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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PCDX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00486

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/18/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 04/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/10/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/11/2017
(L33)

Posted 05/16/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245452
May 10, 2017

Ms. Melissa Schneider, Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Dear Ms. Schneider:

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 11, 2017 the above facility is certified for or recommended for:

131 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 131 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
Minnesota Department of Health
Email: 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 10, 2017

Ms. Melissa Schneider, Administrator
Episcopal Church Home of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: Project Number S5452026

Dear Ms. Schneider:

On March 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 2, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 17, 2017 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 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 11, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2017, effective April 11, 2017 and therefore remedies outlined in our letter to you dated March 17, 2017, 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
245452 Y1	A. Building B. Wing Y2	4/18/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0205	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(d)(1)(i)-(iv)(2)	Completed	Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(ii)	Completed
LSC	04/11/2017	LSC	04/11/2017	LSC	04/11/2017
ID Prefix F0312	Correction	ID Prefix F0323	Correction	ID Prefix F0371	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.60(i)(1)-(3)	Completed
LSC	04/11/2017	LSC	04/11/2017	LSC	04/11/2017
ID Prefix F0411	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.55(a)(1)(2)(4)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. #	Completed
LSC	04/11/2017	LSC	04/11/2017	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 05/10/2017	SIGNATURE OF SURVEYOR 16022	DATE 04/18/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
3/2/2017

☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245452	A. Building 01 - MAIN BUILDING 01 B. Wing	4/17/2017

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0754	Correction Completed 03/28/2017	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/28/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/10/2017	SIGNATURE OF SURVEYOR 37010	DATE 04/17/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/1/2017	☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PCDX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00486

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)
13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(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 :
Momodou Fatty, HFE NE II 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 04/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/11/2017 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 20, 2017

****AMENDED LETTER** This letter redacts and replaces the letter dated March 17, 2017.****

Ms. Melissa Schneider, Administrator
Episcopal Church Home of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: Project Number S5452026

Dear Ms. Schneider:

On March 2, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5452035 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 11, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 2, 2017 (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 2, 2017 (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 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, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 17, 2017

Ms. Melissa Schneider, Administrator
Episcopal Church Home of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: Project Number S5625002

Dear Ms. Schneider:

On March 2, 2017, 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. In addition, at the time of the March 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5452035 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 11, 2017, 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 11, 2017 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 2, 2017 (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 2, 2017 (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, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
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
	245452	A. BUILDING _____ B. WING _____	C 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted February 27, February 28, March 1, and March 2, 2017. Board and Care Beds = 50 (All first floor beds with the exception of 131 &132) 101-130 and 133-151 Medicare Certified Beds = 81 (All 2nd and 3rd Floor beds with 131 & 132) 131, 132, and 201-320 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. An investigation of complaint H5452035 was also completed at the time of the standard survey. H5452035 was found not to be substantiated.	F 000		
F 205 SS=B	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 205		4/11/17

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

Electronically Signed | 03/29/2017

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F 205	Continued From page 1 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide family members or legal representatives with the facility bed hold policy, at the time of transfer, for 4 of 4 residents (R311, R10, R123 and R67) who were transferred to the hospital. Findings include: R311's chart was reviewed and a nurses noted dated 5/29/16, revealed R311 had called 911 per self to be transferred to the hospital due to suicidal feelings. Documentation further identified	F 205	F205: It is the policy of ECH to provide written and verbal notification to the resident and a family member or legal representative before transferring out of the facility. Plan of correction for residents cited with this survey: R10, R123, R67 had the facility bed hold policy reviewed with the resident and the resident's representative during the time of survey. R311 no longer resides in the facility.	

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F 205	Continued From page 2 that R311 returned to the facility on 5/30/16, however was sent to the hospital again on 5/31/16, because of suicidal ideation. Review of documentation from a social service (SS) note, dated 5/31/16, identified the family had been contacted by SS regarding the 5/29/16 hospital transfer and family requested a bed hold. However, there was no note to indicate the family had been contacted when R311 was again transferred to the hospital 5/31/16. Documentation from a SS note, dated 6/2/16, addressed that the administrator had requested for SS to contact the family regarding the bed hold policy for the 5/31/16, hospital transfer. R10's family member (FM)-B was interviewed 2/28/17, at 11:46 a.m. and stated not being notified of the facility's bed hold policy when R10 was transferred to the hospital on 2/5/17. FM-B stated being aware of the facility's bed hold policy, as information had been provided at the time of R10's previous hospital transfers, however, had not been notified for the 2/5/17, transfer. R10's progress notes were reviewed from 2/5/17 to present. Although the record lacked documentation of whether FM-B had been notified of the facility's bed hold policy at the time of R10's hospital transfer, R10 had been admitted back to the facility. R123's progress notes, dated 2/15/17, revealed R123 was transferred to the hospital on 2/15/17 and returned to the facility on 2/18/17. Although R123 admitted back to the facility, there was no documentation found in the medical record to indicate the family had been notified of the	F 205	Plan to address/prevent this deficiency for other residents: Education was completed for all social service staff on 3/21/17.Social service staff will be responsible for reviewing bed hold policy during the admission process. The bed hold policy will be sent with any resident transferring out of the facility upon time of transfer. Social service staff will be responsible for contacting the resident and resident's representative no later than 24 hours after transfer out from the facility to verbally confirm bed hold status. The social worker will chart the date and time in which the resident and the resident's representative were contacted in the medical record to ensure proper follow up is taking place. Measures put in place to prevent reoccurrence: The Director of Social Service will be responsible for completing ongoing education for the Social Service staff and for reviewing and updating the facility bed hold policy as necessary. Plan to monitor: Audits will be completed weekly to ensure the resident and resident's representative have been contacted within 24 hours of transferring out of the facility. Results of the audits will be reviewed at the quarterly QA meeting. Audits will continue as warranted and reports will be given at QA ongoing quarterly until the committee is satisfied the plan of correction is working. Responsible for maintaining compliance : Administrator	

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F 205	Continued From page 3 facility's bed hold policy at the time of the transfer. An interview on 3/2/17, at 3:00 p.m., with R123's primary family member acknowledged not being notified, at the time of R123's transfer, of the facility's bed hold policy. FM-M stated "No they didn't," and explained FM-M had "assumed" R123's bed would be held. R67's medical record was reviewed and revealed R67 had numerous hospital transfers (11/28/16, 1/4, 2/21 and 2/28/17) since being admitted to the facility on 11/17/16. The record lacked documentation of the family being informed of the facility's bed hold policy at the time of the transfers. Although R67 had been admitted back to the facility, an interview with the primary family member, FM-K, on 3/2/17 at 3:15 p.m., FM-K stated, "No" regarding being told about the facility's bed hold policy each time R67 was sent to the hospital. Interview with registered nurse (RN)-F on 3/1/17, at 2:10 p.m., stated there was a form to complete regarding bed holds. When asked to provide documentation regarding R10's family having been notified of the facility's bed hold policy, RN-F was unable to locate bed hold documentation for the 2/5/17 hospitalization. On 3/1/17, at 3:03 p.m. licensed social worker (LSW)-A was interviewed regarding the facility's bed hold policy. LSW-A stated the bed hold policy was given at the time of admission to the family and R10 had received the information when admitted to the transitional care unit and when transferred to the long term care side of the facility.	F 205	Correction Date: 04/11/2017	

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F 205	Continued From page 4	F 205		

LSW-A explained that at the time of a hospital transfer, SS contacts the resident's family member and asks if interested in holding the bed. LSW-A further explained that if a resident was on Medical Assistance (MA) the bed hold was automatic. LSW-A stated social services are to document in the electronic health record in the progress note section. LSW-A looked at this section in R10's record, for the 2/5/17 hospital transfer, and verified there was no documentation to indicate FM-B had been notified of the facility's bed hold policy at the time of R10's hospital transfer.

The facility's bed hold policy was requested of LSW-A and the policy provided was a 5/15 form titled Bed Hold Policy, which for R10 was dated 2/10/16. LSW-A stated this was the form signed at the time of R10's admission.

On 3/1/17, at 3:28 p.m. LSW-A stated being told that for MA patients the resident's bed was automatically held. At 3:38 p.m. LSW-A also explained that the transfer packet, that went with a patient upon transfer to the hospital, had information about the facility's bed hold policy.

On 3/2/17, at 11:15 a.m., LSW-A was interviewed regarding the bed hold policy being provided to the resident's family member or legal representative. LSW-A stated not being aware the information had to be given to the family member, but again stated the hospital transfer packet contained the bed hold policy.

A review of the hospital transfer packets, on the Isabella unit, confirmed that the packets contained a transfer form, the facility's bed hold policy and a hospital transfer checklist.

