Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 20, 2025

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

RE: CCN: 245625

Cycle Start Date: August 18, 2025

Dear Administrator:

On November 6, 2025, 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.

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 26, 2025

Administrator
EPISCOPAL CHURCH HOME THE GARDENS

1860 UNIVERSITY AVENUE WEST
SAINT PAUL, MN 55104

RE: CCN:245625

Cycle Start Date: August 18, 2025

Dear Administrator:

On August 18, 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 November 18, 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 February 18, 2026 (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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE GARDENS	1860 UNIVERSITY AVENUE WEST , SAINT PAUL, Minnesota, 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
F0000	INITIAL COMMENTS On 8/14/25 & 8/18/25, 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. H56252101C / 2586591 with a deficiencies issued at F550, F689, F760 Deficient practice was identified related to incidental finding at F700, F849, F909 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.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550	1. Corrective action for those residents was found to have been affected by the deficient practice: R1, R2, and R3 were immediately re-educated on their rights to be assisted in the bathroom upon their requests. R1, R2, and R3 will be assessed to determine their current toileting needs and preferences which will be reflected in the residents' care plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility policy on rights residents reviewed and found it to be appropriate. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:	10/03/2025

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 reverse for further 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.

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

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F0550 SS = D	Continued from page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure 3 of 3 residents (R1, R2, and R3) reviewed had a dignified existence when the three residents had been told to use an incontinent brief to toilet rather than staff assisting them to the bathroom. Findings include: Upon observation and interview on 8/14/25 at 8:40 a.m. R1 was struggling to find her call light as it was wrapped around her bed rail and hanging to a floor. A voice from her camera saw the surveyor and asked to assist R1 as she needed to use the bathroom. A nursing assistant could not be found in the hallway, so licensed practical nurse (LPN)-A was asked to come into the room at 8:44 a.m. LPN-A placed her call light within her reach. At 8:45 a.m. R1 pushed her call light. At 8:47 a.m. nursing assistant (NA)-B entered the room, turned off the light and told R1 she would return. At 9:07 NA-B returned with another NA and started morning cares on R1. R1 stated it was common	F0550	Continued from page 1 Re-education will occur with nursing staff on resident rights to dignity, privacy, and choices including assistance to the toilet rather than nursing staff directing to use incontinent product. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will complete random audits of 4 residents per week for 4 weeks, and then monthly for 3 months, to interview residents and ensure their toileting needs are met per their care plan. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance as needed.	

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F0550 SS = D	Continued from page 2 practice for the nursing assistances to turn off her light and tell her they would be back, sometimes they do and sometimes they do not. “They always tell me to just go in my pad.” R1’s care plan dated 3/20/25 indicated for toilet use R1 required the assistance of one staff member for the transfer. Assistance of one staff member with toileting tasks and changing in bed. Staff was to offer and assist R1 with toileting upon rising, before and after meals, before bed and as needed when R1 requested to use the toilet. Use assistance of two staff members as needed related to weakness. R1’s quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1’s Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1’s pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone), chronic kidney disease, pain, and unspecified dementia. An audio and video recording dated 8/17/25 showed R1 waving her hands to an unidentified nursing assistant (NA) who was in her room speaking with a maintenance staff member. R1 was heard saying, “wait I have to pee, I have to pee.” The NA replied, “I’m in another room now, just let loose if you have to pee, you have a brief on.” R1 stated “I already did let loose.” The NA left the room. An email from family member (FM)-A dated 8/18/25 at 12:19 p.m. indicated the video footage had been taken at the end of the day shift on 8/17/25. The NA’s partner had left early leaving the NA by herself. A woman down the hall was on the toilet when the NA was called to assist maintenance with a call light. The NA left R1 to help the other woman. R1 knows now just to go in pants. When R1 did get to the toilet she had explosive diarrhea. The smell was so awful. The mess was awful. FM-A should have taken pictures. FM-A cleaned poop from the side of the toilet and the toilet seat. Upon interview on 8/14/25 at 9:43 FM-A stated she had	F0550		

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F0550 SS = D	Continued from page 3 multiple videos of staff telling R1 to use her incontinent pad instead of taking her to the bathroom. This has been the reason for a lot of her falls, R1 trying to self-transfer to the bathroom and not have to urinate in her pad. R2's quarterly MDS dated 5/21/25 indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively impaired. R2 was totally dependent upon staff for dressing, bathing, toileting, and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs with cognitive functions and awareness. R2's care plan dated 2/27/25 indicated R2's required assistance of two staff members and assistance with the Sara Steady (mechanical lift) for toileting and to have a urinal at bedside. R2's care plan dated 3/19/25 indicated R2 sometimes experienced confusion, weakness, and inability to communicate needs. Staff was to encourage R2 to use his urinal or the bathroom and would provide him reassurance and redirection. Upon interview on 8/14/25 at 4:18 p.m. FM-C stated she could not recall the date, but she overheard an NA telling R2 to urinate in his pad. She reported this to the director of nursing DON and the NA was talked to. FM-C stated she watched the video camera in his room, and she does not see him being offered toileting or his urinal. She witnessed staff changing his pad and at times does not witness staff in his room at all overnight. "They don't honor our request to have him taken to the bathroom." Upon interview on 8/18/25 at 9:40 a.m. R2 stated he did not like to urinate in his pad, but he has no choice. R2 would not elaborate on his statement. Upon observation and interview on 8/18/25 at 11:30 a.m. R3 and family member (FM-D) were in R3's room. R3 was in her recliner. R3 stated she waited for staff often and has had skin breakdown due to waiting in a wet brief, but not currently. She stated she not aware that she had the choice to use the toilet. She asked	F0550		

