Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

Administrator
EPISCOPAL CHURCH HOME THE GARDENS
1860 UNIVERSITY AVENUE WEST
SAINT PAUL, MN 55104

RE: CCN: 245625
Cycle Start Date: March 26, 2025

Dear Administrator:

On May 22, 2025, we notified you a remedy was imposed. On August 6, 2025 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 July 18, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 26, 2025 be discontinued as of July 18, 2025.

In our letter of May 22, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 26, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location 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

August 20, 2025

Administrator
EPISCOPAL CHURCH HOME THE GARDENS
1860 UNIVERSITY AVENUE WEST
SAINT PAUL, MN 55104

Re: Reinspection Results
Event ID: WUL512

Dear Administrator:

On June 10, 2025 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 survey completed on March 26, 2025. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2025

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

RE: CCN: 245625
Cycle Start Date: March 26, 2025

Dear Administrator:

On March 26, 2025, a survey was completed at your facility by the Minnesota Department of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 June 26, 2025 (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 September 26, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html**

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
	245625	A. BUILDING _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE 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 3/19/25, 3/20/25, 3/25/25, and 3/26/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H56251405C (MN111497) and H56251406C (MN111580), with a deficiency cited at F684 and F657. 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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		6/2/25

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

Electronically Signed | 04/21/2025

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

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F 657	Continued From page 1 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R2) who were reviewed for falls. Findings include: R2's face sheet dated 3/27/25, identified diagnosis of Parkinson's disease, dementia, and kidney disease. R2's quarterly Minimum Data Set (MDS) dated 2/12/25, identified moderate cognitive impairment, maximum assistance for bed mobility, dependent for transfers, and two or more falls since admission without injury. R2's fall focus care plan dated 11/13/24, identified at risk for falls. Goal of will not sustain serious injury. Interventions added as followed: -11/13/24 to place call light within reach and encourage to use it	F 657	Plan of correction for residents cited with this survey: R2□s care plan and care sheets will be reviewed and updated to reflect current fall interventions. Plan to address/prevent this deficiency for other residents: Facility will review and update individualized care plans when changes occur and quarterly with MDS schedule. Interventions will be updated on care plan and will be communicated via care sheets. Plan to prevent recurrence: Education with clinical staff/clinical nurse leaders on updating care plans and sheets related to fall interventions will be completed. Plan to monitor: Audits of residents□ fall care plan and sheet interventions will be completed 2x weekly for 4x weeks.	

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F 657	Continued From page 2 -12/11/24 ensure R2's phone is close to her bed where can be easily reached. -12/23/24 R2 sometimes wakes up confused and agitated, she will scream and attempt to get out of bed on her own, staff to provided reassurance and redirection until calmed. -12/26/24 R2 sometimes wakes up confused and attempts to climb out of bed, staff to inquire about toileting needs and assist to bathroom when necessary. -3/24/25 staff to avoid having R2 in living room -3/21/25 staff to sit with resident for five to ten minutes when restless and provide reassurance such as "I am here to help, you are safe, it is okay, how can I help you." Review of R2's nursing assistant care sheets on 3/26/25 identified fall risk and interventions: place call light within reach, mobility bar in place, phone kept at bedside, staff to sit with R2 for ten-15 minutes when restless and avoid having R2 in living room. R2's incident report dated 12/21/25 at 2:06 a.m., identified R2 was found on floor in her room. New intervention for staff to provide reassurance and redirection until calmed. R2's care plan revised on 12/23/24 to provider reassurance until calmed. R2's incident report dated 1/2/25 at 4:46 a.m., identified R2 was found sitting on floor in her room. New intervention of frequent visual checks. R2's care plan did not identify intervention of frequent visual checks. R2's incident report dated 1/18/25 at 3:00 a.m., identified R2 was found lying on floor in room near bed. New intervention to check on every	F 657	Results of findings will be documented and reviewed with IDT and monitored at the facility QA meeting. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing or designee	

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F 657	Continued From page 3 hour when awake and ask if she needs help. R2's care plan did not identify every hour checks. R2's incident report dated 1/24/25 at 7:33 a.m., identified R2 was found on floor near her bed. New intervention of staff to increase safety checks. R2's care plan did not identify safety checks. R2's incident report dated 2/16/25 at 10:30 a.m., identified R2 was found on floor on knees on side of bed. New intervention of staff to provide reassurance to R2 every shift. During an interview on 3/26/25 at 1:39 p.m., nursing assistant (NA)-C stated they do frequent checks for R2, but were not instructed on a specific timeframe on how often to check on her. NA-C stated staff did not document in R2's chart when they checked on her. During an observation and interview on 3/26/25 at 1:38 p.m., R2 was lying in bed with her call light within reach, bed in lowest position and a fall mat placed on the floor on the right side of her bed. NA-D stated R2 was high risk for falls, and they had been placing a fall mat next to her bed to protect her if she fell, however, NA-D verified the fall mat had not been added to the nursing assistant care sheet. NA-D stated if unfamiliar staff were working with R2 and were not aware of the fall mat, they could forget to place it on the floor. Review of R2's care plan on 3/26/25 did not identify fall mat to be placed next to bed. During an interview on 3/26/25 at 1:55 p.m., licensed practical nurse (LPN)-B stated R2's care	F 657		