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 6 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R189) with identified dental needs. Findings include: Record review revealed R189 was admitted to the facility on 3/11/16, and the admission Minimum Data Set (MDS) did not indicate any broken or missing natural teeth. However, on 4/4/16, a registered dental hygienist completed a dental assessment which indicated R189 did not have dentures, but had several exposed root tips and there was a broken tooth, which was cutting R189's tongue. The assessment also indicated there were inflamed or bleeding gums or loose natural teeth. The assessment recommended	F 279	F279: It is the policy of ECH to develop and implement a comprehensive person-centered care plan for each resident which includes dental services that are furnished to attain or maintain the resident's highest practical well-being. Plan of correction for residents cited in this survey: R189 was scheduled for a dental appointment. Resident was seen by the dentist on 03/07/2017. Plan to address/prevent this deficiency for other residents: All long term care residents had their care plan/MDS reviewed for any dental areas addressed by 03/08/17. Care plans were updated	

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F 279	Continued From page 7 further dental check up and that R189 did not care for the dentist she had been seeing. The assessment indicated R189 could see the dentist from Apple Tree, if interested. A review of the care plan initiated on 3/30/16, did not address R189's dental status and need for dental services. The care plan only indicated R189 required assistance of one for oral care. On 3/2/17, at 11:30 a.m. R189's medical power of attorney (POA) was interviewed. The POA verified being the individual contacted for all medical issues and attended all care conferences. The POA stated R189's dental status had not been discussed at care conferences, even as recently as the 12/8/16, care conference. The POA stated not being aware of R189's dental needs until 3/2/17.	F 279	and dental appointments were scheduled as needed by the Nurse Manager. Measures put in place to prevent reoccurrence: Documentation/communication flow practice updated for facility dental practice. Following dental hygienist exam resident screening tool will be given to the Nurse Manager and Health Information for review prior to filing. Facility policy updated to reflect change. Education was provided to Health Information, Social Service staff and Nurse Managers on the facility policy and regulatory standards for dental service/intervention and care planning. Plan to monitor: Care audit results will be summarized and reported at the QA meeting every month for 3 months and then quarterly going forward until the QA committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing Date of Compliance: 04/11/2017	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	F 282		4/11/17

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(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 282	Continued From page 8 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 provide services in accordance with residents written plan of care for 1 of 4 residents (R307) who required assist with shaving and failed to ensure medication orders in the comprehensive care plan were followed for 1 of 6 residents (R8) reviewed for unnecessary medications. Findings include: The care plan dated 2/17/17, identified R307 had alteration in ADL's and directed staff, "The resident has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Limited ROM, Pain at left hip and left arm due to recent fall with fracture. PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of 1". The temporary care plan dated 2/6/17, read, "Cognitive Status alert oriented to Person Place Times Situation. Grooming Assist in all area". On 2/27/17 at 7:12 p.m., R307 was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. R307 was able to communicate needs when queried at the time and explained that the shaver fell, came apart, was non-functional, and could not be put back together due to limited range of motion of R307's left upper extremity. On 2/28/17 at 11:02 a.m., R307 was observed in room sitting in wheelchair and observed to have	F 282	F282: It is the policy of ECH to provide care in line with the resident's written plan of care. Plan of correction for residents cited in this survey: R307 who had not been shaved per the plan of care was shaved by nursing staff on 2/28/17. The patient's broken electric razor was repaired by nursing staff on 2/28/17. Temporary care plan for R307 was reviewed and updated. R8 with an order for an apical pulse to be obtained prior to the administration of had the medication administration record (MAR) corrected. The nurse practitioner and family were notified of the error. Medication error report completed per facility policy. On review of the clinical record the resident's pulses were checked weekly and noted to be above 50 consistently. The nurse practitioner stated that there was no negative outcome and that she had intended to discontinue pulse monitoring. Pulse monitoring is discontinued. Plan to address/prevent this deficiency for other residents: Temporary care plan template for TCU patients has been updated to include more detail on grooming needs. All residents were reviewed and shaved as needed. Staff that transcribed order for R8 did review the facility policy and had education provided. All residents receiving Atenolol	

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	245452	A. BUILDING _____ B. WING _____	C 03/02/2017

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F 282	Continued From page 9 numerous facial hairs. On 2/28/17 at 3:34 p.m., R307 was observed in room sitting in wheelchair and observed to have numerous facial hairs. In addition, R307 indicated, shaver machine is sitting in bathroom and staff did not assist with fixing it. R307 explained it had been a couple of days now that [R307] could not shave. Further stated, "I would like it to be fixed and get shaved." On 2/28/17 at 3:38 p.m. registered nurse (RN)-B walked into R307's room and confirmed R307 was unshaven and that the shaver located by the sink in the bathroom, was detached and non-functional. While RN-B attempted to fix the shaving machine at 3:43 p.m., R307 indicated the shaver was expensive and would like to have a new one if this cannot be fixed. During an interview with RN-B on 2/28/17 at 3:50 p.m., mentioned, expectation for nursing assistant registered (NAR) in the morning, is to complete ADLs which includes shaving, personal hygiene, etc. and let resident participate as much as possible and NAR's should follow the care plan as directed. During an interview with the director of nursing on 2/28/17 at 4: 15 p.m. stated, expectation is for NAR's to find out and/or ask residents what their needs are in terms of ADLs especially if residents are cognitively intact. Review of R8's comprehensive care plan revealed a medication order for 50 milligrams of atenolol daily, for hypertension. The order, which started on 8/11/15, specified for staff to check R8's apical pulse (a stethoscope is used to listen	F 282	were reviewed to ensure parameters included in the orders were being followed. Measures put in place to prevent reoccurrence: Education on care planning for ADL needs provided to nurse managers. Training and education for grooming needs provided to all nursing staff. Education on assessing ADL equipment such as razors for repair or replacement when necessary provided to all nursing staff. Education provided to nurses and trained medication aides on medication administration and the ECH policy. Plan to monitor: Nursing assistant observations will be completed randomly on all LTC households and on the TCU for completion of ADL tasks. Audit results will be reviewed and presented at the QA committee and reviewed quarterly until the QA committee determines the plan of correction is successful. Medication administration audits will be completed monthly. Audit results will be summarized at the QA meeting every month for 3 months and quarterly thereafter until the QA committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing Date of Compliance: 04/11/2017	

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F 282	Continued From page 10	F 282		

to the heart) upon rising for one minute, to hold the medication if the apical pulse is less than 50, to notify the NP if there are 2 consecutive irregular heart rates, and to document pulse.

Review of the medication administration record (MAR) for 2/2017 revealed R8 received atenolol daily at 8:00 a.m. The order on the MAR included the specification to check and document apical pulse, and hold the medication if the pulse was less than 50. Staff had not documented apical pulse on the MAR.

In an interview on 3/2/17, at 2:45 p.m., when asked if staff listened to the resident's heart in the mornings, R8 replied, "Sometimes."

During interview on 3/2/17, at 2:48 p.m. registered nurse (RN)-E seemed unaware of the requirement to take R8's apical pulse daily. RN-E said usually if there was a pulse required for a medication, it would pop up on the order computer screen to remind nursing staff to enter a pulse when giving the medication. RN-E did not believe this order was set up to require a pulse in the computer, and RN-E could not find documentation of a daily apical pulse. RN-E said this morning she did check R8's pulse at the wrist, but said it was after giving the medication.

In an interview on 3/2/17, at 3:08 p.m. RN-F was unable to find the apical pulse documentation for R8. In a follow-up interview at 4:18 p.m. RN-F said the apical pulse was added to the atenolol order so now when staff gave the medication, the computer would require them to enter the apical pulse. RN-F said some of the nurses claimed they were checking apical pulse, but confirmed he did not have documentation for that.