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F0550 SS = D	Continued from page 4 multiple times during the interview if she could use the bathroom instead of urinating in her brief. FM-D stated he was not certain that R3 could transfer to the toilet as he had not seen her or heard her using the bathroom in months. FM-D stated he would talk to management about having her use the bathroom when she requests. R3's care plan dated 4/16/25 indicated R3's toilet use was an extensive assistance of 1-2 with transferring to the toilet with a gait belt. R3 would state the need for toileting, wears a brief. Usually incontinent of bowel and bladder. Apply moisture barrier with each incontinence or brief change. Report symptoms of constipation to the nurse. R3's quarterly MDS dated 7/21/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3 required maximum assistance with toileting, bathing, dressing, and hygiene and transferring from her bed to a chair. R3's pertinent diagnoses were degenerative disease of the nervous system (progressive decline and death or nerve cells), chronic pain, cerebrovascular disease (disease that affects the blood vessels in the brain), hemiplegia (one side weakness following a stroke) following cerebral infarction and unspecified dementia. Upon interview on 8/18/25 at 2:02 p.m. the DON stated it was not o.k. to tell a resident to urinate or go to the bathroom in their incontinent brief. When the NA's are busy, they need to reach out to the nurses to assist them. Upon interview on 8/18/25 at 3:15 p.m. the Regional Operations Manager (filling in for the Administrator) stated telling residents to urinate in their incontinent brief was not the standard of care the facility endorsed. A facility policy regarding dignity was requested however none was received.	F0550		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	1. Corrective action for those residents was found to have been affected by the deficient practice: R1 and R2 alarms were removed after completing assessments and updated the residents' families. R1 and R2 care plans were updated to reflect adequate	10/03/2025

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F0689 SS = D	Continued from page 5 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate supervision to reduce the risk of accidents for residents 2 of 3 (R1 and R2) reviewed for supervision. The facility did not assess and document the aimed use for the intent of alarms to be used temporarily to assess patterns and routines of the residents. R1 and R2's family requested the alarms following multiple falls and concerns about adequate supervision. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's care plan dated 3/20/25 – 8/18/25 did not indicate any scheduled supervision of staff interventions for R1 including patterns or routines with the use of the position alarm. R1's fall log dated 3/20/25 – 8/18/25 included falls on 4/7/25, 5/13/25, 5/20/25, 5/27/25, 6/6/25, 6/27/25, 6/28/25 and 7/12/25. R1's care plan intervention related to potential for falls dated 5/15/25 indicated R1 forgets she cannot transfer or ambulate without assistance and will often attempt to transfer independently which leads to her falls. Signs placed by her bedside to remind her to use her call light to seek help.	F0689	Continued from page 5 supervision and individualized fall preventions intervention. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility-wide audit will be conducted to identify any residents with alarms. Residents and families will be educated on the facility's policy of maintaining a restraint-free environment, including the use of bed alarms. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility will review and update the Fall Risk Assessment policies and Restraint policy as needed. Nursing staff will be re-educated on fall preventions, interventions, and fall risk/physical device assessments. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will audit R1, R2, and another resident for care plan supervision once a week for 4 weeks, then monthly for 3 months. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance as needed.	

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F0689 SS = D	Continued from page 6 R1's care plan intervention related to potential for falls dated 5/17/25 indicated R1 believed she could crawl from her bed to the bathroom. Each shift reminds R1 to use her all light and to seek help and staff will point to her call light render posted by her bedside until she develops a habit to use her call light. R1's care intervention related to potential for falls dated 6/9/25 indicated R1 was experiencing increase in confusion and inability to remember to use the call light for help. Hospice was to evaluate her medications. R1's care intervention related to potential for falls dated 6/10/25 indicated R1 had the inability to understand her diminished physical mobility and therefor attempts to self-transfer. R1 would be toileted after each meal, at bedtime and upon rising in the morning to prevent her from self-transferring. R1's care intervention related to potential falls dated 6/27/25 indicated R1 was kneeling by her bedside with no call light on. Family reporting observing R1 on camera attempting to turn her television off. Staff will turn off her television at bedtime. R1's care intervention related to potential falls dated 6/30/25 indicated R1 was attempting to pick up her cell phone charger from the floor while in bed, which led to her rolling out of bed and landing on the floor. Staff was to be sure R1's cell phone charger was secured to her bed rail and in a reachable position. R1' care plan dated 7/2/25 indicated R1 had an alternation in mobility and a potential for injury related to a fall risk. Staff was to ensure bed/chair alarm was under R1 and check for alarm placement and function every shift. R1's care plan for potential fall intervention dated 7/14/25 indicated R1 was attempting to self-transfer from to the toilet without seeking support after lunch. Staff was to toilet R1 after each meal to prevent her from attempting to self-transfer.	F0689		

