on the comprehensive care plan and ensure that all contractures or range of motion limitations identified in the comprehensive assessment are addressed on the comprehensive care plan with quarterly care plan reviews. Plan to Monitor: Will continue to audit Comprehensive assessments and	

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F 279	Continued From page 2	F 279	Comprehensive care plans to ensure that range of motions limitations are address on Comprehensive Care Plans to maintain current level of range of motion and prevent further declines in range of motion. Responsible for maintaining compliance: DON Correction target date: 04/12/2016	
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 follow the care plan for 1 of 5 residents (R4) reviewed for unnecessary medications, and for 1 of 4 residents (R45) reviewed for urinary incontinence. Findings include: The facility failed to follow the care plan for 1 of 5 residents (R4) reviewed for unnecessary medications. R4's care plan dated 2/1/16, identified R4 received an antipsychotic medication related to paranoid personality disorder. The care plan did identify Seroquel as an antipsychotic medication	F 282	Plan of correction for the Elders cited with this survey: upon notification of these findings (R4)and(R45) care plans were reviewed and revised to reflect services, interventions and approaches for Unnecessary medications and urinary incontinence. Deficiency with other elders: Reviewing all care plans and medical records of elders receiving antipsychotic medications to ensure that orthostatic blood pressures are being monitored, recorded in medical record and addressed on comprehensive plan of care. Consulting pharmacist reviewing medical	4/12/16

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F 282	Continued From page 3 and direction for staff to monitor for side effects, target behaviors and orthostatic blood pressure (BP). However medical record lacked documentation of orthostatic blood pressure monitoring. On 3/3/16 at 11:38 a.m. R4 was observed to be awake, walking in the hallway independently with walker. When approached and interviewed regarding the medication, Seroquel, that she takes, R4 randomly talk things that does not make much sense. During the interview R4 was observed to be relaxed with no behaviors noted. During an interview with registered nurse (RN)-A on 3/3/16 at 3:01 p.m. regarding R4's medical record lacked documentation of orthostatic blood pressure monitoring, RN-A stated, facility has an order to monitor side effects of psychotropic medications. During interview on 3/3/16 at 3:25 p.m. the acting director of nursing confirmed R4's medical record lacked documentation of orthostatic blood pressure monitoring and stated, orthostatic blood pressure should be done monthly and it is in facility standing orders and expectation is staff should do it. R45's care plan dated 6/16/15, indicated "I demonstrate bladder and bowel incontinence, functional, r/t [related to] decreased mobility, decreased cognition, UTI [urinary tract infection]...INCONTINENT: Offer me to toilet and provide assistance every 2 hours. Check me for incontinence and provide perineal care." 2/26/16, Bowel and Bladder Comprehensive Evaluation indicated R45 was unable to ask to	F 282	records of all elders receiving antipsychotic medication to ensure orthostatic blood pressures are monitored. Education provided to nursing staff regarding monitoring potential side effects of psychoactive medications. All elders with urinary incontinence will have care plans reviewed with revisions made as needed for toileting and urinary incontinence. Measures to prevent reoccurrence: Will audit medical record of all elders receiving antipsychotic medications on a monthly basis to ensure that all elders receiving antipsychotic medications or any newly started antipsychotic medication is addressed on comprehensive care plan and medical record reflects at least monthly orthostatic blood pressures. Consulting pharmacist will continue to review medical records for appropriate monitoring of antipsychotic medications on a monthly basis. Education provided to the NAR on care plan and services to be provided with elders with urinary incontinence and toileting plans. Plan to Monitor: will continue to review medical record quarterly with antipsychotic medication review assessments and continue monthly Consulting Pharmacist review. An audit of care plan for elders with urinary incontinence and toileting assistance provided by nursing assistants will be completed and reevaluated on a quarterly basis.	

