Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2023

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: October 20, 2022

Dear Administrator:

On December 19, 2022, we notified you a remedy was imposed. On January 23, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 20, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 13, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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February 7, 2023

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: Reinspection Results
Event ID: REIG12

Dear Administrator:

On December 23, 2022 and January 11, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 20, 2022 and November 21, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
November 7, 2022

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: October 20, 2022

Dear Administrator:

On October 20, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 20, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by April 20, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING ______ B. WING ______	C 10/20/2022

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
E 000	Initial Comments On 10/17/22 through 10/20/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/17/22 through 10/20/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5452082C (MN79961), and H54523494C (MN85392). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2022

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

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to update the care plan with identified fall interventions for 1 of 3 residents (R49) reviewed for falls. Findings include: R49's significant change Minimum Data Set	F 657	Plan of correction for residents cited with this survey: R49□s care plan was reviewed and updated to reflect interventions for falls. Plan to address/prevent this deficiency for other residents: all residents triggering for falls will have their care plans reviewed	12/23/22

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F 657

Continued From page 2

(MDS) assessment dated 8/25/22, identified R2 had severely impaired cognition and required extensive assistance from two staff for bed mobility, transfers, dressing, hygiene and toileting. R49 was able to eat independently after set up and required extensive assist of one staff for locomotion on and off the unit. R49 used wheelchair for mobility and walking had not occurred. R49's diagnoses included heart failure, arthritis and absence of right leg below the knee. Additionally, R49 had one fall without injury since admission or prior assessment.

R49's care plan revised 9/9/22, identified R49 was at risk for falls related to immobility, right BKA (below the knee amputation) and psychotropic medication. A goal was listed for R49 to not have falls through the next review date. Interventions included: educate family to alert staff when R49 would be alone in his room, educate resident/family/caregivers about safety reminders and what to do if fall occurred, ensure call light in reach and encourage R49 to use it, follow facility fall protocol, safe environment (clear floors, adequate light, functional call light, personal items in reach), w/c (wheelchair) brakes off to allow for movement around in w/c, observation, and PT evaluation if ordered/needed.

R49's nursing assistant (NA) assignment sheet provided on 10/19/22, identified one intervention under the "safety" column: call light within reach.

R49's fall Incident Reports identified the following post fall interventions:
- 8/5/22, offer to toilet after meals and keep urinal at bedside
- 8/26/22, when in room without family offer to put

F 657

and update to reflect accurate and appropriate fall interventions.

Measures put in place to prevent reoccurrence: The policy Fall (Post) assessment was reviewed, which indicates to add interventions to the care plan. Education on the policy will be provided to all direct care staff.

Plan to monitor: Audits of residents care plans with new falls will be done weekly for the next 4 weeks and progress will be reported at the next facility QA meeting. Ongoing audits will also be completed on the spot as new falls occurs. Audit results will be reviewed monthly by the QA committee and will continue as needed until the QA committee determines the plan of correction is successful.

Responsible for maintaining compliance: Director of Nursing

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F 657	Continued From page 3	F 657		

R49 in bed for a rest or recliner with call light
- 9/21/22, keep bed in low position
- 9/27/22, perimeter mattress placed on bed
-10/11/22, keep bed in low position with blue mat at bedside and sensitive call light and "Dysum" (non-slip material) between cushion and bottom of wheelchair

The above interventions identified in the fall Incident Reports were not included on R49's care plan nor NA assignment sheet .

During an observation on 10/17/22, at 6:50 p.m. R49 was observed in bed with family visiting. R49 had a low bed and a mat on the floor.

During an interview on 10/19/22, at 1:58 p.m. licensed practical nurse (LPN)-C stated she normally worked in a different unit. LPN-C was unable to articulate what fall interventions R49 had in place currently. LPN-C stated she would look at the care plan and rely on verbal report from the preceding nurse for fall risk interventions. LPN-C reviewed R49's care plan and agreed it lacked interventions that were currently observed such as the low bed.

During an interview on 10/19/22, at 2:06 p.m. NA-A stated she knew of the following interventions for R49: call light in place, bed in low position, fall mat by bed and frequent safety checks. NA-A was unable to articulate other interventions but said "we all just know what to do" for fall interventions via verbal shift-to-shift report.

During an interview on 10/20/22, at 10:02 a.m. the director of rehabilitation (DOR) stated R49's falls were reviewed at the daily interdisciplinary team huddles. R49 was more frequently found to

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F 657	Continued From page 4 be crawling out of bed and not technically falling. The DOR stated without the interventions listed on the care plan for continuity of care there was a risk of staff not being aware of current interventions. During an interview on 10/20/22, at 11:18 a.m. the director of nursing (DON) stated stated the verbal shift-to-shift report passed on information regarding fall interventions and care plans should have been updated by the nurse manager. The DON agreed that if interventions were not accessible on the care plan or assignment sheets it might increase the risk of falls. The facility policy Fall (Post) Assessment dated 5/2017, identified documentation included to care plan the fall and fall prevention measures and update caregivers as warranted.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		12/23/22

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F 676	Continued From page 5 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide routine personal hygiene assistance for 1 of 3 residents (R90) who required staff assistance with shaving. Findings include: R90's quarterly Minimum Data Set (MDS) assessment dated 6/30/22, indicated intact cognition. R90's quarterly MDS assessment dated 9/28/22, indicated behavior was not exhibited for rejection of care and R90 required limited assist for personal hygiene. The MDS identified diagnoses that included: depression, psychotic disorder other than schizophrenia, and pain.	F 676	Plan of correction for residents cited with this survey: R90 was shaved at the time of survey. R90□s care plan was reviewed and updated to give staff direction on personal grooming needs. Plan to address/prevent this deficiency for other residents: All residents were reviewed for shaving needs and shaved if appropriate. Care plans were updated where necessary. Measures put in place to prevent reoccurrence: ADLs/Cares policy was reviewed which includes direction on dignity and grooming. Education on grooming and standards of care done with	

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F 676 Continued From page 6

R90's treatment administration record for October 2022, indicated R90 had a bath/shower every Saturday am.