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F0689 SS = D	Continued from page 7 Upon interview on 8/14/25 at 8:40 a.m. R1 stated she was aware that she had the bed alarm, and she did not like it because she felt there was a resistance, and she had to lay still. She stated she did want the alarm because her family wanted her to have it because of so many falls so staff would hear the alarm and would come quickly. Upon interview on 8/14/25 at 9:43 a.m. R1's family member FM-A stated she heard another family at the facility used a bed alarm because they did not feel their family member was being supervised so FM-A decided to get one for R1. She stated it is so awful to watch an elderly family member struggle to get out of bed on their own when they needed something or to use the bathroom. At least if she had the alarm, she would get staffs attention to assist her. R2's fall log dated 2/18/25 – 3/18/25 indicated R2 had falls on 2/18/25, 2/20/25, 2/21/25, 3/5/25, 3/17/25, and 6/2/25. R2's care plan dated 2/27/25 indicated R2 was a fall risk. R2 was to have call light within reach. R2 needed prompt response. R2's family was to be educated about safety reminders and what to do if R2 falls. R2's fall risk care plan intervention dated 3/6/25 indicated R2 sometimes attempted to self-transfer without using his call light, staff was to perform hourly checks and asked elder if he needed help when awake. R2's fall risk care plan intervention dated 3/6/25 indicated staff would check R1's chair/bed alarm placement and function every shift. R2's quarterly MDS dated 5/21/25 indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively impaired. R2 was totally dependent upon staff for dressing, bathing, toileting, and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs with cognitive functions and awareness.	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 8 R2's Physical Device Review Comprehensive dated 5/21/25 indicated R2 had an alarming device. The reason for the device was an alternation in safety awareness due to cognitive impairment, history of falls, difficulty with balance or trunk control and medications that increase the risk of falls. R2's alarm was to indicate to staff when R2 was getting out of bed. The alarm was to help at night when R2 got up unattended for staff to be aware. The device was used for fall prevention. Upon interview on 8/14/15 at 12:00 p.m. nursing assistant (NA)-B stated R2 did not need safety checks because he had an alarm to notify staff of when he moved. Upon interview on 8/14/25 at 4:15 p.m. R2's family member FM-C stated when R2 first moved to the facility in 2/2025 he had fallen and when she watched the video of the fall, she noticed that R2 had been on the floor for hours. She stated the facility took care of that matter and put in hourly safety checks, however when she viewed the video recording, she could still see no staff entering R2's room all night and the checks were not being performed during the day as well. She decided to put in a position change alarm to "babysit" R2. She stated at least she can peace of mind knowing if R2 continued to fall he would be tended to, or it could prevent a fall making staff was aware when he was up. Upon interview on 8/18/25 at 12:35 p.m. the facilities Medical Director was not aware that the facility had bed alarms in place. She stated that during QAPI (Quality Assurance and Performance Improvement) meetings the facility were addressing falls, however the alarms had not been brought up. She stated she understood the concerns of the families, however using an alarm does not absolve the facility from supervising residents. Upon interview on 8/18/25 at 2:02 p.m. the Director of Nursing, (DON) stated the bed alarms were placed due to the requests of the families that the facility does not recommend the alarms. She stated bed alarms can inhibit the residents from moving and she explained that the families. She said the residents get checked on every couple of hours, 2-3 hour at night. The DON was certain the residents were supervised. The facility had not have any audits of the staffing rounds on any of the shifts.	F0689		

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F0689 SS = D	Continued from page 9 Upon interview on 8/18/25 at 3:15 p.m. the Regional Operations Manager (filling in for the Administrator) stated two residents in the facility have positioning alarms. The facility did not offer alarms to families. She stated the families who have them felt like they needed another safety intervention. The facility uses a greenhouse of model, meaning they have private rooms and not a visible nurses station. The facility was starting a PIP (performance improvement plan) on falls and how the checks on residents for safety and if staff is following the care plan and the Kardex. The staff does two hours rounding for safety checks unless a resident does not want to any safety checks. A facility policy titled Fall Risk Assessments dated 4/2022 indicated All residents who are assessed as being at risk for falls will be identified and individualized fall precautions will be developed to decrease the number of falls whenever possible. It is the goal of the facility to achieve the resident's maximum potential of physical functioning, prevent injury, reduce falls, and enhance the resident's self-worth and dignity. Procedure: 1. A Fall Risk Assessment will be completed at a minimum upon admission, quarterly in conjunction with the MDS schedule, upon significant change in status. 2. Identified Fall risks will have appropriate interventions and precautions implemented and communicated to staff. 3. Initiate, review and/or revise the care plan as appropriate. 4. The IDT will, at a minimum of quarterly, review the resident's fall risk and care plan. 5. The resident, responsible party and MD/NP will participate in the development of the plan to reduce falls. 6. A post fall assessments will occur to review contributing factors and prevent recurrence of falls. 7. Falls will be discussed at IDT daily stand up, Safety Committee and Quality Assurance meetings as	F0689		

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F0689 SS = D	Continued from page 10 warranted. 8. Manufacturer’s recommendations will be followed for fall prevention devices as needed.	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication, and mobility for 3 of 3 residents (R1, R2, and R3) reviewed for bed rails. In addition, R2 had side rails used in conjunction with an air mattress. Findings include: Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manu	F0700	1. Corrective action for those residents was found to have been affected by the deficient practice: Bed rails were removed from R1, R2 and R3 and alternatives were put into place. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All bed rails were removed, and facility policy will be followed for any residents deemed as appropriate. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The facility’s bed safety policy was reviewed and revised as needed. Nursing, therapy, and maintenance were re-educated on facility bed safety and restraint policy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will complete audits of any bed rails are in place and appropriate, assessments, risk/benefits, care plan. The facility has 4 residents audited once a week for 4 weeks, then monthly for 3 months.	10/03/2025