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F 282	Continued From page 4 use the restroom and was frequently incontinent of bowel and bladder. The evaluation indicated R45 was totally dependent on staff for toileting. On 3/3/16, at 8:46 a.m. R45 was sitting at dining room table in her wheelchair (w/c) with her head down and her eyes closed. At 9:10 a.m. a nursing assistant (NA)-B pushed resident in her w/c into the dayroom and then transferred R45 into her recliner and raised her feet. At 9:20 a.m. a registered nurse (RN)-A administered R45's eye drops. At 10:51 a.m. RN-B asked R45 if she had any pain. The resident did not answer, and RN-B stated R45 was unable to understand the question. At 11:10 a.m. NA-C stated R45 was unable to be understood or to understand and she assisted her to the toilet about every two hours. When asked when R45 last used the toilet NA-C said she did not know, but was waiting for NA-B to return from break and then she planned to assist her to the bathroom. From 8:46 a.m. to 11:21 a.m. no staff had approached R45 regarding toileting while she sat in the recliner. At 11:21 a.m. NA-C approached R45 and said "Let's go to the bathroom." NA-C explained that after getting to know the residents, "I can just tell when the residents have to go to the bathroom." NA-C transferred R45 from recliner to the w/c and assisted her to the dining area. At 11:25 a.m. NA-C and NA-B transferred R45 to the toilet. NA-B took off R45's brief and stated it was a little wet which the surveyor verified. NA-B stated R45's brief was usually wet but not soaked. At 9:05 a.m. earlier the same day NA-C stated that night staff had assisted R45 up that	F 282	Responsible for maintaining compliance: DON Correction target date: 04/12/2016	

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F 282	Continued From page 5 morning about 6:30 a.m. and that she NA-C had not performed cares or assisted R45 to the toilet, as that was completed by the night shift staff. She explained that she and NA-B were not individually assigned to care for residents, rather shared the assignment. At 10:57 a.m. NA-C stated sometimes R45 was dry and voided on the toilet and sometimes she was already wet when taken to the toilet. NA-C stated she had not toileted R45, and did not know if the resident had been assisted to use the toilet when she was on break off the unit. At 11:27 a.m. NA-B stated that night staff had assisted R45 to get up that morning and she had not toileted her until 11:25 a.m. (at least 4 hours, 55 minutes). RN-C stated at 1:26 p.m. she expected the NAs to follow R45's care plan which directed them to toilet the resident every two hours. On 3/3/16, at 3:08 p.m. the acting director of nursing also stated she expected staff to follow residents' care plans.	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.	F 309		4/12/16

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide services to heal and prevent worsening of a toe wound for 1 of 4 residents reviewed, R1. Findings include: On 3/3/16 at 10:16 a.m. surveyor observed the toes on R1's left foot. The area between the 4th and 5th toes was reddened but not currently open. The floor nurse, (LPN)-A, cleaned the toes with gauze and spray then dried it and put gauze and Nystatin powder between R1's toes. LPN-A reported this was a regular task to complete for R1, although he may not always be documenting treatment of R1's toes in the medication and treatment record. LPN-A reported he was not the only nurse who was responsible for providing care for R1's toes. LPN-A reported if it was not marked as completed it would not appear as if it had been completed. On 3/2/16 at 1:45 p.m. a family member of R1, (F)-A reported R1 had red areas between the toes on her left feet. F-A reported she visited very frequently and had observed times when staff were not providing cares for R1's toes including ensuring R1's feet were kept dry and placing gauze between R1's toes. Review of the medication and treatment administration record for February 2016 revealed a nursing order to apply gauze twice in the morning and off in the afternoon between R1's left 4th and 5th toe. Out of 15 days opportunities between 2/5/16 and 2/20/16 treatment was recorded as refused once and not completed fully	F 309	It is the policy of The Gardens to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care. Plan of correction for Elders cited with this survey: Upon notification of this finding, (R1) treatment plan reviewed. Nurses educated on proper completion of treatments and proper documentation of treatments provided. Deficiency with other Elders: audits completed for all of Elders' Physicians Orders to identify those with treatments. Audit completed on all treatment records for documentation compliance. Audits completed of treatment administration of those elders receiving treatment to ensure treatments are completed. Measures in place to prevent reoccurrence: Policy for Administration of Medication/Treatment and Comprehensive Care plans reviewed with all nurses. All new staff will be trained on these policies. Plan to monitor: an audit of all Treatment administration records will continue on weekly basis x one monthly and then continue monthly thereafter for documentation compliance. Will complete audits of 10% of random	

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F 309	Continued From page 7 on six days. Review of R1's current medication orders revealed an order for Nystatin powder (antifungal) to be applied twice daily between R1's 4th and 5th toes followed by placement of gauze between the toes effective 3/1/16. Review of R1's care plan, last revised 1/8/16, directed staff "Open area between left 4th and 5th toes and resulting cellulitis present on left foot." and "Medication and treatment per MD [medical doctor] order to left food open area/cellulitis." and "Monitor left foot for continued/resolution of s/s [signs and symptoms] to let foot." On 3/3/16, at 9:32 a.m. an interview was completed the administrator and director of nursing (DON) on telephone and the registered nurse manager, (RN)-C present onsite. The DON and RN-C reported they were familiar with the ulcer on R1's toes and there had been numerous orders and order changes recently related to R1's left toes. RN-C reported she would expect staff to complete the ordered cares and note the completion in the medication and treatment administration record.	F 309	administration of treatments weekly x one month for compliance and continue to audit random treatments on monthly basis x 3months then quarterly to ensure treatments are being completed. The results of the audits will be reported on at the QA meeting and audits will continue as until committee has determined compliance sustained. Responsible for maintaining compliance: DON or Nurse Designee Correction Target Date: 4/12/16	
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.	F 315		4/12/16

