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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: POIC

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 **04/08/2014** (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:

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

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

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

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 04/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/08/2014 (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
04/09/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5452

On 04/08/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 04/15/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 02/13/14 standard survey, effective 03/28/14. Refer to the CMS 2567B for both health and life safety code.

Effective 03/28/14, the facility is certified for 81 skilled nursing facility beds. 50 Skilled Nursong II Beds

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5452

May 8, 2014

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

Dear Ms. Krebs:

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

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

Effective March 28, 2014 the above facility is certified for:

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

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 16, 2014

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

RE: Project Number S5452023

Dear Ms. Krebs:

On March 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 8, 2014 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 February 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2014, effective March 28, 2014 and therefore remedies outlined in our letter to you dated March 6, 2014, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245452	A. Building B. Wing	4/8/2014

Name of Facility	Street Address, City, State, Zip Code
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/14/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **03/25/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	05/16/2014	22580	04/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245452	A. Building B. Wing	4/8/2014

Name of Facility	Street Address, City, State, Zip Code
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **03/25/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/16/14	22580	04/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245452	A. Building B. Wing **01 - MAIN BUILDING 01**	4/15/2014

Name of Facility	Street Address, City, State, Zip Code
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **03/07/2014**	ID Prefix Reg. # **NFPA 101** LSC K0018	Correction Completed **03/28/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **03/28/2014**
ID Prefix Reg. # **NFPA 101** LSC K0062	Correction Completed **03/12/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/16/2014	12424	04/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/11/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245452	02 - EPISCOPAL CHURCH HOME OF MN	4/15/2014

Name of Facility	Street Address, City, State, Zip Code
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0062	**03/12/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/16/2014	12424	04/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/11/2014

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: POIC

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**
(L4) **MINNESOTA 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 **02/13/2014** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Mary Beth Lacina, HFE NE II — 03/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 04/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5452
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 2/13/2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4554

March 6, 2014

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

RE: Project Number S5452023

Dear Ms. Krebs:

On February 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 25, 2014, 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 March 25, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 13, 2014 (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 August 13, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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 _____	02/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	OK'd 3/24/14 SER call to Adm 3/24/14 to change completion date. RECEIVED MAR 18 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	**F272:** It is the policy of ECH to comprehensively assess skin within 24 hours of admission, upon identification of a new pressure ulcer, annually and when a significant change in status is identified. Plan of correction for residents cited with this survey: Resident (R96) has discharged from the facility. Plan to address/prevent this deficiency with other residents: An audit of 100% of the residents with pressure ulcers has been completed to ensure compliance. Comprehensive Skin Assessments have been completed on all residents with pressure ulcers.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/12/14

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 _____ B. WING _____	02/13/2014

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 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment, identifying all pressure ulcers upon admission, for 1 of 4 residents (R96) reviewed for pressure ulcers. Findings include: R96's hospital discharge summary dated 10/23/13, identified, "Pressure ulcers on bilateral heels, bilateral anterior ankle, and L [left] lateral calf. Hx [history] of MRSA [Methicillin-resistant Staphylococcus aureus] infection to these ulcers... Wound care nurse following... Continue contact precautions." R96's admission MDS dated 10/31/13, identified diagnoses including diabetes, neurogenic bladder, paraplegia, edema, and coronary artery disease. The MDS noted R96 required extensive assistance with activities of daily living, used a wheelchair for mobility and had three stage three pressure ulcers. R96's Care Area Assessment (CAA) dated 11/5/13, indicated, "Was admitted with 3 [three] unstageable pressure ulcers. L [left]	F 272	Measures put in place to prevent recurrence: The policy and procedure for Comprehensive Skin Assessments has been reviewed and revised to ensure that all requirements for assessment and management of pressure ulcers are met. Staff have been in-serviced on the revised policy and procedure Plan to monitor: An audit of the Comprehensive Skin Assessments for residents with pressure ulcers will be done monthly and reported at the quarterly QA meetings. Responsible for maintaining compliance: Wound Nurse, RN Managers, DON and ADON Correction Date: ~~4/12/14~~ 3/25/14	

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 _____	02/13/2014

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 272	Continued From page 2 and R [right] heels and L calf. Per hospital d/c [discharge] 10/24/13, these were present on admission. Risk factors include paraplegia, dx [diagnoses] of chronic osteomyelitis and diabetes. Blood sugars range from 76 to 289... Is w/c [wheelchair] bound, but able to shift his weight in w/c and able to reposition in bed." Pressure areas to the bilateral anterior ankles noted on the hospital discharge summary, were not identified during facility assessments. During interview on 2/13/14, at 10:40 a.m. RN-A confirmed the anterior bilateral ankle pressure areas identified on R96's hospital discharge summary, were not being followed/ monitored at the facility. She stated, "We needed to document on [the] bilateral anterior ankle pressure ulcers, treatment plans and progression of wounds." RN-A indicated she did not do skin assessments, but documented once notified of wounds. Therefore, she was not aware of what preventative measures were put in place. During interview on 2/13/14, at 12:00 p.m. RN-Y verified the facility had incomplete wound assessments for R96, with no summary or compressive evaluation. RN-Y further stated, nurses should have been documenting on each wound, especially the ankle wound, which she verified was not being done. The facility's Skin and Wound Assessment Protocol revised 9/24/13, directed that for new admissions, nursing staff were to complete the comprehensive skin assessment and Braden scale assessment on the day of admission. The tissue tolerance test and a turn and reposition schedule based on that assessment were also to be initiated on the day of admission.	F 272		

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 _____	02/13/2014

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 279 F 279 SS=D	Continued From page 3 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and resident specific interventions to promote healing of pressure ulcers, for 1 of 4 residents (R155) reviewed for pressure ulcers. Findings include: R155's quarterly Minimum Data Set (MDS) dated1/7/14, identified she was cognitively intact and required extensive assistance with transferring, toileting and bed mobility. The MDS	F 279 F 279	**F279:** It is the policy of ECH to develop a comprehensive care plan using the results of assessments that are interdisciplinary and reflect the care and services provided to attain or maintain the resident's highest level of practicable function. Plan of correction for residents cited with this survey: Upon notification of this finding, (R155) care plan was revised to reflect services, interventions and approaches provided. Plan to address/prevent this deficiency for other residents: All residents with pressure ulcers or those at high risk for the development of alteration in skin integrity had a care plan review with revisions made as needed to reflect the care and services provided. Measures put in place to prevent recurrence: The policy and procedure for Comprehensive Care Plans has been reviewed and revised. Staff have been in-serviced on the revised policy and procedure.	