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F0700 SS = D	Continued from page 11 al-v11811october2023.pdf indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment. Recommendations for Health Care Providers Using Adult Portable Bed Rails retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm indicated Food and Drug Administration (FDA) guidelines ("Recommendations for Health Care Providers about Bed Rails") 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Recommendations for Health Care Providers Using Adult Portable Bed Rails retrieved from	F0700		

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F0700 SS = D	Continued from page 12 https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails indicated be aware that not all bed rails, mattresses, and bed frames are interchangeable, and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. R1's care plan dated 3/20/25 indicated she had bilateral mobility bars at the head of her bed to enhance her participation in positioning and bed mobility. R1's Physical Device Review Comprehensive dated 6/22/25 indicated R1 had right and left mobility bars, a floor mat, and a low bed. The reason for the use of the devices was R1 was non-ambulatory, her level of consciousness fluctuated, she had poor bed mobility or difficulty moving to a sitting position displayed. The devices would be used whenever R1 wanted to relax in her recliner. Her ability to demonstrate the appropriate use was marked as N/A (non-applicable). The device helped her assist with bed mobility. The device was not considered to be a therapeutic intervention to achieve proper body position, balance, or mobility, but indicated it was used for positioning. The devices were not used for fall prevention. The risks vs. benefits where they enabled R1 to assist with bed mobility and repositioning herself in bed. The summary of device use was side rails would assist with mobility and repositioning while in bed. The recliner chair would be used to help R1 relax. No risk or benefits or any other education was documented as provided to R1 or representative. In addition, R1's medical diagnosis, size and weight, cognition, communication, and mobility were not assessed for the medical device evaluation or if R1 could remove the device on her own indicating the device was not a restraint. R1's quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting,	F0700		

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F0700 SS = D	Continued from page 13 and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's MDS did not indicate the use of bed rails. Upon observation and interview on 8/14/25 at 8:40 a.m. R1 was in her bed trying to call for staff assistance R1's had an extended call light cord wrapped around her half-length bed rail on the upper right side of her bed. R1 was placing her hand in and out of rail trying to untangle the light by herself. R1 had a left half-length bed rail as well, a floor mat, and her bed was in the lowest position. Both bed rails were permanently affixed to her bed. R1 stated she used the bed rails when she attempted to get out of bed on her own and reposition in bed. R2's care plan dated 2/19/25 - 8/18/35 did not indicate the use of bed rails. R2's quarterly MDS dated 5/21/25 indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively impaired. R2 was totally dependent upon staff for dressing, bathing, toileting and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs with cognitive functions and awareness. R2's MDS did not indicate the use of bed rails. R2's Physical Device Review Comprehensive dated 5/21/25 indicated the devices used by R2 were an electric reclining chair and an alarm device. The form did not indicate the bed rails on R2's bed. No risk or benefits or any other education was documented as provided to R2 or representative. In addition, R2's medical diagnosis, size and weight, cognition, communication, and mobility were not assessed for the medical device evaluation or if R2 could remove the device on her own indicating the device was not a restraint. Upon observation and interview on 8/14/25 at 9:39 a.m.	F0700		

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F0700 SS = D	Continued from page 14 R2 was seated in his chair, his bed had an air mattress and was positioned in the lowest level with permanently affixed bilateral half-length bed rails on his bed. R2 stated he did not know what the bed rails on his bed were for. R3's Care plan dated 4/16/25 indicated R3's bed mobility was an extensive assist of one staff member, encourage R3 and assist to use bilateral mobility bars. R3's quarterly MDS dated 7/21/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3 required maximum assistance with toileting, bathing, dressing, and hygiene and transferring from her bed to a chair. R3's pertinent diagnoses were degenerative disease of the nervous system (progressive decline and death or nerve cells), chronic pain, cerebrovascular disease (disease that affects the blood vessels in the brain), hemiplegia (one side weakness following a stroke) following cerebral infarction and unspecified dementia. R3's Physical Device Review Comprehensive dated 7/21/25 indicated the devices used were right and left mobility bars. The reason for the use of the device was R3 was non-ambulatory, she had alteration in safety awareness due to cognitive impairment, history of falls, difficulty with balance and trunk control displayed. R3 was able to demonstrate the ability to use the device appropriately. The device benefited her as it served as a mobility enabler, repositioning tool, and safety. The device was considered to be a therapeutic intervention to achieve proper body positioning, balance and mobility and was used for a mobility enabler and positioning. The devices were not utilized as a fall prevention. The risks versus benefits were described as benefit: siderails are used when getting in and out of bed and for repositioning while in bed. The risk was all devices have the ability to cause injuries when not used properly. The summary of the device used indicated side rails were used when getting in and out of bed, and for repositioning while in bed. R3's medical diagnosis, size and weight, cognition, communication, and mobility were not assessed for the medical device evaluation or if R3 could remove the device on her own indicating the device was not a restraint. In addition, the risk and benefits documented did not include if the resident and or representative was educated. Upon observation and interview on 8/14/25 at 11:18 a.m.	F0700		

