Electronically Delivered
February 10, 2022

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: December 15, 2021

Dear Administrator:

On February 3, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 22, 2021

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

RE: CCN: 245625
Cycle Start Date: December 15, 2021

Dear Administrator:

On December 15, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 15, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 15, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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 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
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST 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 12/15/21, 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 complaint was found to be SUBSTANTIATED: H5625031C (MN79219), with deficiencies issued at F600 and F609. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		1/21/22

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

Electronically Signed | 01/02/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R1) reviewed for abuse. Findings include: On 12/10/21, at 1:19 p.m. the facility report to the State Agency (SA) indicated on 12/9/21, at an unidentified time, registered nurse (RN)-A wrote a note stating she went to check on a concerning sound with R1. RN-A found a nursing assistant (NA)-A handling R1 in a rough manner and felt it was inappropriate. R1's Diagnosis List printed on 12/15/21, indicated R1 had a diagnosis of Alzheimer's disease, delusional disorders, hallucinations, and delirium. R1's Minimum Data Set (MDS) dated 10/4/21, indicated R1 was severely cognitively impaired, and demonstrated physical behaviors towards others nearly daily. R1's Care Plan dated 1/13/21, indicated R1 had difficulty with communication, and had impaired cognitive function related to Alzheimer's with dementia and behaviors. R1's care plan indicated she was dependent on staff for transfers with the EZ Stand, and had behaviors of lashing out at staff during cares and being resistive to cares. The care plan directed staff to explain what they	F 600	Administrator has reviewed Vulnerable Adult Prevention of Resident Abuse Policy. Policy has been updated to reflect immediate reporting of non-therapeutic behavior and added definition or suggested behaviors that may qualify as non-therapeutic behavior. Policy now reads that employees should not use their judgement when determining when to report something to VA designee. Instead, all reports of non-therapeutic behavior must be reported regardless of the employees judgement on the level of intent used when providing a care. Facility will educate staff on facility specific Vulnerable Adult Prevention of Resident Abuse Policy. Education will include a general overview of abuse prevention, what to report, how to report, and timeliness of reporting, and who to report too. Education will be documented on paper and through our online learning management system. Policy has already been updated and education has been provided to those directly involved in this investigation. Since all elders residing in the building are vulnerable adults, this policy change applies to all elders and all staff in all potential situations. As a result, further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 2 were doing, and give R1 time to process. On 12/9/21, at 8:00 p.m. RN-A wrote a handwritten note to the director of nursing (DON) and administrator. The note indicated on that day, she was working on floor 6 when she heard strange high pitched shouting coming from R1's room. RN-A went into the room and found nursing assistant (NA)-A and NA-C trying to transfer R1. RN-A documented R1 was in her wheelchair (w/c) and NA-C was in front of R1 behind the EZ Stand (mechanical stand lift). NA-A was behind R1 trying to place a transfer sling behind her. NA-A had her hands on the back of R1's neck, and was trying to push R1's head forward "very hard." R1 was shouting and resisting. RN-A told NA-A to stop the action, not hold any patient by the neck, and it was inappropriate to hold and push a person "in such a manner." RN-A documented she attempted to demonstrate a correct transfer to NA-A, but NA-A argued with RN-A claiming she was right. NA-A refused to accept correction to learn how to properly transfer residents, and RN-A took over the transfer at that point. NA-C confessed to RN-A that NA-A has been rough with residents in the past. RN-A assessed R1 for pain, checked her neck and the area around her neck for injuries, and determined R1 had no injuries. R1's vital signs were taken, and were within normal limits. RN-A documented she had offered R1 Tylenol. The evening supervisor was notified. On 12/13/21, an email to the administrator from SW-A indicated she had interviewed residents, who were unidentified. Some residents had told her NA-A could be difficult to work with, one resident said she was rude, mostly to residents who needed assistance with eating, and some	F 600	education will be provided to all staff with the update of the policy. Revision of the policy, education, and training will be complete by 1/21/2022. Ongoing updated training on this policy and abuse prevention will be provided through annual orientation, online learning management system, new employee orientation, and in our annual skills fair, as well as in other ad hoc trainings throughout the year as necessary. Audits of knowledge will be completed on a regular basis and documented on paper and via our online management system to ensure competency with the new policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 3	F 600		

reported NA-A was rough with cares.

On 12/15/21, at 10:48 a.m. NA-A was interviewed. NA-A stated on 12/9/21, she approached R1 to provide bedtime cares and transfer her to her bed. NA-A stated R1 was yelling and screaming, which were behaviors R1 had, and staff must work through to get her cares done. NA-A stated she was trying to get the EZ Stand sling behind R1 when RN-A entered the room. NA-A stated RN-A didn't say anything to her about providing rough cares. NA-A stated she did not feel she was rough with R1. NA-A stated she was told by RN-A to stay out of R1's room and not provide cares for her for the rest of the night. NA-A stated the following morning she was notified she was under investigation for abuse.

