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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VRPN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00486

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 09/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/08/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/17/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2021

CMS Certification Number (CCN): 245452

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

Dear Administrator:

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

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

Effective August 31, 2021 the above facility is certified for:

81	Skilled Nursing Facility/Nursing Facility Beds
50	Nursing Facility II Beds(certified Board and care homes delete this note)

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2021

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

RE: CCN: 245452
Cycle Start Date: June 10, 2021

Dear Administrator:

On June 29, 2021, we notified you a remedy was imposed. On September 7, 2021 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 August 31, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 29, 2021 be discontinued as of August 31, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 29, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 29, 2021. 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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VRPN

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/10/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Lisa Prokosch, HFE NE II 08/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/13/2021 (L20)

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

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

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3. Both of the Above :

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04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/17/2021
(L33)

DETERMINATION APPROVAL

Electronically delivered

June 29, 2021

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

RE: CCN: 245452
Cycle Start Date: June 10, 2021

Dear Administrator:

On June 10, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 29, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 29, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 29, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 29, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Episcopal Church Home Of Minnesota will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 29, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 10, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 06/10/2021

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 6/7/21 through 6/10/21, 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 6/7/21 through 6/10/21, 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 SUBSTANTIATED: H5452065C (MN50579), H5452066C (MN50100), H5452067C (MN49441), H5452069C (MN42464) however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5452050C (MN59176), H5452061C (MN63803), H5452062C (MN58693), H5452063C (MN58110), H5452064C (MN57950) and H5452068C (MN47850) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 07/08/2021

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 06/10/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		7/29/21

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 06/10/2021

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 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 residents (R59) who were reviewed for dignity and facial hair. Findings include: R59's quarterly Minimum Data Set (MDS) dated 4/27/21, identified R59 had cognitive impairment and required extensive assistance from staff to maintain personal hygiene. R59's diagnoses included dementia with Lewy bodies and Parkinson's disease. R59's care plan revised 9/29/2017, identified R59 had an ADL (activity of daily living) self-care performance deficit related to weakness and dementia. On 6/7/21, at 4:05 p.m. R59 was observed to have numerous hairs on her chin that were approximately 1/2 to 3/4 inches long.	F 550	Plan of correction for residents cited with this survey: R59 was shaved at the time of survey. R59'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: Standard of care policy was reviewed which includes direction on dignity and grooming. Education on grooming and standards of care done with all direct care staff. Plan to monitor: Resident audits of grooming following the plan of care will be completed 3x 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.	

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F 550	Continued From page 3 During an interview on 6/9/21, at 3:08 p.m. licensed practical nurse (LPN)-B stated staff assist residents to shave when they assist with the resident to bathe. LPN-B added if a resident requested not to be shaved or refused staff assistance it should be documented in the resident's medical record and should also be passed along to the next shift so staff could reapproach. During an interview on 6/9/21, at 3:11 p.m. LPN-C stated staff were expected to assist all female residents to shave when assisted with bathing and more frequently if needed. LPN-C added, if a resident refused assistance the nurse should document the refusal in the resident's medical record. During an interview on 6/9/21, at 3:53 p.m. R59 stated she did not want to have facial hair and would remove the hair if she could. During an interview on 6/10/21, at 10:03 a.m. the director of nursing (DON) stated it is the staff's responsibility to ensure female residents' facial hair was removed. If a resident refused staff were expected to reapproach the resident and pass it to the next shift. R59's medical record contained no documentation of refused assistance with shaving. The facility policy titled, "Standard of Care/Elder Rights" revised 1/1/15, included, "minimal requirements include but are not limited to:" "Assistance or supervision of shaving as needed to keep clan [sic] and well groomed."	F 550	Responsible for maintaining compliance: Director of Nursing	