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F 657	Continued From page 4 plan did not identify any safety checks or fall mat and stated, "It should have been added." During an interview on 3/26/25 at 3:08 p.m., director of nursing (DON) stated her expectation would be for any new fall intervention to be added to the care plan in a timely manner to reduce future falls. On 3/26/25 requested facility's care planning policy and did not receive.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor a skin tear (a traumatic wound that occurs when the top layer of skin separates from the underlying layers) for 1 of 1 resident (R3) reviewed for injury of unknown origin. Findings include: R3's face sheet dated 3/26/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should),	F 684	Plan of Correction for resident cited: R3s care plan will be reviewed to ensure appropriate monitoring of the skin tear. R3s orders will be reviewed to ensure appropriate care can be given to the skin tear. Plan to address/prevent this deficiency for other residents: Facility Skin Care Policy will be reviewed, updated, and distributed as necessary. Facility will review other residents with skin concerns to ensure skin assessments are complete and	6/2/25

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F 684	Continued From page 5 chronic obstructive pulmonary disease (a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs). R3's care plan dated 1/22/25, identified R3 had actual impairment to skin integrity related to a healing skin tear on right upper arm. No other areas of skin impairment were identified. R3's admission nursing assessment dated 2/3/25, identified skin tear on right forearm measuring 3.2 centimeters (cm) x 1.2 cm. and included the skin tears need attention. R3's physician orders dated 2/4/25 to 2/20/25, identified an order for right arm skin tears (location of the skin injuries on the arm was not specifically identified): cleanse with normal saline. Apply skin sealant to intact periwound skin, let dry. Cover with non-adherent dressing and secure with roll gauze, tubular stockinet. Until resolved or new treatment. Review of the corresponding treatment administration record (TAR) indicated there were no treatments completed to R3's right arm between 2/21/25 to 3/26/25. R3's weekly skin body audit dated 2/23/25, identified bruising on right and left arm, however, did not have any measurements, description of bruise, or an open area on right forearm. R3's weekly skin body audit dated 3/9/25, identified bruising on left arm, however, did not have any measurements, descriptions, or an	F 684	timely, appropriate interventions are put in place, and changes are reflected on the care plan. The care plan will be revised as necessary. Measures put in place to prevent recurrence: Education will be completed with clinical staff on updated policy and the need to ensure weekly skin checks are completed. Plan to monitor: Audits of skin body audits will be completed 2x weekly for 4x weeks. Results will be summarized and reported to the facility QA committee. Audits will continue as needed until the committee determines the plan of correction is successful. Responsible for maintaining compliance: Director of Nursing or designee.	

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F 684	Continued From page 6 open area on right forearm. R3's skin body audit dated 3/25/25 at 9:02 p.m., identified a resolving open area on right forearm measuring 2.0 centimeters (cm) x 1.0 cm x 0.1 cm. During an interview on 3/25/25 at 5:14 p.m. nursing assistant (NA)-A stated the wound on R3's right forearm has been present since she came back from hospital, and it did not appear to be getting any smaller. During an interview on 3/25/25 at 5:16 p.m., NA-B stated R3's wound on her right forearm has been present since a return from the hospital in February and the nurses are not doing a treatment to the area. During an observation and interview on 3/25/25 at 2:49 p.m., R3 was seated in her wheelchair and had an open area on her right lower arm. Open area was oblong in shape, approximately 2.0 cm x 2.0 cm., base of wound was covered with slight yellow material, appeared dry, and did not have a dressing on the wound. R3 stated that wound had been there for a while, and stated she was not getting a treatment to the wound. Licensed practical nurse (LPN)-C entered R3's room and identified the wound did not have a physician ordered treatment order or nursing directive to monitor the wound. During an observation and interview on 3/25/25 at 3:08 p.m., LPN-B identified R3 had 2.0 cm x 1.0 cm x 0.1 cm wound on her right forearm. LPN-B described the wound as a non-healing skin tear with rolled edges and a slightly reddened center. R3 did not have a current order for	F 684		