On 12/15/21, at 11:53 a.m. RN-A was interviewed. RN-A stated on 12/9/21, she heard noises coming from R1's room. RN-A stated NA-A and NA-C were in the room attempting to put a sling behind R1's back to transfer R1 using an EZ Stand lift. RN-A stated NA-A appeared frustrated. RN-A stated NA-A was behind R1 trying to push her forward "very very hard" by grabbing her on the back of the neck. RN-A told NA-A that wasn't a good spot to push someone as it could injure them. RN-A stated she asked NA-A to stop immediately, and attempted to educate NA-A how to put the sling behind R1's back. RN-A stated at that point, NA-A became upset and walked away from RN-A, ignoring the education. RN-A stated she told NA-A not to provide any further cares for R1 for the remainder of the shift. RN-A stated she had concerns what she witnessed may have caused R1 pain, and gave R1 Tylenol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 4	F 600		

On 12/15/21, at 12:33 p.m. NA-C was interviewed. NA-C stated on 12/9/21, she was assisting NA-A with a transfer to get R1 into bed. NA-C stated NA-A was trying to get R1 to move her head and back forward in her w/c to put the EZ Stand lift sling behind her for the transfer. NA-C stated NA-A had her hand gripped around the back of R1's neck, and was squeezing and pushing her as far forward as she was able to without giving any support to R1's back. NA-C stated R1 was yelling, screaming, and pushing back against NA-A hand. NA-C stated she was concerned with how rough NA-A was being with R1, and had concerns NA-A could have been hurting R1. NA-C stated RN-A entered the room during the transfer and witnessed the rough cares as well. NA-C stated RN-A intervened and tried to show NA-A how to properly place the transfer sling, but NA-A was unreceptive and became angry. NA-C stated she heard RN-A tell NA-A not to provide any further cares to R1 that night and to stay out of her room. NA-C stated she witnessed NA-A go back into R1's room at least two more times, but was unsure if NA-A provided any cares while in the room. NA-C stated she has had multiple concerns with NA-A and how rough her cares with residents were, and stated she had reported her concerns to nursing management just two days prior.

On 12/15/21, at 1:17 p.m. social worker (SW)-A was interviewed. SW-A stated the administrator called her to tell her RN-A wrote a note to him and put it in his office. The administrator had asked her to review it. SW-A stated she read the note and consulted with with the clinical manager (CM)-A. SW-A stated CM-A felt like it was rough cares for sure, but was unsure if it was abuse. SW-A stated she had heard of reports of NA-A's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 5	F 600		

rough care towards residents, and concerns of how she talks to residents.

On 12/15/21, at 1:28 p.m. CM-A was interviewed. CM-A stated he found out about the incident the following morning when he found the note RN-A had left on his desk. CM-A stated he spoke to the administrator who wanted him to review the note to see if it rose to the level of abuse. CM-A stated based on what RN-A wrote in the note, he felt it needed to be reported. CM-A spoke to RN-A who told him NA-A needed more training on how to work with residents. CM-A stated NA-A was not receptive to RN-A's education during the incident, which he viewed as a problem. CM-A stated he re-educated NA-A on her approach with residents, the EZ Stand transfers, and accepting constructive criticism.

On 12/15/21, at 2:03 p.m. family member (FM)-A was interviewed. FM-A stated some of the nursing assistants do not always know how to interact with resident's with dementia. FM-A stated she has had concerns about rough cares with R1.