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		7/29/21

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F 578	Continued From page 5 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a change in resident resuscitation wishes was timely implemented for 1 of 3 residents (R32) reviewed for advance directive. Findings include: R32's annual Minimum Data Set (MDS) indicated intact cognition. R32's Provider Orders for Life-Sustaining Treatment (POLST) form dated 1/7/21, indicated if R32 had no pulse and was not breathing R32's treatment wishes were do not attempt resuscitation (DNR/allow natural death), and selective treatments. R32's POLST form dated 6/7/21, indicated if R32 had no pulse and was not breathing, R32's wanted staff to attempt resuscitation (CPR) and provide full treatment. The POLST was signed by R32's family member due to R32 being unable to sign, and not signed by the physician. R32's progress note dated 6/7/21, at 16:20 (4:20 p.m.) indicated social worker (SW)-A met with R32 and her family member. R32 stated she wanted to receive CPR. A new POLST was completed and the nurse manager was updated. R32 was informed by SW-A the POLST would not be activated until a physician signature was received.	F 578	Plan of correction for residents cited in this survey: R32's POLST was signed and validated by her physician on 06/08/2021. Code status was updated in all areas utilized by staff on this date. Plan to address/prevent this deficiency for other residents: Facility advance directive/POLST policy was reviewed and does reflect appropriate language to honor a change in resident code status immediately. Measures put in place to prevent reoccurrence: Education on POLST policy and practice will be completed with all social workers, nurse leadership team members, and nurses. Plan to monitor: Audits will be done of POLST forms completed. POLST audits 3x weekly 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: Administrator	

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During interview on 6/7/21, at 6:49 p.m. registered nurse (RN)-A stated if needed to find the resuscitation status, she would look first in PCC (Point Click Care- electronic medical record) and would not have looked for a POLST in the paper chart.

During interview on 6/7/21, at 6:51 p.m. RN-B also stated would have looked first in PCC for a resident's resuscitation status and would not have looked for a POLST in the paper chart.

During interview on 6/7/21, at 6:57 p.m. RN-C stated staff were to look in PCC (Point Click Care- electronic medical record) for a resident's resuscitation status and would not have looked for a POLST in the paper chart.

During document review and interview on 6/8/21, at 3:12 p.m. PCC showed R32 continued to have DNR status, almost 23 hours after she updated her wishes to want CPR. Licensed practical nurse (LPN)-A, confirmed R32 was still DNR in PCC even though her wishes were to receive CPR. LPN-A stated the physician did not have a chance to sign the order on 6/7/21, or 6/8/21, so she would wait until 6/10/21, when the physician would come to the facility next. When LPN-A was asked if it was acceptable to wait three days to update changed resuscitation status preference she stated the new order was not valid without a physician signature. On 6/8/21, at 3:23 p.m. LPN-A called R32's primary care provider nurse practitioner (NP)-A and received a telephone order to update the resuscitation status to CPR.

During interview on 6/9/21, at 11:20 a.m. SW-A stated she thought they needed a physician's

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signature to change a resuscitation status. SW-A stated she was re-educated and now knows they can call the physician or provider and get a telephone or verbal order to implement a changed resuscitation status.

During interview on 6/09/21, at 12:35 p.m. SW-B stated the expectation with a changed resuscitation status was to update the medical record right away and that had always been the practice.

During interview on 6/09/21, at 1:09 p.m. RN-C stated a changed resuscitation status should have been implemented right away.

During interview on 6/09/21, at 1:25 p.m. the assistant director of nursing (ADON) stated if a resident changed their resuscitation status the new wishes should be reflected in PCC right away.

During interview on 6/09/21, at 1:31 p.m. the director of nursing (DON) stated if R32's POLST was not signed by the physician and the resident coded or had a change in condition they would not have been able to immediately perform CPR. The DON stated in that situation they would have called the provider to get a telephone order for CPR.

During interview on 6/10/21, at 3:25 p.m. NP-A stated was aware R32 wanted to have her code status changed to CPR. NP-A stated had been updated by facility staff on 6/7/21, and stated he gave a verbal acknowledgement of the changed code status. NP-A stated the facility should have updated the code status on 6/7/21, in accordance with R32's wishes.