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F 282	Continued From page 11 The facility policy titled Administration of Medications, dated 1/1/15, required medications to be administered "in accordance with the prescriber's orders."	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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 reviewed, the facility failed to provide personal hygiene care for 1 of 4 residents (R307) who was dependent upon staff for personal cares. Findings Include: On 2/27/2017 at 7:12 p.m., R307 was observed to have several gray/white facial hairs to the upper lip and the chin area approximately 1 inch long. R307 explained that the shaver had fallen, came apart and was nonfunctional. R307 explained being unable to put it back together due to limited range of motion. On 2/28/17 at 11:02 a.m. and at 3:34 p.m., R307 was observed in room sitting in wheelchair and again had numerous facial hairs. R307 said the shaver was in the bathroom and staff did not assist with fixing it. R307 explained it had been a couple of days without being shaved. R307 stated, "I would like it to be fixed and get shaved." On 2/28/17 at 3:38 p.m. registered nurse (RN)-B	F 312	F312: It is the policy of ECH to ensure that any resident unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Plan of correction for residents cited in this survey: R307 who had not been shaved per the plan of care was shaved by nursing staff on 2/28/17. The patient's broken electric razor was repaired by nursing staff on 2/28/17. Temporary care plan for R307 was reviewed and updated. Plan to address/prevent this deficiency for other residents: Temporary care plan template for TCU patients has been updated to include more detail on grooming needs. All residents were reviewed and shaved as needed. Measures put in place to prevent reoccurrence: Education on care planning	4/11/17

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F 312	Continued From page 12 confirmed R307 was unshaven and the shaver was detached, sitting by the sink in the bathroom and nonfunctional. RN-B attempted to fix the shaver at 3:43 p.m. R307 stated the shaver was expensive and would like to have a new one if this one could not be fixed. R307's admission and clinical records noted R307 admitted to facility on 2/6/17, and had diagnoses, which included diabetes II and fracture of upper end of right humerus. R307's admission/Medicare 5-day Minimum Data Set (MDS) dated 2/13/17, identified R307 required extensive assist of one staff with personal hygiene needs - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers). The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 2/17/17, reads, "... [R307] had a BIMS score of 8 with errors in recall and temporal areas. There were no indicators of delirium in the look back period. [R307] had a PHQ9 score of 4. [R307] presented with no hallucinatory or delusional content or behavioral symptoms in the reference period. ... [R307] requires hands on assist to stabilize self during transitions. [R307] has impaired functional ability to left upper extremity and bilateral lower ones... [R307] is receiving occupational and physical therapy at this time. [R307] required extensive assist with bed mobility, transfers (use of mechanical device) along with locomotion. [R307] was able to eat with setup and supervision. [R307] required extensive assist with dressing, grooming, bathing	F 312	for ADL needs provided to nurse managers. Training and education for grooming needs provided to all nursing staff. Education on assessing ADL equipment such as razors for repair or replacement when necessary provided to all nursing staff. Plan to monitor: Nursing assistant observations will be completed randomly on all LTC households and on the TCU for completion of ADL tasks. Audit results will be reviewed and presented at the QA committee quarterly until the QA committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing Date of compliance: 04/11/2017	

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F 312	Continued From page 13 and toilet use...." The care plan dated 2/17/17, identified R307 had alteration in ADL's and directed staff, "The resident has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Limited ROM, Pain at left hip and left arm due to recent fall with fracture. PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of 1". The temporary care plan dated 2/6/17, read, "Cognitive Status alert oriented to Person Place Times Situation. Grooming Assist in all area". During an interview with RN-B on 2/28/17 at 3:50 p.m., mentioned, expectation for nursing assistant registered (NAR) in the morning, is to do the complete ADLs that includes shaving, personal hygiene, etc. and let resident participate as much as possible. NAR should follow the care plan as indicated. Resident can communicate desires. During an interview with the director of nursing on 2/28/17 at 4: 15 p.m. stated, expectation is NAR to ask residents of what their needs are in terms of ADLs especially if residents are cognitively intact. Policy and procedure subject: STANDARDS OF CARE / ELDER RIGHTS dated November 2016, reads, "A. The care ECH [Episcopal Church Home] and the Gardens focuses on quality of life, maintaining each elder's dignity and confidentiality in an elder centered and individualized way. B. d. Assistance or supervision of shaving as needed to keep clan [clean] and well-groomed".	F 312		

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F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure water temperatures in resident bathrooms and/or bathing rooms were maintained at a comfortable range. This had the potential to affect 10 residents identified by the facility on 3/2/17, at 3:28 p.m. as having diagnoses that included Alzheimer's, dementia or other related diagnoses of the 33 residents who resided on the two units affected by high water temperatures.	F 323	F323: It is the policy of ECH to ensure all resident rooms and bathroom/tubroom water temperatures are between 105 and 115 degrees Fahrenheit. Plan of Correction for Residents Cited in this Survey: A specific mixing valve was determined to be the source of the high water temperatures in the affected resident rooms on 2/28/17 during the	4/11/17

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F 323	Continued From page 15 Findings include: On 2/27/17, water in the bathroom sinks of resident rooms 148 and 312 were noted to feel overly warm to touch. At 7:00 p.m. the administrator was called to find a thermometer to check water temperatures. The administrator borrowed a digital thermometer from the dietary department. On 2/27/17, the following hot water temperatures were taken by the administrator, and verified by surveyors: At 7:23 p.m., the water in room 148 measured 129.7 degrees Fahrenheit (F). At 7:29 p.m., the water in room 312 measured 123.4 degrees F. In an interview on 2/27/17, at 7:23 p.m., the administrator said she did not know, when asked about appropriate water temperatures ranges. On 2/28/17, at 8:31 a.m. maintenance technician (MT)-A confirmed there was a problem with water temperatures due to a problem with the mixing valve. MT-A said "the pneumatic system went haywire on me" but explained closing the valve that morning to begin bringing water temperatures down, and calling for outside help to fix the problem. After closing the valve, on 2/28/17, MT-A measured the following hot water temperatures in resident units that were previously identified to be too hot: At 8:39 a.m. room 148 measured 126 degrees F. At 8:40 a.m. room 149 measured 123 degrees F. At 8:42 a.m. room 151 measured 124 degrees F.	F 323	facility survey. The valve was fixed and water temperatures were tested in affected rooms 148, 312, 149, 151, 310, 245, 249, 250,252, 251 on the afternoon of 2/28/17. All rooms had temperatures in the appropriate 105-115 level and this information was provided to the onsite survey team. Rooms were re-tested on 3/01/17 during the annual fire marshal inspection. All rooms were found to be within the acceptable level by the fire marshal. Plan to address/prevent this deficiency for other residents: ECH policy for testing water temperatures has been updated to include testing the water temperatures in rooms that reside in each of the six separate water system areas monthly to ensure all separate valve lines are tested each month. Measures put in place to prevent reoccurrence: The policy developed for testing temperatures in each six separate water systems monthly will prevent reoccurrence of a missed issue caused by any of the six separate water lines if another part of the building has compliant temperatures. Education provided to nursing staff to alert maintenance immediately if water in rooms or tub rooms ever feel overly warm to the touch. Policy reviewed in safety committee meeting 03/28/17. Plan to monitor: Auditing of the room temperature logs will be done monthly with results to be reported at the facility	

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F 323	Continued From page 16 At 8:49 a.m. room 312 measured 117 degrees F. At 8:51 a.m. room 310 measured 117 degrees F. In an interview on 2/28/17, at 8:53 a.m. MT-A explained checking the water temperatures of different resident units approximately twice per year. MT-A confirmed that different units were on different water systems, and because of that, water in different units could be at different temperatures. The administrator said going forward, maintenance would check the water temperature in one room from each resident unit monthly. Review of undated facility instructions for checking water temperatures through the Direct Supply TELS system required maintenance staff to ensure patient room water temperatures were between 105 and 115 degrees F. On 2/28/17, at 9:53 a.m. the water temperature in the bathroom of room 245 felt overly warm to touch. The water temperature was tested at this time by MT-B and found to be 126 degrees F. When R189 was asked how the water felt, R189 was unable to answer the question. Water temperatures were noted in the following areas on 2/28/17, to be greater than 120 degrees Fahrenheit (F). The temperatures were taken with a facility thermometer by MT-B and verified by the surveyor. Room 249 had a water temperature of 125.7 degrees F at 9:56 a.m. Room 250 had a water temperature of 126 degrees F at 9:58 a.m. Room 252 had a water temperature of 125.9 degrees F at 10:02 a.m. When the resident in the	F 323	QA meeting. The Director of Plant Operations will be responsible to monitor temperature logs monthly going forward indefinitely per facility policy. Responsible for maintaining compliance: Director of Plant Operations Date Corrected: 04/11/2017	

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F 323	Continued From page 17 room was interviewed regarding the temperature of the water, the resident was unable to answer. Room 251 had a water temperature of 127 degrees F at 10:04 a.m. When interviewed the resident residing in the room stated the water temperature was "fine." On 3/1/17, at 8:51 a.m. before starting cares for R189 nursing assistant (NA)-B had R189 feel the temperature of the water. R189 stated it was too warm and NA-B changed the water with a cooler temperature that was then acceptable to R189. NA-A and NA-B both stated they always have residents check the water prior to bathing to see if it's acceptable to the resident, because some residents have very fragile skin.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		4/11/17