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F0700 SS = D	Continued from page 15 R3 was seated in her reclining chair, she had permanently affixed half-length bilateral bed rails on her bed. R3 stated she required the rails for all movement in bed. Upon interview on 8/14/15 at 11:09 a.m. licensed practical nurse (LPN)-A stated the facility assessed bed rails on all the residents on each quarterly assessment. The residents and/or representative is educated on the risks and benefits however the facility did not have a place to document the education. The facility did not try any alternative methods prior to the use of the bed rails and the bed rails are used for safety of the residents while in bed. Upon interview on 8/18/25 at 2:02 p.m. the director of nursing (DON) stated during the survey when surveyor requested bed rail information the facility realized they did not have all the criteria of the bed rail safety policy and removed most of the bed rails from residents except for a select few whose family were onsite and opposed the removal. The facility was going to start the side rails assessments from scratch following the survey. The DON stated the facility did not try alternative methods prior to installing the bed rails, asking what else are you going to use? She stated none of the rails the facility had on the bed were considered restraints because the residents were able to get in and out of bed. Upon interview on 8/18/25 at 3:15 p.m. the regional operations manager (filling in for the Administrator) stated the facility realized during the survey process that the facility was not following through on their process in regard to bed rails and on 8/15/25 removed most of the bed rails from the residents bed until new assessments could be completed. The facility sent an email to all the residents and/or resident representatives. A facility policy titled Bed Safety Policy dated 1/1/18 indicated half-side rails will be used only after an assessment has been made indicating a benefit to the resident's functional status. Continued use of the half-side rail will be reassessed periodically to determine if the side rails enhance the resident's mobility while in bed or restricts the resident's freedom of movement.	F0700		
F0760 SS = D	Residents are Free of Significant Med Errors	F0760	1. Corrective action for those residents was found to	10/03/2025

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F0760 SS = D	Continued from page 16 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure a system to reduce the risk of significant medication errors for transdermal opioid patches for 1 of 3 residents (R1) reviewed for medication administration. R1 was ordered by her hospice agency to have a transdermal opioid patch (narcotic medicated patch that slowly releases the medication into the body) placed on her skin every seven days. On two occasions the nursing staff failed to remove the old patch from her skin when the new patch was placed on her. Findings include: R1's hospice care plan dated 5/28/25 indicated buprenorphine (Butrans) 5 micrograms per hour (mcg/hr.) patch (an opioid patch used to treat opioid use disorder but also used for pain management) was to be applied once every week. Remove old patch prior to new patch application for chronic pain. R1's facility providers order dated 5/29/25 indicated Butrans transdermal patch 5 mcg/hr. Apply 1 patch transdermal one time a day every seven days for pain. The facility's order did not include to remove the old patch. R1's quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's progress notes dated 8/1/25 – 8/18/25 did not	F0760	Continued from page 16 have been affected by the deficient practice: R1's outdated patch was immediately removed, and a new patch was applied with proper signature and date documentation. The Nurse Manager updated the MAR to clearly outline the removal and application schedule. All nursing staff on the unit were re-educated regarding proper patch removal following the two identified instances of failure to remove the old patch. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents with prescribed transdermal patches were assessed to ensure patches were properly removed and accurately documented. Each resident MARs were reviewed for accuracy, and corrections were completed as necessary. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Medication Administration policy was reviewed and revised as necessary. Update med error form to include notifying hospice. Nurses and TMAs were re-educated on the updated policy, administration removal of transdermal patches and the medication error process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will conduct audits on 3 residents with medication patches x1 a week for 4 weeks, then monthly for 3 months. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F0760 SS = D	Continued from page 17 provide any documentation regarding medication error monitoring or follow-up. R1's medication error on 8/1/25 or the error on 8/8/25 including any follow-up assessments. A facility report titled Record of Customer and Family Concern dated 8/1/25 indicated hospice staff reported that they found two pain patches on R1 during her weekly shower. The oldest patch was removed and the newest was left on. R1's vital signs were obtained and were within baseline, staff was to continue to monitor R1, no acute changes noted. The Administrator and the director of nursing (DON) were notified on 8/4/25. The staff member who provided care was interviewed and stated she did not see an old patch and always removed an old patch. The action taken was patch training conducted, staff demonstrate understanding of the patch removal. R1's care plan and treatment administrator were updated. R1's family was notified on 8/4/25. The form did not indicate hospice, or the facilities medical provider were notified to obtain an order for any assessments following the error. A facility report titled Medication Error Report dated 8/11/25 indicated on 8/8/25 R1's family member (FM)-A notified staff that R1 had two pain patches on her, one was dated 7/31/25 and the other was not dated. Both patches were removed, and a new patch was applied. Hospice was updated on 8/11/25 and the staff was to monitor R1. The form did not indicate who was notified at hospice and what the staff was to monitor, in addition hospice was notified three days after the error occurred. There was no documentation of initial interventions to assess R1. A typed form by the facility dated 8/12/25 indicated FM-A was assisting change R1 into her nightgown and found two pain patches on R1's body. The first patch was on the front of R1 and not dated, while the second was dated and placed on her back. FM-A requested both patches to be removed by the nurse based on the instruction of a family member who was a doctor. The form did not indicate any communicate with hospice. The intervention was patch training conducted, staff administrating medications will ensure that the old patch was removed prior to new patch administration. There were no documented interventions for the care of R1 following the error.	F0760		