On 12/15/21, at 2:51 p.m. the administrator was interviewed. The administrator stated during the incident, R1 was agitated but not quite yelling, she was resistive to cares. The administrator stated NA-A pushed R1 on the upper back closer to the neck. The administrator stated R1 had dementia and may have yelled out because she could not see NA-A. The administrator stated RN-A thought it was not an appropriate transfer, but did not think it was abusive. The administrator stated he did not feel NA-A was abusive to R1, but rather used a poor approach. The administrator stated both RN-A and NA-C felt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 600	Continued From page 6 there was no intent of abuse, but rather NA-A's approach. The administrator stated some concerns had come up in the past with NA-A and her communication with residents which had been addressed. The administrator stated there were concerns with the level of care provided by NA-A, but not to the level of her being removed from the floor. The facility's Right to Be Free from Maltreatment policy dated 10/27/16, directed the definition of abuse is any non-therapeutic conduct that produces or could reasonably be expected to produce physical pain or injury and is not accidental, or any repeated conduct that produces mental or emotional distress. The facility's Vulnerable Adult Prevention of Resident Abuse Policy dated 11/1/16, defined preventing resident abuse is a primary concern. The policy further directed assess residents with signs and symptoms of behavioral problems, develop and implement care plans that can assist in resolving behavioral issues.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		1/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 609	Continued From page 7 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the state agency (SA) for 1 of 3 residents (R1) reviewed for abuse. Findings include: On 12/10/21, at 1:19 p.m. a facility report to the SA indicated on 12/9/21, at an unidentified time, registered nurse (RN)-A wrote a note stating she went to check on a concerning sound with R1. RN-A found a nursing assistant (NA)-A handling R1 in a rough manner and felt it was inappropriate. R1's Diagnosis List printed on 12/15/21, indicated R1 had a diagnosis of Alzheimer's disease, delusional disorders, hallucinations, and delirium.	F 609	Administrator has reviewed Vulnerable Adult Prevention of Resident Abuse Policy. Policy has been updated to reflect immediate reporting of non-therapeutic behavior and added definition or suggested behaviors that may qualify as non-therapeutic behavior. Policy now reads that employees should not use their judgement when determining when to report something to VA designee. Instead, all reports of non-therapeutic behavior must be reported regardless of the employees judgement on the level of intent used when providing a care. Facility will educate staff on facility specific Vulnerable Adult Prevention of Resident Abuse Policy. Education will include a general overview of abuse prevention, what to report, how to report,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 609	Continued From page 8 R1's Minimum Data Set (MDS) dated 10/4/21, indicated R1 was severely cognitively impaired, and demonstrated physical behaviors towards others nearly daily. R1's Care Plan dated 1/13/21, indicated R1 had difficulty with communication, and had impaired cognitive function related to Alzheimer's with dementia and behaviors. R1's care plan indicated she was dependent on staff for transfers with the EZ Stand, and had behaviors of lashing out at staff during cares and being resistive to cares. The care plan directed staff to explain what they were doing, and give R1 time to process. On 12/9/21, at 8:00 p.m. RN-A wrote a handwritten note to the director of nursing (DON) and administrator. The note indicated on that day, she was working on floor 6 when she heard strange high pitched shouting coming from R1's room. RN-A went into the room and found nursing assistant (NA)-A and NA-C trying to transfer R1. RN-A documented R1 was in her wheelchair (w/c) and NA-C was in front of R1 behind the EZ Stand (mechanical stand lift). NA-A was behind R1 trying to place a transfer sling behind her. NA-A had her hands on the back of R1's neck, and was trying to push R1's head forward "very hard." R1 was shouting and resisting. RN-A told NA-A to stop the action, and to not hold any patient by the neck, and it was inappropriate to hold and push a person "in such a manner." RN-A documented she attempted to demonstrate a correct transfer to NA-A, but NA-A argued with RN-A claiming she was right. NA-A refused to accept correction to learn how to properly transfer residents, and RN-A took over the transfer at that point. NA-C confessed to RN-A that NA-A has been rough with residents in the past. RN-A assessed R1 for	F 609	and timeliness of reporting, and who to report too. Education will be documented on paper and through our online learning management system. Policy has already been updated and education has been provided to those directly involved in this investigation. Since all elders residing in the building are vulnerable adults, this policy change applies to all elders and all staff in all potential situations. As a result, further education will be provided to all staff with the update of the policy. Revision of the policy, education, and training will be complete by 1/21/2022. Ongoing updated training on this policy and abuse prevention will be provided through annual orientation, online learning management system, new employee orientation, and in our annual skills fair, as well as in other ad hoc trainings throughout the year as necessary. Audits of knowledge will be completed on a regular basis and documented on paper and via our online management system to ensure competency with the new policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 609	Continued From page 9	F 609		

pain, checked her neck and the area around her neck for injuries, and determined R1 had no injuries. R1's vital signs were taken, and were within normal limits. RN-A documented she had offered R1 Tylenol. The evening supervisor was notified.

On 12/15/21, at 11:53 a.m. RN-A was interviewed. RN-A stated on 12/9/21, she heard noises coming from R1's room. RN-A stated NA-A and NA-C were in the room attempting put a sling behind R1's back to transfer R1 using an EZ Stand lift (mechanical stand assist). RN-A stated NA-A appeared frustrated. RN-A stated NA-A was behind R1 trying to push her forward "very very hard," by grabbing her on the back of the neck. RN-A told NA-A that wasn't a good spot to push someone as it could injure them. RN-A stated she asked NA-A to stop immediately, and attempted to educate NA-A how to put the sling behind R1's back. RN-A stated at that point, NA-A became upset and walked away from RN-A ignoring the education. RN-A stated she told NA-A not to provide any further cares for R1 for the remainder of the shift. RN-A stated she had concerns what she witnessed may have caused R1 pain, and gave R1 Tylenol. RN-A stated they had 24 hours to report abuse to the SA, and knew it could be handled the following day. RN-A stated she did inform her supervisor within an hour after the incident.