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 _____	02/13/2014

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 279	Continued From page 4 revealed R155 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS also noted R155 was at risk for pressure ulcers and had one stage two pressure ulcer at the time of assessment. R155's current plan of care updated 8/6/13, identified she was at risk for skin alterations due to immobility, incontinence and chronic disease. Interventions directed nursing staff to apply barrier cream to her peri/rectal area, assess perirectal area at the time of her skin check, complete a tissue profusion assessment per facility policy, keep her clean and dry and place a pressure reducing/relieving mattress on her bed. R155's care plan directed staff to toilet her in the morning before breakfast and when she expressed the urge to have a bowel movement. The care plan directed, "Educate resident/patient on expanding intervals between trips to bathroom and negotiate increasing intervals." No specific time frames were identified for offering R155 opportunities to use the toilet. The care plan did not address R155's preference for sitting in her chair the majority of time and the impact this preference may have had on her skin. The plan directed, "My nursing staff will turn and reposition me every__." However, there was no time period specified for turning and repositioning. There were also no directions to use a pressure distribution cushion for R155's wheelchair. A physician order for R155 dated 1/2/14, noted, "Remind resident to offload weight frequently." No time frames were identified for how often she was to be offloaded. The nursing assistant (NA) care sheet was revised on 2/10/14, to direct staff to turn and	F 279	Plan to monitor: The RN Managers, DON and ADON will audit the care plans monthly x 3 months and then randomly x 1 year to ensure that residents with pressure ulcers or high risk to develop altered skin conditions have a comprehensive care plan that reflect services, interventions and approaches. Findings will be reported on at the quarterly QA meetings. Based on the findings, the QA committee will recommend continuing or discontinuing the audits. Responsible for maintaining compliance: RN Managers, DON and ADON Correction Date: ~~4/12/14~~	3/25/14

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 _____	02/13/2014

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 279	Continued From page 5 reposition R155 every two hours and to offload her every two hours while she was in her wheelchair. No instructions related to wheelchair cushions were identified on the NA care sheet. During observation on 2/12/14, at 11:40 a.m. R155 was seated in her wheelchair at the dinner table. R155 was seated on a flower print placemat, observed atop her pressure reducing wheelchair cushion. R155 independently wheeled herself from the dining room table to her resident room at 12:15 p.m., at which time NA-E asked R155 if she would stand up. R155 asked why she should stand up. NA-E responded that if she did not want to stand up, she could just shift her bottom on her seat. Upon interview, R155 was not able to articulate why she was being asked to stand up. NA-E then explained to R155 that she was being asked to stand up, in order to help heal the wound on her coccyx. With this explanation, R155 agreed to stand up and ambulate. NA-E assisted R155 in standing and walking the hallway, with use of a transfer belt and walker. Upon her rising, the flower print placemat was again noted atop R155's pressure reducing wheelchair cushion. R155 was assisted in sitting back down on her wheelchair after walking. There was no attempt to remove the flowered placemat from on top of the wheelchair cushion. After this observation, NA-E was interviewed. NA-E reported she had cared for R155 for several months, on a part-time basis. NA-E reported she assisted R155 with a once daily walking program during the day shift and had been doing so for quite some time. However, NA-E confirmed that nursing staff were not directed to assist R155 with offloading every two hours until after R155 developed the pressure ulcer on her coccyx.	F 279		

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 _____	02/13/2014

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 279	Continued From page 6 During interview on 2/12/14, at 1:30 p.m. registered nurse (RN)-A (the facility's wound nurse) explained R155's decreased mobility and incontinence likely contributed to the development of the pressure ulcer. RN-A confirmed R155 needed to stand up and get off of her bottom, that shifting in her seat was not sufficient to offload. During observation and interview on 2/12/14, at 2:00 p.m. RN-A and RN-B (R155's nurse manager) assisted R155 to stand. The pressure reducing wheelchair cushion remained covered by a flower print placemat and a folded hand towel was also observed atop her wheelchair cushion at this time. Upon questioning, R155 reported she did not think it was a problem to have the placemat and folded hand towel covering her wheelchair cushion. RN-A explained the wheelchair cushion should not been covered by the placemat and hand towel, as it significantly decreased the effectiveness of the pressure distribution cushion, which was intended to help heal and prevent worsening of R155's coccyx ulcer. R155 then agreed to try sitting on just the pressure distribution cushion. RN-B removed the flowered placemat and folded hand towel. RN-A and R155 reported that there was a goal for R155 to remain in her wheelchair as much as possible for independence; however, RN-A confirmed that potential outcomes to R155's skin in relation to this goal were not addressed in her care plan. On 2/12/14, at 2:43 p.m. the director of nursing [DON] confirmed R155's care plan was not up to date or complete, particularly as it related to repositioning needs. On 2/12/14, at 4:17 p.m. the assistant director of	F 279		

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 _____	02/13/2014

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 279	Continued From page 7 nursing (ADON) provided R155's Turning/Repositioning forms which indicated R155 was assisted with turning and repositioning a total of 22 times between 1/1/14, and 2/12/14. R155's medication administration record (MAR) for 2/14, directed, "Ambulate with walker, transfer belt and wheelchair follow up to 250 feet as tolerated two times per day during Day, Evening." The ADON confirmed no further documentation was available to evidence a turning/ repositioning/offloading schedule or completion of turning/repositioning/offloading for R155. On 2/12/14, at 3:45 p.m. NA-D reported she had regularly worked with R155 for the past two years. NA-D reported she assisted R155 with a turning and repositioning schedule while in bed and with a walking program once per each evening shift. NA-D added R155 did not like being repositioned in bed. NA-D reported the program for helping R155 stand up from her wheelchair to offload had started only a week prior. NA-D reported she became aware of the wound on R155's coccyx only one week prior. NA-D reported R155 put her call light on to notify staff of the need to use the toilet and there was no set schedule to offer assistance in doing so. On 2/13/14, at 9:00 a.m. occupational therapist (OT)-A reported she had assessed R155 on 11/1/13, for wheelchair positioning, related to R155's kyphosis. At that time, she advised not to get a new wheelchair as it would have decreased R155's independence in propelling herself throughout the facility. OT-A reported she did adjust the straps on R155's wheelchair at that time. OT-A reported she was not aware R155 now had a pressure ulcer. At 9:54 a.m., OT-A further explained R155 was referred for a consult	F 279		

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 _____	02/13/2014

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 279	Continued From page 8 to a medical supply company approximately two months ago and a Comfort M2 cushion made of gel and foam with contour was purchased as a result of concerns with her positioning. OT-A reported the cushion was recommended in response to R155's pressure ulcer. However, she confirmed the cushion should not have other material on it, such as a towel or other fabric. At 12:00 p.m., OT-A reported she had just received a referral from nursing staff to help increase R155's time out of her chair. OT-A reported it had been a long time goal of R155's to remain in her chair as much as possible. The facility's Skin and Wound Assessment Protocol revised 9/24/13, noted that any alteration in skin integrity would be documented and a Pressure Ulcer Management checklist initiated. The checklist included the following: 1. Evaluate and respond to treatment issues, determining which wound treatment product, bed and mattress were appropriate. 2. Update/amend the resident's care plan as warranted.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	**280:** It is the policy of ECH that care plans remain current and up to date to reflect the care and services provided to our residents. Plan of correction for residents cited with this survey: (R210) has discharged from the facility.	