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F0760 SS = D	Continued from page 18 Upon interview on 8/14/25 at 11:09 a.m. licensed practical nurse (LPN)-A the nurse manager stated R1 did have two patches placed on her body at the same time twice. He stated the first time. R1 had two patches on it was the hospice nursing assistant who notified him. He stated he did monitor R1 following the error on 8/1/25 however he did not document exactly what he monitored. The second time the error happened he was not certain if hospice was notified as he was not onsite that day and he was not certain of the immediate action taken by staff to care for R1. Upon interview on 8/14/25 hospice registered nurse (RN)-A at 12:26 p.m. stated she was not aware of the doubling of the patches on 8/1/25, but was aware of the 8/7/25 incident as FM-A notified her. She stated the facility should have obtained orders to assess R1 and maybe even have the hospice staff make a visit if necessary. Upon interview on 8/14 at 1:01 p.m. R1’s family member (FM)-B stated the facility failed R1 twice. FM-B's spouse was a Medical Doctor, and he told the facility they needed to remove both patches and start a new one. The facility was not able tell FM-B what their system was for a transdermal patch error. FM-B watched on R1’s room camera if the staff checked in and completed vital signs often on R1 following the error and no additional monitoring was noticed. The day after the error R1 was “very emotional” and was calling the family crying, unable to state why she felt so “awful.” Upon interview on 8/18/25 at 8:39 a.m. the hospice Pharmacist stated the medication error caused R1 to receive an unintended increase in dose and how it affected her would be dependent on multiple different areas such as tolerance, how long both patches were on her, other medications. R1 should have been assessed for excess sedation, dizziness, it could have caused hypotension (low blood pressure) she could have had an increase in falls. The Pharmacist stated he would call have two opioid patches on an elderly residents skin at once a significant medication error because of the medication being an opioid and the route of administration, "applying a patch is a significant nursing error as the nurse should ensure there is patch to remove or not.” Upon interview on 8/18/25 at 8:55 a.m. the hospice	F0760		

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F0760 SS = D	Continued from page 19 medical provider stated hospice was not notified of the errors, there was no documentation in R1's hospice notes. R1 should have been assessed for drowsiness, dizziness and respirations can drop. Vital signs are very important following an opioid error. The provider would have ordered vital signs every 30 minutes for the first 4 hours, especially watching the pulse and respirations. This was a significant medication error. Upon interview on 8/18/25 at 12:35 p.m. the facilities medical director stated the patches should have been dated and since one of them was not both patches should have been removed during both error incidents and new patches applied. The prescribed should have been notified with an error of opioids for direction and awareness. Upon interview on 8/18/25 at 1:49 p.m. LPN-B stated she placed a patch on R1 and was re-educated by the facility. She stated she was told she did not remove an old patch on R1. She stated sometimes orders do not come in on time, so she thought maybe R1 did not have a patch on as she did not see one. LPN-B was a new nurse and reported not having training regarding patches and when and if to remove an old patch. She stated the order did not say to remove an old one. Upon interview on 8/18/25 at 2:02 p.m. the director of nursing (DON) stated she was unaware until the survey that R1 had medication error on 8/1/25 and was not certain what notifications were made following the error or how R1 had been monitored. She was aware of the error on 8/7/25 and stated LPN-B followed-up and re-educated the staff about removing an old patch. She stated R1's vital signs were documented following the second error, but no other monitoring was documented as being completed. A facility policy titled Med Error with a revision date of 8/1/21 indicated Policy: Medication Errors must be reported to the Supervisor immediately. Procedure: A medication Incident report must be filled out within 24 hours once the error has been discovered. Information should include the following. 1. Name of Elder 2. Date and time of incident	F0760		

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F0760 SS = D	Continued from page 20 3. Medications involved - give dose and directions for use 4. Route of administration 5. Detailed description of the error 6. Physician notified 7. Treatment given to the elder to counteract the effects of the error -if ordered 8. Measures taken to rectify the error 9. Any adverse consequences noted 10. Elders general condition 11. Name of staff responsible for error 12. Preventative Action All reports must be turned in to the Director of nursing immediately. Each medication/treatment error will also be reviewed by the Medical Director and the Consulting Pharmacist. DON will counsel staff and any disciplinary issues will be dealt with according to facility policy. Education will be provided to the staff if necessary and a copy will be kept.	F0760		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F0849	1. Corrective action for those residents was found to have been affected by the deficient practice: R1's care plan was reviewed and updated to include hospice involvement. The interdisciplinary team designated the DON as the hospice coordinator. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The DON/designee will audit all residents currently receiving hospice services to ensure their plan of care reflects the facility hospice collaboration. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur:	10/03/2025

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F0849 SS = D	Continued from page 21 §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care,	F0849	Continued from page 21 The facility will review and update the Hospice Care policy as needed. The nurse managers will be re-educated on hospice communication expectations and DON's role as the hospice coordinator. The DON will collaborate with hospice, nurse managers, and other healthcare providers to ensure consistent communication between hospice and the facility. Additionally, the facility will contact each hospice provider to confirm that a designated hospice coordinator is identified and documented within the plan of care. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The hospice coordinator will conduct 3 random hospice charts audits for consistent coordination with hospice, once a week for 4 weeks, then monthly for 3 months. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F0849 SS = D	Continued from page 22 meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and	F0849		