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F 315	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain highest practicable level of urinary continence for 1 of 4 residents (R45) reviewed for urinary continence. Findings include: R45's 6/22/15, significant change Minimum Data Set (MDS) indicated R45 was frequently incontinent of bladder, was continent of bowel and was not on a toileting program. A subsequent MDS dated 12/10/15, for R45 was always incontinent of bowel and bladder and was not on a toileting program. R45 was severely cognitively impaired and needed extensive staff assist with activities of daily living and toileting. 2/26/16, Bowel and Bladder Comprehensive Evaluation indicated R45 was unable to ask to use the restroom and was frequently incontinent of bowel and bladder. The evaluation indicated R45 was totally dependent on staff for toileting. On 3/3/16, at 8:46 a.m. R45 was sitting at dining room table in her wheelchair (w/c) with her head down and her eyes closed. At 9:10 a.m. a nursing assistant (NA)-B pushed resident in her w/c into the dayroom and then transferred R45 into her recliner and raised her feet. At 9:20 a.m. a registered nurse (RN)-A administered R45's eye drops. At 10:51 a.m. RN-B asked R45 if she had any pain. The resident did not answer, and RN-B stated R45 was unable to understand the question.	F 315	It is the policy of The Gardens to ensure that an elder that enters the facility incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Plan of correction for Elders cited with this survey: upon notification of this finding, (R45) care plan reviewed and revised to reflect services, interventions and approaches for urinary tract infection prevention and urinary continence. Nursing assistances educated of plan of care. Deficiency with other Elders: all care plans for Elders with urinary incontinence and toileting plans will be reviewed and revised. Education provided regarding revisions made to care plans with staff providing care. Audit completed of toileting plans/assistance being provided by staff. Measures in place to prevent reoccurrence: Review policy for Bowel and Bladder programs, Bowel and Bladder Assessment and Management, and Bowel and Bladder Assessment with Nurses and NAR. Will continue to complete Urinary Assessment and Bowel and bladder record with admission, quarterly reviews and significant changes to establish	

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F 315	Continued From page 9 At 11:10 a.m. NA-C stated R45 was unable to be understood or to understand and she assisted her to the toilet about every two hours. When asked when R45 last used the toilet NA-C said she did not know, but was waiting for NA-B to return from break and then she planned to assist her to the bathroom. From 8:46 a.m. to 11:21 a.m. no staff had approached R45 regarding toileting while she sat in the recliner. At 11:21 a.m. NA-C approached R45 and said "Let's go to the bathroom." NA-C explained that after getting to know the residents, "I can just tell when the residents have to go to the bathroom." NA-C transferred R45 from recliner to the w/c and assisted her to the dining area. At 11:25 a.m. NA-C and NA-B transferred R45 to the toilet. NA-B took off R45's brief and stated it was a little wet which the surveyor verified. NA-B stated R45's brief was usually wet but not soaked. At 9:05 a.m. earlier the same day NA-C stated that night staff had assisted R45 up that morning about 6:30 a.m. and that she NA-C had not performed cares or assisted R45 to the toilet, as that was completed by the night shift staff. She explained that she and NA-B were not individually assigned to care for residents, rather shared the assignment. At 10:57 a.m. NA-C stated sometimes R45 was dry and voided on the toilet and sometimes she was already wet when taken to the toilet. NA-C stated she had not toileted R45, and did not know if the resident had been assisted to use the toilet when she was on break off the unit. At 11:27 a.m. NA-B stated that night staff had assisted R45 to get up that morning and she had	F 315	toileting plan for each Elder. Will communicate toileting plans to staff providing cares for toileting plans. Will audit cares being provided by NAR to ensure compliance. All new staff will be trained on these measures. Plan to monitor: will complete random audits of 10% of care plans to cares provide for urinary programs to ensure compliance weekly x1 month then monthly x 3 months and quarterly thereafter. Will audit all new admissions to ensure urinary continence evaluated and program set up to maintain or improve continence established, objective care planed and cares provided as outlined by plan of care. Weekly x 1 month, monthly x 3 months then quarterly thereafter. The results of the audits will be reported on at the QA meeting with audits continuing with quarterly reviews and as needed. Responsible for maintaining compliance: DON and Nurse Designee Correction Target Date: 4/12/16	