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F 578	Continued From page 8 During interview on 6/9/21, at 3:14 p.m. family member (FM)-A stated had been present when R32 met with SW-A and changed her code status from DNR to full code. FM-A stated SW-A said R32's wishes would not be implemented until the physician signed the POLST. FM-A stated the facility said that might be three days or more. During follow up interview on 6/09/21, at 3:52 p.m. the DON stated staff were expected to get a telephone order from the physician, if the physician was not on site and update a changed resuscitation status in PCC right away. Facility policy titled Advance Directives POLST, undated, directed staff to complete a new POLST during a change in condition, where appropriate. Further, a telephone order would be taken for any changes in physician orders until the POLST form could be signed by the physician. A copy of the telephone order should be stapled to the POLST form indicating the current order. Additionally, all staff members and the medical team should refer to the POLST form indicating the resident's wishes prior to initiation or discontinuation of any treatment and that all treatments provided must be in keeping with the resident's wishes.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		7/29/21

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F 684	Continued From page 9 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure treatment orders were provided as ordered for 1 of 2 resident (R164) reviewed for wound care. Findings include: R164's admission Minimum Data Set (MDS) dated 6/4/21, indicated intact cognition. R164 required extensive assist with dressing. R164 had two venous ulcers and had dressings applied to her feet. R164's care plan dated 6/2/21, identified potential/actual impairment to skin integrity r/t [related to] right lower extremity wound, hx [history] of cellulitis and venous insufficiency. Nursing staff were directed to follow facility protocols for treatment of injury. R164's vascular follow up note dated 6/8/21, with an outside wound care specialist indicated chief complaints of right and left lower leg ulcers and chronic swelling. R164's diagnoses included atrial fibrillation (irregular heartbeat), congestive heart failure and lymphedema (swelling) of both lower extremities (BLE) and venous insufficiency of BLE. Wound care orders specified four inch double ace wraps should be applied to BLE from toes to knee in a figure eight pattern. R164's treatment administration record had an order with start date of 6/8/21, which directed nursing staff to apply four inch double ace wrap from toes to below knees in a figure eight pattern.	F 684	Plan of correction for residents cited in this survey: R164 had the ace wraps re-done at the time of survey during observation. Plan to address/prevent this deficiency for other residents: This was an isolated order with no impact on other residents. Measures put in place to prevent reoccurrence: Orders were correctly transcribed in the resident's record. The nurse was educated during the time of survey on following orders as directed. All nursing staff will be educated on the importance of following wound care orders as specifically written. Plan to Monitor: Audits of wound care procedures 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 684	Continued From page 10 During interview on 6/10/21, at 8:57 a.m. R164 stated had seen a wound specialist. R164 stated had chronic wounds to her lower legs due to circulation issues related to heart conditions. Additionally, R164 stated when pockets of fluid accumulated in her lower legs those areas would open up and become wounds. During observation on 6/10/21, at 12:31 p.m. registered nurse (RN)-B completed treatments for R164's wounds. RN-B removed R164's ace wraps from BLE that were previously applied from toes to knee in a figure eight pattern. R164 was observed to have +2 pitting edema (approximately 4 millimeter indentations) in both lower legs. RN-B completed wound care to the right lower extremity. RN-B wrapped the right lower extremity from the ankle to knee with an ACE wrap, leaving the foot unwrapped. RN-B taped the ACE wrap in place. RN-B wrapped the left lower extremity from the ankle to knee with an ACE wrap, leaving the foot unwrapped. RN-B taped that ACE wrap in place as well. RN-B put R164's grippy socks back on her feet and went into R164's bathroom to perform hand hygiene. While in the bathroom surveyor asked if R164's ace wraps should start from the toes or ankles. RN-B stated the ankle. RN-B was shown the order in the computer which indicated to start wrapping from the toe. RN-B stated was not aware and having thought about it stated R164's feet could have swollen if the wraps were applied incorrectly. RN-B stated had looked at the treatment orders prior to wound care, and was not sure why she completed it differently than ordered. RN-B proceeded to re-do the ACE wraps in accordance with the order.	F 684		

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F 684	Continued From page 11 During interview on 6/10/21, at 1:20 p.m. the the director of nursing (DON) stated would have expected the nurses to know and follow orders for wound care. Facility policy titled Skin Care, dated 9/12/12, indicated a resident with pressure injury wound receive necessary treatment and services to promote healing, prevent infection and prevent new injuries from developing. Facility protocol titled Wound Care, undated, directed staff to implement measures as indicated.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		7/29/21