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F 371	Continued From page 18 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was prepared and stored under sanitary conditions in the main kitchen and TCU kitchenettes which had the potential to affect residents who resided on the transitional care unit which has a capacity for 36 residents of the 125 residents residing in the facility. Findings include: During a kitchen tour on 3/2/17, from 1:10 to 1:27 p.m. there was an undated when opened bag of Italian sausage nuggets; and two 20 pound plastic containers of beef and chicken base, which were also undated when opened. Approximately 24 plastic bowls and 12 plastic coffee cups were observed to be stored wet; and seven frying pans had baked on brown or black debris inside the pans on the bottom and/or sides. The chef manager stated, the frying pans were not used frequently. Both the chef manager and the director of culinary services verified the wet bowls/cups, the undated food items and the condition of the frying pans. During a tour of the facility's kitchenettes on 2/28/17 from 3:00 p.m. to 4:15 p.m. the following observations were made.	F 371	F371: It is the policy of ECH to store, distribute, and serve food in accordance with professional standards for food service safety. Plan of correction for residents cited in this survey: No residents specifically identified during the survey. Plan to address/prevent this deficiency for other residents: The seven frying pans identified were thrown away immediately upon direction from the survey team on 02/28/17. An audit was done of all frying pans to ensure the remaining pans were in good working condition and replaced if necessary. The undated food items were disposed of during the survey. An audit of all supplements was completed to ensure all were dated appropriately. Measures put in place to prevent reoccurrence: The policy for labeling and dating of food was updated and implemented as of 03/21/17. All food service staff was educated and all other staff with access to the refrigeration and freezers in ECH will have education on the policy and procedure by the correction date. The policy and procedure regarding proper dishwashing procedures was reviewed and implemented as of	

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(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 371	Continued From page 19 The third floor transitional care unit (TCU) refrigerator contained ten mighty shakes and four juice supplements which were thawed and undated. The second floor TCU refrigerator contained three juice supplements and one mighty shake which were thawed and undated. The mighty shake and juice supplement cartons had instructions on them to store thawed in the refrigerator for no more than 14 days for safe consumption by residents. The dietary supervisor (DS), present during the tour, reported, would expect the supplements to be dated when thawed as they should only be in the refrigerator for 14 days after thawed. DS disposed of the supplements. Review of the diet type report for second floor TCU, dated 2/28/17 revealed 4 residents were ordered mighty shakes or juice supplements. Review of the diet type report for third floor TCU, dated 2/28/17, revealed 3 residents were ordered mighty shakes or juice supplements. The facility's 1/16, policy titled Labeling/dating of supplements indicated items when removed from the freezer for thawing were to be dated; and per industry standards discarded at maximum of 14 days or per manufacturers' guidance.	F 371	03/21/17. All food service staff will be educated regarding the policy with focus pertaining to air drying clean dishes without stacking, and that pots and pans should be free of carbon buildup, grease and food particles. The policy for labeling and dating of supplements was reviewed and all ECH staff will be educated on the procedure by the date of correction. Plan to Monitor: The Dining Service Director and the Dietician will audit supplement dating on a monthly basis to ensure compliance. Audit results will be reported quarterly at facility QA meetings until the QA committee is satisfied with the correction. Audits for pot and pan cleanliness and food labeling and dating will be monthly indefinitely. Responsible for maintaining compliance: Dining Service Director Correction Date: 04/11/2017	
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to	F 411		4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	C 03/02/2017

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F 411	Continued From page 20 meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain dental services for 1 of 1 resident (R189) with identified dental needs. Findings include: Record review revealed R189 was admitted to the facility on 3/11/16, and the admission Minimum Data Set (MDS) did not indicate any broken or missing natural teeth. However, on 4/4/16, a registered dental hygienist completed a dental assessment which indicated R189 did not have dentures, but had several exposed root tips and there was a broken tooth, which was cutting R189's tongue. The assessment also indicated there were inflamed or bleeding gums or loose natural teeth. The assessment recommended further dental check up and that R189 did not care for the dentist she had been seeing. The assessment indicated R189 could see the dentist from Apple Tree, if interested. However, there was no documentation indicating R189 had seen a dentist or the dental recommendation had been	F 411	F411: It is the policy of ECH to provide access to and assist in the scheduling of routine and emergency dental service to meet the needs of each resident. Plan of correction for residents cited in this survey: R189 was scheduled for a dental appointment. Resident was seen by dentist on 03/07/2017. Plan to address/prevent this deficiency for other residents: All long term care residents had their care plan/MDS reviewed for any dental areas addressed completed 03/08/17. Care plans were updated and dental appointments were scheduled as needed by the Nurse Manager. Measures put in place to prevent reoccurrence: Documentation/communication flow practice updated for facility dental practice. Following dental hygienist exam	

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F 411	Continued From page 21 followed up on. A nurses note, dated 12/6/16, noted a "swollen (bump-like) area on the gum; inner area on right lower gum, no discoloration, no pain as stated by elder. Nurse on floor informed. Dental appointment made." A care conference note dated 12/8/17, revealed there was no discussion with the family regarding R189's dental needs at the time of the care conference. A nurses note dated 12/12/16, indicated to check with the family if the resident should be seen by a dentist, as R189 was not a patient of the dental service which came to the facility. There was no documentation indicating communication regarding R189's dental needs were discussed with the family at the care conference; and there was no documentation indicating R189 had seen a dentist since admission. A nurses note dated 12/31/16, indicated R189 was having difficulty chewing and was placed on a 3-day mechanical soft diet trial; and on 1/2/17, a physician's order was given for a mechanical soft diet. The care plan revised on 2/10/17, did not address the swollen (bump-like) area on R189's gum or the need for dental services. The care plan indicated R189 was to receive oral care, but there was no frequency and dental services were not identified on the care plan. On 3/1/17, at 9:08 a.m. nursing assistant (NA)-A and NA-B stated R189 did not complain of pain or discomfort when oral care was provided; there were not many problems with R189 eating or chewing and R189 was encouraged to feed self and brush own teeth. However, staff usually	F 411	resident screening tool will be given to the Nurse Manager and Health Information for review prior to filing. Facility policy updated to reflect change. Education was provided to Health Information, Social Service staff and Nurse Managers on the facility policy and regulatory standards for dental service/intervention and care planning. Plan to monitor: Care audit results will be summarized and reported at the QA meeting every 3 months and then quarterly going forward until the QA committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing Date of Compliance: 04/11/2017	

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	245452	A. BUILDING _____ B. WING _____	C 03/02/2017

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F 411	Continued From page 22 ended up brushing R189's teeth. On 3/1/17, at approximately 10:05 a.m. licensed practical nurse (LPN)-A observed R189's mouth with the surveyor. There were two pink bump-like areas noted on R189's lower right gum, which looked different when compared to the left lower gum and several missing and broken teeth were also noted. After LPN-A completed the oral examination, NA-A began oral cares gently using a toothbrush. R189 did not complain of any discomfort until the upper left teeth/gum area was brushed. No bleeding was noted with the oral hygiene. At 10:10 a.m. LPN-A asked nurse practitioner (NP)-E if aware of any growths on R189's gums. NP-E stated not being aware. The NP-E examined R189's mouth, stating R189 had several broken teeth; and R189 was not observed to vocalize any pain or discomfort when pressure was applied to the growth by NP-E. NP-E asked if R189 was on a mechanical soft diet and nursing assistant (NA)-A stated the resident had been having difficulty chewing and was on a mechanical soft diet. NP-E stated R189 should probably see a dentist. On 3/2/17, at 11:30 a.m. R189's medical power of attorney (POA) was interviewed. The POA verified being the individual contacted for all medical issues and attended all care conferences. The POA stated R189's dental status had not been discussed at care conferences, even as recently as the 12/8/16, care conference. The POA stated he had not been contacted by the facility regarding 189's dental needs until 3/2/17.	F 411		

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F 431	Continued From page 23	F 431		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 24 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure areas where medications were stored, remained locked when unattended on 1 of 7 units observed for medication storage and the facility failed to assure that facility staff were aware of the process for destroying Fentanyl, narcotic patches. Findings include: During the initial tour of the facility the medication room, Team Room door on May Household, on 2/27/17, at 12:19 p.m. was propped open with a door stopper. There were no staff or residents visible in the immediate area and the units nurse was down the hallway, out of sight, passing medications. In the room, inside a closed, but unlocked cupboard the following stock medications were stored: 5-bottles of Tylenol, 2-bottles of milk of magnesia, 2-bottles of Geri-Tussin (cough	F 431	F431: It is the policy of ECH to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and to store all drugs and biologicals in accordance with state and federal laws in locked compartments under proper temperature controls, and to permit only authorized personnel to have access to the keys. Plan of correction for residents cited in this survey: No residents specifically identified during the survey. Plan to address/prevent this deficiency for other residents: All residents with topical narcotics reviewed. The facility policy for documentation and destruction of Fentanyl patches was reviewed and updated. Nurses in the May house were educated on maintaining the locked	

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	245452	A. BUILDING _____ B. WING _____	C 03/02/2017