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F 315	Continued From page 10 not toileted her until 11:25 a.m. (at least 4 hours, 55 minutes). RN-C stated at 1:26 p.m. she expected the NAs to follow R45's care plan which directed them to toilet the resident every two hours. R45's care plan dated 6/16/15, indicated "I demonstrate bladder and bowel incontinence, functional, r/t [related to] decreased mobility, decreased cognition, UTI [urinary tract infection]...INCONTINENT: Offer me to toilet and provide assistance every 2 hours. Check me for incontinence and provide perineal care." On 3/3/16, at 3:08 p.m. the acting director of nursing also stated she expected staff to follow residents' care plans.	F 315		
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 provide services to maintain range of motion of the upper extremities, following completion of occupational therapy for 1 of 1 resident reviewed for range of motion, R61.	F 318	It is the policy of The Gardens to ensure that an elder with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	4/12/16

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F 318	Continued From page 11 Findings include: R61's recent minimum data set [MDS], dated 11/25/15, revealed R61 was cognitively intact. R61's medical diagnosis list revealed R61 had a principal diagnosis of Parkinson's disease and additional diagnoses of epilepsy, hand contracture and osteoarthritis. On 3/1/16 at 12:00 p.m. R61 was observed with limited range of motion in her left hand, fingers and wrist and no splint device was in place. On 3/3/16 at 11:26 a.m. R61 reported she used a toilet paper roll filled with caulk and wrapped in two fitted cotton socks to hold in her left hand at night. R61 reported the only other splint device she had was a hard plastic molded hand splint that she could stretch her hands out in. She showed surveyor both of these devices. R61 reported she had been using the toilet paper roll filled with caulk and wrapped in socks since prior to moving to the facility and thought the hard plastic molded hand splint was also from prior to her moving into the facility. R61 did not have pinky finger on her left hand and showed surveyor how she had previously used the hard plastic molded hand splint. R61 reported she did not like using the hard plastic molded hand splint because she could not use her hand with it on. R61 reported she thought she should be pushing down on her hand more to help stretch it out. R61 reported her hand had gotten stiffer over time and hurt at night. R61 reported she was in therapy for her hand but was no longer. R61 reported she wanted more help and therapy with maintaining range of motion in her hand. R61 reported she had trouble with her nerves and tendons in her left hand, wrist and forearm.	F 318	Plan of correction for Elders cited with this survey: upon notification of this finding, (R61) therapy discharge plan, comprehensive care plan reviewed and revised to include objectives to maintain current range of motion and prevent further declines in range of motion. Deficiency with other Elders: all Elders have Range of motion assessments completed and comprehensive care plan reviewed and revised, with referrals /notifications made as warranted. Therapy discharge summaries reviewed to ensure recommendations are part of the comprehensive care plan. Measures in place to prevent reoccurrence: Nursing staff educated on Assessment of Range of motion and Policy for Therapy recommendations and Comprehensive Care Plans. All Elders range of motion assessed. Audited comprehensive care plans and revised to include objectives to maintain current level of range of motion. Range of motion deficits will be reported to Doctor or designee and assessed for therapy needs. Therapy recommendations will be included in the comprehensive care plan. All new staff will be trained on these measures. Range of motion assessments will be completed with admission, quarterly review and significant changes. All new staff will be trained on these measures. Plan to monitor: will review all discharge	

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	245625	A. BUILDING _____ B. WING _____	03/03/2016