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F 758	Continued From page 12 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) and document clinical rationale for the extended use of an as needed (PRN) psychotropic medication used beyond 14 days for 1 of 5 residents (R46) reviewed for unnecessary medications. Findings include: R46's admission Minimum Data Set (MDS) dated 1/16/21, identified R46 had congestive heart	F 758	Plan of correction for residents cited in this survey: R46 had their PRN lorazepam discontinued on 06/10/2021. Plan to address/prevent this deficiency for other residents: Facility policy for use of psychoactive medication was reviewed and found to be appropriate to meet the language of the regulation. All residents were reviewed by the facility consulting pharmacist. No other PRN orders were found to be out of compliance. Measures put in place to prevent	

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F 758	Continued From page 13 failure and a brief interview for mental status (BIMS) of 14 which indicated R46 was cognitively intact. R46 was admitted with an order for lorazepam (a sedative) 0.5 milligrams (mg) as needed for anxiety. On 3/15/21, the consultant pharmacist recommended on the monthly Consultant Pharmacist's Medication Regimen Review (MRR), if not already done, please consider obtaining a stop date for PRN (as needed) lorazepam and complete psychotropic monitoring. R46 was started on Remeron (anti-depressant) 7.5 mg every night for depression and sleep on 4/12/21. On 4/19/21, the MRR included PRN lorazepam and Remeron, and indicated, if not already done, please consider obtaining a stop date for lorazepam as R46 is now on Remeron and complete psychotropic monitoring. On 6/09/21, at 2:04 p.m. registered nurse (RN-D) confirmed pharmacy requests from 3/15/21 and 4/19/21, were not reported to the provider. RN-D reported wanted to wait to see if the Remeron would "work" and then ask for the lorazepam to be discontinued. On 6/09/21, at 2:37 p.m. the nurse practitioner (NP), reported he had spoken to facility nurses, guardian and resident about the lorazepam. The date and specific staff could not be determined. The NP recalled multiple conversations with the facility to the fact R46 has been on lorazepam for years, was 99 years old, and the guardian and NP did not want it scheduled it every day and stated it was easier to track if medication was used PRN basis. The NP had reordered Lorazepam 0.5 mg every 10 days as he was not shown the	F 758	reoccurrence: Education on the facility psychoactive mediation policy will be completed with all nurse managers and nurses. Plan to monitor: Facility DON will review the consulting pharmacist comments monthly and validate any comments related to PRN psychotic medications do have follow up. Random audits of medication orders will be completed 3x weekly for 4 weeks to ensure any PRN psychoactive medications meet the regulatory guidance for duration. Results of audits will be reviewed monthly at the facility QA meeting until the committee determines the plan of correction is successful. Responsible for maintaining compliance: DON	

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F 758	Continued From page 14 pharmacy MRR. The NP confirmed the discussions with the resident, guardian and facility were not documented by him at the facility. On 6/10/21, 10:08 a.m. The director of nursing (DON) confirmed there had not been a trial dose reduction of the lorazepam and the Remeron had been started. The DON stated all consultant pharmacist MRRs were to be reported to the provider immediately by the floor nurse manager. The DON confirmed there was no documentation for notification to the provider. The DON stated the facility had missed the 14 day GDR and the facility did not follow the pharmacy's recommendation. The DON recognized R46's prescription lorazepam was filled every 10 days during interview and stated that it was a facility error. The Psychoactive Medication policy dated 3/1/18, indicated "as needed (PRN) orders for psychotropic drugs are limited to 14 days. Once the attending physician or prescribing practitioner feels that it is appropriate to extend the PRN beyond 14 days, the practitioner must document their rationale for the extension and indicate the duration for the PRN order in the medical record. Elders receiving psychoactive medications will have gradual dose reductions (GDR) per standard guidelines unless a reduction is clinically contraindicated."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		7/29/21