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F0849 SS = D	Continued from page 23 coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at	F0849		

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F0849 SS = D	Continued from page 24 §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to establish a communication process between the facility and the hospice provider to ensure that the needs of a resident were addressed and met for 1 of 3 residents (R1) reviewed for hospice services. R1 did not receive the necessary care and services when she had the same medication error occur twice. In addition, the facility failed to have a designated member of the interdisciplinary team who was responsible to work with hospice to ensure residents receiving hospice services needs were met. Findings include: R1's hospice care plan dated 5/28/25 indicated buprenorphine (Butrans) 5 micrograms per hour (mcg/hr.) patch (an opioid patch used to treat opioid use disorder but also used for pain management) was to be applied once every week. Remove old patch prior to new patch application for chronic pain. R1's facility providers order dated 5/29/25 indicated Butrans transdermal patch 5 mcg/hr. Apply 1 patch transdermal (on the skin) one time a day every seven days for pain. R1's quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. A facility report titled Record of Customer and Family Concern dated 8/1/25 indicated hospice staff reported that they found two pain patches on R1 during her weekly shower. The oldest patch was removed and the newest was left on. R1's vital signs were obtained and were within baseline, staff was to continue to monitor the elder, no acute changes noted. The Administrator and the director of nursing (DON) were notified on	F0849		

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F0849 SS = D	Continued from page 25 8/4/25. The staff member who provided care was interviewed and stated she did not see an old patch and always removed an old patch. The action taken was patch training conducted, staff demonstrate understanding of the patch removal. R1's care plan and treatment administrator were updated. R1's family was notified on 8/4/25. The date of the training was 8/13/25 and 8/14/25. The form did not indicate hospice, or the facilities medical provider were notified. A facility report titled Medication Error Report dated 8/11/25 indicated on 8/8/25 R1's family member (FM)-A notified staff that R1 had two pain patches on her, one was dated 7/31/25 and the other was not dated. Both patches were removed, and a new patch was applied. Hospice was updated on 8/11/25 and the staff was to monitor R1. The form did not indicate who was notified at hospice and what the staff was to monitor, in addition hospice was notified three days after the error occurred. A typed form by the facility dated 8/12/25 indicated FM-A was assisting change R1 into her nightgown and found two pain patches on R1's body. The first patch was on the front of R1 and not dated, while the second was dated and placed on her back. FM-A requested both patches to be removed by the nurse based on the instruction of a family member who was a doctor. The form did not indicate any communicate with hospice. The intervention was patch training conducted, staff administrating medications will ensure that the old patch was removed prior to new patch administration. Upon interview on 8/14/25 at 11:09 a.m. licensed practical nurse (LPN)-A the nurse manager stated R1 did have two patches placed on her body at the same time twice. He stated the first time. R1 had two patches on it was the hospice nursing assistant who notified him. He stated since it was the hospice aid was part of the hospice she would report to her leaders. The second time the error happened he was not certain if hospice was notified as he was not onsite that day. LPN-A stated the facility did not have a hospice coordinator to report incidents to. Upon interview on 8/14/25 hospice registered nurse (RN)-A stated she was not aware of the doubling of the patches on 8/1/25, but was aware of the 8/7/25 incident as FM-A notified her. RN-A stated she did not know of a hospice coordinator at the facility, she just spoke	F0849		

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F0849 SS = D	Continued from page 26 with the nurse on each floor of any orders, updates or concerns she had. Upon interview on 8/14/25 at 1:35 p.m. the Administrator in training stated she was not certain if the facility had a hospice coordinator. She stated to ask the DON as she had been at the facility for a long time. Upon interview on 8/14/25 at 1:35 p.m. the DON stated the facility did not have one actual person as the coordinator, it was a team effort. The social worker worked on referrals and admissions and the nurse manager work with the hospice companies once they are onboard. The facilities contract with hospice dated 3/14/22 indicated: Facility Representative: Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice to coordinate care provided by Facility staff and Hospice staff to any Hospice Patient under Hospice's care. Such interdisciplinary team member shall be responsible for the following: (i) collaborating with Hospice and coordinating Facility staff participating in the hospice care planning process for those Hospice Patients who are under Hospice's care; (ii) communicating with Hospice and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Hospice Patient and family; (iii) ensuring that Facility communicates with the Hospice medical director, the Hospice Patient's attending physician, and other practitioners participating in the provision of care to the Hospice Patient as needed to coordinate the hospice care with the medical care provided by other physicians. A facility hospice policy was requested however none was provided.	F0849		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a	F0909	1. Corrective action for those residents was found to have been affected by the deficient practice: The beds, mattresses, and side rails for R1, R2, and R3 were inspected for safety following the facility's bed safety policy and manufacturers guidelines.	10/03/2025

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F0909 SS = D	Continued from page 27 regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 3 of 3 residents (R1, R2, and R3) reviewed. The bed manufacturer guidelines indicated to visually inspect the bed and accessories monthly and indicated to follow the FDA guidance. Findings include: Recommendations for Health Care Providers Using Adult Portable Bed rails dated 2/27/2023 retrieved on 8/14/25 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, when evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone	F0909	Continued from page 27 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Maintenance Supervisor and designees are inspecting all resident beds, mattresses, and side rails, and remove any bed rails found to be out of compliance. For residents approved to retain bed rails, measurements were taken and documented. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The Bed Safety Policy will be reviewed and updated as needed. The TELS systems will be updated to include monthly bed and rail safety inspections by manufacturers. Maintenance staff will be re-educated on proper documentation of inspections and follow-up repairs. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Maintenance Director or designee will review monthly bed inspection reports on TELS for completion and accuracy. Administrator will audit monthly for 4 months to ensure bed inspection audits are completed. Results will be addressed at quarterly QAPI meetings for ongoing monitoring and corrective action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME THE GARDENS	1860 UNIVERSITY AVENUE WEST , SAINT PAUL, Minnesota, 55104

