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

Electronically delivered

May 22, 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 April 11, 2025, we informed you that we may impose enforcement remedies.

On May 19, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be 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.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 26, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 26, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 26, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Episcopal Church Home The Gardens will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 26, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 22, 2025

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

Re: Event ID: F68011

Dear Administrator:

The above facility survey was completed on May 19, 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 05/19/2025

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 5/16/25 - 5/19/25 , 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 complaints were reviewed. H56253727C / MN112609 with a deficiency issued at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		6/27/25

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

Electronically Signed | 05/30/2025

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 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an allegation of abuse was reported immediately to the state agency and administrator of the facility, but not later than two hours after the allegation is made for 1 of 3 residents (R1) reviewed for abuse. R1 reported to multiple staff members the care she received was rough causing pain, staff yelled at her, and a staff member heard another staff member yelling at R1. Findings include: The facilities grievance log dated 1/1/25 - 5/16/25 did not indicate any grievances about R1. R1's re-admission Minimum Data Set (MDS) dated 4/10/25 indicated R1's Brief Inventory of Mental Status (BIMS) score indicated a 99 meaning unable to complete. R1 was dependent upon staff for toileting hygiene, bathing, lower	F 609	1. Corrective action for those residents was found to have been affected by the deficient practice: The allegation of abuse reported by Resident R1 was investigated by the facility upon discovery of the concern. The allegations were found to be unsubstantiated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Staff will review the grievance log from the last 30 days to identify any other residents with concerns about staff behavior or care practices that may not have been reported properly. Any issues not reported appropriately will be addressed, if applicable. 3. What measures will be put into place,	

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F 609	Continued From page 2 body dressing, and moving from a lying to a sitting position on the side of her bed. R1's pertinent diagnoses were hypovolemia (deficiency of volume of blood in the body), cirrhosis of the liver (scar tissue in the liver), unspecified dementia, unspecified severity without behaviors/psychosis/anxiety and an unspecified personality disorder. Upon interview on 5/16/25 at 1:58 p.m. R1 stated staff was always rough with her when repositioning her. A couple of weeks ago a nursing assistant (NA)-F entered her room "the one who always yells at me," and was yelling at R1 telling her she had to go to bed and have her incontinence pad changed. Then NA-G came in to assist the NA-F and they jerked her around like she was a "rag doll." This caused pain for the next days. R1 reported the incident to other staff members who she trusted. R1 stated she remembers incidents but does not recall the dates. She had lost the ability to write down dates and times because she was compromised on the right side of her body. Upon interview on 5/16/26 at 2:20 p.m. NA-A stated a few weeks ago she heard a serious confrontation of yelling between NA-B and R1. NA-A walked away from the situation as she did not want to get involved because she had a recent confrontation with NA-B as well. NA-A reported the yelling to licensed practical nurse (LPN)-A the nurse manager. NA-A referred to the yelling as verbal abuse and stated she did what she was supposed to and reported to the nurse manager. Upon interview on 5/16/25 at 2:45 p.m. NA-C stated R1 had aggressive behaviors because she	F 609	or systemic changes made, to ensure that the deficient practice will not recur: The facility's abuse reporting policy and NHA notification policy will be reviewed to clarify expectations for all staff levels. Re-education will occur with staff on the abuse prevention policy and NHA notification policy, including mandatory reporting timelines (within 2 hours for abuse/serious injury and within 24 hours for all other incidents). 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator will conduct random staff interviews (audits) 2x week for 4 weeks to assess staff knowledge of abuse reporting requirements and ensure concerns are being escalated appropriately. Results of audits and training will be reviewed at the facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure continued compliance and adjust interventions as needed.	

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F 609	Continued From page 3 would yell at staff, she had never heard staff yell back at R1. R1 told NA-C that a NA-F yelled at her. NA-C did not report the yelling allegations because she did not hear it firsthand. R1 always complained of rough cares and the nurses knew about R1's rough care concerns because R1 complained of rough cares to the nurses when they were assisting R1 with the nursing assistance. Upon interview on 5/16/25 an anonymous staff member stated R1 reported to them that the evening staff was rough with her, and she did not feel safe. R1 had cognitive deficits, so she is not the most accurate historian for reporting the dates. R1 did have the ability to accurately report occurrences and when negative occurrences happened at the facility and R1 tended to have more behaviors to defend herself. R1 told the staff member that two staff members were so forceful with her that she was frightened and felt pain for several days. R1 described one staff member who always yelled at her. The anonymous staff member stated they were aware that allegations of abuse are to be reported to the state agency within two hours. The staff member did report the allegations to the state agency in two hours but was not reporting on behalf of the facility. The staff member did not report the allegations to the facility because there had been "enough instances" where the facility had not investigated allegations, reported to the state agency, or taken any action. The staff member felt education about cares needed to be articulated to the staff and a level of trust needed to be displayed by the management team. Upon interview on 5/19/25 at 8:45 a.m. NA-D stated R1 told her that there is a huge difference	F 609		

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F 609	Continued From page 4 between day and night shifts. The night shift performs their cares rough and argue with R1. NA-D did not hear any staff arguing with R1. She stated she reported to LPN-A R1 had complained of rough cares. NA-D stated nobody had followed-up with her after she reported the rough cares. Upon interview on 5/19/25 at 9:03 a.m. NA-E stated R1 mentioned that NA-F had yelled at her a few weeks ago, but he disregarded it because R1 was always yelling at staff herself and always complaining. Upon interview on 5/19/25 at 10:02 a.m. trained medication assistant (TMA)-A stated R1 had gotten angry at all staff. R1 complains of rough cares, but nothing specific is mentioned. TMA-A stated she reported rough cares to the supervisor multiple time over the past months. Upon interview on 5/19/25 at 10:15 a.m. LPN-A, nursing manager stated no staff member reported any specific concerns regarding R1. She stated she heard rumors that someone had pushed R1 over too hard. She did not investigate the rumors. She recalled NA-A had a complaint about NA-B yelling but could not recall the details. Upon interview on 5/29/25 at 1:07 p.m. the administrator stated her expectation would be for staff to report yelling and rough cares to their immediate supervisor and that supervisor to report any abuse allegations to the director of nursing or administrator. A facility policy titled Reporting and Investigation Procedure dated 11/15/23 indicated any employee, family member, volunteer or resident	F 609		

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F 609	Continued From page 5 who suspects that an incident of maltreatment has occurred shall immediately report such incident to either the nurse on the station where the alleged incident occurred or to the employee/volunteer's immediate supervisor. NOTE: (NHA Notification Policy for immediate reporting requirement to facility administrator). Anyone who has reason to suspect that an incident of abuse or neglect has occurred has the right to make a report to the Office of Facility Health Complaints at the MDH. Incidents that must be reported to immediately to MDH: -Mistreatment -Neglect -Abuse - Inclusive of Resident-to-Resident Abuse and Self Abusive Behavior -Sexual Abuse -Injuries of an unknown source	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 05/19/2025

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

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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 5/16/25 - 5/19/25, 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	2 000		

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

Electronically Signed | 05/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Continued From page 1 the survey. H56253727C / MN112609 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.	2 000		