R90's progress notes indicated R90 refused a bath/shower on 10/15/22, 10/1/22, and 9/17/22.

R90's care plan revised 1/14/22, indicated R90 required assistance by staff to provide bath/shower one time a week and as necessary. The care plan also indicated R90 could perform personal hygiene, but required assist with personal hygiene during times of weakness.

R90's care sheet provided 10/19/22, indicated R90 required assist of one for personal hygiene and bathing.

During interview and observation on 10/19/22, at 11:03 a.m. R90 was in bed and had a thick growth of hair under her chin. R90 stated did not receive assistance with hygiene and stated she would like to have assist with removing facial hair under her chin.

During interview and observation on 10/19/22, at 1:15 p.m. nursing assistant (NA)-B stated R90 was independent, but was getting weaker. NA-B stated she reviewed care sheets in order to understand cares required for residents. NA-B stated personal hygiene on the care sheet included brushing teeth, washing a resident's face, combing hair, trimming nails and shaving residents. NA-B stated she offered to help R90 with her food, but did not offer personal hygiene because R90 did that on her own. NA-B stated assist of one indicated a resident required one person assist. NA-B stated R90 did not refuse

F 676

all direct care staff.

Plan to monitor: Resident audits of grooming following the plan of care will be completed 1x weekly for 4 weeks. Audit results will be reviewed monthly by the QA committee and will continue as needed until the QA committee determines the plan of correction is successful.

Responsible for maintaining compliance: Director of Nursing

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F 676	Continued From page 7	F 676		

cares. NA-B's care sheet indicated R90 required assist of one for personal hygiene and bathing.

During interview on 10/19/22, at 1:31 p.m. licensed practical nurse (LPN)-A stated personal hygiene included oral and peri cares, washing arms, shaving, and nail care and stated assist of one indicated staff needed to help a resident. LPN-A stated she would expect the NA to help if a resident's care sheet indicated assist of one, and stated she would expect the NA to report refusal of care and NA-B did not report R90 refused cares.

During interview and observation on 10/19/22, at 1:42 p.m. R90 was in bed and LPN-A stated she saw the hair under R90's chin and would assist R90.

During interview on 10/19/22, at 2:46 p.m. the assistant director of nursing stated he noticed R90 had chin hair, and expected that staff should have helped R90. He also stated R90 had not been aggressive since moving to the unit, and education was needed regarding assist of one on the care sheet.

During interview on 10/20/22, at 11:35 a.m. the director of nursing stated the care sheets are used by the NA's to determine cares needed for residents and stated her expectation was that staff were required to help a resident whose care sheet indicated assist of one.

Facility policy ADLs/Cares, dated 1/1/15, indicated residents were provided with necessary care and services and minimal requirements for activities of daily living (ADLs) included assistance or supervision with shaving as

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 8 needed.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to reduce the development of pressure ulcers for 1 of 2 (R65) residents reviewed for pressure ulcers. Findings Include: R65's admission Minimum Data Set (MDS) assessment dated 8/21/22, indicated R65 had diagnoses of pressure induced deep tissue damage of left heel, pressure induced deep tissue damage of other site, lymphedema, cellulitis of left lower limb, and gout. It further indicated R65 had intact cognition, was at risk for developing pressure ulcers, and required extensive assistance with all activities of daily living (ADL) except eating.	F 686	Plan of correction for residents cited in this survey: R65□s care plan was reviewed to ensure appropriate pressure injury interventions were in place. Plan to address/prevent this deficiency for other residents: Residents with pressure injuries and at risk for pressure injuries have been reviewed to ensure care plan interventions are in place. Measures put in place to prevent reoccurrence: Nursing team will meet every Friday after team meeting to discuss skin integrity and pressure injury prevention. Those with pressure injuries will also be discussed to ensure appropriate interventions have been put in	12/23/22

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F 686	Continued From page 9 R65's progress note dated 8/24/2022, included "patient was noted to have a pressure sore stage 2 on left (L) heel. Writer called HP [health provider] and was not able to get a hold of no one so writer left a msg requesting dressing orders for patient and informing them on the pressure sore." R65's care plan last revised on 9/29/22, indicated the resident had pressure injury or potential for pressure injury development related to immobility, stage 2 pressure ulcer on left heel, mild foot Planter pressure ulcer stage 2, left lateral foot, left 5th lateral toe, right 2nd toe. R65 lacked any documentation of interventions to prevent pressure ulcers that were implemented before 8/24/22. 10/19/22 11:59 a.m. the nurse manager (RN-B) verified R65 did not have any interventions in place to prevent pressure ulcers until 8/24/22 when the facility discovered R65 had a pressure ulcer on his left heel. During an interview at 12:54 p.m., Nurse Practitioner (NP)-A said when R65 first came in NP-A recalled assessing R65 and his feet were fine, never had issues before, and felt came on all of a sudden. NP-A felt the issue was the foot of the bed. R65 is a tall man and his feet pushed up against the foot board and the foot board could not be removed due to an air mattress. NP-A said the nurses thought the wounds were arterial and had ordered R65 to be sent in for evaluation. NP-A was coming up with plan of care, wound clinic was backed up, white count was elevated and R65 was put on antibiotics. NP said R65 had horrible peripheral neuropathy and had no sensation to his feet, there were other factors, and encouraged R65 to reposition and he	F 686	place. Plan to Monitor: A risk assessment tool for residents with pressure injuries and at risk for pressure injuries will be reviewed monthly. An audit of pressure injury interventions will be done weekly 1x per week for 4 weeks. Audits will we reviewed monthly by the QA committee and continue thereafter until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 686	Continued From page 10 needs to keep his feet off the foot board. R65 became verbally aggressive and didn't want to be boosted up in bed. During an interview on 10/20/22, at 10:44 a.m. occupational therapy assistant (OTA-A) stated R65 had OT once a day and she would try to get him out of bed every time. She also stated there were times she wasn't able to get him out of bed. OTA-A further stated R65 was able to reposition in bed "a little bit but if he wasn't constantly cued, he wouldn't remember to do it." During an interview on 10/20/22, at 11:20 p.m. the director of rehab (DOR)-A stated R65 had physical therapy six times a week to work on transfers and mobility. DOR-A stated they were trying to figure out if R65 would be able to move back home because he was pretty immobile and there were times she wasn't able to get him out of bed. She further stated "I think he probably could, but I don't think he is" in regards to re-positioning himself.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		12/23/22

