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 Therefore, the NATCEP prohibition is rescinded.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

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: 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

December 5, 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 November 7, 2022, we informed you that we may impose enforcement remedies.

On November 21, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 20, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 20, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2023.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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 $11,292, 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 January 20, 2023, 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 January 20, 2023. 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" and/or an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 April 20, 2023 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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.

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 11/21/2022

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 000	INITIAL COMMENTS On 11/21/22, a standard abbreviated survey was conducted at your facility. 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: H54525935C (MN88412), with a deficiencies cited at F658 and F760 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 that substantial compliance with the regulations has been attained.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow standards of practice related to safe assisted resident transfers. The staff did not use a gait belt in the	F 658	Plan of correction for residents cited in this survey: R1, R2, and R3□s care plans were reviewed and staff were educated on the use of gait belts as a standard of care	12/23/22

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

Electronically Signed | 12/15/2022

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 658	Continued From page 1 transfer assistance for three of three residents (R1, R2 and R3). Findings: R1's quarterly Minimum Data Set (MDS) dated 9/19/22, indicated R1 had a Brief Inventory Mental Status (BIMS) Score of 15 indicating no cognitive impairment. R1's pertinent diagnoses were atherosclerotic heart disease, polymyalgia rheumatica (an inflammatory disease-causing muscle pain) and unsteadiness on feet. R1 required assistance of one staff member with bed mobility, transfer assistance, and locomotion. R1's care plan dated 10/7/22, indicated R1 required assistance of one staff member for toilet use and required contact guard assistance from one staff member to move between surfaces. Upon interview on 11/21/22, at 9:40 a.m. R1 stated she stays in bed most of the time because staff members have "grabbed my arms too many times." She stated that some of the staff will use a gait belt, and others will not. R1's family has hired an outside Physical Therapist (PT) to work with R1 five days a week. R1 stated that the only time she feels comfortable transferring and walking is with the hired therapist. R2's care plan dated 5/25/22, indicated R2 required extensive assistance of one staff member for bed mobility, toilet use, and transfer assistance. R2's quarterly MDS dated 11/16/22, indicated R2 had a BIMS score of 7 indicating cognitive impairment. R2's diagnoses were Alzheimer's Disease and morbid obesity. R2 required	F 658	for all residents needing assistance with transfers. Gait belts were provided for staff and placed in each resident□s room. Plan to address/prevent this deficiency for other residents: Care plans for other residents needing assistance with transfers will be reviewed. Gait belts will be ordered and provided to all direct care staff. New hires will receive a gait belt during new hire paperwork. Measures put in place to prevent reoccurrence: The facility policy on gait belts was reviewed and updated. Direct care staff will be trained on the gait belt policy. Plan to Monitor: Audits of transfers requiring gait belts will be completed for residents requiring assistance with transfers will be done 1x per week for 4 weeks. Audits will we reviewed by the quarterly QA committee and will continue until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 658	Continued From page 2 assistance of one staff member with bed mobility, transfer assistance, toilet use and locomotion. Upon observation on 11/21/22, at 11:08 a.m. R2 was seated in her wheelchair in the commons area and stated to nursing assistant (NA-A) in passing that she needed to use the restroom. NA-A wheeled R2 into her bathroom, locked the wheels on the wheelchair. R2 was instructed by NA-A to use the grab bars to pull herself up. NA-A placed her right arm under R2's right arm from behind R2 and assisted R2 to a standing position. NA-A placed her hands around R2's hips and pivoted her to a seated position on the toilet without using a gait belt. Upon interview on 11/21/22, at 11:10 a.m. NA-A stated R2 stands well on her own and does not always need a gait belt and due to the R2's weight it is difficult to place the belt on R2. Upon observation on 11/21/22, at 11:16 a.m. NA-A got a transfer belt to assist R2 off the toilet to her wheelchair. Upon interview on 11/21/22, at 1:44 p.m. NA-A stated that assistance of one means a gait belt is necessary and extensive assistance of one staff member means a gait belt is required and may require the assistance of two staff members. NA-A stated she would use a belt with all transfers going forward. Upon interview on 11/21/22, at 2:10 p.m. R2 stated the staff always uses her arms to lift her and none of the staff use a gait belt. R3's care plan dated 6/11/18, indicated R3 required extensive assistance of one staff	F 658		