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F 684	Continued From page 7 treatment/monitoring for the wound. R3 only had an order for treatment of the skin tear on her right forearm after a re-admission on 2/3/25 from the hospital and it was discontinued on 2/20/25. LPN-B indicated according to the record there was not a comprehensive assessment related to the right forearm wound and the record did not include a reason why the treatment was stopped. LPN stated R3 had weekly skin check done on 2/3/25 upon re-admission, however, after that the skin checks were not being done consistently. The next skin check that was completed was not until 2/23/25, which did not identify the open area on the right forearm. A skin check did not get completed again until 2/23/25, and did not identify open area on right forearm. LPN-B stated all skin tears should have a weekly assessment to determine if they are healing. During an interview on 3/25/25 at 5:00 p.m., director of nursing (DON) stated her expectation would be for weekly skin assessments to be completed for all residents, and any new skin concern the nurses should report to the physician and have a treatment put in place until healed. Review of the facility's Skin Care Policy dated 1/2015, identified expected outcomes: -Assessment of potential skin problems are completed upon admission, on a routine basis, and as needed. -The healing of pressure injuries or other skin conditions that are present is promoted (including prevention of infection to the extend possible). -Prevention of the development of additional pressure ulcers or other skin problems is promoted.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: WUL511

Dear Administrator:

The above facility was surveyed on March 19, 2025 through March 26, 2025 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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
	30004	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE 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 3/19/25, 3/20/25, 3/25/25, and 3/26/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H56251405C (MN111497) and H56251406C (MN111580) with a licensing order issued at 0570 and 0875. 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R2) who were reviewed for falls. Findings include: R2's face sheet dated 3/27/25, identified diagnosis of Parkinson's disease, dementia, and kidney disease.	2 570	Corrected	4/21/25

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2 570	Continued From page 3 R2's quarterly Minimum Data Set (MDS) dated 2/12/25, identified moderate cognitive impairment, maximum assistance for bed mobility, dependent for transfers, and two or more falls since admission without injury. R2's fall focus care plan dated 11/13/24, identified at risk for falls. Goal of will not sustain serious injury. Interventions added as followed: -11/13/24 to place call light within reach and encourage to use it -12/11/24 ensure R2's phone is close to her bed where can be easily reached. -12/23/24 R2 sometimes wakes up confused and agitated, she will scream and attempt to get out of bed on her own, staff to provided reassurance and redirection until calmed. -12/26/24 R2 sometimes wakes up confused and attempts to climb out of bed, staff to inquire about toileting needs and assist to bathroom when necessary. -3/24/25 staff to avoid having R2 in living room -3/21/25 staff to sit with resident for five to ten minutes when restless and provide reassurance such as "I am here to help, you are safe, it is okay, how can I help you." Review of R2's nursing assistant care sheets on 3/26/25 identified fall risk and interventions: place call light within reach, mobility bar in place, phone kept at bedside, staff to sit with R2 for ten-15 minutes when restless and avoid having R2 in living room. R2's incident report dated 12/21/25 at 2:06 a.m., identified R2 was found on floor in her room. New intervention for staff to provide reassurance and redirection until calmed. R2's care plan revised on 12/23/24 to provider reassurance until calmed.	2 570		

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2 570	Continued From page 4 R2's incident report dated 1/2/25 at 4:46 a.m., identified R2 was found sitting on floor in her room. New intervention of frequent visual checks. R2's care plan did not identify intervention of frequent visual checks. R2's incident report dated 1/18/25 at 3:00 a.m., identified R2 was found lying on floor in room near bed. New intervention to check on every hour when awake and ask if she needs help. R2's care plan did not identify every hour checks. R2's incident report dated 1/24/25 at 7:33 a.m., identified R2 was found on floor near her bed. New intervention of staff to increase safety checks. R2's care plan did not identify safety checks. R2's incident report dated 2/16/25 at 10:30 a.m., identified R2 was found on floor on knees on side of bed. New intervention of staff to provide reassurance to R2 every shift. During an interview on 3/26/25 at 1:39 p.m., nursing assistant (NA)-C stated they do frequent checks for R2, but were not instructed on a specific timeframe on how often to check on her. NA-C stated staff did not document in R2's chart when they checked on her. During an observation and interview on 3/26/25 at 1:38 p.m., R2 was lying in bed with her call light within reach, bed in lowest position and a fall mat placed on the floor on the right side of her bed. NA-D stated R2 was high risk for falls, and they had been placing a fall mat next to her bed to protect her if she fell, however, NA-D verified the fall mat had not been added to the nursing assistant care sheet. NA-D stated if unfamiliar	2 570		