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§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on interview, observation and document review, the facility failed to implement a occupational (OT) and physical therapy (PT) ordered restorative nursing program to prevent potential decrease in range of motion (ROM) for 1 of 2 residents (R17) reviewed for restorative nursing programs.

Findings include:

R17's quarterly Minimum Data Set (MDS) assessment dated 7/27/22, identified R17 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. R17 had functional limitation of ROM in upper and lower extremities. R17 had zero days of restorative nursing programs, including active or passive ROM (PROM), in the past seven days. R17's diagnoses included stroke and paralysis on one side of the body.

R17's Order Summary Report, included the following active orders:
-dated 8/18/22, begin supine PROM bilateral lower extremities (BLE) one time per day. Pictures posted on the wall in patient's room and in rehab section of medical chart
-dated 8/18/22, begin supine PROM to left upper extremity (UE) one time per day. Pictures are posted on the wall in patient's room and in rehab section of medical chart.

Plan of correction for residents cited in this survey: R17s care plan was reviewed, and staff were educated on the importance of completing the restorative nursing program.

Plan to address/prevent this deficiency for other residents: Other residents with limited ROM or therapy directed ROM programs were reviewed to ensure accurate documentation and training.

Measures put in place to prevent reoccurrence: The facility policy on Rehabilitation Nursing care will be reviewed, updated if necessary, and all direct care staff will be trained on the basic rehab/restorative principles.

Plan to Monitor: Audits of completion for residents with ROM programs will be done weekly 1x per week for 4 weeks. Audits will we reviewed monthly by the QA committee and continue thereafter until the committee determines the plan of correction is successful.

Responsible for maintaining compliance: Director of Nursing

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R17's PT Discharge Summary dated 9/9/21, identified PROM was designed and implemented with staff education to be completed daily to maintain current ROM. Training was provided to nursing, nurse manager and other nursing assistant staff on PROM with pictures placed on wall and hard chart for staff reference.

R17's OT Discharge Summary dated 9/16/21, identified caregiver education was initiated with aide and family focusing on PROM and to continue with daily written and pictorial HEP (home exercise program) by aides.

R17's activities of daily living (ADL) care plan dated 5/3/22, identified an intervention of PT/OT evaluation and treatment per doctor's orders. The care plan lacked any interventions for restorative nursing programs or ROM.

R17's nursing assistant (NA) task list, identified a restorative nursing program for passive PROM to BLE one time per day and indicated pictures were posted on the wall in R17's room. R17 wanted to do the program around 10:00 a.m.

R17's NA restorative nursing program documentation sheet dated 9/21/22 - 10/19/22, identified out of 30 opportunities, the PROM program was carried out three times. According to the documentation, R17 was not available one day, had refused five times and the rest of the opportunities were marked "not applicable".

During an interview on 10/17/22, at 1:04 p.m. R17 stated staff were supposed to do exercises with her arms and legs and they had not been. R17 stated she wanted staff to do the exercises and

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F 688	Continued From page 13	F 688		

she thought staff did not know how. R17 identified papers taped on the wall in her room and stated those were a list of her programs. The papers included a description of the PROM along with pictures for:
1. ankle dorsiflexion and plantar flexion
2. knee flexion and extension
3. hip abduction and adduction
4. hip flexion and extension
5. flexion and extension of the fingers of the right hand
6. elbow flexion and extension of the right elbow
7. turning the right palm up and down
8. turning the right shoulder in and out
9. moving the right thumb
10. moving the right-hand side to side
11. shoulder flexion.

During an observation on 10/19/22, at 11:25 a.m. NA-C and NA-D assisted R17 with morning cares which included hygiene, dressing and grooming. NA-C and NA-D transferred R17 out of bed into her wheelchair using a lift device. R17's PROM was not completed.

During a follow up interview with NA-C and NA-D on 10/19/22, at 1:17 p.m. NA-D stated she would document "not applicable" for R17's PROM because she had not done it and was not trained how to do it. NA-C also agreed the program was not done today and was unable to provide a rationale why R17's PROM was not completed as ordered.

During an interview on 10/19/22 at 3:03 p.m. the director of rehabilitation (DOR) stated R17 was working with OT right now but only on a new wheelchair and not on PROM. The DOR stated there was no mention by the OT of any worsening

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F 688	Continued From page 14 ROM for R17 due to the PROM program not being carried out as ordered. The DOR stated restorative nursing programs were important for reasons such as improved mobility, pain and help prevent contractures. The DOR stated she would expect nursing to carry out the programs in accordance with PT/OT discharge instructions. During an interview on 10/20/22, at 10:10 a.m. registered nurse (RN)-E stated the NA's were responsible for completing restorative nursing programs and PROM. RN-E stated she worked with R17 routinely and was not aware R17's programs were not being done. During an interview on 10/20/22, at 11:51 p.m. the director of nursing stated she would expect the restorative nursing programs to be completed as written and to update the nurse manager if the programs were not working. The facility policy Rehabilitation Nursing Care dated 1/1/15, indicated all nursing staff were trained on basic rehab/restorative principles and when the resident needed more a referral to therapy would be completed. Additionally, a resident with limited ROM would receive appropriate treatment and services to prevent further decrease in ROM.	F 688		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		12/23/22

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This REQUIREMENT is not met as evidenced by:

During observation, interview, and document review, the facility failed to monitor and consistently administer as needed pain medication for 1 of 2 residents (R319) whom had visible and verbal complaints of pain.