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

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F 318	Continued From page 12 On 3/03/16 at 1:34 p.m. the registered nurse manager, RN-D reviewed the care plan with surveyor and reported she could not find the limited range of motion addressed in the care plan. RN-D could not find occupational therapy notes in the facility chart and called occupational therapy staff to obtain documentation. RN-D reported she was not aware of the history of R61's range of motion of her upper extremities as she had not worked at the facility very long. On 3/3/16 at 2:03 p.m. the occupational therapist who worked with R61, (OT)-A, reported R61 had received the hard plastic molded hand splint, called an anti-spasticity splint, from her physician after her pinky amputation before she received occupational therapy in June and July of 2015. OT-A reported R61 had worked on improved range of motion in her shoulder, hand and wrist during occupational therapy. OT-A reported R61 only needed to wear her anti-spasticity splint for an hour a day to help promote wrist flexion and range of motion in her left hand. She should use slo-foam, a foamy cushion to squeeze and maintain range of motion in left hand and use pulleys that were set up in her bathroom to do range of motion shoulder exercises. OT-A goals focused on training R61 on home exercise program. OT-A reported R61 had showed her the toilet paper with caulk in it and wrapped in socks. OT-A reported she had told R61 that while it would not be harmful, it would not be very helpful to use it. OT-A reported she would expect staff to continue to help set up and remind R61 to do home exercises now that R61 was discharged from occupational therapy. A review of occupational therapy notes, dated	F 318	summaries of all elders receiving therapies to ensure that recommendations are included in the comprehensive care plan. Will continue to audit clinical records of 10% of elders' clinical record to ensure that range of motion assessment completed, and referrals made as warranted and objectives included on the comprehensive care plan to maintain and prevent declines in range of motion are being completed weekly x 1 month then monthly x3 months. Will continue quarterly audits of each elders Range of motion plan of care and services provided to ensure objectives are being completed to maintain highest level of range of motion. Results of audits will be reported at QA committee and will continue until committee has determined compliance sustained. Responsible for maintaining compliance: DON or Nurse Designee Correction Target Date: 4/12/16	

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F 318	Continued From page 13 6/4/15 to 7/31/15 revealed R61 worked on the goal of home exercise program for her left hand and wrist and shoulders including slo-foam, anti-spasticity splint and pulleys. A review of R61's care plan, last revised 2/29/16, did not include problems, goals or interventions related to limited range of motion in her left upper extremities. A review of the March 2016 medication and treatment administration record did not include interventions related to limited range of motion in her left upper extremities.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		4/12/16

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring of an antipsychotic medication for 1 of 5 residents (R4) who used Seroquel (antipsychotic). Findings include: R4 had diagnoses that included dementia, major depression, anxiety disorder, insomnia, legal blindness and paranoid personality disorder. The Physician Orders with revision date of 2/8/16, indicated R4 had an order for Seroquel 12.5 mg by mouth daily, which was initiated on 2/9/16. On 3/3/16 at 11:38 a.m. R4 was observed to be awake, walking in the hallway independently with walker. When approached and interviewed regarding the medication, Seroquel, that she takes, R4 randomly talk about things that did not pertain to the questions asked. During the interview R4 was observed to be relaxed with no behaviors noted. Quarterly MDS dated 1/24/16 revealed, R4's BIMS score of 3. R4 requires extensive assist with bed mobility, transfers, toileting, dressing, and grooming and use walker for ambulation. R4's care plan dated 2/1/16, identified R4 received an antipsychotic medication related to paranoid personality disorder. The care plan did identify Seroquel as an antipsychotic medication and directed staff to monitor for side effects,	F 329	Plan of correction for the Elders cited with this survey: upon the notification of this finding, (R4) comprehensive plan of care and clinical documentation was updated to include a monthly orthostatic blood pressure. Deficiency with other elders: Reviewed all care plans and medical records of elders receiving antipsychotic medications to ensure that orthostatic blood pressures are being monitored, recorded in medical record and addressed on comprehensive plan of care. Consulting pharmacist reviewing medical records of all elders receiving antipsychotic medication to ensure orthostatic blood pressures are monitored. Education provided to nursing staff regarding monitoring potential side effects of psychoactive medications. Measures to prevent reoccurrence: Will review policy for Psychoactive Medications and Monitoring with the nurses. Consulting pharmacist will continue to review medical records for appropriate monitoring of psychoactive medications on a monthly basis. Plan to Monitor: will continue to review medical record quarterly with psychoactive medication review assessments and continue monthly Consulting Pharmacist reviews.	

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F 329	Continued From page 15 target behaviors and orthostatic blood pressure (BP). However medical record lacked documentation of orthostatic blood pressure monitoring. During an interview with registered nurse (RN)-A on 3/3/16 at 3:01 p.m. R4's medical record lacked documentation of orthostatic blood pressure monitoring and stated, facility had an order to monitor the side effects of psychotropic medications. During interview on 3/3/16 at 3:25 p.m. the acting director of nursing confirmed R4's medical record lacked documentation of orthostatic blood pressure monitoring and stated, orthostatic blood pressures should be done monthly and it is in facility standing orders and expectation is staff should do it. On 3/3/16 at 4:15 p.m. telephone call was made to the pharmacy consultant and voice message was left. No return call received. Policy and procedure titled PSYCHOACTIVE MEDICATION dated 1/1/15 reads, "8. All elders receiving antipsychotic medication will have monthly orthostatic BP checks documented in the medical record."	F 329	Responsible for maintaining compliance: DON or nurse designees Correction target date: 4/12/16	
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	F 371		3/31/16