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F 431	Continued From page 25 medicine), 1-bottle of the laxative polyethylene glycol, 1-bottle of Pepto-Bismol, 2-bottles of Geri-Lanta (for gastric distress), 2-boxes of albuterol sulfate (for shortness of breath), and 1-bottle of the laxative Sorbitol. Inside another closed, but unlocked cupboard the following meds were observed for a resident (R30) who discharged on 12/7/16: 2-bottles of Travatan eye drops, 1-bottle of the anti-hypertensive medication losortan; 3-medication blister packs of the muscle relaxant Baclofen 10 milligrams (mg), 1-blister pack of Atropine 0.4 mg (a nervous system blocker), 3-blister packs of Haldol 0.5 mg (an antipsychotic), 1-blister pack each of Tolerodine 2 mg (for bladder leakage), and the blood-thinner Eliqus 5 mg. In the same unlocked, but closed cupboard was a bottle of Novalog insulin for a resident (R86) and Trazadone 50 mg (anti-depressant) for a resident (R212). In the unlocked refrigerator there was a vial of the of tuberculosis testing solution Tubersol and a plastic container which contained rectal suppositories for three residents (R30, R77, R54); and another plastic container which contained two bottles of Novolog insulin for a resident (R86). The facility's pharmacy manual dated 12/7/16, and titled Medication Storage in the Facility indicated medication rooms were to be locked and only licensed nurses, the consulting pharmacist and those lawfully authorized, were allowed access to medications.	F 431	medication room door. Door stopper removed. Plant operations notified of lock repair needed on cabinets. Lock repairs completed 03/27/17. Measures put in place to prevent reoccurrence: Education provided to all nurses and trained medication aides on facility policy and regulatory guidelines for narcotic destruction. Authorization for key access verified and education provided to all nursing staff on the responsibility of locking medication room doors. Plan to monitor: Audits will be completed weekly x 4 weeks, monthly x 3 months and quarterly for one year. Results of audits will be summarized and reported at facility QA meetings and will continue quarterly thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing Date of Compliance: 04/11/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 26 During a facility tour with the maintenance supervisor on 3/1/17, at 1:39 p.m. the medication room, May Household Team Room door, was open and a nursing assistant was in the room washing hands. Registered nurse (RN)-C stated staff were having trouble locking the door to the room and the medications stored in the unlocked cupboards were either discontinued or stock meds. RN-C stated [RN-C] generally kept the door closed/locked until the repair was done. RN-C then asked the maintenance supervisor to fix the door. Review of a facility policy regarding destruction of Fentanyl narcotic patch, the policy dated 12/7/16, was from the consulting pharmacy and indicated Fentanyl patches were to be folded in half, with the sticky sides together. The patch was then to be flushed down the toilet/hopper and the flushing was to be witnessed by a second staff member or according to facility protocol for destruction of a controlled substance. The policy further indicated the two staff members witnessing the destruction were to document the disposal. During interviews with facility staff it was learned that staff had different understandings regarding the process: When interviewed, on 3/1/17, at 11:02 a.m. licensed practical nurse (LPN)-C stated, Fentanyl patches were removed and disposed of in a special container. LPN-C stated the disposal of the patches was not witnessed by another nurse. At 11:15 a.m. RN-C stated, nurses would cut Fentanyl patches into quarters and flush the patch down the toilet. RN-C stated this procedure is what the pharmacist had recommended and this procedure was done by one nurse and not witnessed by a second nurse.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 27 At 11:30 a.m. RN-G indicated, nurses were to flush the patches down the toilet, and the flushing was to be witnessed by two nurses. At 2:18 p.m. LPN-B explained that Fentanyl patches were disposed of by rolling the patch up and placing the patch in the sharps container. At 2:49 p.m. the director of nurses (DON) stated, was not aware there were residents in the facility receiving Fentanyl patches. The DON stated, expectation was that if a resident had a Fentanyl patch it would be disposed of in the toilet by two nurses. The DON stated the Fentanyl patch removal policy was from the consulting pharmacy.	F 431		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245452	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/2/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245452	A. BUILDING: _____ B. WING _____	3/2/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245452	A. BUILDING: _____ B. WING _____	3/2/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 2

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services for 1 of 3 residents (R255) reviewed for liability notice and beneficiary appeal rights.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245452	A. BUILDING: _____ B. WING _____	3/2/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 3

Findings Include:

During review of facility liability notice and beneficiary appeal rights for R255 on 2/28/17, the following was noted:
Although the plan for R255 was to be discharged from the facility, review of Notice of Medicare Provider Non-Coverage forms (CMS-10123) on 2/28/17, for R255 revealed recipient did not sign these forms at least 48 hours prior to the end of their Medicare coverage in the facility. Medicare coverage for R255 ended on 10/13/16 and signed by the rep/resident on 10/12/16.

R255's Notice of Medicare non-coverage letter, read, "The Effective Date Coverage of Your Current Services Will End: 10/13/2016". It was signed and dated by resident or representative on 10/12/16, and it indicated, "I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]."

During an interview with registered nurse (RN)-A on 2/27/17 at 9:27 a.m. stated, the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage should be given at least two days before covered services would end and the Lady who had done this notice, no longer worked at the facility.

Policy and procedure title MEDICARE NOTICE OF NONE COVERAGE dated, January 2015, directed staff "Episcopal Church home (ECH) will provide at least a two day notice on denial of Medicare benefits utilizing appropriate denial letters per law. These letters will include information regarding the appeal rights for each resident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2017**

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

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

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 COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found NOT in 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) 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:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2017**

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 3 buildings will be surveyed as one building. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a licensed capacity of 131 beds	K 000		

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K 000	Continued From page 2 and had a census of 124 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 754 SS=D	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On the facility tour between 0800 and 1100 on	K 754	K754: Soiled linen and trash containers should not exceed 32 gallons in a 64 square foot area. How the deficiency was corrected: The square footage of each soiled linen storage room was measured and all over sized receptacles were removed and replaced with appropriate sized collection receptacles per regulation. With rooms varying in size the replacement storage receptacles were labeled and assigned to	3/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 754	Continued From page 3 03/01/2017 it was found that the facility was storing multiple bins exceeding 32 gallons for soiled linen containers per 64 square feet (in area) and areas that are open to the corridors and not in the required hazardous storage areas. This deficient practices was confirmed by the Facility Manager.	K 754	a designated soiled linen room. Completion Date:03/24/2017 Responsible for maintaining compliance: Director of Plant Operations	
K 918 SS=C	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		3/28/17

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K 918	Continued From page 4 circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 0800 and 1100 on 03/01/2017, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing the generator. This deficient practice was verified by Building Maintenance Engineer.	K 918	K918: Essential electrical system maintenance and testing. How the deficiency was corrected: Documentation confirming that the 5 minute cool down period, per regulation, was occurring after each testing of the emergency generator was not verifiable. Staff have been made aware of the regulation and re-trained to document the correct procedure of allowing the 5 minute cool down period at the end of the running cycle of the emergency generator. Staff will document the 5 minute cool down on both the summary log page within the life safety book, as well as within our TELS software. Completion date: 03/28/2017 Responsible for maintaining compliance: Director of Plant Operations	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
March 17, 2017

Ms. Melissa Schneider, Administrator
Episcopal Church Home of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5625002

Dear Ms. Schneider:

The above facility was surveyed on February 27, 2017 through March 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5452035 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

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

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

Please feel free to call me with 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

Enclosure(s)
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
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 27, 28, March 1 and 2nd, 2017,surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint H5452035 was completed. The complaint was found not to be substantiated.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R189) with identified dental needs. Findings include: Record review revealed R189 was admitted to the facility on 3/11/16, and the admission Minimum Data Set (MDS) did not indicate any broken or missing natural teeth. However, on 4/4/16, a registered dental hygienist completed a dental assessment which indicated R189 did not have dentures, but had several exposed root tips	2 560	Corrected.	4/11/17

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2 560	Continued From page 3 and there was a broken tooth, which was cutting R189's tongue. The assessment also indicated there were inflamed or bleeding gums or loose natural teeth. The assessment recommended further dental check up and that R189 did not care for the dentist she had been seeing. The assessment indicated R189 could see the dentist from Apple Tree, if interested. A review of the care plan initiated on 3/30/16, did not address R189's dental status and need for dental services. The care plan only indicated R189 required assistance of one for oral care. On 3/2/17, at 11:30 a.m. R189's medical power of attorney (POA) was interviewed. The POA verified being the individual contacted for all medical issues and attended all care conferences. The POA stated R189's dental status had not been discussed at care conferences, even as recently as the 12/8/16, care conference. The POA stated not being aware of R189's dental needs until 3/2/17. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		4/11/17

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2 565	Continued From page 4 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with residents written plan of care for 1 of 4 residents (R307) who required assist with shaving and failed to ensure medication orders in the comprehensive care plan were followed for 1 of 6 residents (R8) reviewed for unnecessary medications. Findings include: The care plan dated 2/17/17, identified R307 had alteration in ADL's and directed staff, "The resident has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Limited ROM, Pain at left hip and left arm due to recent fall with fracture. PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of 1". The temporary care plan dated 2/6/17, read, "Cognitive Status alert oriented to Person Place Times Situation. Grooming Assist in all area". On 2/27/17 at 7:12 p.m., R307 was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. R307 was able to communicate needs when queried at the time and explained that the shaver fell, came apart, was non-functional, and could	2 565	Corrected.	