Findings include:

R319's admission Minimum Data Set (MDS) assessment dated 10/17/22, included diagnoses of periprosthetic fracture around internal prosthetic right hip joint, presence of right artificial hip joint, Parkinson's disease, muscle weakness, and difficulty in walking. It further included R319 had intact cognition, required extensive assistance with all activities of daily living (ADL) except eating, and had frequent severe pain that affects sleep and daily activities.

R319's doctor's orders dated 10/11/22, included Hydromorphone HCL Tablet 2 milligrams (MG). Give 0.5 tablet by mouth every 4 hours as needed for pain related to displaced fracture of epiphysis (separation) upper of right femur, subsequent encounter for closed fracture with routine healing.

R319's care plan included the "Resident is at risk for alteration in comfort related to right leg pain related to right femur fracture with an intervention to give pain medications as ordered.

During an interview on 10/17/22, at 12:48 p.m. R319 stated she was always in pain (due to a recent hip surgery) and she has told several staff at the facility (unknown) she would like pain medication in the morning before she get's up but they "don't listen." R319 further stated she really

F 697

Plan of correction for residents cited in this survey: R319s care plan was reviewed, and staff were educated on the importance of pain management and basic signs and symptoms of pain.

Plan to address/prevent this deficiency for other residents: All residents were reviewed that are triggering for pain to ensure their pain is managed and appropriate pain management interventions are in place.

Measures put in place to prevent reoccurrence: The facility policy on Pain will be reviewed which includes promoting comfort and providing access to the best level of pain relief that can safely be given to improve a resident□s quality of life. Education on pain management will be provided with all direct care staff.

Plan to Monitor: Audits of care plans for residents triggering for pain will be done weekly 1x per week for 4 weeks. Audits will we reviewed monthly by the QA committee and continue thereafter until the committee determines the plan of correction is successful.

Responsible for maintaining compliance: Director of Nursing

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had to assert herself to stop physical therapy this morning because she was in so much pain and she tried to explain to the therapist (PT)-A that it wasn't just an average hip replacement.

During observation on 10/19/22, at 7:27 a.m. registered nurse (RN)-A was performing a dressing change on R319's right hip and RN-B was assisting her. RN-B asked R319 if she was having any pain and R319 stated "I don't know anymore." Once the dressing change was completed R319 stated her pad was wet so RN-A & RN-B changed her brief. Throughout the process R319 had facial grimacing and said "ouch!" several times. Neither RN-A or RN-B stopped performing cares on R319, reassessed her pain, or offered any pain medication when R319 expressed verbal and non verbal indicators of pain.

During an interview on 10/19/22, at 7:42 a.m. RN-A stated R319's last dose of pain medication (Hydromorphone) was administered on 10/18/22, at 4:30 p.m. and R319 could have received another dose at any time.

During an interview on 10/19/22 8:48 a.m. the nurse manager RN-B stated if a resident was exhibiting signs of pain, staff should stop the care, find out what's going on, and see what pain medication they can give, even if the resident previously denied having any pain. RN-B further stated R319 should receive pain medication before therapy and once the pain medication was administered, therapy should wait an hour before starting so the medication has time to start working. RN-B also stated if therapy arrives early, the nurse would be expected to let them know R319 hadn't had her pain medication yet and they

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F 697	Continued From page 17 would have to come back later. During an interview on 10/19/22, at 10:20 a.m. PTA-A stated R319's pain was "quite an issue." PTA-A further stated she reported to her supervisor (the director of rehab) that R319's pain was interfering with therapy and she wasn't making any progress. PTA-A further stated "In the beginning she was going to therapy without using pain medications, it's my job is to make sure she (R319) get's her pain medications scheduled before we work out." During an interview on 10/20/22, at 9:29 a.m. the director of nursing (DON) stated she would expect the nurses to stop cares if a resident was exhibiting signs of pain. The DON further stated resident's should be given pain medication before attending therapy and if the resident hadn't received their pain medication, therapy should come back later. The facilities policy on pain last revised in August of 2022, included "It is the policy of Episcopal Church Homes (ECH) to promote comfort, thereby improving quality of life. Residents will be provided access to the best level of pain relief that may safely be given through pharmacological and non-pharmacological interventions."	F 697		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 760	Plan of correction for residents cited with	12/23/22

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facility failed to follow physician orders for the administration of intravenous (IV) antibiotics after readmission to the facility for 1 of 1 residents (R76) reviewed for IV antibiotics.

Findings include:

R76's quarterly Minimum Data Set (MDS) assessment dated 9/19/22, identified he had moderately impaired cognition, required extensive assist of two staff with dressing and hygiene and had not walked. R76's diagnoses include heart failure, rheumatoid arthritis, and enlarged prostate with lower urinary tract symptoms.

R76's progress note dated 10/10/22, at 16:02 (4:02 p.m.), identified he was weak with urinary symptoms while on antibiotics for a urinary tract infection (UTI). The nurse practitioner was notified and R76 was sent to the hospital.

R76's hospital Discharge Summary dated 10/17/22, identified a principal diagnosis of "severe sepsis" (medical emergency from a current infection that triggered a chain reaction throughout the body). The Discharge Summary included an order for Zosyn (antibiotic) 3.375 gram (G) injection every eight hours for diagnoses of severe sepsis.