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 _____	02/13/2014

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 280	Continued From page 9 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the plan of care (POC) related to the transferring needs for 1 of 3 residents (R210) reviewed for rehabilitation. Findings include: Resident (R210) was admitted to the facility for rehabilitation, the POC was not revised periodically to reflect R210's improving transferring needs. The POC dated 10/15/13, indicated R210 had difficulty with transfers and ambulation due to left knee pain. The goal was for R210 to perform safe transfers and ambulation. The approaches included therapies five times per week and assistance of two nursing staff with an EZ stand (a mechanical lift used for partial weight-bearing transfers) to assist with transfers. Physical therapy updates from R210 ' s care conferences indicated the following: · On 10/2/13, R210 required the use of an EZ stand and assistance of two staff for transfers. · On 10/22/13, R210 had improved and was	F 280	Plan to address/prevent this deficiency for other residents: All residents' care plans were reviewed to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for revising the care plan has been reviewed and revised. The staff have been in-serviced on the revisions to the policy and procedure. Plan to monitor: A random audit of resident care plans will be conducted the next 3 months to ensure compliance. The results of the audit will be reported on at the QA meeting with audits continuing as warranted. Responsible for maintaining compliance: RN Managers, DON and ADON Correction Date: ~~4/12/14~~	3/25/14

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 _____	02/13/2014

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 280	Continued From page 10 able to ambulate 25 to 100 feet with podium walking. R210 required a sliding board and maximum assistance of two staff for transferring needs. · On 12/3/13, R210 was walking 30 feet with a walker and required minimum to moderate assistance of one staff with transfers, using an uplift transfer pole. · On 12/23/13, R210 continued to improve and was walking 120 feet with a walker, requiring minimum to maximum assistance. R210 was also able to go up and down four stairs with minimum assistance and required assistance from one staff for transfers. · On 12/29/13 R210 was discharged to home. The POC was not revised to reflect R210's progress with transferring needs, ensuring staff followed the therapy recommendations, and promoting as much independence during transfers as possible to maintain and improve his ability to perform safe transfers. During an interview with physical therapy assistant (PTA)-A on 2/12/14, at 1:40 p.m. she indicated R210 was initially needing the EZ stand and extensive assistance from staff with transfers. However, with therapy sessions R210 improved in his transferring abilities and went home needing assist of only one person with transfers. During an interview with the assistant director of nursing (ADON) on 2/13/14, at 1:10 p.m. she stated R210's POC should have been revised to reflect his current transferring abilities. ADON stated, "It doesn't appear that they updated the care plan for this resident."	F 280		

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 _____	02/13/2014

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 281	Continued From page 11	F 281		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an admission (initial) plan of care (POC) to meet the skin condition needs of 1 of 1 resident (R244) who was recently admitted to the facility. Findings include: R244 was admitted on 11/3/13. The initial POC dated 11/3/13, was not complete, with several areas pertinent to her care/needs left blank. These areas included skin condition, cognitive health, discharge planning needs and bowel/bladder-continence/incontinence needs. R244 remained in the facility for 17 days before being discharged on 11/20/13. R244 was admitted to the facility with a surgical wound to the left lower leg and a splint/cast which covered the wound area. The admission evaluation of skin condition form indicated, "Present on the left lower shin is a surgical incision site." The Skin Condition Report with Images dated 11/3/13, described each wound/bruise areas. These areas included the following: Right brachial area was bruised, right upper forearm was bruised, left lower shin had a surgical incision with a splint on it, and left brachial area was bruised. The report dated, 11/5/13, indicated	F 281	**F281:** It is the policy of ECH that care plans remain current and up to date to reflect the care and services provided to our residents. Plan of correction for residents cited with this survey:(R244) has discharged from the facility. Plan to address/prevent this deficiency for other residents: An audit of 100% of the current initial care plans has been done with revisions made as warranted to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for revising the initial care plan has been reviewed and revised. The staff have been in-serviced on the revised policy and procedure. Plan to monitor: A random audit of initial care plans will be conducted the next 3 months to ensure compliance. The results of the audit will be	

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 _____	02/13/2014

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 281	Continued From page 12 the left lower shin surgical site had a splint and an ace wrap, which needed to stay on until the physician's appointment on 11/11/13, per orders. The report also addressed the bruises observed on 11/3/13. The Skin Condition Report dated 11/11/13, described that when R244 complained of pain in the left lower leg, two stage three pressure ulcers were discovered on her left middle and lower calf area. The left middle calf area pressure ulcer measured: length 2.5 centimeters (cm), width 3.0 cm and depth 0.1 cm. The left lower calf pressure area measured: length 2.0 cm and width 3.0 cm. R244 was assessed by the physician and wound care was provided at the clinic on 11/11/13. The Skin Condition Report dated 11/12/13, addressed all of the bruises discovered on 11/3/13, and the pressure ulcer treatments. On 11/15/13, the calf pressure ulcer treatments included cleansing the area with wound cleanser and applying dressings. It indicated the wound was covered with "eschar." The Skin Condition Report dated 11/19/13, indicated her calf wounds were scabbed over and treatments were discontinued. The initial POC, dated did not include R244's altered skin condition and the treatment plans to improve the skin tissue health. During interview on 2/12/13, at 12:00 p.m. the assistant director of nursing (ADON) verified the initial POC for R244 lacked pertinent information under several sections, including the skin section. ADON stated the nurses needed to complete and	F 281	reported on at the QA meeting with audits continuing as warranted. Responsible for maintaining compliance: RN Managers, DON and ADON Correction Date: ~~4/12/14~~	3/25/14

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 _____	02/13/2014

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 281	Continued From page 13 revise each section on the POC as R244's health condition changed to provide adequate care and treatment.	F 281		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to prevent the development, and to promote healing, of existing pressure ulcers for 4 of 4 residents (R155, R193, R244 and R96) reviewed for pressure ulcers. Findings include: R155's record was reviewed. According to the progress notes, R155 developed a pressure ulcer on her coccyx that went from a healing stage two (partial thickness loss of dermis) with no drainage, to a stage three (full thickness loss of dermis) with drainage and no signs of healing. The facility failed to develop and implement sufficient interventions to promote healing. R155's quarterly Minimum Data Set (MDS)	F 314	**F314:** It is the policy of ECH to provide all residents with the necessary care and services needed to maintain or attain the resident's highest level of practicable function. Plan of correction for residents cited with this survey: Residents (R244) and (R96) have discharged from the facility. Resident (R193) and resident (R155) have had their clinical condition and pressure ulcer risk factors re-evaluated immediately. Interventions that are consistent with (R193) and (R155) needs, goals and recognized standards of practice have been defined and implemented using an interdisciplinary team approach. Monitoring and re-evaluation of the impact of these interventions is in place to ensure compliance. Plan to address/prevent this deficiency for other residents: An audit has been conducted to review	

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 _____	02/13/2014

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 314	Continued From page 14 dated1/7/14, identified she was cognitively intact and required extensive assistance with transferring, toileting and bed mobility. The MDS revealed R155 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS also noted R155 was at risk for pressure ulcers and had one stage two pressure ulcer at the time of assessment. R155's current plan of care updated 8/6/13, identified she was at risk for skin alterations due to immobility, incontinence and chronic disease. Interventions directed nursing staff to apply barrier cream to her peri/rectal area, assess perirectal area at the time of her skin check, complete a tissue profusion assessment per facility policy, keep her clean and dry and place a pressure reducing/relieving mattress on her bed. R155's care plan directed staff to toilet her in the morning before breakfast and when she expressed the urge to have a bowel movement. The care plan directed, "Educate resident/patient on expanding intervals between trips to bathroom and negotiate increasing intervals." No specific time frames were identified for offering R155 opportunities to use the toilet. The care plan did not address R155's preference for sitting in her chair the majority of time or address the impact this preference may have had on interventions used to maintain skin integrity and heal wounds. The plan directed, "My nursing staff will turn and reposition me every_[left blank]_." However, there was no time period specified for turning and repositioning. There were also no directions to use a pressure distribution cushion for R155's wheelchair. Review of Skin Condition Report dated 11/27/13, indicated R155 developed a stage two pressure	F 314	and revise when needed, the assessments, services and plans of care for all residents with pressure ulcers or those residents at high risk for the development of alterations in skin integrity to ensure compliance. Measures put in place to prevent recurrence: The policy and procedure for the prevention, care and treatment of pressure ulcers has been reviewed and revised. The staff have been in-serviced on the revised policy and procedure. Plan to monitor: The RN Managers will forward all new skin alterations to the Certified Wound Nurse to ensure appropriate identification and implementation of interventions that are consistent with the resident needs, goals and recognized standards of practice. Certified Wound Nurse will make weekly wound rounds for residents with pressure ulcers and other	