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2 565	Continued From page 5 not be put back together due to limited range of motion of R307's left upper extremity. On 2/28/17 at 11:02 a.m., R307 was observed in room sitting in wheelchair and observed to have numerous facial hairs. On 2/28/17 at 3:34 p.m., R307 was observed in room sitting in wheelchair and observed to have numerous facial hairs. In addition, R307 indicated, shaver machine is sitting in bathroom and staff did not assist with fixing it. R307 explained it had been a couple of days now that [R307] could not shave. Further stated, "I would like it to be fixed and get shaved." On 2/28/17 at 3:38 p.m. registered nurse (RN)-B walked into R307's room and confirmed R307 was unshaven and that the shaver located by the sink in the bathroom, was detached and non-functional. While RN-B attempted to fix the shaving machine at 3:43 p.m., R307 indicated the shaver was expensive and would like to have a new one if this cannot be fixed. During an interview with RN-B on 2/28/17 at 3:50 p.m., mentioned, expectation for nursing assistant registered (NAR) in the morning, is to complete ADLs which includes shaving, personal hygiene, etc. and let resident participate as much as possible and NAR's should follow the care plan as directed. During an interview with the director of nursing on 2/28/17 at 4: 15 p.m. stated, expectation is for NAR's to find out and/or ask residents what their needs are in terms of ADLs especially if residents are cognitively intact.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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2 565	Continued From page 6 Review of R8's comprehensive care plan revealed a medication order for 50 milligrams of atenolol daily, for hypertension. The order, which started on 8/11/15, specified for staff to check R8's apical pulse (a stethoscope is used to listen to the heart) upon rising for one minute, to hold the medication if the apical pulse is less than 50, to notify the NP if there are 2 consecutive irregular heart rates, and to document pulse. Review of the medication administration record (MAR) for 2/2017 revealed R8 received atenolol daily at 8:00 a.m. The order on the MAR included the specification to check and document apical pulse, and hold the medication if the pulse was less than 50. Staff had not documented apical pulse on the MAR. In an interview on 3/2/17, at 2:45 p.m., when asked if staff listened to the resident's heart in the mornings, R8 replied, "Sometimes." During interview on 3/2/17, at 2:48 p.m. registered nurse (RN)-E seemed unaware of the requirement to take R8's apical pulse daily. RN-E said usually if there was a pulse required for a medication, it would pop up on the order computer screen to remind nursing staff to enter a pulse when giving the medication. RN-E did not believe this order was set up to require a pulse in the computer, and RN-E could not find documentation of a daily apical pulse. RN-E said this morning she did check R8's pulse at the wrist, but said it was after giving the medication. In an interview on 3/2/17, at 3:08 p.m. RN-F was unable to find the apical pulse documentation for R8. In a follow-up interview at 4:18 p.m. RN-F said the apical pulse was added to the atenolol order so now when staff gave the medication, the	2 565		

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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2 565	Continued From page 7 computer would require them to enter the apical pulse. RN-F said some of the nurses claimed they were checking apical pulse, but confirmed he did not have documentation for that. The facility policy titled Administration of Medications, dated 1/1/15, required medications to be administered "in accordance with the prescriber's orders." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document reviewed, the facility failed to provide personal	2 920	Corrected.	4/11/17

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2 920	Continued From page 8 hygiene care for 1 of 4 residents (R307) who was dependent upon staff for personal cares. Findings Include: On 2/27/2017 at 7:12 p.m., R307 was observed to have several gray/white facial hairs to the upper lip and the chin area approximately 1 inch long. R307 explained that the shaver had fallen, came apart and was nonfunctional. R307 explained being unable to put it back together due to limited range of motion. On 2/28/17 at 11:02 a.m. and at 3:34 p.m., R307 was observed in room sitting in wheelchair and again had numerous facial hairs. R307 said the shaver was in the bathroom and staff did not assist with fixing it. R307 explained it had been a couple of days without being shaved. R307 stated, "I would like it to be fixed and get shaved." On 2/28/17 at 3:38 p.m. registered nurse (RN)-B confirmed R307 was unshaven and the shaver was detached, sitting by the sink in the bathroom and nonfunctional. RN-B attempted to fix the shaver at 3:43 p.m. R307 stated the shaver was expensive and would like to have a new one if this one could not be fixed. R307's admission and clinical records noted R307 admitted to facility on 2/6/17, and had diagnoses, which included diabetes II and fracture of upper end of right humerus. R307's admission/Medicare 5-day Minimum Data Set (MDS) dated 2/13/17, identified R307 required extensive assist of one staff with personal hygiene needs - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup,	2 920		

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2 920	Continued From page 9 washing/drying face and hands (excludes baths and showers). The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 2/17/17, reads, "... [R307] had a BIMS score of 8 with errors in recall and temporal areas. There were no indicators of delirium in the look back period. [R307] had a PHQ9 score of 4. [R307] presented with no hallucinatory or delusional content or behavioral symptoms in the reference period. ... [R307] requires hands on assist to stabilize self during transitions. [R307] has impaired functional ability to left upper extremity and bilateral lower ones... [R307] is receiving occupational and physical therapy at this time. [R307] required extensive assist with bed mobility, transfers (use of mechanical device) along with locomotion. [R307] was able to eat with setup and supervision. [R307] required extensive assist with dressing, grooming, bathing and toilet use...." The care plan dated 2/17/17, identified R307 had alteration in ADL's and directed staff, "The resident has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Limited ROM, Pain at left hip and left arm due to recent fall with fracture. PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of 1". The temporary care plan dated 2/6/17, read, "Cognitive Status alert oriented to Person Place Times Situation. Grooming Assist in all area". During an interview with RN-B on 2/28/17 at 3:50 p.m., mentioned, expectation for nursing assistant registered (NAR) in the morning, is to do the complete ADLs that includes shaving,	2 920		

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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2 920	Continued From page 10 personal hygiene, etc. and let resident participate as much as possible. NAR should follow the care plan as indicated. Resident can communicate desires. During an interview with the director of nursing on 2/28/17 at 4: 15 p.m. stated, expectation is NAR to ask residents of what their needs are in terms of ADLs especially if residents are cognitively intact. Policy and procedure subject: STANDARDS OF CARE / ELDER RIGHTS dated November 2016, reads, "A. The care ECH [Episcopal Church Home] and the Gardens focuses on quality of life, maintaining each elder's dignity and confidentiality in an elder centered and individualized way. B. d. Assistance or supervision of shaving as needed to keep clan [clean] and well-groomed". SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to dental services cares and treatment plan and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a	21095		4/11/17

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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21095	Continued From page 11 manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was prepared and stored under sanitary conditions in the main kitchen and unit kitchenettes. This had the potential to affect 125 of 125 residents residing in the facility. Findings include: During a kitchen tour on 3/2/17, from 1:10 to 1:27 p.m. there was an undated when opened bag of Italian sausage nuggets; and two 20 pound plastic containers of beef and chicken base, which were also undated when opened. Approximately 24 plastic bowls and 12 plastic coffee cups were observed to be stored wet; and seven frying pans had baked on brown or black debris inside the pans, on the bottom and/or sides. The chef manager stated, the frying pans were not used frequently. Both the chef manager and the director of culinary services verified the wet bowls/cups, the undated food items and the condition of the frying pans.	21095	Corrected.	

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21095	Continued From page 12 During a tour of the facility's kitchenettes on 2/28/17 from 3:00 p.m. to 4:15 p.m. the following observations were made. The third floor transitional care unit (TCU) refrigerator contained ten mighty shakes and four juice supplements which were thawed and undated. The second floor TCU refrigerator contained three juice supplements and one mighty shake which were thawed and undated. The mighty shake and juice supplement cartons had instructions on them to store thawed in the refrigerator for no more than 14 days for safe consumption by residents. The dietary supervisor (DS), present during the tour, reported, would expect the supplements to be dated when thawed as they should only be in the refrigerator for 14 days after thawed. DS disposed of the supplements. Review of the diet type report for second floor TCU, dated 2/28/17 revealed 4 residents were ordered mighty shakes or juice supplements. Review of the diet type report for third floor TCU, dated 2/28/17, revealed 3 residents were ordered mighty shakes or juice supplements. The facility's 1/16, policy titled Labeling/dating of supplements indicated items when removed from the freezer for thawing were to be dated; and per industry standards discarded at maximum of 14 days or per manufacturers' guidance. SUGGESTED METHOD OF CORRECTION: The director of dietary and dietary staff could	21095		

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EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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21095	Continued From page 13 assure that food is stored properly in containers, which adequate size containers are available to store clean pans, and that thawed mighty shakes are dated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain dental services for 1 of 1 resident (R189) with identified dental needs. Findings include: Record review revealed R189 was admitted to the facility on 3/11/16, and the admission Minimum Data Set (MDS) did not indicate any broken or missing natural teeth. However, on 4/4/16, a registered dental hygienist completed a dental assessment which indicated R189 did not have dentures, but had several exposed root tips	21325	Corrected.	4/11/17

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

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21325	Continued From page 14	21325		

and there was a broken tooth, which was cutting R189's tongue. The assessment also indicated there were inflamed or bleeding gums or loose natural teeth. The assessment recommended further dental check up and that R189 did not care for the dentist she had been seeing. The assessment indicated R189 could see the dentist from Apple Tree, if interested. However, there was no documentation indicating R189 had seen a dentist or the dental recommendation had been followed up on.