R76's facility medication administration record (MAR) included an order with a start date of 10/18/22, for Zosyn 3.375 G IV one time per day at midnight (0000), 8:00 a.m. (0800) and 4:00 p.m. (1600). R76's MAR indicated he was not on any other antibiotics for his infection.

R76's progress notes included the following:
-10/18/22 at 1:46 a.m. nursing was unable to give

F 760

this survey: R76 was sent to hospital at time of survey to have PICC line replaced. Education was provided to nurses to make immediate notification to primary should PICC line have issues again.

Plan to address/prevent this deficiency for other residents: All residents were reviewed for potential significant med error risk related to IV administration. Training and education was done with the nurses involved with this specific situation.

Measures put in place to prevent reoccurrence: Facility policy Clearing Occluded PICC line and Midline Catheters was reviewed, which identifies immediate notification to the provider with suspected catheter occlusion. Education on this policy will be completed with all nurses.

Plan to monitor: Resident audits for those with PICC lines will be completed 3x weekly for 4 weeks, or at another frequency as appropriate with the current population of residents. Nurses will be asked about the procedure and if they are aware of what to do when such instance occurs. Audit results will be reviewed monthly by the QA committee and will continue as needed until the QA committee determines the plan of correction is successful.

Responsible for maintaining compliance: Director of Nursing

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IV antibiotic due to the line being "clogged". The progress note lacked notification to the provider of the missed dose of antibiotic or the IV line not working.
-10/18/22 at 7:51 a.m. the line continued to be clogged and the IV antibiotic was unable to be administered. The progress note lacked notification to the provider of the missed dose of antibiotic or the IV line not working.
-10/18/22, at 12:04 p.m. it was documented the pharmacy was updated on the IV line not working which was 12 hours after the first missed dose of IV antibiotics. The progress note lacked notification to the provider of the missed dose of the antibiotic or IV line not working.

During an interview on 10/18/22, at 1:56 p.m. licensed practical nurse (LPN)-C stated R76 was unable to get his midnight and 8:00 a.m. IV Zosyn because the peripherally inserted central catheter (PICC) line would not flush. LPN-C stated she updated the nurse manager but had not updated the provider. LPN-C stated the PICC company was supposed to be at the facility by now to replace the IV but had not been.

During an interview on 10/18/22, at 2:07 p.m. registered nurse (RN)-G stated she called the IV phone line to come and restart the IV. RN-V acknowledged the provider had not been updated yet and stated the provider should have been updated when the IV antibiotic was first unable to be administered at midnight..

During an interview on 10/18/22, at 2:33 p.m. the assistant director of nursing (ADON) stated the provider and pharmacy should have been notified without delay of the IV antibiotics not able to be administered because the IV line was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING ______ B. WING ______	C 10/20/2022

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 760	Continued From page 20	F 760		

working.

During an interview on 10/18/22, at 2:51 p.m. the consultant pharmacist (CP) stated for sepsis IV Zosyn should be administered as close to the time it was ordered as possible and if not able to administer the provider should be updated right away.

During an interview on 10/18/22, at 2:58 p.m. R76's primary care provider medical doctor (MD)-A stated he had not been notified and would have expected to be when the antibiotic was first unable to be administered. The MD stated he was notified just now and ordered the resident to be sent to the emergency room due to missed antibiotics for over 24 hours. MD-A stated the missed antibiotics could result in a return of R76's infection because the levels of antibiotics in R76's body systems would have been diminished.

During an interview on 10/18/22, at at 5:00 p.m. RN-A stated R76's PICC line did not work on the night shift and she was unable to administer the IV antibiotics. RN-A stated she knew there was a 24 hours IV phone line and physician line to call but had not. RN-A stated she did not because she read in the hospital notes they had problems with the IV line so she did not think it was urgent and left a voicemail for the nurse manager to follow up on it. RN-A stated the nurse manager normally comes in around 8:00 AM. RN-A stated R76 was known to be difficult to start an IV in so had not attempted to start a new IV.

R76's progress notes identified he was sent to the emergency department on 10/18/22, at 3:10 p.m. and returned on 10/19/22, at 1:50 a.m. with a new PICC line placed. There were no new

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F 760	Continued From page 21 orders. During an interview on 10/19/22, at 9:49 a.m. the director of nursing (DON) agreed not administering antibiotics as ordered could place a resident at risk of infection. The DON stated the provider and IV line should have been notified immediately on 10/18/22 at 12:00 a.m. midnight when the antibiotic was first not able to be administered. Facility policy, undated Clearing Occluded PICC line and Midline Catheters, identified the physician should be notified immediately of suspected catheter occlusion and type of occlusion and obtain treatment orders, administer thrombolytic agent as ordered, if unsuccessful notify provider and obtain orders for IV team to assess/replace line.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/23/22

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F 812	Continued From page 22 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated foods were disposed of after expiration date and properly labeled and dated when the original packaging was opened in the main kitchen. This deficient practice had the potential to affect all 39 residents identified by the facility who received food from the tray line service. Findings include: During the initial tour of the main kitchen on 10/17/22, at 11:54 a.m. with the director of culinary services (DCS), the following areas of concern were noted: The transitional care unit (TCU) tray line refrigerators were observed to have: - two open and partially full ½ gallons of skim milk with a factory stamped date of best by 10/12/22. The milk was not dated when opened - a bottle of International Coffee Delight iced coffee with a factory stamped best by date of 10/5/22. The iced coffee container was not dated when opened - a metal container with a tan color food covered in plastic wrap labeled "puree dessert Tuesday noon" and did not specify a date for the Tuesday. A second metal container with tan colored food covered in plastic wrap labeled "TC 6 puree dessert" and was not dated. The tan-colored pureed food inside the container had started to dry on the edges - three 40-ounce bottles of thickened liquids	F 812	Plan of Correction for Residents Cited in this Survey: Undated food items were discarded at the time of survey. Plan to address/prevent this deficiency for other residents: Facility policy for storage of opened food items was reviewed and found to be appropriate. Measures put in place to prevent reoccurrence: All staff who participate with meal service will be trained on the facility policy for labeling and discarding opened food items. Plan to monitor: Audits of facility kitchen refrigerators will be completed 3x weekly for 4 weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Administrator	

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F 812	Continued From page 23	F 812		

opened and approximately ½ full not dated when opened
- individual serving sized clear fruit containers covered in plastic lids and not dated when prepared.