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F 761	Continued From page 15 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure un-authorized staff and residents did not have access to 1 of 5 refrigerators that was unsecured and filled with insulin, calcium supplement medications and prescription eye drops. Also 1 out of 5 nursing station medication cabinets which was observed to be unsecured and accessible to residents. Findings include: During observation on 6/9/21, at 2:36 p.m. in an open nursing station, registered nurse (RN)-F opened the unlocked medication storage cabinet to allow inspection of 21 medications ready for disposal. In addition, the small medication	F 761	Plan of correction for residents cited in this survey: The medication fridge and cabinet identified were secured at the time of survey. Plan to address/prevent this deficiency for other residents: All areas of medication storage were assessed and appropriately secured. Measures put in place to prevent reoccurrence: Education will be completed with all nurses and nurse managers on the facility policy for securing medications. Plan to monitor: Random audits of medication storage locations will be completed 3x weekly for 4 weeks. Results	

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F 761	Continued From page 16 refrigerator in the same area was observed to be unlocked. During observation, the refrigerator was noted to contain insulin pens, prescription eye drops and calcium supplement medication. During observation on 6/10/21, at 11:01 a.m. in an open nursing station, licensed practical nurse (LPN)-E opened the unlocked medication storage cabinet to allow inspection of 21 medication ready for disposal. In addition, the small medication refrigerator in the same area was observed to be unlocked. During observation, the refrigerator was noted to contain insulin pens, prescription eye drops and calcium supplement medication. During interview, LPN-E stated the cabinet and refrigerator should be locked and he had the ability to lock both with a key. During interview, on 6/10/21, at 11:12 a.m. RN-G stated the cabinet and medication refrigerator must be locked at all times when not in use. During observation with RN-G medication cabinet medication was observed to contain medication which belonged to one resident (R80) who passed away on 5/21/21, and another resident (R20) with a medication change. During interview on 6/10/21, at 11:50 a.m. director of nursing (DON) stated her expectation was medications that needed disposal would be placed in a locked cabinet until time when nurse manager would destroy per policy. DON stated currently with unsecured medication storage, residents on that unit were at risk to obtain and use medications that were not properly locked up. The facility policy titled Med Storage dated 1/1/2015, stated all areas that hold medication will be locked. "Procedure: The following equipment	F 761	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: Director of Nursing	

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F 761	Continued From page 17 and supplies are acquired and maintained by the facility for proper storage, preparation, and administration of Medications: Lockable medication carts, medication cabinets, drawers and rooms with well-lit dose preparation areas".	F 761		
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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outdated food items were not available for resident consumption in 3 of 6 satellite kitchens. This had the potential to affect all of the residents that received food from those kitchens. Finding include:	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	7/29/21

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F 812	Continued From page 18 On 6/8/21, at 1:38 p.m. open, partially empty food and beverage containers, which were not labeled with the date when opened, were observed in the Gilbert House kitchen refrigerator. These included: one container of orange juice, one container of thickened water, three containers of thickened juice, and two jars of marmalade. Nursing assistant (NA)-B also observed the undated items in the refrigerator and stated all food and beverage items should be labeled with the date it was opened. On 6/9/21 at 7:00 a.m. a plate containing noodles covered in gravy with a side of green and yellow beans, which was on the menu for lunch on 6/8/21, was observed in the fridge undated. Additionally, two containers of juice and a container of whipped margarine were observed opened and partially used and not labeled with the date it was opened. Also, an open, partially empty half gallon container of non-fat milk with an expiration date of 5/26/21, was observed in the fridge. A laminated sign on the fridge reads, "Everything stored must be labeled and dated. Discard after 7 days." On 6/9/21, at 10:05 a.m. three previously opened juice boxes (original containers) were stored in the refrigerator located in the satellite kitchen on second floor. The boxes were covered but not labeled with the date the boxes were opened. The boxes were the original containers. Licensed practical nurse (LPN)-D stated the juices were used frequently and were usually completely consumed within two or three meals. LPN-D stated she did not label the juices and was not aware of any policy that stated the juices needed to be labeled.	F 812	with meal service will be trained on the facility policy for labeling and discarding opened food items. Plan to monitor: Random 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: Director of Nursing	