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 _____	02/13/2014

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 314	Continued From page 15 ulcer to her coccyx that was not present at the time of her admission to the facility. The ulcer measured one (1) centimeter (cm) in length, by 0.5 cm in width, by 0.5 cm in depth (1 x 0.5 x 0.5 cm). No odor or drainage was apparent and no pain was associated with the wound. The wound base was visible, with pink surrounding tissue and regular margins. A pressure reducing or relieving devices was noted as in place for R155's chair, a turning and repositioning program was identified for implementation, and the likelihood of healing was noted as fair. R155's risk factors included co-morbidities, decreased mobility and encouragement was needed to reposition herself in the bed and wheelchair. Review of R155's record revealed few notes to indicate R155's pressure ulcer was being monitored between 11/27/13, and 1/2/14. The notes that were present lacked measurements, thorough description of the wound bed, and description of the healing progress for the wound. The next Skin Condition Report measurement of R155's pressure ulcer did not occur until 1/2/14. The ulcer measured two (2) x 1 x 0.5cm. The skin was not blanchable, with moist mucous membranes and fair skin turgor. The skin was tender to touch, but appeared to be healing, with a divet in the skin. The wound was identified as a stage two pressure ulcer. A physician order for R155 dated 1/2/14, noted, "Remind resident to offload weight frequently." No time frames were identified for how often she was to be offloaded, which required physical assistance from staff. The Skin Condition Report measurement of	F 314	conditions as warranted and maintain a log of progress. A plan of care and services audit has been conducted for 100% of the residents with pressure ulcers to ensure appropriate care, services and assessments are in place. This audit will continue monthly by the Certified Wound Nurse or RN Mangers and be reported on at the QA meetings. Responsible for maintaining compliance: Wound Nurse, RN Mangers, DON and ADON Correction Date: ~~4/12/14~~	3/25/14

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 _____	02/13/2014

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 314	Continued From page 16 R155's pressure ulcer on 1/15/14, was 0.3 x 0.3 cm, with no measurement of depth noted. Improvement of the site was noted. The wound was identified as a stage two pressure ulcer. The Skin Condition Report included a measurement of R155's pressure ulcer on 1/28/14, of 0.3 x 0.3 x 0.1 cm. The skin was not blanchable and site improvement was noted. The wound was identified as a stage two pressure ulcer. The Skin Condition Report included a measurement of R155's pressure ulcer on 2/4/14, of 1 x 0.8 x 0.2 cm. The skin was not blanchable, mucous membranes were dry, and the skin turgor was noted as poor. The report indicated, "Open area is showing signs of healing. No drainage noted." The wound was identified as a stage two pressure ulcer. The most recent Skin Condition Report measurement for R155's pressure ulcer was on 2/10/14. The wound measured 0.8 x 1 x 0.2cm. The skin was not blanchable and no odor was apparent. However, drainage was identified as thin, clear and red tinged. The report noted, "Ulcer showing no signs of healing. Noted thin yellow slough on wound bed." The wound was now identified as a stage three pressure ulcer. The nursing assistant (NA) care sheet was revised on 2/10/14, to direct staff to turn and reposition R155 every two hours and to offload her every two hours while she was in her wheelchair. No instructions related to wheelchair cushions were identified on the NA care sheet. During observation on 2/12/14, at 11:40 a.m.	F 314		

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 _____	02/13/2014

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 314	Continued From page 17 R155 was seated in her wheelchair at the dinner table. R155 was seated on a flower print placemat, observed atop her pressure reducing wheelchair cushion. R155 independently wheeled herself from the dining room table to her resident room at 12:15 p.m., at which time NA-E asked R155 if she would stand up. R155 asked why she should stand up. NA-E responded that if she did not want to stand up, she could just shift her bottom on her seat. Upon interview, R155 was not able to articulate why she was being asked to stand up. NA-E then explained to R155 that she was being asked to stand up, in order to help heal the wound on her coccyx. With this explanation, R155 agreed to stand up and ambulate. NA-E assisted R155 in standing and walking the hallway, with use of a transfer belt and walker. Upon her rising, the flower print placemat was again noted atop R155's pressure reducing wheelchair cushion. R155 was assisted in sitting back down on her wheelchair after walking. There was no attempt to remove the flowered placemat from on top of the wheelchair cushion. After this observation, NA-E was interviewed. NA-E reported she had cared for R155 for several months, on a part-time basis. NA-E reported she assisted R155 with a once daily walking program during the day shift and had been doing so for quite some time. However, NA-E confirmed that nursing staff were not directed to assist R155 with offloading every two hours until after R155 developed the pressure ulcer on her coccyx. During interview on 2/12/14, at 1:30 p.m. registered nurse (RN)-A (the facility's wound nurse) explained R155's decreased mobility and incontinence likely contributed to the development of the pressure ulcer. RN-A reported a program to	F 314		

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 _____	02/13/2014

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 314	Continued From page 18 assist R155 with repositioning and offloading would have been helpful in preventing the development of her pressure ulcer. RN-A confirmed R155 needed to stand up and get off of her bottom, that shifting in her seat was not sufficient to offload. During observation and interview on 2/12/14, at 2:00 p.m. RN-A and RN-B (R155's nurse manager) assisted R155 to stand. The pressure reducing wheelchair cushion remained covered by a flower print placemat and a folded hand towel was also observed atop her wheelchair cushion at this time. Upon questioning, R155 reported she did not think it was a problem to have the placemat and folded hand towel covering her wheelchair cushion. RN-A explained the wheelchair cushion should not have been covered by the placemat and hand towel, as it significantly decreased the effectiveness of the pressure distribution cushion, which was intended to help heal and prevent worsening of R155's coccyx ulcer. R155 then agreed to try sitting on just the pressure distribution cushion. RN-B removed the flowered placemat and folded hand towel. RN-A and R155 reported for R155's goal was to remain in her wheelchair as much as possible. R155's goal was not addressed in her care plan. On 2/12/14, at 2:43 p.m. the director of nursing [DON] confirmed R155's care plan was not up to date or complete, particularly as it related to repositioning and offloading needs. On 2/12/14, at 4:17 p.m. the assistant director of nursing (ADON) provided R155's Turning/Repositioning forms which indicated R155 was assisted with turning and repositioning	F 314		