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label, date, store, and dispose of expired food, having the potential to impact all 59 residents who were served meals at the facility. Findings include: On 2/29/16, at 12:16 p.m. tour of the seven kitchens began with culinary service director (CSD). The CSD stated the Food Guide located in each kitchen provided instruction as to how long food in refrigerators could be kept once it was opened. In addition, staff was to date food upon opening. The CSD verified the following observations: 1) In the refrigerator on fourth floor kitchen 24 bacon strips in an unsealed bag were dated 2/16/16. The CSD stated the staff did not probably know how long bacon should have been kept once opened, but the guide indicated a week, and the bacon should probably have been thrown out. The CSD disposed of the opened bacon. 2) In the refrigerator in the third floor kitchen two plates of chicken, salad, fruit and bread and Jell-O were uncovered and undated. Also, a package of ham was unsealed and dated 2/16/16. The Food Guide in the kitchen directed staff to discard after 3-5 days after opening or refreeze, and the CSD said the ham should have been discarded. Bags of onions undated and	F 371	Plan of Correction The attached Plan of Correction regarding labeling and dating of food will be implemented immediately (as of 3/17/16). All food service staff (cooks, chefs, supervisors and FSD) will be in-serviced regarding the plan of correction by 3/22/16, and all other staff with access to the refrigeration and freezers in The Gardens will be in-serviced on the policy and procedure by 3/31/16. A copy of the attendance log(s) for the in-services, verifying that current staff have attended and understand the plan of correction regarding labeling and dating of foods will be kept on file by the FSD, and all new staff will be educated by the FSD, Gardens executive chef or trainer designated by the FSD, on the plan of correction regarding labeling and dating. Chefs and shahbazim (NA/R) will complete a checklist daily, after each meal service, which includes monitoring dates and labels of food items. Kitchen audits will be conducted by the FSD on a weekly basis. Re-education will be provided to Shahbazim (NA/R), nurses, and chefs if the plan of correction is not appropriately being followed. The FSD will enforce the policies and	

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F 371	Continued From page 17 bags of lettuce, cucumbers and tomatoes dated 10/23. Jell-O dated 2/17. 3) In the fourth floor refrigerator two applesauce open containers approximately 1/6 full dated 2/8/16, and 2/14/16. CSD stated the applesauce according to the guide was good 2-4 days after opening. The chef stated he would say it was good for seven days as it was a non-perishable item. The CSD threw out the applesauce. 4) In the third floor refrigerator was 1/3 pitcher full of orange juice, one cranberry pitcher 1/6 full, which the CSD said was from "yesterday" and she disposed of both juices. Eleven strips of bacon from 2/16/16, were thrown away. The CSD stated chefs had been hired and would now be responsible for stocking the refrigerators and ensuring food was properly stored. Previous to the chefs, the CSD was responsible. 5) In the second floor refrigerator the CSD disposed of four burritos that were dated 9/25 with ice inside,1/2 pitcher juice undated, one sliced turkey breast package dated 12/2, one package chicken breast opened and dated 2/19 (the Food Guide indicated were good for 3-5 days after opening). A package of ham was dated 2/26/16, opened but not sealed. CSD instructed the two nursing assistants (NAs) standing nearby to put dates on the juices. 6) The storage room contained dented water chestnut cans, which the CSD instructed the dietary aide (DA)-A to throw away. DA-A stated he dated the packages of frozen foods when he opened them to take food out to deliver to the six floors. The CSD verified the freezers in the storage room contained an opened bag of sausage labeled with an illegible date, frozen chicken breasts opened and unsealed, eight frozen filets in an opened, unsealed and undated bag. DA-A stated he did not know who had	F 371	procedures regarding labeling and dating of food and will ensure the audits are being completed. Documentation on in-services, audits, meal service checklists, and re-education is to be kept on file. Ongoing, there will be an annual kitchen in-service for all staff that will cover food service policies and procedures. Plan for completion: 3/31/2016 Responsible for monitoring: Director of Culinary Services	