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F 812	Continued From page 19 During an interview 6/9/21, at 1:30 p.m. the registered dietician (RD) stated juices and other non-dairy liquids were to be dated once they were opened and discarded by the expiration date. Daily products and yogurts were to be discarded by the expiration date. Thickeners for liquids were to be discarded by the expiration date. If any food or beverage items are observed in a facility fridge, not labeled with the date it was opened, the item should be thrown out. The facility's "Storage of Food" policy (undated), included, "All food, chemicals, and supplies should be stored in a manner that ensures quality and maximizes safety of the food served."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		7/29/21

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F 880	Continued From page 20 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 21 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their infection prevention and control program to prevent the transmission of COVID-19 in accordance with Center for Disease Control (CDC) guidelines when staff did not wear the appropriate personal protective equipment (PPE) that included eye protection and/or properly worn medical-grade facemask's. This had the potential to affect all residents in May house, Gilbert house, Sister Annette house and King house. In addition, the facility failed to ensure proper hand hygiene was implemented during a dressing change for 1 of 1 resident (R43) reviewed for gastric tube cares. Findings include: PPE Current CDC guidelines Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, last updated 3/29/21, directed health care personnel (HCP) to wear a well-fitting face mask. Further, the fit of the medical device used to cover the wearer's mouth and nose was a critical factor in the level of source control (preventing exposure of others) and level of the wearer's exposure to infectious particles. Additionally, the guidelines directed HCP to wear eye protection during patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions.	F 880	Plan of Correction for Residents Cited in this Survey: Point in time education was done with the staff identified to be non-compliant at the time of survey. Plan to address/prevent this deficiency for other residents: The facility will adhere to the directed plan of correction provided by the Minnesota Department of Health as detailed below. The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with Governing Body oversight will conduct a root cause analysis (RCA) to identify the problem that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. Measures put in place to prevent reoccurrence: The Infection Preventionist, Director of Nursing and Clinical Education Coordinator have implemented competency assessments for staff on proper hand hygiene and have developed a system to ensure all staff have received the training and are competent. As a part of corrective action plan, the facility will provide training for all staff providing direct care to residents, and all staff entering resident□s rooms, whether	

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F 880	Continued From page 22 During observation of the May house on 6/7/21, at 5:01 p.m. licensed practical nurse (LPN)-A was observed to assist R86 to eat and wore goggles and a face mask. At 5:07 p.m. LPN-A took off the goggles, hung them on her scrub suit shirt and continued to assist R86 to eat until 5:25 p.m. LPN-A was within 2-3 feet of R86 at the time of the meal observation. During interview on 6/7/21, at 5:34 p.m. LPN-A confirmed that in all patient care areas and while patient cares were provided, staff must don masks and eye protection. LPN-A stated "I had to take off my goggles they were fogging up." LPN-A confirmed the facility had face shields that could be used if needed instead of goggles. During interview on 6/7/21, at 5:40 p.m. the infection preventionist (IP) verified the policy was that masks and eye protection were to be worn in all patient cares areas, that included hallways and during all patient cares. The IP confirmed there were plenty of goggles and shields in the supply area that could be used if needed for all staff. Eye Protection during COVID 19 policy dated 4/19/21, indicated that all staff will wear eye protection at all times in resident care areas and halls. Eye protection will be provided for staff through staffing, nursing manager or infection preventionist. Facemasks as Source Control Measure policy dated 3/19/21, indicated that staff who work in areas of minimal to no community transmission should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures.	F 880	it be for residents dietary needs or cleaning and maintenance services. The training will cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. Plan to monitor: Hand Hygiene: The Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits will continue until 100% compliance is met. PPE Use: The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us. The Director of Nursing, Infection Preventionist, and other facility leadership	