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 _____	02/13/2014

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 314	Continued From page 19 a total of 22 times between 1/1/14, and 2/12/14. R155's medication administration record (MAR) for 2/14, directed, "Ambulate with walker, transfer belt and wheelchair follow up to 250 feet as tolerated two times per day during Day, Evening." The ADON confirmed no further documentation was available to evidence a turning/ repositioning/offloading schedule or completion of turning/repositioning/offloading for R155. On 2/12/14, at 3:45 p.m. NA-D reported she had regularly worked with R155 for the past two years. NA-D reported she assisted R155 with a turning and repositioning schedule while in bed and with a walking program once per each evening shift. NA-D added R155 did not like being repositioned in bed. NA-D reported the program for helping R155 stand up from her wheelchair to offload had started only a week prior. NA-D reported she became aware of the wound on R155's coccyx only one week prior. NA-D reported R155 put her call light on to notify staff of the need to use the toilet and there was no set schedule to offer assistance in doing so. On 2/12/14, at 3:50 p.m. licensed practical nurse (LPN)-B reported he was unsure when the plan to offload R155 every two hours started, but reported it was standard procedure for any resident who needed assistance to move from their wheelchair. During observation and interview on 2/13/14, at 9:20 a.m. RN-A changed the dressing on R155's coccyx. Per RN-A, the wound was a "healing stage three," measuring 0.7 x 0.9 x 0.1cm. Her documentation of the dressing change in the Skin Condition Report, dated 2/13/14, indicated: " Stage 3, Length in cm.= 0.7, width in cm.= 0.9 "	F 314		

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 _____	02/13/2014

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 314	Continued From page 20 " Wound bed with thin yellow strands of slough. " " Wound base is visible. Pink wound base = 25%, Red wound base = 50%, Yellow wound base =25%, Granulation tissue type =50%, Slough tissue type=25%, Epithelial type tissue=25% " On 2/13/14, at 9:00 a.m. occupational therapist (OT)-A reported she had assessed R155 on 11/1/13, for wheelchair positioning, related to R155's kyphosis. At that time, she advised not to get a new wheelchair as it would have decreased R155's independence in propelling herself throughout the facility. OT-A reported she did adjust the straps on R155's wheelchair at that time. OT-A reported she was not aware R155 now had a pressure ulcer. At 9:54 a.m., OT-A further explained R155 was referred for a consult to a medical supply company approximately two months ago and a Comfort M2 cushion made of gel and foam with contour was purchased as a result of concerns with her positioning. OT-A reported the cushion was recommended in response to R155's pressure ulcer. However, she confirmed the cushion should not have other material on it, such as a towel or other fabric. At 12:00 p.m., OT-A reported she had just received a referral from nursing staff to help increase R155's activity level. OT-A reported it had been a long time goal of R155's to remain in her chair as much as possible. R193 developed a stage three pressure ulcer after admission to the facility. The facility failed to evaluate her wheelchair cushions to identify whether they may have been a contributing factor to the development of the pressure ulcer and whether they were appropriate to promote healing of her wound.	F 314		

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 _____	02/13/2014

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 314	Continued From page 21 R193's undated Face Sheet identified diagnoses including mild malnutrition and closed fracture of the pubis. R193's quarterly MDS dated 10/1/13, indicated she was severely cognitively impaired, required physical assistance from one staff for bed mobility and was independent with transfers from wheelchair and toileting surfaces. R193's Braden Scale for Predicting Pressure Sore Risk and dated 10/1/13, indicated a she was not at risk for developing pressure ulcers. A progress note for R193 on 1/24/14, at 8:21 p.m. indicated a new wound was discovered, measuring 2 x 2cm. A progress note on 1/29/14, noted, "Lately a 1.5 x 1.5 cm wound was noted on the right buttock at the ischial tuberosity and it has caused her discomfort and today shows approximately 50% slough. Treatment has been with an Allevyn dressing, but we will need to go a step further and replace the foam pad in her chair with a gel one." A Skin Condition Report by RN-A on 1/29/14, at 10:28 a.m. noted, "Pressure ulcer stage 3 [three] present on the rt [right] lower buttocks. 1.5 width by 1.5 length and .01 depth with red wound base 85%, yellow wound base 15%, granulation tissue type 85%, slough tissue type 15%." During interview on 2/13/14, at 10:00 a.m. NA-A was not aware of the open area on R193's right ischeal tuberosity. When asked if any cares were performed for R193, NA-A stated, "I just took out the trash, she is independent. We don't do anything for her."	F 314		

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 _____	02/13/2014

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 314	Continued From page 22 During interview on 2/13/14, at 10:20 a.m. NA-B was not aware of the open area on R193's right ischial tuberosity. When asked if any cares were performed for R193, NA-B stated, "She is independent. I didn't do any cares for her. I just made the bed this morning." During interview on 2/13/14, at 10:30 a.m. LPN-A confirmed R193 was independent in her cares and transfers, but required reminders because she had trouble remembering to offload and reposition herself. LPN-A further acknowledged that R193 kept putting a pillow on top of the gel cushion and she had to keep taking it out. During observation and interview on 2/13/14, at 11:50 a.m. with R193 and RN-A, R193 locked the brakes on her wheel chair and laid down in her bed. Three types of cushions were observed on the seat of the wheelchair. First was a small, blue, personal pillow that was approximately ten by eight inches. R193 stated, "Leave that pillow in there, it feels better to sit on because it is softer." Second was a gel/foam cushion, with gel on one side and foam on the other, approximately 1 inch thick. The third and bottom cushion was a blue, foam cushion with a date of 2007 noted on the tag. A rolling dip, with the combination of the three cushions, was observed and verified by RN-A. The dip could have potentially contributed to the pressure on R193's ischial tuberosity and may have been the reason why R193 kept adding a small pillow for comfort. RN-A verified nursing staff, rather than therapy staff assessed R193's wheelchair and cushion(s). At 12:30 p.m. RN-A stated, "The bottom blue cushion is not supposed to be in the wheel chair, according to [RN-B], so now we will send a referral to physical therapy to evaluate the wheel chair and cushion."	F 314		

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 _____	02/13/2014

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 314	Continued From page 23 When interviewed on 2/13/14, at 2:00 p.m. the director of physical therapy (DPT) explained that the nursing department ordered general cushions for resident wheelchairs and the therapy department ordered specialty cushions, but only after receiving a referral from the nursing department. Generally after evaluating a resident, the therapy department may have called in a specialty vendor for input as to what type of cushion was best for the individual resident. When interviewed on 2/13/14, at 2:10 p.m. the DON stated, "[R193's] cushion was not purchased by us, she brought that in with her. It's her own and she won't let us change it." The DON further verified she did not know when regular wheelchair cushions were last ordered by nursing, but indicated that they were ordered routinely. The DON reported that many types of cushions were available for residents to use in their wheelchairs at the facility. The DON and RN-B collaborated that the facility was working on a standard to determine the most effective cushions to prevent skin breakdown for residents, but the process was not yet completed. The facility did not have a standard developed for the thickness of a gel cushion when treating a stage three wound. The one inch gel cushion that was given to R193 was from the general facility supply. When interviewed on 2/13/14, at 3:30 p.m. RN-B verified the company that supplied the bottom cushion (dated 2007) recommended the cushions be used for a maximum of three to five years, depending on their use. RN-B stated, "The blue cushion has been removed from the chair."	F 314		