During an interview on 10/17/22, at 11:54 a.m. the dietary aide (DA)-A stated there was a tray line cleaning checklist that included reviewing the fridge for expired items. Additionally the list indicated all food items should be sealed and dated and to discard any items that were outdated (7 days max). DA-A showed the clipboard with the checklist, and it had not been checked off as completed since 10/2/22. DA-A stated it was everyone's responsibility, but she had not had a chance to do the checklist yet.

During an interview on 10/17/22, at 11:54 a.m. the DCS removed any questionable items from the fridges, confirmed the above findings and indicated the expectations were for staff to take safety precautions and measures with food handling. The DCS said food and drink items that were opened should be thrown out after 7 days. The DCS stated there were two residents on thick liquids or puree food that could have been affected by the unlabeled undated puree food and bottles of thickened liquids. The DCS stated staff were expected to label and date food items when opened. The DCS stated all expired food items should have been removed and thrown out immediately due to possible causing food borne illness and bacteria to grow.

The facility policy Household Refrigerators, undated, indicated all storage all food products not in their original containers will be placed in approved seamless, tightly sealed containers

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F 812	Continued From page 24 which could be sanitized labeled and dated for storage. All foods must be labeled and dated. The best practice would be to include a label with the product name and ate in which the product was opened or prepared. The policy lacked direction for how long items could be kept in the cold storage once opened.	F 812		

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	245452	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/18/2022

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/18/2022. At the time of this survey, Episcopal Church Home of Minnesota was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2022

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

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/18/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Episcopal Church Home of Minnesota 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	K 000		

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K 000	Continued From page 2 the addition meet the construction type allowed for existing buildings, the 3 buildings will be surveyed as one building. The facility has a capacity of 131 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.3.2.1, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 10/18/2022 between 9:00 AM and 1:00 PM, it was revealed by observation that a large number of plastic storage containers were being stored in stairwell F5, 3rd floor on steps leading to the roof. An interview with Facility Maintenance Director verified this deficiency finding at the time of	K 211	Plan of correction for residents cited with this survey: Items found to be in the egress will be moved and stored in a new location. Plan to address/prevent this deficiency for other residents: All other means of egress were inspected to ensure there are no inappropriate items or hazards. Measures put in place to prevent reoccurrence: Education will be provided to the maintenance team regarding k211 and maintenance of means of egress. Plan to monitor: Means of egress will be	12/23/22

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K 211	Continued From page 3 discovery.	K 211	inspected 1x/week for 4 weeks to ensure no items are placed in the egress. Responsible for maintaining compliance: Maintenance Director	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement and all hazards risk assesment per NFPA 99 (2012 edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/18/2022 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the facility did not have a copy of their fundamental risk assessments for review. An interview with Facility Maintenance Director	K 901	Plan of correction for residents cited with this survey: The all-hazards systems risk assessment tool will be completed. An all-hazards vulnerability assessment was completed and is currently in the facility wide assessment and emergency plan. Plan to address/prevent this deficiency for other residents: The all-hazards systems risk assessment tool will be complete, which will address the risk for all residents in the building. Measures put in place to prevent reoccurrence: Once the assessment is complete, it will be reviewed and update on an annual basis. Significant changes	12/23/22

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	**10/18/2022**

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K 901	Continued From page 4 verified this finding at the time of discovery.	K 901	will be reviewed by the safety committee. Plan to monitor: The all-hazards risk assessment tool will be completed by December 23rd 2022 and will be reviewed at least annually going forward. Responsible for maintaining compliance: Maintenance Director	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 7, 2022

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: REIG11

Dear Administrator:

The above facility was surveyed on October 17, 2022 through October 20, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	C 10/20/2022

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/17/22 through 10/20/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders	3 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed 11/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	C 10/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	Continued From page 1	3 000		

and identify the date when they will be completed.

The following complaints were found to be UNSUBSTANTIATED: H5452082C (MN79961) and H54523494C (MN85392).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Rules, Chapter 4655 for Boarding Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	C 10/20/2022

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3 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in bed. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to implement a occupational (OT) and physical therapy (PT) ordered restorative nursing program to prevent potential decrease in range of motion (ROM) for 1 of 2 residents (R17) reviewed for restorative nursing programs. Findings include:	3 945	Corrected	11/25/22

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3 945	Continued From page 3	3 945		

R17's quarterly Minimum Data Set (MDS) assessment dated 7/27/22, identified R17 had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. R17 had functional limitation of ROM in upper and lower extremities. R17 had zero days of restorative nursing programs, including active or passive ROM (PROM), in the past seven days. R17's diagnoses included stroke and paralysis on one side of the body.

R17's Order Summary Report, included the following active orders:
-dated 8/18/22, begin supine PROM bilateral lower extremities (BLE) one time per day. Pictures posted on the wall in patient's room and in rehab section of medical chart
-dated 8/18/22, begin supine PROM to left upper extremity (UE) one time per day. Pictures are posted on the wall in patient's room and in rehab section of medical chart.

R17's PT Discharge Summary dated 9/9/21, identified PROM was designed and implemented with staff education to be completed daily to maintain current ROM. Training was provided to nursing, nurse manager and other nursing assistant staff on PROM with pictures placed on wall and hard chart for staff reference.