A nurses note, dated 12/6/16, noted a "swollen (bump-like) area on the gum; inner area on right lower gum, no discoloration, no pain as stated by elder. Nurse on floor informed. Dental appointment made." A care conference note dated 12/8/17, revealed there was no discussion with the family regarding R189's dental needs at the time of the care conference. A nurses note dated 12/12/16, indicated to check with the family if the resident should be seen by a dentist, as R189 was not a patient of the dental service which came to the facility. There was no documentation indicating communication regarding R189's dental needs were discussed with the family at the care conference; and there was no documentation indicating R189 had seen a dentist since admission.

A nurses note dated 12/31/16, indicated R189 was having difficulty chewing and was placed on a 3-day mechanical soft diet trial; and on 1/2/17, a physician's order was given for a mechanical soft diet.

The care plan revised on 2/10/17, did not address the swollen (bump-like) area on R189's gum or the need for dental services. The care plan indicated R189 was to receive oral care, but there

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21325	Continued From page 15	21325		

was no frequency and dental services were not identified on the care plan.

On 3/1/17, at 9:08 a.m. nursing assistant (NA)-A and NA-B stated R189 did not complain of pain or discomfort when oral care was provided; there were not many problems with R189 eating or chewing and R189 was encouraged to feed self and brush own teeth. However, staff usually ended up brushing R189's teeth.

On 3/1/17, at approximately 10:05 a.m. licensed practical nurse (LPN)-A observed R189's mouth with the surveyor. There were two pink bump-like areas noted on R189's lower right gum, which looked different when compared to the left lower gum and several missing and broken teeth were also noted. After LPN-A completed the oral examination, NA-A began oral cares gently using a toothbrush. R189 did not complain of any discomfort until the upper left teeth/gum area was brushed. No bleeding was noted with the oral hygiene.

At 10:10 a.m. LPN-A asked nurse practitioner (NP)-E if aware of any growths on R189's gums. NP-E stated not being aware. The NP-E examined R189's mouth, stating R189 had several broken teeth; and R189 was not observed to vocalize any pain or discomfort when pressure was applied to the growth by NP-E. NP-E asked if R189 was on a mechanical soft diet and nursing assistant (NA)-A stated the resident had been having difficulty chewing and was on a mechanical soft diet. NP-E stated R189 should probably see a dentist.

On 3/2/17, at 11:30 a.m. R189's medical power of attorney (POA) was interviewed. The POA verified being the individual contacted for all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21325	Continued From page 16 medical issues and attended all care conferences. The POA stated R189's dental status had not been discussed at care conferences, even as recently as the 12/8/16, care conference. The POA stated he had not been contacted by the facility regarding 189's dental needs until 3/2/17. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure appropriate dental care is sought for residents who present with dental problems. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21426	Continued From page 17 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate tuberculosis (TB) screening according to facility policy and Minnesota Department of Health (MDH) guideline titled Regulations for Tuberculosis Control in Minnesota Health Care Settings for 2 of 5 employees (E3, E5), and 5 of 5 residents (R3, R14, R115, R155, R166) reviewed for TB screening. Findings include: Review of page 13 of the MDH guideline Regulations for Tuberculosis Control in Minnesota Health Care Settings (version July 2013) revealed health care workers (HCWs) with undocumented history of a previous positive tuberculin skin test (TST) or blood test "should undergo the same screening procedures as HCWs without previous positive results." Facility policy titled TB Control Plan, last revised 1/1/15, was consistent with this MDH guideline. Page 10 of the MDH guideline also required TST documentation to include the millimeters of induration. Review of employee records revealed employee (E)-3 began working at the facility on 8/19/16. E3 had a letter on file, dated 9/15/16, from the employee's health clinic. The letter stated that E3	21426	Corrected.	

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 18 had "a history of a positive TB screening test and has had negative chest xrays in the past" but did not include dates or original documentation of the positive test result or negative chest x-rays. The letter also stated that a chest x-ray was medically contraindicated for E3. E3's employee file contained a TB symptom screen, dated 9/1/16, which was negative. No further medical evaluation, TST, or TB blood test was obtained at the time of hire. Review of employee records revealed E5 began working at the facility on 11/18/16. E5's first step TST was documented as negative on 12/10/16, but millimeters of induration was not documented. In an interview on 3/2/16, at 1:33 p.m. registered nurse (RN)-G said the millimeters of induration should be documented for all TSTs. RN-G also reviewed the letter from E3's health clinic, and said she thought E3 should have received a TB blood test in addition to the symptom screen at the time of hire. Review of the MDH guideline Regulations for Tuberculosis Control in Minnesota Health Care Settings (version July 2013) revealed that the baseline TB screening of residents in boarding care homes and nursing homes consists of three components: assessing for current symptoms of active TB disease, assessing for TB risk factors and TB history, and testing for the presence of infection by administering either a two-step TST or single blood test. Facility policy titled TB Control Plan, last revised 1/1/15, was consistent with the MDH guideline, in that it required the elder TB screening to include an assessment of risk factors for TB, and any current TB symptoms, and a two-step TST or a single blood test.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 19 Review of resident TB screening records in the electronic medical record (eMR) revealed the following: R3 and R14 did not have a TB symptom screen or TB history on file. R115 did not have a TB symptom screen or TB history on file. Additionally, R115's first step TST, dated 12/13/16, was interpreted as negative, but millimeters of induration was not documented. Results for R115's second step TST, dated 12/23/16, were still pending in the eMR. R155 did not have a TB symptom screen or TB history on file. Additionally, R155's second step TST, dated 12/12/16, was interpreted as negative, but millimeters of induration was not documented. R166 did not have a TB symptom screen or TB history on file. Additionally, R166's first step TST, dated 1/6/17, was interpreted as negative, but millimeters of induration was not documented. R166 did not have a second step TST documented. In an interview on 3/2/17, at 9:46 a.m. RN-G confirmed that resident TST results were missing millimeters of induration, and said they should be documented in the eMR. In a follow-up interview at 1:46 p.m. RN-G confirmed staff did not read R115's second step TST results. Regarding the TB symptom screens, RN-G said that the admission nursing assessment was currently functioning as the TB symptom screen, because it was a "head to toe" assessment. RN-G said that the director of nursing was working on getting a form for TB symptoms into the eMR.	21426		

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21615	Continued From page 20	21615		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure areas where medications were stored, remained locked when unattended on 1 of 7 units observed for medication storage and the facility failed to assure that facility staff were aware of the process for destroying Fentanyl, narcotic patches. Findings include: During the initial tour of the facility the medication room, Team Room door on May Household, on 2/27/17, at 12:19 p.m. was propped open with a door stopper. There were no staff or residents visible in the immediate area and the units nurse was down the hallway, out of sight, passing medications. In the room, inside a closed, but unlocked cupboard the following stock medications were stored: 5-bottles of Tylenol, 2-bottles of milk of magnesia, 2-bottles of Geri-Tussin (cough medicine), 1-bottle of the laxative polyethylene glycol, 1-bottle of Pepto-Bismol, 2-bottles of Geri-Lanta (for gastric distress), 2-boxes of albuterol sulfate (for shortness of breath), and	21615	Corrected.	4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21615	Continued From page 21 1-bottle of the laxative Sorbitol. Inside another closed, but unlocked cupboard the following meds were observed for a resident (R30) who discharged on 12/7/16: 2-bottles of Travatan eye drops, 1-bottle of the anti-hypertensive medication losortan; 3-medication blister packs of the muscle relaxant Baclofen 10 milligrams (mg), 1-blister pack of Atropine 0.4 mg (a nervous system blocker), 3-blister packs of Haldol 0.5 mg (an antipsychotic), 1-blister pack each of Tolerodine 2 mg (for bladder leakage), and the blood-thinner Eliqus 5 mg. In the same unlocked, but closed cupboard was a bottle of Novalog insulin for a resident (R86) and Trazadone 50 mg (anti-depressant) for a resident (R212). In the unlocked refrigerator there was a vial of the of tuberculosis testing solution Tubersol and a plastic container which contained rectal suppositories for three residents (R30, R77, R54); and another plastic container which contained two bottles of Novolog insulin for a resident (R86). The facility's pharmacy manual dated 12/7/16, and titled Medication Storage in the Facility indicated medication rooms were to be locked and only licensed nurses, the consulting pharmacist and those lawfully authorized, were allowed access to medications. During a facility tour with the maintenance supervisor on 3/1/17, at 1:39 p.m. the medication room, May Household Team Room door, was open and a nursing assistant was in the room	21615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21615	Continued From page 22 washing hands. Registered nurse (RN)-C stated staff were having trouble locking the door to the room and the medications stored in the unlocked cupboards were either discontinued or stock meds. RN-C stated [RN-C] generally kept the door closed/locked until the repair was done. RN-C then asked the maintenance supervisor to fix the door. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designees could assure medications are locked, that staff are trained regarding the proper procedure and that the system is monitored, assessed and evaluated to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure areas where medications were stored, remained locked when unattended on 1 of 7 units observed for medication storage and the facility failed to assure that facility staff were aware of the process for destroying Fentanyl, narcotic patches. Findings include: During the initial tour of the facility the medication	21620	Corrected.	4/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21620	Continued From page 23	21620		