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 _____	02/13/2014

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 314	Continued From page 24 R244 was identified with multiple stage three pressure ulcers. The facility failed to develop the admission (initial) plan of care to provide proper care and treatment to minimize the risk for further development or worsening of current pressure ulcers. R244's admission evaluation dated 11/3/13, indicated R244 was admitted with a surgical wound to the left lower leg and a splint/cast covering the wound area. The evaluation of skin condition form indicated, "Present on the Left Lower Shin is a Surgical Incision Site." R244's admitting diagnoses included diabetes mellitus, anemia, and unspecified open fracture of ankle. R244 was admitted for rehabilitation and received ongoing therapies while at the facility. The initial plan of care, dated 11/3/13 was not completed; several pertinent areas were left blank which included skin condition, cognitive health, discharge planning needs and bowel/bladder continence/incontinence needs. The admission MDS assessment dated 11/3/13, identified R244 was at risk for pressure ulcers, but had no current pressure ulcers. R244's Skin Condition Report dated 11/3/13, described each wound/bruise area, which included right brachial area was bruised, right upper forearm was bruised, left lower shin had a surgical incision with a splint on it, and left brachial area was bruised. The report dated 11/5/13, indicated the left lower shin surgical site had a splint on and an ace wrap, which needed to stay on until the physician appointment scheduled for 11/11/13, per orders. It also addressed the bruises observed on 11/3/13.	F 314		

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 _____	02/13/2014

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 314	Continued From page 25 The Skin Condition Report dated 11/11/13, noted R244 complained of pain in the left lower leg. The report indicated two stage three pressure ulcers were discovered on the left middle and lower calf area. The left middle calf area pressure ulcer measured 2.5 x 3.0 x 0.1 cm. The left lower calf pressure area measured 2.0 x 3.0cm. R244 was assessed by the physician and wound care was provided at the clinic on 11/11/13. The Skin Condition Report dated 11/12/13, addressed all of R244's bruises discovered on 11/3/13 and the pressure ulcer treatments. On 11/15/13, the calf pressure ulcer treatments included cleansing the area with wound cleanser and applying a dressing. The report indicated the wound was covered with "eschar." The Skin Condition Report dated 11/19/13, indicated R244's calf wounds were scabbed over and treatments were discontinued. R244's initial care plan was not updated to include the altered skin condition and the treatment plans to improve the skin tissue health. During an interview on 2/12/13, at 12:00 p.m. ADON verified the initial plan of care for R244 lacked pertinent information under several sections, including the skin section. ADON stated the nurses needed to complete and revise each section on plan of care as R244's health condition changed to provide adequate care and treatment. R244 remained in the facility for 17 days before being discharged on 11/20/13. The discharge MDS dated 12/30/13, identified R244 had no	F 314		

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 _____	02/13/2014

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 314	Continued From page 26 unhealed pressure ulcers. R96 was admitted with pressure ulcers, without a comprehensive skin assessment which addressed all areas identified on the hospital discharge summary. In addition, upon R96's discharge from the facility, there was no summary of his open areas, treatments and healing progress. R96's hospital discharge summary dated 10/23/13, identified, "Pressure ulcers on bilateral heels, bilateral anterior ankle, and L [left] lateral calf. Hx [history] of MRSA [Methicillin-resistant Staphylococcus aureus] infection to these ulcers... Wound care nurse following... Continue contact precautions." R96's admission MDS dated 10/31/13, identified diagnoses including diabetes, neurogenic bladder, paraplegia, edema, and coronary artery disease. The MDS noted R96 required extensive assistance with activities of daily living, used a wheelchair for mobility and had three stage three pressure ulcers. R96's Care Area Assessment (CAA) dated 11/5/13, indicated, "Was admitted with 3 [three] unstageable pressure ulcers. L [left] and R [right] heels and L calf. Per hospital d/c [discharge] 10/24/13, these were present on admission. Risk factors include paraplegia, dx [diagnoses] of chronic osteomyelitis and diabetes. Blood sugars range from 76 to 289... Is w/c [wheelchair] bound, but able to shift his weight in w/c and able to reposition in bed." Pressure areas to the bilateral anterior ankles noted on the hospital discharge summary, were not identified during facility assessments. Review of R96's Skin Condition Reports revealed the following: · On 10/25/13, at 12:13 a.m. Site A- "Present on the left top of foot is a redness, unblanchable." · On 10/25/13, at 3:27 p.m. Site B- "Present on	F 314		

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 _____	02/13/2014

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 314	Continued From page 27 the left calf is a pressure ulcer... Unable to accurately stage - slough and /or Eschar covered." The ulcer measured 1.2 x 0.6 x 0.3, with no apparent odor and minimal drainage present that was clear and yellow in color. · On 10/29/13, at 2:40 p.m. Site C- "Present on the left heel is a pressure ulcer... Unable to accurately stage..." The ulcer measured 1 x 6 x 0cm, the skin was not blanchable, with no apparent odor and moderate drainage present that was thin, clear and red-tinged. · On 10/29/13 at 2:49 p.m. Site B- The pressure ulcer to the left middle calf was identified as stage three, measuring 1 x 0.6 x 0.2, with no apparent odor and minimal drainage present that was thin, clear and yellow. · On 10/29/13, at 2:56 p.m. Site D- "Present on the right heel is a pressure ulcer... Unable to accurately stage..." The ulcer measured 4 x 3 x 0.1cm, the skin was not blanchable, with no apparent odor and moderate drainage present that was thin, clear, yellow and red-tinged. · On 11/7/13, at 12:46 p.m. Site E- "Present on the rectal area is a pressure ulcer..." The ulcer was identified as a stage two, which measured 1 x 1cm, with no apparent odor or drainage. The current plan of care, indicated R96 had unstageable pressure ulcers to the bilateral heels and left calf. Interventions included, "Assess pressure ulcer, color, odor, amount of drainage if present from wound and surrounding skin..." During interview on 2/13/14, at 10:40 a.m. RN-A confirmed the anterior bilateral ankle pressure areas identified on R96's hospital discharge summary, were not being followed/ monitored at the facility. She stated, "We needed to document on [the] bilateral anterior ankle pressure ulcers, treatment plans and progression of wounds." RN-A indicated she did not do skin assessments,	F 314		

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 _____	02/13/2014

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 314	Continued From page 28 but documented once notified of wounds. Therefore, she was not aware of what preventative measures were put in place. During interview on 2/13/14, at 12:00 p.m. RN-Y verified the facility had incomplete wound assessments for R96, with no summary or compressive evaluation. RN-Y further stated, nurses should have been documenting on each wound, especially the ankle wound, which she verified was not being done. RN-Y stated, the discharge summary should also have described/ documented R96's open wounds, treatments and should have noted whether the wounds were improving or not. The facility's Skin and Wound Assessment Protocol revised 9/24/13, directed that for new admissions, nursing staff were to complete the comprehensive skin assessment and Braden scale assessment on the day of admission. The tissue tolerance test and a turn and reposition schedule based on that assessment were also to be initiated on the day of admission. The protocol instructed staff to assure that all skin preventative measures were in place and weekly head to toe skin assessments were completed by a licensed nurse at the time of the resident's bath. The protocol noted that any alteration in skin integrity would be documented and a Pressure Ulcer Management checklist initiated. The checklist included the following: 1. Measure and record, the size of the wound, including the length, width, and depth. 2. Record odor, pain, type and amount of drainage. 3. Describe the wound granulation process. 4. Evaluate and respond to treatment issues, determining which wound treatment product, bed	F 314		

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 _____	02/13/2014

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 314	Continued From page 29 and mattress were appropriate. 5. Have the dietician review and provide input. 6. Have the wound care nurse evaluate wounds weekly on rounds and as needed. 7. Update the physician on resident wound status and their response to treatment. 8. Update/amend the resident's care plan as warranted.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	**F356:** ECH posts nursing hours as requires Plan of correction for residents cited with this survey: No residents were affected by this practice. Plan to address/prevent this deficiency for other residents: Format of posted nursing hours was changed at the time of survey. Measures put in place to prevent recurrence: Format was changed at time of survey Plan to monitor: Staffing Coordinator and Receptionist will see that posted nursing hours are at the front desk daily. A random audit will be done monthly x 3 to ensure compliance.	