R17's OT Discharge Summary dated 9/16/21, identified caregiver education was initiated with aide and family focusing on PROM and to continue with daily written and pictorial HEP (home exercise program) by aides.

R17's activities of daily living (ADL) care plan dated 5/3/22, identified an intervention of PT/OT evaluation and treatment per doctor's orders. The care plan lacked any interventions for restorative

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3 945	Continued From page 4	3 945		

nursing programs or ROM.

R17's nursing assistant (NA) task list, identified a restorative nursing program for passive PROM to BLE one time per day and indicated pictures were posted on the wall in R17's room. R17 wanted to do the program around 10:00 a.m.

R17's NA restorative nursing program documentation sheet dated 9/21/22 - 10/19/22, identified out of 30 opportunities, the PROM program was carried out three times. According to the documentation, R17 was not available one day, had refused five times and the rest of the opportunities were marked "not applicable".

During an interview on 10/17/22, at 1:04 p.m. R17 stated staff were supposed to do exercises with her arms and legs and they had not been. R17 stated she wanted staff to do the exercises and she thought staff did not know how. R17 identified papers taped on the wall in her room and stated those were a list of her programs. The papers included a description of the PROM along with pictures for:
1. ankle dorsiflexion and plantar flexion
2. knee flexion and extension
3. hip abduction and adduction
4. hip flexion and extension
5. flexion and extension of the fingers of the right hand
6. elbow flexion and extension of the right elbow
7. turning the right palm up and down
8. turning the right shoulder in and out
9. moving the right thumb
10. moving the right-hand side to side
11. shoulder flexion.

During an observation on 10/19/22, at 11:25 a.m. NA-C and NA-D assisted R17 with morning cares

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3 945	Continued From page 5 which included hygiene, dressing and grooming. NA-C and NA-D transferred R17 out of bed into her wheelchair using a lift device. R17's PROM was not completed. During a follow up interview with NA-C and NA-D on 10/19/22, at 1:17 p.m. NA-D stated she would document "not applicable" for R17's PROM because she had not done it and was not trained how to do it. NA-C also agreed the program was not done today and was unable to provide a rationale why R17's PROM was not completed as ordered. During an interview on 10/19/22 at 3:03 p.m. the director of rehabilitation (DOR) stated R17 was working with OT right now but only on a new wheelchair and not on PROM. The DOR stated there was no mention by the OT of any worsening ROM for R17 due to the PROM program not being carried out as ordered. The DOR stated restorative nursing programs were important for reasons such as improved mobility, pain and help prevent contractures. The DOR stated she would expect nursing to carry out the programs in accordance with PT/OT discharge instructions. During an interview on 10/20/22, at 10:10 a.m. registered nurse (RN)-E stated the NA's were responsible for completing restorative nursing programs and PROM. RN-E stated she worked with R17 routinely and was not aware R17's programs were not being done. During an interview on 10/20/22, at 11:51 p.m. the director of nursing stated she would expect the restorative nursing programs to be completed as written and to update the nurse manager if the programs were not working.	3 945		

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3 945	Continued From page 6 The facility policy Rehabilitation Nursing Care dated 1/1/15, indicated all nursing staff were trained on basic rehab/restorative principles and when the resident needed more a referral to therapy would be completed. Additionally, a resident with limited ROM would receive appropriate treatment and services to prevent further decrease in ROM. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for range of motion to assure they are receiving the necessary treatment/services to prevent decreased range of motion. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for decreased range of motion. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 945		
31105	MN Rule 4655.7810 Distribution of Medications A system shall be developed in each boarding care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the	31105		11/25/22

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resident's personal care record.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to follow physician orders for the administration of intravenous (IV) antibiotics after readmission to the facility for 1 of 1 residents (R76) reviewed for IV antibiotics.

Corrected

Findings include:

R76's quarterly Minimum Data Set (MDS) assessment dated 9/19/22, identified he had moderately impaired cognition, required extensive assist of two staff with dressing and hygiene and had not walked. R76's diagnoses include heart failure, rheumatoid arthritis, and enlarged prostate with lower urinary tract symptoms.

R76's progress note dated 10/10/22, at 16:02 (4:02 p.m.), identified he was weak with urinary symptoms while on antibiotics for a urinary tract infection (UTI). The nurse practitioner was notified and R76 was sent to the hospital.

R76's hospital Discharge Summary dated 10/17/22, identified a principal diagnosis of "severe sepsis" (medical emergency from a current infection that triggered a chain reaction throughout the body). The Discharge Summary included an order for Zosyn (antibiotic) 3.375 gram (G) injection every eight hours for diagnoses of severe sepsis.

R76's facility medication administration record (MAR) included an order with a start date of 10/18/22, for Zosyn 3.375 G IV one time per day at midnight (0000), 8:00 a.m. (0800) and 4:00

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p.m. (1600). R76's MAR indicated he was not on any other antibiotics for his infection.

R76's progress notes included the following:
-10/18/22 at 1:46 a.m. nursing was unable to give IV antibiotic due to the line being "clogged". The progress note lacked notification to the provider of the missed dose of antibiotic or the IV line not working.
-10/18/22 at 7:51 a.m. the line continued to be clogged and the IV antibiotic was unable to be administered. The progress note lacked notification to the provider of the missed dose of antibiotic or the IV line not working.
-10/18/22, at 12:04 p.m. it was documented the pharmacy was updated on the IV line not working which was 12 hours after the first missed dose of IV antibiotics. The progress note lacked notification to the provider of the missed dose of the antibiotic or IV line not working.

During an interview on 10/18/22, at 1:56 p.m. licensed practical nurse (LPN)-C stated R76 was unable to get his midnight and 8:00 a.m. IV Zosyn because the peripherally inserted central catheter (PICC) line would not flush. LPN-C stated she updated the nurse manager but had not updated the provider. LPN-C stated the PICC company was supposed to be at the facility by now to replace the IV but had not been.