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2 570	Continued From page 5 staff were working with R2 and were not aware of the fall mat, they could forget to place it on the floor. Review of R2's care plan on 3/26/25 did not identify fall mat to be placed next to bed. During an interview on 3/26/25 at 1:55 p.m., licensed practical nurse (LPN)-B stated R2's care plan did not identify any safety checks or fall mat and stated, "It should have been added." During an interview on 3/26/25 at 3:08 p.m., director of nursing (DON) stated her expectation would be for any new fall intervention to be added to the care plan in a timely manner to reduce future falls. On 3/26/25 requested facility's care planning policy and did not receive. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and	2 875		4/21/25

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2 875	Continued From page 6 proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor a skin tear (a traumatic wound that occurs when the top layer of skin separates from the underlying layers) for 1 of 1 resident (R3) reviewed for injury of unknown origin. Findings include: R3's face sheet dated 3/26/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), chronic obstructive pulmonary disease (a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs). R3's care plan dated 1/22/25, identified R3 had actual impairment to skin integrity related to a healing skin tear on right upper arm. No other areas of skin impairment were identified. R3's admission nursing assessment dated 2/3/25, identified skin tear on right forearm measuring 3.2 centimeters (cm) x 1.2 cm. and included the skin tears need attention.	2 875	Corrected	

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2 875	Continued From page 7 R3's physician orders dated 2/4/25 to 2/20/25, identified an order for right arm skin tears (location of the skin injuries on the arm was not specifically identified): cleanse with normal saline. Apply skin sealant to intact periwound skin, let dry. Cover with non-adherent dressing and secure with roll gauze, tubular stockinet. Until resolved or new treatment. Review of the corresponding treatment administration record (TAR) indicated there were no treatments completed to R3's right arm between 2/21/25 to 3/26/25. R3's weekly skin body audit dated 2/23/25, identified bruising on right and left arm, however, did not have any measurements, description of bruise, or an open area on right forearm. R3's weekly skin body audit dated 3/9/25, identified bruising on left arm, however, did not have any measurements, descriptions, or an open area on right forearm. R3's skin body audit dated 3/25/25 at 9:02 p.m., identified a resolving open area on right forearm measuring 2.0 centimeters (cm) x 1.0 cm x 0.1 cm. During an interview on 3/25/25 at 5:14 p.m. nursing assistant (NA)-A stated the wound on R3's right forearm has been present since she came back from hospital, and it did not appear to be getting any smaller. During an interview on 3/25/25 at 5:16 p.m., NA-B stated R3's wound on her right forearm has been present since a return from the hospital in February and the nurses are not doing a treatment to the area.	2 875		

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2 875	Continued From page 8 During an observation and interview on 3/25/25 at 2:49 p.m., R3 was seated in her wheelchair and had an open area on her right lower arm. Open area was oblong in shape, approximately 2.0 cm x 2.0 cm., base of wound was covered with slight yellow material, appeared dry, and did not have a dressing on the wound. R3 stated that wound had been there for a while, and stated she was not getting a treatment to the wound. Licensed practical nurse (LPN)-C entered R3's room and identified the wound did not have a physician ordered treatment order or nursing directive to monitor the wound. During an observation and interview on 3/25/25 at 3:08 p.m., LPN-B identified R3 had 2.0 cm x 1.0 cm x 0.1 cm wound on her right forearm. LPN-B described the wound as a non-healing skin tear with rolled edges and a slightly reddened center. R3 did not have a current order for treatment/monitoring for the wound. R3 only had an order for treatment of the skin tear on her right forearm after a re-admission on 2/3/25 from the hospital and it was discontinued on 2/20/25. LPN-B indicated according to the record there was not a comprehensive assessment related to the right forearm wound and the record did not include a reason why the treatment was stopped. LPN stated R3 had weekly skin check done on 2/3/25 upon re-admission, however, after that the skin checks were not being done consistently. The next skin check that was completed was not until 2/23/25, which did not identify the open area on the right forearm. A skin check did not get completed again until 2/23/25, and did not identify open area on right forearm. LPN-B stated all skin tears should have a weekly assessment to determine if they are healing.	2 875		

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2 875	Continued From page 9 During an interview on 3/25/25 at 5:00 p.m., director of nursing (DON) stated her expectation would be for weekly skin assessments to be completed for all residents, and any new skin concern the nurses should report to the physician and have a treatment put in place until healed. Review of the facility's Skin Care Policy dated 1/2015, identified expected outcomes: -Assessment of potential skin problems are completed upon admission, on a routine basis, and as needed. -The healing of pressure injuries or other skin conditions that are present is promoted (including prevention of infection to the extend possible). -Prevention of the development of additional pressure ulcers or other skin problems is promoted. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		