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F 880	Continued From page 23 The Standard Precautions in Resident Care policy dated 3/10/20, indicated mask, eye goggles or face shields were to be worn to protect mucous membranes of the eyes, nose, and mouth during procedures and resident cares. On 6/9/21, at 7:26 a.m. during observation of the Gilbert house, registered nurse (RN)-E approached R58, did not wear eye protection and her face mask was under her nose. RN-E patted R58's shoulder when she talked with him before she returned to the medication cart and continued to prepare medications and did not adjust her mask or apply appropriate eye protection. On 6/9/21, at 7:26 a.m. nursing assistant (NA)-B was observed to exit R58's room and carried a bag of dirty linen and did not wear eye protection. NA-B walked through the neighborhood to deposit the bag in the soiled linen room. NA-B returned and spoke with R58, retrieved a blanket from her room and then wrapped it around R58. NA-B did not wear eye protection throughout her interaction with R58. On 6/9/21, at 7:49 a.m. RN-E was observed to enter R94's room and did not wear appropriate eye protection. RN-E gave R94 his medication. When interviewed upon exit of R94's room RN-E stated appropriate personal protective equipment (PPE) included face masks and goggles or face shield at all times and gloves with any resident contact. RN added that she felt her eyeglasses were sufficient eye protection but clarified that she also had goggle she had left in her car. On 6/9/21, at 8:05 a.m. RN-E was observed to check R4's blood sugar with her mask below her	F 880	will conduct real time audits on proper use of gowns to ensure PPE is in use. The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. Responsible for maintaining compliance: Infection Preventionist Documents and audits uploaded 7/29/21	

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nose and did not wear appropriate eye protection.

On 6/9/21, at 8:05 am NA-C was observed to enter the dining room and approached NA-B and RN-E, both who were did not wear eye protection. NA-C offered each a face shield. Both NA-B and RN-E declined the equipment. When interviewed after the interaction NA-C stated both NA-B and RN-E told her they did not need the face shield she offered.

On 6/10/21, at 9:58 a.m. the director of nursing (DON) stated staff were expected to wear goggles or a face shield and a face mask that covered both their mouth and nose in all patient care areas.

During observation on 6/10/21, at 9:29 a.m. LPN-D brought R51's medications to the Sister Annette dining room. LPN-D talked to R51 and gave her medications with a spoon. LPN-D had no eye protection on. LPN-D left the dining room and went back to the medication room.

During observation and interview on 6/10/21, at 9:54 a.m. LPN-D brought R28's medications to the dining room. LPN-D talked to R28 and gave him medications with a spoon. At 9:57 a.m. LPN-D left the dining room. LPN-D stated had started work today at 6:30 a.m. LPN-D stated had not worn eye protection yet. LPN-D stated there was ample supply of eye protection but thought staff no longer had to wear it, even on the resident care units. LPN-D stated was aware the facility was currently undergoing outbreak testing for COVID-19 again due to a COVID-19 positive diagnosis in the facility recently. LPN-D left the unit and at 10:03 a.m. LPN-D returned with a face shield on.

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F 880	Continued From page 25 On 6/8/21, at 2:01 p.m. during observation at the King house, registered nurse (RN)-F wore a facemask under her nose while she worked with residents. Stated the masks were difficult to wear and too big for her face. On 6/8/21, at 2:24 p.m. RN-F was observed to wear a facemask under her nose while worked with residents and handled medications. On 6/8/21, at 2:34 p.m. RN-F was observed to wear a facemask under her nose while she worked with residents. There were no attempts made to readjust the mask. HAND HYGIENE R43's Admission Record printed 4/10/20, indicated R43's diagnoses included cerebral vascular accident that resulted in left sided spastic hemiplegia and dysphagia. R43's quarterly Minimum Data Set (MDS) dated 4/09/21, indicated R43 required extensive assist with bed mobility, transfers, toilet use and personal hygiene. R43's care plan dated 4/10/20, directed staff to use standard precautions and clean technique when worked with the gastrostomy tube (G-tube). The G-tube insertion site was to be cleansed each shift with soap and water. On 6/08/21 at 2:10 PM RN-F was observed to change the dressing on R43's G-tube insertion site. RN-F placed a wet washcloth with soap directly onto the bedside table. Scissors from RN-F's pocket were used to loosen the tape on the dressing and cut the old gauze dressing. The	F 880		

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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 880	Continued From page 26	F 880		

old dressing was removed and placed in the trash can. RN-F used the soapy washcloth to clean the insertion site. RN-F did not remove the gloves or perform hand hygiene before the wound was cleansed or the new dressing was applied. RN-F stated she did not need to remove the gloves, wash her hands, or put on new gloves before the wound was cleansed or the new dressing was applied because the wound was considered clean, mostly healed, and not sterile.