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F 658	Continued From page 3 member for bed mobility, toilet use, and transfer assistance. R3's quarterly MDS dated 10/26/22, indicated R3 had a BIMs score of 11 indicating she had mild cognitive impairment. R3's pertinent diagnoses were spinal stenosis (narrowing of the spinal canal), osteoarthritis and an artificial knee joint. R3 required assistance of one staff member for bed mobility, toilet use and transfers. Upon observation on 11/21/22, at 10:58 a.m. R3 was seated in her room with her call light on. NA-A entered the room to assist her. NA-A assisted R3 to a standing position by placing her right arm under R3's left arm. NA-A ambulated with R3 to the bathroom without a gait belt. Upon interview on 11/21/22, at 11:00 a.m. NA-A stated she didn't use a gait because R3 stands well on her own. Upon interview on 11/21/22, at 11:29 a.m. R3 stated some staff use a gait belt with her and some do not. R3 denied any pain to her back or shoulders with the lifting assistance without a gait belt but stated she does not always feel safe with the transfers when she is weak. Upon interview on 11/21/22, at 1:55 p.m. RN-A stated all staff are trained at orientation and at the yearly competency skills fair that a gait is required when a resident needs transfer assistance by staff. Upon interview on 11/21/22, at 3:29 p.m. the director of nursing (DON) stated nursing staff are trained at orientation and at the yearly skills fair to use a gait belt when a resident needs assistance	F 658		

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F 658	Continued From page 4 with transferring. A facility policy titled Gait Belt Use dated 2021, indicated all residents who require assistance with transfers and do not require an electric lift will utilize a gait belt with all transfers.	F 658		
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 observation, interviews, and record review the facility failed to provide an acceptable standard for medication administration whwn the facility administered a medication that was not to be crushed to one of three residents (R1) investigated for medication concerns. Findings include: R1's physical order dated 9/14/22, indicated R1 was to take Potassium Chloride ER (extended release) tablet 10 milliequivalents (meq) one time a day with food for hypokalemia (low blood levels of potassium). R1's quarterly Minimum Data Set (MDS) dated 9/19/22, indicated R1 had a Brief Inventory Mental Status (BIMS) Score of 15 indicating no cognitive impairment. R1's pertinent diagnoses were atherosclerotic heart disease, cardiac arrhythmias (improper beating of the heart), and hypokalemia. R1's care plan dated 10/7/22, indicated R1	F 760	Plan of correction for residents cited in this survey: R1□s order for was potassium was updated to include DO NOT CRUSH. Pharmacy was consulted. Education was provided to the Nurse to not crush the medication and that medication could be dissolved with water per pharmacy□s recommendation. Plan to address/prevent this deficiency for other residents: Other residents with orders for medication that cannot be crushed will be reviewed to ensure their order or clinical chart clearly indicates not to crush the medication. Measures put in place to prevent reoccurrence: The facility medication administration policy was updated. Education will be provided to Nurses on the medication administration policy and appropriate medication pass. Plan to Monitor: Audits of medication pass will be complete 1x per week for 4 weeks. Audits will we reviewed by the quarterly QA committee and will continue until the	12/23/22

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F 760	Continued From page 5 required assistance with medication administration as ordered and to monitor and document for side effects and effectiveness. Upon observation on 11/21/22, at 10:38 a.m. LPN-A was asked by R1 to crush the medications she stated she could not swallow. LPN-A took the medication, crushed the medications, and placed the medications in pudding for R1 to take. Upon interview on 11/21/22, at 10:40 a.m., R1 stated she was uncertain which medications LPN-A crushed, stating staff always crush the large ones. "I think they are my vitamins and minerals." Upon interview on 11/21/22, at 10:45 a.m. LPN-A stated she crushed R1's potassium and magnesium and mixed the medications in pudding as R1 requested. LPN-A stated she crushes medication requested by R1 most days that she works with her. LPN-A stated she was unsure if there was an order to crush R1's medications. Upon interview on 11/21/22, at 11:28 a.m. a pharmacist from the company that supplies the medications for R1 stated the pharmacy had not been contacted by the facility to crush any medications for R1. She stated when a request is made to crush medications, a resident specific list is sent to the facility that indicates which medications can be crushed. If a medication can not be crushed the provider is notified and an alternative option is recommended. The Pharmacist stated the problem with crushing potassium is it could be released too fast in the system and cause cardiac events. The Pharmacist denied concerns with the crushing of	F 760	committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing	