During an interview on 10/18/22, at 2:07 p.m. registered nurse (RN)-G stated she called the IV phone line to come and restart the IV. RN-V acknowledged the provider had not been updated yet and stated the provider should have been updated when the IV antibiotic was first unable to be administered at midnight..

During an interview on 10/18/22, at 2:33 p.m. the

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assistant director of nursing (ADON) stated the provider and pharmacy should have been notified without delay of the IV antibiotics not able to be administered because the IV line was not working.

During an interview on 10/18/22, at 2:51 p.m. the consultant pharmacist (CP) stated for sepsis IV Zosyn should be administered as close to the time it was ordered as possible and if not able to administer the provider should be updated right away.

During an interview on 10/18/22, at 2:58 p.m. R76's primary care provider medical doctor (MD)-A stated he had not been notified and would have expected to be when the antibiotic was first unable to be administered. The MD stated he was notified just now and ordered the resident to be sent to the emergency room due to missed antibiotics for over 24 hours. MD-A stated the missed antibiotics could result in a return of R76's infection because the levels of antibiotics in R76's body systems would have been diminished.

During an interview on 10/18/22, at at 5:00 p.m. RN-A stated R76's PICC line did not work on the night shift and she was unable to administer the IV antibiotics. RN-A stated she knew there was a 24 hours IV phone line and physician line to call but had not. RN-A stated she did not because she read in the hospital notes they had problems with the IV line so she did not think it was urgent and left a voicemail for the nurse manager to follow up on it. RN-A stated the nurse manager normally comes in around 8:00 AM. RN-A stated R76 was known to be difficult to start an IV in so had not attempted to start a new IV.

R76's progress notes identified he was sent to

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31105	Continued From page 10 the emergency department on 10/18/22, at 3:10 p.m. and returned on 10/19/22, at 1:50 a.m. with a new PICC line placed. There were no new orders. During an interview on 10/19/22, at 9:49 a.m. the director of nursing (DON) agreed not administering antibiotics as ordered could place a resident at risk of infection. The DON stated the provider and IV line should have been notified immediately on 10/18/22 at 12:00 a.m. midnight when the antibiotic was first not able to be administered. Facility policy, undated Clearing Occluded PICC line and Midline Catheters, identified the physician should be notified immediately of suspected catheter occlusion and type of occlusion and obtain treatment orders, administer thrombolytic agent as ordered, if unsuccessful notify provider and obtain orders for IV team to assess/replace line. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days, then weekly, then monthly, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of	31105		

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31105	Continued From page 11 any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31105		
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	2 000		

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2 000	Continued From page 12 INITIAL COMMENTS: On 10/17/22 through 10/20/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: . S895, S900, S1545. The following complaints were found to be UNSUBSTANTIATED: H5452082C (MN79961), and H54523494C (MN85392). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 13 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		11/25/22

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2 900	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to reduce the development of pressure ulcers for 1 of 2 (R65) residents reviewed for pressure ulcers. Findings Include: R65's admission Minimum Data Set (MDS) assessment dated 8/21/22, indicated R65 had diagnoses of pressure induced deep tissue damage of left heel, pressure induced deep tissue damage of other site, lymphedema, cellulitis of left lower limb, and gout. It further indicated R65 had intact cognition, was at risk for developing pressure ulcers, and required extensive assistance with all activities of daily living (ADL) except eating. R65's progress note dated 8/24/2022, included "patient was noted to have a pressure sore stage 2 on left (L) heel. Writer called HP [health provider] and was not able to get a hold of no one so writer left a msg requesting dressing orders for patient and informing them on the pressure sore." R65's care plan last revised on 9/29/22, indicated the resident had pressure injury or potential for pressure injury development related to immobility, stage 2 pressure ulcer on left heel, mild foot Planter pressure ulcer stage 2, left lateral foot, left 5th lateral toe, right 2nd toe. R65 lacked any documentation of interventions to prevent pressure ulcers that were implemented before 8/24/22. 10/19/22 11:59 a.m. the nurse manager (RN-B) verified R65 did not have any interventions in place to prevent pressure ulcers until 8/24/22	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00486	A. BUILDING: ______ B. WING ______	C 10/20/2022

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2 900	Continued From page 15	2 900		

when the facility discovered R65 had a pressure ulcer on his left heel.

During an interview at 12:54 p.m., Nurse Practitioner (NP)-A said when R65 first came in NP-A recalled assessing R65 and his feet were fine, never had issues before, and felt came on all of a sudden. NP-A felt the issue was the foot of the bed. R65 is a tall man and his feet pushed up against the foot board and the foot board could not be removed due to an air mattress. NP-A said the nurses thought the wounds were arterial and had ordered R65 to be sent in for evaluation. NP-A was coming up with plan of care, wound clinic was backed up, white count was elevated and R65 was put on antibiotics. NP said R65 had horrible peripheral neuropathy and had no sensation to his feet, there were other factors, and encouraged R65 to reposition and he needs to keep his feet off the foot board. R65 became verbally aggressive and didn't want to be boosted up in bed.

During an interview on 10/20/22, at 10:44 a.m. occupational therapy assistant (OTA-A) stated R65 had OT once a day and she would try to get him out of bed every time. She also stated there were times she wasn't able to get him out of bed. OTA-A further stated R65 was able to reposition in bed "a little bit but if he wasn't constantly cued, he wouldn't remember to do it."

During an interview on 10/20/22, at 11:20 p.m. the director of rehab (DOR)-A stated R65 had physical therapy six times a week to work on transfers and mobility. DOR-A stated they were trying to figure out if R65 would be able to move back home because he was pretty immobile and there were times she wasn't able to get him out of bed. She further stated "I think he probably could,

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2 900	Continued From page 16 but I don't think he is" in regards to re-positioning himself. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		