On 06/10/21, at 12:45 p.m. RN-D stated the gloves should have been removed and hands washed between the time the dressing was removed, the wound cleansed, and the new dressing applied. Stated there were no specific policies pertaining to non-complex dressing changes. It is expected of nurses practice to professional standards.

On 6/10/21 at 1:45 The Infection Preventionist (IP) stated the gloves should have been removed and hands washed between the time the dressing was removed, the wound cleansed, and the new dressing applied. IP stated the washcloth should have been placed in a clean basin and not directly onto the bedside table.

The facility policy Hand Hygiene reviewed April 2021, 8/19, directed, "It is the policy of Episcopal Church Home and the Gardens that all employees are educated on and perform proper hand hygiene." The policy further stated, "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately before and after gloves are removed, and when otherwise indicated to avoid transfer of microorganisms to other elders,

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F 880	Continued From page 27 personnel, equipment and/or the environment.	F 880		

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	245452	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/08/2021. At the time of this survey, Episcopal Church Home of MN was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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		07/09/2021

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

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K 000	Continued From page 1 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 MN is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1971, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. In 2008, an addition was constructed to the north side of the building that was determined to be of Type II(222) construction. Because the original building and	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 119 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		8/31/21

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install a commercial cooking suppression system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 10.5.1 and 10.5.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 06/08/2021 between 9:00 AM to 3:00 PM, it was revealed that the manual pull station for the hood extinguisher system is not located in the path of egress and is located more than 20' from cooking equipment. This deficient condition was verified by the Facility Maintenance Director.	K 324	POC: Manual pull station is scheduled to be moved to a location within 20’ from the cooking equipment within the path of egress. Facility has contracted Summit Fire Protection and is currently awaiting a confirmed service date to be scheduled within the next month. Responsible for Compliance: Maintenance Director	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		7/1/21

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K 353	Continued From page 4 _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/08/2021, between 9:00 AM to 3:00 PM, it was revealed that the facility did not complete its quarterly automatic fire sprinkler system testing. This deficient condition was verified by the Facility Maintenance Director.	K 353	POC: The procedure for testing, inspecting and maintaining automatic sprinkler systems was completed and added as a task to the facility maintenance log software TELS with a report to check future compliance. Responsible for Compliance: Maintenance Director	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		8/31/21

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K 521	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect smoke and fire dampers in the heating, ventilation, and cooling system per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.1, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/08/2021 between 9:00 AM to 3:00 PM, it was revealed that the facility had not completed its smoke/fire damper testing within the last four years. This deficient condition was verified by the Facility Maintenance Director.	K 521	POC: Maintenance Supervisor has scheduled Johnsons Control, and a HVAC tech to test all smoke and fire dampers in the heating, ventilation, and cooking systems. This will be scheduled ongoing per the regulation timeframe for future testing as well to meet future compliance. Testing will take place within the next month per contractor.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at	K 914		7/1/21

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K 914	Continued From page 6 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles at patient bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.4.1 through 6.3.4.1.5, 6.3.4.2.1.1, and 6.3.4.2.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/08/2021 between 9:00 AM to 3:00 PM, it was revealed that the facility had not completed their annual electrical outlet testing at patient bed locations. This deficient condition was verified by the Facility Maintenance Director.	K 914	POC: Maintenance supervisor completed this task and added electrical systems maintenance and testing to the facility maintenance log TELS software along with a receptacle testing checklist. Regular audits of reports in TELS will ensure future compliance.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application,	K 926		7/28/21

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K 926	Continued From page 7 maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain a medical gas safety and training program per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1.1 through 11.5.2.1.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/08/2021 between 09:00 AM to 3:00 PM, it was revealed that the facility has not completed their annual medical gas training for all staff. This deficient condition was verified by the Facility Maintenance Director.	K 926	POC: Training is completed during general orientation for all new hires. Training will be included in the facility annual training all staff attend annually. Education records will be documented and logged by the facility education director as well as documented within the maintenance record book.	