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F0909 SS = D	Continued from page 28 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The manufacture user-service manual for Joerns Assist Device and Side Rails Vari-Care Models, undated, indicated Maintenance/Inspection Information: Visually inspect the assist handle and mounting bracket, and check for loose hardware monthly. Tighten loose hardware as stated in the installation instructions. Warning: Risk of Serious Injury or Death. Properly locate the mounting brackets. The gap between the head/foot panel and the assist device or side rail must be small enough to prevent a resident from getting their head or neck caught in this location (see the installation instructions for more information, if applicable). If multiple assist devices are needed, position them such that the gap between them is large enough that the trunk and hips can easily pass through. Make sure that raising or lowering the bed, or adjusting the sleep surface, does not create hazardous gaps. The assist devices or side rails should not be used if ANY openings within the bed system allow a resident to get their head or neck lodged within these openings. Failure to do so could result in serious injury or death.	F0909		

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F0909 SS = D	Continued from page 29 Warning: An optimal bed system assessment should be conducted for each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration. Further information can be obtained at the following web address: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/default.htm Upon observation and interview on 8/14/25 at 8:40 a.m. R1 was in her bed trying to call for staff assistance R1's had an extended call light cord wrapped around her half-length bed rail on the upper right side of her bed. R1 was placing her hand in and out of rail trying to untangle the light by herself. R1 had a left half-length bed rail as well, a floor mat, and her bed was in the lowest position. Both bed rails were permanently affixed to her bed. R1 stated she used the bed rails when she attempted to get out of bed on her own and reposition in bed. R1's quarterly Minimum Data Set (MDS) dated 6/23/25 indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's MDS did not indicate the use of bed rails. Upon observation and interview on 8/14/25 at 9:39 a.m. R2 was seated in his chair, his bed had an air mattress was in the lowest position with permanently affixed bilateral half-length bed rails on his bed. R2 stated he did not know what the bed rails on his bed were for. R2's quarterly MDS dated 5/21/25 indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively	F0909		

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F0909 SS = D	Continued from page 30 impaired. R2 was totally dependent upon staff for dressing, bathing, toileting, and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs with cognitive functions and awareness. R2's MDS did not indicate the use of bed rails. Upon observation and interview on 8/14/25 at 11:18 a.m. R3 was seated in her reclining chair, she had permanently affixed half-length bilateral bed rails on her bed. R3 stated she required the rails for all movement in bed. R3's quarterly MDS dated 7/21/25 indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3 required maximum assistance with toileting, bathing, dressing, and hygiene and transferring from her bed to a chair. R3's pertinent diagnoses were degenerative disease of the nervous system (progressive decline and death or nerve cells), chronic pain, cerebrovascular disease (disease that affects the blood vessels in the brain), hemiplegia (one side weakness following a stroke) following cerebral infarction and unspecified dementia. On 8/14/25 at 4:35 p.m. an email was sent to the Administrator in training requesting the maintenances department documentation of bed rail safety checks. An email response was received on 8/18/25 at 8:54 a.m. with a logbook page dated 8/15/25 with documentation of four residents on the fourth floor. The heading was "bed" and the form indicating zone 1, zone 2, zones 3 and 4 zone "pass" was checked after each zone. No other information was documented regarding the rails. Upon interview on 9:50 a.m. the maintenance director stated the maintenance department adds the rails to the beds upon nursing requests. The rails are stored in safe storage and them for safety when they are installed. The nurses notify maintenance of any concerns once the rails are on the beds. No other monitoring was completed by maintenance. Upon interview on 8/18/25 at 2:02 p.m. the director of nursing (DON) stated during the survey when surveyor requested side rail information the facility realized they did not have all the criteria of the side rail	F0909		

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F0909 SS = D	Continued from page 31 safety policy in place and that included any audits from the maintenance department. Upon interview on 8/18/25 at 3:15 p.m. the regional operations manager (filling in for the Administrator) stated the facility realized during the survey process that the facility was not following through on their process regarding side rails. In addition, there was not documentation of audits from the maintenance department. She stated the TELS system (the software system that notifies maintenance of tasks to complete) did not have the side rail safety inspector turned on to notify the staff. A facility policy titled Bed Safety Policy dated 1/1/18 indicated Maintenance monitors all bed rails for gaps between the mattress and bed rail, checks the mechanics of each side rail. Repair or replacement of the side rail is completed by the Maintenance department. Maintenance and/or the Health Unit Coordinator, or other designee, will replace any mattress with large gaps between the mattress and side rail.	F0909		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 26, 2025

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

Re: Event ID: 1D3F80-H1

Dear Administrator:

The above facility survey was completed on August 18, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/18/2025**

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20000	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 8/14/25 & 8/18/25 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H56252101C / 2586591	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		