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 _____	02/13/2014

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 356	Continued From page 30 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to include the actual hours worked by staff each shift on the required daily nurse staffing posting. This practice had the potential to affect all 126 of 126 residents who resided in the facility, along with family and visitors. Findings include: The facility's daily nurse staffing postings were observed on 2/10/14, at 7:00 a.m., on 2/11/14, at 11:35 a.m., and on 2/12/14, at 8:05 a.m. Upon review, the postings included the total number of staff scheduled to work for each day, evening and night shift. The daily staffing posting forms lacked the actual shift hours worked by staff. On 2/12/14, at 11:45 a.m. assistant director of nursing (ADON) indicated he was not aware that the actual hours needed to be included on the daily nurse staffing posting. ADON indicated they would add the missing information to the daily nurse staffing posting form.	F 356	Audit findings will be reported on at the QA meeting with audits continuing if warranted. Responsible for maintaining compliance: Administrator Correction Date: ~~4/12/14~~ 3/25/14 **F371:** It is the policy of ECH to procure food from sources approved or considered satisfactory by federal, state, or local authorities, and store prepare, distribute and serve food under sanitary conditions. Plan of correction for residents cited with this survey: No residents were harmed by this practice. Plan to address/prevent this deficiency for other residents: All Food Service staff working in the kitchen were re-educated on ware washing policy and procedure. Prior to use, each sheet pan will be visually inspected by the food service staff for residue, oil and carbon build-up. If any	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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 _____	02/13/2014

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 371	Continued From page 31 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain 13 of 16 baking sheet pans in a manner which minimized the risk for foodborne illness. This had the potential to affect all 126 of 126 residents who ate in the building. Findings include: During the initial tour observation of the kitchen on 2/10/14, at 7:15 a.m. 13 of 16 baking sheet pans stored on a rack contained brown, crusty residue on the rim of the pans. During interview on 2/11/14, at 5:30 p.m. the director of dining services stated that the baking pans with brown residue should be replaced.	F 371	residue, oil or carbon build-up is present, the sheet-pan will be rewashed and sanitized per the ware washing policy and procedure. Measures put in place to prevent recurrence: Monthly, all sheet pans will be inspected by the Chef and/or FSD. Any sheet pans found to be in unsatisfactory condition (warped, burned, scored) will be disposed of. Plan to monitor: Daily, the food service staff will inspect the sheet pans. Three times per month random audits will be conducted by the Chef and/or FSD.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	Audit findings will be reported on at the QA meeting with audits continuing if warranted. Responsible for maintaining compliance: Food Service Director, Administrator Correction Date: Immediately	2/14/14

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 _____	02/13/2014

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 431	Continued From page 32 appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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 medications were stored and labeled properly for 10 of 20 residents (R137, R14, R31, R85, R152, R189, R57, R261, R268 and R271) whose medications were observed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R137, R14, R31, R85, R152, R189, R57, R261, R268 and R271, which included insulin, eye drops and oral medication bottles, lacked dates to indicate when they were opened, or the	F 431	**F431:** It is the policy of ECH to establish and maintain accurate labeling and dispensing of medications that have not expired. Plan of correction for residents cited with this survey: (R261), (R 271) and (R268) have discharged from the facility. (R137), (R14), (R189), (R152), (R57), (R31) and (R85) had identified medications immediately discarded and replaced when identified during the survey and labeled correctly. Plan to address/prevent this deficiency for other residents: An audit of all resident medications has been conducted to identify and correct any that have expired or require a date when opened to ensure compliance. Those out of compliance were removed, discarded, replaced and properly labeled. Measures put in place to prevent recurrence: The policy and procedure for medications that require date when opened or that have expired has been reviewed and revised. The staff	

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 _____	02/13/2014

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 431	Continued From page 33 medications were expired. During the medication storage tour on 2/11/14, at 5:29 p.m. with licensed practical nurse (LPN)-B, in the Cooke House medication storage area, one stock bottle of Nitrostat sublingual tablets (for chest pain) was observed as opened and available for use, with an expiration date of 11/15/13. In addition, R137's Systane lubrication eye drop bottle, stored in the medication cart, lacked a proper label, with R137's name, dosage and the date it was opened. During interview with LPN-B on 2/11/14, at 5:35 p.m. she indicated R137's eye drop bottle needed a proper label and date to identify when it was opened. LPN-B added, she would order a new Nitrostat bottle from the pharmacy immediately. Review of R137's medication administration record (MAR) for 1/14, and 2/14, revealed the improperly labeled Systane eye drops were administered to R137, daily. During the medication storage tour on 2/11/14, at 6:40 p.m. with LPN-C, in the Isabella House, multiple opened, undated and unlabeled medication bottles were stored in medication carts. Observations included the following: · R14's two bottles of patanol (anti-allergy) eye drops and two bottles of Timolol (anti-glaucoma) eye drops were stored in a Zip-lock bag, were opened, had been used and were undated. · R31's refresh (lubricant) eye drop bottle was expired with a date of 12/1/13. · R85's latanoprost (anti-glaucoma) eye drop bottle was opened, used and was undated. · R152's two refresh (lubricant) eye drop bottles were opened, unlabeled and undated. In	F 431	have been re-educated on the policy and procedure revisions. Plan to monitor: RN Managers or designee will conduct random audits of medications in use x 3 months to ensure compliance. Audit results will be reported on at the QA meeting with audits continuing as warranted. Responsible for maintaining compliance: RN Managers and DON Correction Date: ~~4/12/14~~	3/25/14

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 _____	02/13/2014

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 431	Continued From page 34 addition, one bacitracin eye ointment (antibiotic/lubricant) was opened and undated. · R189's one latanoprost (anti-glaucoma) eye drop bottle was opened and undated. During interview on 2/11/14, at 6:51 p.m. LPN-C verified the medications needed to be stored properly, with proper labels and dated when opened. Further, LPN-C stated he would notify his supervisor as to what was observed and take the steps needed to correct the issue. During the medication storage tour on 2/11/14, at 6:57 p.m. the transitional care unit medication storage cart was reviewed. The following observations were made: · R57's Humulin insulin bottle was opened and undated. · R261's prednisolone (for Macular degeneration) eye drop bottle was opened and undated. In addition, R261's artificial tear (lubricant) eye drop bottle was opened and undated. · R268's Travatan Z (anti-glaucoma) eye drop bottle was opened and undated. · R271's Lispro insulin bottle was opened and undated. During interview on 2/11/14, at 7:05 p.m. registered nurse (RN)-C verified the medications needed to be labeled and stored properly. RN-C added that opened medications needed to be dated when opened and expired medications needed to be removed from the storage area. RN-C further stated, "We are going to order some new ones." During interview on 2/12/14, at 11:20 a.m. the director of nursing (DON) indicated, the facility	F 431		