room, Team Room door on May Household, on 2/27/17, at 12:19 p.m. was propped open with a door stopper. There were no staff or residents visible in the immediate area and the units nurse was down the hallway, out of sight, passing medications.

In the room, inside a closed, but unlocked cupboard the following stock medications were stored: 5-bottles of Tylenol, 2-bottles of milk of magnesia, 2-bottles of Geri-Tussin (cough medicine), 1-bottle of the laxative polyethylene glycol, 1-bottle of Pepto-Bismol, 2-bottles of Geri-Lanta (for gastric distress), 2-boxes of albuterol sulfate (for shortness of breath), and 1-bottle of the laxative Sorbitol.

Inside another closed, but unlocked cupboard the following meds were observed for a resident (R30) who discharged on 12/7/16: 2-bottles of Travatan eye drops, 1-bottle of the anti-hypertensive medication losortan; 3-medication blister packs of the muscle relaxant Baclofen 10 milligrams (mg), 1-blister pack of Atropine 0.4 mg (a nervous system blocker), 3-blister packs of Haldol 0.5 mg (an antipsychotic), 1-blister pack each of Tolerodine 2 mg (for bladder leakage), and the blood-thinner Eliqus 5 mg.

In the same unlocked, but closed cupboard was a bottle of Novalog insulin for a resident (R86) and Trazadone 50 mg (anti-depressant) for a resident (R212).

In the unlocked refrigerator there was a vial of the of tuberculosis testing solution Tubersol and a plastic container which contained rectal suppositories for three residents (R30, R77, R54); and another plastic container which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21620	Continued From page 24 contained two bottles of Novolog insulin for a resident (R86). The facility's pharmacy manual dated 12/7/16, and titled Medication Storage in the Facility indicated medication rooms were to be locked and only licensed nurses, the consulting pharmacist and those lawfully authorized, were allowed access to medications. During a facility tour with the maintenance supervisor on 3/1/17, at 1:39 p.m. the medication room, May Household Team Room door, was open and a nursing assistant was in the room washing hands. Registered nurse (RN)-C stated staff were having trouble locking the door to the room and the medications stored in the unlocked cupboards were either discontinued or stock meds. RN-C stated [RN-C] generally kept the door closed/locked until the repair was done. RN-C then asked the maintenance supervisor to fix the door. Review of a facility policy regarding destruction of Fentanyl narcotic patch, the policy dated 12/7/16, was from the consulting pharmacy and indicated Fentanyl patches were to be folded in half, with the sticky sides together. The patch was then to be flushed down the toilet/hopper and the flushing was to be witnessed by a second staff member or according to facility protocol for destruction of a controlled substance. The policy further indicated the two staff members witnessing the destruction were to document the disposal. During interviews with facility staff it was learned that staff had different understandings regarding the process: When interviewed, on 3/1/17, at 11:02 a.m. licensed practical nurse (LPN)-C stated, Fentanyl	21620		

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21620	Continued From page 25 patches were removed and disposed of in a special container. LPN-C stated the disposal of the patches was not witnessed by another nurse. At 11:15 a.m. RN-C stated, nurses would cut Fentanyl patches into quarters and flush the patch down the toilet. RN-C stated this procedure is what the pharmacist had recommended and this procedure was done by one nurse and not witnessed by a second nurse. At 11:30 a.m. RN-G indicated, nurses were to flush the patches down the toilet, and the flushing was to be witnessed by two nurses. At 2:18 p.m. LPN-B explained that Fentanyl patches were disposed of by rolling the patch up and placing the patch in the sharps container. At 2:49 p.m. the director of nurses (DON) stated, was not aware there were residents in the facility receiving Fentanyl patches. The DON stated, expectation was that if a resident had a Fentanyl patch it would be disposed of in the toilet by two nurses. The DON stated the Fentanyl patch removal policy was from the consulting pharmacy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly, two nurses to sign narcotic book and properly discarding medication patches. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance.	21620		

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21620	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure water temperatures in resident bathrooms and/or bathing rooms were maintained at a comfortable range. This had the potential to affect 10 residents identified by the facility on 3/2/17, at 3:28 p.m. as having diagnoses that included Alzheimer's, dementia or other related diagnoses of the 33 residents who resided on the two units affected by high water temperatures. Findings include: On 2/27/17, water in the bathroom sinks of resident rooms 148 and 312 were noted to feel overly warm to touch. At 7:00 p.m. the administrator was called to find a thermometer to check water temperatures. The administrator borrowed a digital thermometer from the dietary department. On 2/27/17, the following hot water temperatures were taken by the administrator, and verified by surveyors: At 7:23 p.m., the water in room 148 measured 129.7 degrees Fahrenheit (F).	21665	Corrected.	4/11/17

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	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21665	Continued From page 27 At 7:29 p.m., the water in room 312 measured 123.4 degrees F. In an interview on 2/27/17, at 7:23 p.m., the administrator said she did not know, when asked about appropriate water temperatures ranges. On 2/28/17, at 8:31 a.m. maintenance technician (MT)-A confirmed there was a problem with water temperatures due to a problem with the mixing valve. MT-A said "the pneumatic system went haywire on me" but explained closing the valve that morning to begin bringing water temperatures down, and calling for outside help to fix the problem. After closing the valve, on 2/28/17, MT-A measured the following hot water temperatures in resident units that were previously identified to be too hot: At 8:39 a.m. room 148 measured 126 degrees F. At 8:40 a.m. room 149 measured 123 degrees F. At 8:42 a.m. room 151 measured 124 degrees F. At 8:49 a.m. room 312 measured 117 degrees F. At 8:51 a.m. room 310 measured 117 degrees F. In an interview on 2/28/17, at 8:53 a.m. MT-A explained checking the water temperatures of different resident units approximately twice per year. MT-A confirmed that different units were on different water systems, and because of that, water in different units could be at different temperatures. The administrator said going forward, maintenance would check the water temperature in one room from each resident unit monthly. Review of undated facility instructions for checking water temperatures through the Direct	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 28 Supply TELS system required maintenance staff to ensure patient room water temperatures were between 105 and 115 degrees F. On 2/28/17, at 9:53 a.m. the water temperature in the bathroom of room 245 felt overly warm to touch. The water temperature was tested at this time by MT-B and found to be 126 degrees F. When R189 was asked how the water felt, R189 was unable to answer the question. Water temperatures were noted in the following areas on 2/28/17, to be greater than 120 degrees Fahrenheit (F). The temperatures were taken with a facility thermometer by MT-B and verified by the surveyor. Room 249 had a water temperature of 125.7 degrees F at 9:56 a.m. Room 250 had a water temperature of 126 degrees F at 9:58 a.m. Room 252 had a water temperature of 125.9 degrees F at 10:02 a.m. When the resident in the room was interviewed regarding the temperature of the water, the resident was unable to answer. Room 251 had a water temperature of 127 degrees F at 10:04 a.m. When interviewed the resident residing in the room stated the water temperature was "fine." On 3/1/17, at 8:51 a.m. before starting cares for R189 nursing assistant (NA)-B had R189 feel the temperature of the water. R189 stated it was too warm and NA-B changed the water with a cooler temperature that was then acceptable to R189. NA-A and NA-B both stated they always have residents check the water prior to bathing to see if it's acceptable to the resident, because some residents have very fragile skin.	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: _____ B. WING _____	C 03/02/2017

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

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21665	Continued From page 29 SUGGESTED METHOD OF CORRECTION: The maintenance supervisor, administrator or designee could review and revise policies and procedures related to ensuring hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures. The maintenance supervisor, administrator or designee could develop a system to educate staff and develop a monitoring system to ensure hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable	21800		4/11/17