On 12/15/21 at 2:51 p.m. administrator was interviewed and verified the alleged abuse was not reported timely.

The facility Reporting and Investigation Procedure policy dated 11/19/19, directed the SA was to be notified immediately, which is not to exceed two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	**1860 UNIVERSITY AVENUE WEST 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 609	Continued From page 10 hours, for any potential abuse or neglect.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2021

Administrator
Episcopal Church Home Gardens
1860 University Avenue West
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: EG8611

Dear Administrator:

The above facility was surveyed on December 15, 2021 through December 15, 2021 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
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
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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 12/15/21, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5625031C (MN79219), with a licensing order issued at 625.557 Subd 3 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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	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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	21980		1/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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
21980	Continued From page 3 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the state agency (SA) for 1 of 3 residents (R1) reviewed for abuse. Findings include: On 12/10/21, at 1:19 p.m. a facility report to the SA indicated on 12/9/21, at an unidentified time, registered nurse (RN)-A wrote a note stating she went to check on a concerning sound with R1. RN-A found a nursing assistant (NA)-A handling R1 in a rough manner and felt it was inappropriate. R1's Diagnosis List printed on 12/15/21, indicated R1 had a diagnosis of Alzheimer's disease,	21980	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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
21980	Continued From page 4 delusional disorders, hallucinations, and delirium. R1's Minimum Data Set (MDS) dated 10/4/21, indicated R1 was severely cognitively impaired, and demonstrated physical behaviors towards others nearly daily. R1's Care Plan dated 1/13/21, indicated R1 had difficulty with communication, and had impaired cognitive function related to Alzheimer's with dementia and behaviors. R1's care plan indicated she was dependent on staff for transfers with the EZ Stand, and had behaviors of lashing out at staff during cares and being resistive to cares. The care plan directed staff to explain what they were doing, and give R1 time to process. On 12/9/21, at 8:00 p.m. RN-A wrote a handwritten note to the director of nursing (DON) and administrator. The note indicated on that day, she was working on floor 6 when she heard strange high pitched shouting coming from R1's room. RN-A went into the room and found nursing assistant (NA)-A and NA-C trying to transfer R1. RN-A documented R1 was in her wheelchair (w/c) and NA-C was in front of R1 behind the EZ Stand (mechanical stand lift). NA-A was behind R1 trying to place a transfer sling behind her. NA-A had her hands on the back of R1's neck, and was trying to push R1's head forward "very hard." R1 was shouting and resisting. RN-A told NA-A to stop the action, and to not hold any patient by the neck, and it was inappropriate to hold and push a person "in such a manner." RN-A documented she attempted to demonstrate a correct transfer to NA-A, but NA-A argued with RN-A claiming she was right. NA-A refused to accept correction to learn how to properly transfer residents, and RN-A took over the transfer at that point. NA-C confessed to RN-A that NA-A has been rough	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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
21980	Continued From page 5	21980		

with residents in the past. RN-A assessed R1 for pain, checked her neck and the area around her neck for injuries, and determined R1 had no injuries. R1's vital signs were taken, and were within normal limits. RN-A documented she had offered R1 Tylenol. The evening supervisor was notified.

On 12/15/21, at 11:53 a.m. RN-A was interviewed. RN-A stated on 12/9/21, she heard noises coming from R1's room. RN-A stated NA-A and NA-C were in the room attempting put a sling behind R1's back to transfer R1 using an EZ Stand lift (mechanical stand assist). RN-A stated NA-A appeared frustrated. RN-A stated NA-A was behind R1 trying to push her forward "very very hard," by grabbing her on the back of the neck. RN-A told NA-A that wasn't a good spot to push someone as it could injure them. RN-A stated she asked NA-A to stop immediately, and attempted to educate NA-A how to put the sling behind R1's back. RN-A stated at that point, NA-A became upset and walked away from RN-A ignoring the education. RN-A stated she told NA-A not to provide any further cares for R1 for the remainder of the shift. RN-A stated she had concerns what she witnessed may have caused R1 pain, and gave R1 Tylenol. RN-A stated they had 24 hours to report abuse to the SA, and knew it could be handled the following day. RN-A stated she did inform her supervisor within an hour after the incident.

On 12/15/21 at 2:51 p.m. administrator was interviewed and verified the alleged abuse was not reported timely.

The facility Reporting and Investigation Procedure policy dated 11/19/19, directed the SA was to be notified immediately, which is not to exceed two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME GARDENS	1860 UNIVERSITY AVENUE WEST 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
21980	Continued From page 6 hours, for any potential abuse or neglect. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures regarding abuse and a regular maintenance schedule. The administrator or designee could educate all appropriate staff on the policies and procedures for reporting abuse. The administrator or designee could develop a mock reporting drill to audit staff understanding of recoginizing abuse. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		