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F 371	Continued From page 18 opened the bag. The CSD instructed DA-A to throw the fish away. The CSD explained that another staff person would be taking over supervision of the storage units. On 3/2/16, at 7:50 a.m. the CSD stated that she had talked to her supervisor the previous day, and he had informed her all leftover food in refrigerators was good for seven days only and that she should utilize the facility's leftover policy. The CSD said going forward, they would utilize the leftover policy versus the Food Guides, and staff would be retrained. On fourth floor, at 9:10 a.m. NA-B stated lunch meats were good for a week and that she followed the Food Guide. NA-B also stated the CSD checked the refrigerators weekly. At 12:45 p.m. NA-C stated food was only good for two days after being opened and that three days was too long, so after two days she threw the food away. At 12:55 p.m. the CSD stated chefs would be trained to check the foods in the refrigerators daily. A copy of the 2/12, Food Storage Guide was provided that staff had been using, as well as a copy of the 5/08, Storage of Leftovers policy the facility planned to begin implementing. The revised 5/08, Storage of Leftovers indicated "Policy: To avoid contamination due to bacterial growth, leftovers will be properly stored in food-approved containers. Procedure: 1. The Food Service Director is responsible to ensure that foods are stored properly. ... 3. Leftover containers must be covered tightly and clearly labeled with the name of the contents and date ... 5. Leftovers must be used within seven (7)	F 371		

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F 371	Continued From page 19 calendar days or less ... 6. the date that the item is placed in freezer must be written on the label ... Monitoring: A designated employee will check refrigerators daily to verify that foods are date marked and that foods exceeding the 7-day time period are not being used or stored. Corrective Action: Foods that are not date marked or that exceed the 7-day time period will be discarded."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consulting pharmacist identified medication irregularities for 1 of 5 residents (R4) reviewed for unnecessary medication use. Findings include: R4 had diagnoses that included dementia, major depression, anxiety disorder, insomnia, legal blindness and paranoid personality disorder. The Physician Orders with revision date of 2/8/16,	F 428	Plan of correction for the Elders cited with this survey: upon the notification of this finding, (R4) comprehensive plan of care and clinical documentation was updated to include a monthly orthostatic blood pressure. Deficiency with other elders: All clinical records and comprehensive care plans of elders receiving psychoactive medications were reviewed by consulting pharmacist to ensure proper monitoring of the medications with the March monthly	4/12/16

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F 428	Continued From page 20 indicated R4 had an order for Seroquel 12.5 mg by mouth daily, which was initiated on 2/9/16. On 3/3/16 at 11:38 a.m. R4 was observed to be awake, walking in the hallway independently with walker. When approached and interviewed regarding the medication, Seroquel, that she takes, R4 randomly talked about things that did not pertain to the questions asked. During the interview R4 was observed to be relaxed with no behaviors noted. Quarterly MDS dated 1/24/16 revealed, R4's BIMS score of 3. R4 requires extensive assist with bed mobility, transfers, toileting, dressing, and grooming and uses walker for ambulation. R4's care plan dated 2/1/16, identified R4 received an antipsychotic medication related to paranoid personality disorder. The care plan did identify Seroquel as an antipsychotic medication and directed staff to monitor for side effects, target behaviors and orthostatic blood pressure (BP). However medical record lacked documentation of orthostatic blood pressure monitoring. During an interview with registered nurse (RN)-A on 3/3/16 at 3:01 p.m. regarding R4's medical record lacked documentation of orthostatic blood pressure monitoring, RN-A stated, facility has an order to monitor the side effects of psychotropic medications. During interview on 3/3/16 at 3:25 p.m. the acting director of nursing confirmed R4's medical record lacked documentation of orthostatic blood pressure monitoring and stated, orthostatic blood pressures should be done monthly and it is in facility standing orders and expectation is staff should do it.	F 428	pharmacy review. Nursing to review all clinical records and comprehensive care plans of elders receiving psychoactive medication and ensure monitoring of the medication is addressed in the comprehensive care plan and clinical record. Measures to prevent reoccurrence: education will be provided to nurses and nurse managers regarding policy for monitoring psychoactive medication. Consulting pharmacist to continue to review drug regimen monthly and identify any irregularities. Plan to Monitor: will continue to review medical record quarterly with psychoactive medication review assessments and continue monthly Consulting Pharmacist review. Pharmacist recommendations will continue to be acted on. Nursing will audit pharmacy recommendations monthly to ensure noted irregularities are acted on. Responsible for maintaining compliance: DON Correction target date: 4/12/16	

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F 428	Continued From page 21 On 3/3/16 at 4:15 p.m. telephone call was made to the pharmacy consultant and voice message was left. No return call was received. Policy and procedure titled PSYCHOACTIVE MEDICATION dated 1/1/15 reads, "8. All elders receiving antipsychotic medication will have monthly orthostatic BP checks documented in the medical record."	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**03/01/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR 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 The Gardens 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: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING **01 - EPISCOPAL CHURCH HOME GARDENS** B. WING _____	**03/01/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME 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
K 000	Continued From page 1 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 6-story building with a partial basement. The original building was constructed in 2012 and was determined to be of Type II(222) construction. 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. The facility has a licensed capacity of 60 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that	K 046	A. Monthly Inspection ⁞⁞ Upon receipt of deficiency, a 30-second functional test	4/12/16