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 _____	02/13/2014

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 431	Continued From page 35 recently changed pharmacies on 2/01/14, and the old pharmacy was not auditing the medication storage areas for expired, undated and unlabeled medications. DON added, sometimes the residents' families brought in medications, without a date to indicate when they were opened. DON added, if a medication was not dispensed by the pharmacy, then they did not put the label on the medication bottles. DON stated, staff were supposed to date medication bottles when opened, check for expired medications, remove expired medications and re-order them from the pharmacy. DON explained, all medications removed from the storage area had been re-ordered from the pharmacy. During interview on 2/12/14, at 11:29 a.m. the facility's consultant pharmacist (CP) stated his expectation was for facility staff to date each medication bottle when opened. In addition, the pharmacist, stated, "It is recommended to date [an] insulin vial when opened and as for Xalatan and Latanoprost, they expired 45 days after [the] open date." The facility's Medication Expiration/Date When Open policy effective 1/12/13, directed, "Record date when opened on the date when opened sticker for eye drops, insulin. Key basic storage guides: Keep meds in original outer packages to protect from sunlight." The facility's undated, Medication Expiration Dates policy read, "Expire date medications will be discarded according to date open, expiration date, or according to the manufacturer expiration date, whichever comes first."	F 431		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE	F 456		

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 _____	02/13/2014

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 456 SS=F	Continued From page 36 OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 walk-in freezers were maintained in good repair, for safe operating conditions. This had the potential to affect all 126 of 126 residents who ate in the facility. Findings include: During observation of the kitchen on 2/11/14, at 5:30 p.m. the exterior temperature gauge on the large walk-in freezer read 20 degrees Fahrenheit (F), with the interior thermometer reading 14 degrees F. The smaller walk-in freezers had a significant frost collection on the ceiling and frozen moisture droplets on the ceiling. Also, only one of the two fans was working in the smaller freezer. Temperature logs for the large and small walk-in freezers revealed temperatures ranging from four to 18 degrees F for the month of 2/14. The log indicated that the maximum freezer temperature should have been zero degrees F. During interview on 2/11/14, at 5:30 p.m. the director of dining services verified the freezer temperatures, frost, and frozen moisture droplets. She stated that she expected the kitchen staff to inform her of high freezer temperatures or any possible malfunctions with the freezers. The director of dining services reported she was unaware of the temperatures, frost and frozen moisture droplets. She stated that she was also	F 456	**F456:** It is the policy of ECH to maintain all essential mechanical, electrical and patient care equipment in safe operating consistent. Plan of correction for residents cited with this survey: No residents were harmed by this practice. Plan to address/prevent this deficiency for other residents: All food service staff was reeducated. Freezer temperatures will be checked twice daily and the temperatures recorded on the posted temperature log. The freezers will be monitored for ice build-up and proper operation. Measures put in place to prevent recurrence: The chef and/or FSD will be responsible for monitoring the log on a daily basis for temperature compliance. Staff will be coached to bring to the attention of the chef or FSD any instances of non-compliance of freezer temperatures.	

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 _____	02/13/2014

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 456	Continued From page 37 unaware of any recent maintenance or repairs done on the freezers.	F 456	The freezers will be monitored weekly for ice build-up. If any ice accumulation is noted, the Environmental Services department will be immediately notified to provide any repairs necessary, and the ice accumulation will be physically removed. In the event that any element of the freezer function is not operating correctly (I.e. fans not spinning, temperatures incompliant, ice accumulations, loud sounds from fans) the Environmental Services department will be immediately notified to provide any repairs necessary. Plan to monitor: The temperature log will be reviewed and reported on at the QA meeting with audits continuing if warranted. Responsible for maintaining compliance: Food Service Director, Administrator Correction Date: ~~4/12/14~~	3/25/14

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

7545202a

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POC ok FS 3-14-14 RECEIVED MAR 14 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 2-13-14 DC: 3-25-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/12/14

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 _____	02/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building.. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a licensed capacity of 131 beds	K 000		

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 _____	**02/11/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 and had a census of 129 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a fire barrier wall in accordance with the requirements at NFPA 101 (00) Chapter 19, Section 19.1. In a fire emergency, this deficient practice could adversely affect all residents, visitors and staff within the affected smoke compartment. Findings Include: On facility tour between 9:00 AM and 02:00 PM on 02/11/14, it was observed that the 90 minute fire rated door in the 2 hour rated fire wall from the 1st floor Cafe' to the Iris Park apartments did not latch into its frame because of a missing latching device. This deficiency was verified by Director of Engineering (BK).	K 011	**K 011:** The 1st floor door in the café area will had a latching device installed on March 7th. The maintenance technician and Administrator will be responsible for ensuring the latch does not get removed. 3-7-14	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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 _____	02/11/2014

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 018 SS=D	Continued From page 3 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 9:00 AM and 02:00 PM on 02/11/14, it was observed that it was observed that the corridor door to the 3rd floor Linen Closet by the Nurse Station had the latching hardware removed and was held closed with a side hasp. This deficiency was verified by Director of	K 018	**K 018:** ECH will install proper latching devices in the linen closet on the 3rd floor by March 28th. The maintenance technician and Administrator will be responsible for compliance. 3-28-14	

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 _____	**02/11/2014**

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 018	Continued From page 4 Engineering (BK).	K 018		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This is not a resident sleeping floor. Findings include: On facility tour between 9:00 AM and 02:00 PM on 02/11/14, it was observed that penetrations in the corridor wall around conduit and wires Where the fire stopping has been removed or fallen out in the following areas: 1) 3rd floor TCU Med / Storage room. 2) 2nd floor Gilbert House Homemaker Storage / Mechanical Room. 3) 1st floor King House Storage Room By room 143. This deficiency was verified by Director of	K 029	**K 029:** The 3rd floor TCU med/storage room, 2nd floor Gilbert House storage room, and 1st floor King House storage room will be re- caulked by March 28th. The Administrator and maintenance technician will be responsible for compliance. 3-28-14	

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 _____	**02/11/2014**

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 029	Continued From page 5 Engineering (BK).	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to properly maintain the fire sprinkler system. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 02:00 PM on 02/11/14, it was discovered, during review of available documentation, that the facility did not conduct quarterly fire sprinkler testing as required in the last 12 months. This deficiency was verified by Director of Engineering (BK).	K 062	**K 062:** ECH will document all quarterly sprinkler flow tests beginning immediately. The Administrator, maintenance technicians, and Safety committee will be responsible for ensuring this takes place. 3-12-14	

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

F5452022

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 02 - EPISCOPAL CHURCH HOME OF MN B. WING _____	02/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Episcopal Church Home of MN was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POC ok PR 3-14-14 RECEIVED MAR 14 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/12/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING 02 - EPISCOPAL CHURCH HOME OF MN B. WING _____	02/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Episcopal Church Home of MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the 2 buildings will be surveyed as one building. The 2008 building will be surveyed as a separate building.. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. The facility has a licensed capacity of 131 beds	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING **02 - EPISCOPAL CHURCH HOME OF MN** B. WING _____	**02/11/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 and had a census of 129 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to properly maintain the fire sprinkler system. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 9:00 AM and 02:00 PM on 02/11/14, it was discovered, during review of available documentation, that the facility did not conduct quarterly fire sprinkler testing as required in the last 12 months. This deficiency was verified by Director of Engineering (BK).	K 062	**K 062:** ECH will document all quarterly sprinkler flow tests beginning immediately. The Administrator, maintenance technicians, and Safety committee will be responsible for ensuring this takes place.	3-10-14