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F 760	Continued From page 6 the magnesium tablet. Upon interview on 11/21/22, at 1:36 p.m. LPN-A stated she was unable to locate an order to crush any medications for R1 and she had called the pharmacy to initiate an order for an alternative option. Upon interview on 11/21/22, at 1:55 p.m. RN-A reported upon new hire orientation the nurses are trained to check in the Medication Administration Record (MAR) before cutting or crushing any medications. If the MAR does not indicate the medication can be crushed the nurse is to notify the provider and the pharmacy for instructions and/or a new order. Upon interview on 11/22/22, at 3:29 p.m. the director of nursing (DON) stated before nursing staff is able to crush a medication, they must notify the provider and get an order for the medication to be crushed, dissolved, or cut. A facility policy titled Administration of Medication, dated 1/1/15 indicated medications must be administered timely and in accordance with the prescribers' orders. A facility policy about crushing medications was requested, however none provided.	F 760		

Electronically delivered
December 5, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 9W7S11

Dear Administrator:

The above facility was surveyed on November 21, 2022 through November 21, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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 11/21/2022

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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/21/22, a complaint 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 and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54525935C (MN88412), with a licensing order issued at ST1545. 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 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or	21545		12/23/22

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21545	Continued From page 3 designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide an acceptable standard for medication administration whwn the facility administered a medication that was not to be crushed to one of three residents (R1) investigated for medication concerns. Findings include: R1's physical order dated 9/14/22, indicated R1 was to take Potassium Chloride ER (extended release) tablet 10 milliequivalents (meq) one time a day with food for hypokalemia (low blood levels of potassium). R1's quarterly Minimum Data Set (MDS) dated 9/19/22, indicated R1 had a Brief Inventory Mental Status (BIMS) Score of 15 indicating no cognitive impairment. R1's pertinent diagnoses were atherosclerotic heart disease, cardiac arrhythmias (improper beating of the heart), and hypokalemia. R1's care plan dated 10/7/22, indicated R1	21545	Corrected.	

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21545	Continued From page 4 required assistance with medication administration as ordered and to monitor and document for side effects and effectiveness. Upon observation on 11/21/22, at 10:38 a.m. LPN-A was asked by R1 to crush the medications she stated she could not swallow. LPN-A took the medication, crushed the medications, and placed the medications in pudding for R1 to take. Upon interview on 11/21/22, at 10:40 a.m., R1 stated she was uncertain which medications LPN-A crushed, stating staff always crush the large ones. "I think they are my vitamins and minerals." Upon interview on 11/21/22, at 10:45 a.m. LPN-A stated she crushed R1's potassium and magnesium and mixed the medications in pudding as R1 requested. LPN-A stated she crushes medication requested by R1 most days that she works with her. LPN-A stated she was unsure if there was an order to crush R1's medications. Upon interview on 11/21/22, at 11:28 a.m. a pharmacist from the company that supplies the medications for R1 stated the pharmacy had not been contacted by the facility to crush any medications for R1. She stated when a request is made to crush medications, a resident specific list is sent to the facility that indicates which medications can be crushed. If a medication can not be crushed the provider is notified and an alternative option is recommended. The Pharmacist stated the problem with crushing potassium is it could be released too fast in the system and cause cardiac events. The Pharmacist denied concerns with the crushing of the magnesium tablet.	21545		

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21545	Continued From page 5 Upon interview on 11/21/22, at 1:36 p.m. LPN-A stated she was unable to locate an order to crush any medications for R1 and she had called the pharmacy to initiate an order for an alternative option. Upon interview on 11/21/22, at 1:55 p.m. RN-A reported upon new hire orientation the nurses are trained to check in the Medication Administration Record (MAR) before cutting or crushing any medications. If the MAR does not indicate the medication can be crushed the nurse is to notify the provider and the pharmacy for instructions and/or a new order. Upon interview on 11/22/22, at 3:29 p.m. the director of nursing (DON) stated before nursing staff is able to crush a medication, they must notify the provider and get an order for the medication to be crushed, dissolved, or cut. A facility policy titled Administration of Medication, dated 1/1/15 indicated medications must be administered timely and in accordance with the prescribers' orders. A facility policy about crushing medications was requested, however none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21545		