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K 046	Continued From page 2 emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could effect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 0930 to 1400 on 03/01/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (DL) revealed that the facility could not provide any documentation verifying that the battery backup emergency lights had been tested monthly or annually. This deficient practices were confirmed by the Plant Operations Director (ML) at the time of discovery.	K 046	has been added to our Preventative Maintenance software, which will ensure the maintenance staff to perform the required test and provide appropriate documentation. B. Annual Inspection : Upon receipt of deficiency, a 90-minute functional test has been added to our Preventative Maintenance software, which will ensure the maintenance staff assigned to The Gardens will perform the required test and provide appropriate documentation. C. Record of documentation and ongoing compliance with K046 will be monitored by the Plant Operations Director.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101	K 050	A. Upon receipt of the deficiency, the fire drill form has been updated to reflect the Life Safety Code Record Review form that	4/12/16

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K 050	Continued From page 3 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 0930 and 1400 on 03/01/2016, based on review of available documentation it was revealed that fire drills were not being performed or documented per shift per quarter throughout the last year. This deficiency was verified by the Plant Operations Director (ML) at the time of discovery.	K 050	was provided by the State Fire Marshall. B. This schedule has been entered into our Preventative Maintenance software which will remind the maintenance staff to complete a drill each month, as a part of routine maintenance. Being aware that each shift must have a drill each quarter, at a random time during that specified shift. C. Staff, on the varied shifts, will be trained to react appropriately during these drills, in accordance with the facility's fire policies and procedures. Attendance logs will be kept to document those employees reacting to the fire drills. D. These drills will be planned and conducted by the Plant Operation Director or the Campus Maintenance Supervisor or by a Nurse Supervisor that is trained to conduct these drills. E. Compliance with K050 will be monitored by the Administrator.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 51 of 51 residents.	K 052	A. Obtain documentation from Fire Alarm Monitoring company each month, in the form of a digital alarm communicator transmitter (DACT) report to reference and confirm all incidents of the fire alarm system being activated have been received. This report will be requested	4/12/16

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K 052	Continued From page 4 FINDINGS INCLUDE: On 03/01/2016 between 0930 and 1400, while reviewing the facility's fire alarm inspection and testing reports, the Plant Operations Director (ML) failed to produce documentation verifying that the facility's digital alarm communicator transmitter (DACT) was being tested monthly This finding was confirmed with the Plant Operations Director (ML).	K 052	after each fire drill, in order to confirm proper operation of DACT. The person assigned to conduct the drill will be responsible for obtaining the DACT report on an ongoing basis. B. Compliance with K052 will be monitored and enforced by the Plant Operation Director.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7 and 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all residents, staff, and guests. Findings include: On 03/01/2016 between 0930 and 1400, while reviewing the facility's fire sprinkler inspection and testing reports, the Plant Operations Director (ML) failed to produce documentation verifying that the facility's sprinkler system was being tested quarterly. This deficient practice was confirmed by the Plant Operations Director (ML) at the time of discovery.	K 062	A. Monthly Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. B. Quarterly Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Inspection - these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to schedule the fire sprinkler company to perform the required inspections and provide appropriate documentation. D. Long Term - Be aware the current age of the equipment and the appropriate	4/12/16

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K 062	Continued From page 5	K 062	requirement of both wet and dry systems. E. Staff and Contractor are to use the Fire Sprinkler System Historical Log to document each event. F. Compliance with K062 will be monitored by the Plant Operation Director.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. This deficient practice could adversely affect 60 of 60 residents. FINDINGS INCLUDE: On 03/01/2016 between 0930 and 1400, during a review of the facility's emergency generator inspection and testing logs failed to document weekly visual inspections of the emergency generator.. This finding was confirmed with the Plant Operations Director (ML).	K 144	A. Weekly Inspection □ these duties have been added to our Preventative Maintenance software which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. Staff is to use the Generator Weekly Inspection Checklist to document each inspection. Inspections are to be completed by an individual who has been trained to look for abnormalities with the generator. B. Monthly Inspection □ these duties have been added to our Preventative Maintenance software, which will remind the maintenance staff to perform the required inspection and provide appropriate documentation. C. Annual Testing □ these duties have been added to our Preventative Maintenance software. Contractor will perform required annual maintenance and inspection. D. Compliance with K144 will be monitored by the Plant Operation Director.	4/12/16