Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 9, 2024

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

RE: CCN: 245625
Cycle Start Date: March 4, 2024

Dear Administrator:

On April 3, 2024, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 9, 2024

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

Re: Reinspection Results
Event ID: MCKN12

Dear Administrator:

On April 3, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 4, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2024

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

RE: CCN: 245625
Cycle Start Date: March 4, 2024

Dear Administrator:

On March 4, 2024, 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, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
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 June 4, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 4, 2024 (six months after

the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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
March 14, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: MCKN11

Dear Administrator:

The above facility was surveyed on February 29, 2024 through March 4, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. BUILDING _____ B. WING _____	C 03/04/2024

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 2/29/24, 3/1/24, and 3/4/24, 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. H56251324C (MN00100550) and H56259136C (MN00100215) The following complaints were reviewed. H56259852C (MN00096352) with a deficiency issued at F656. 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		3/29/24

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

Electronically Signed | 03/21/2024

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 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 656	F656 Develop/Implement Comprehensive	

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

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F 656	Continued From page 2 failed to develop a care plan for one of one resident (R3) reviewed for care plans when interventions were not put into the care plan following a care conference that led to a fall. Findings include: R3 was admitted to the facility on 6/13/22 with a primary diagnosis of dementia. Additional diagnoses included osteoarthritis, abnormalities of gait and mobility, pain, muscle weakness, morbid obesity, difficulty walking, reduced mobility, Alzheimer's Disease, fecal urgency, urinary incontinence, and incontinence of feces. R3's care plan dated 9/13/22 indicated R3 was at high risk for falls related to cognitive impairment, difficulty remembering to use walker, and incontinence. Interventions placed included making sure the call light is within reach, encourage the use of her call light for assistance, and evaluate and treat pain as needed. R3's Fall Risk Evaluation dated 6/2/23 indicated R3 had a history of falls. The evaluation indicated R3's predisposing fall risks included balance issues, decline in functional status, impaired balance, needed to rock body to push off chairs to stand, gait problems, required assistance to use restroom, impaired vision with correct lenses, fear of falling, a decline in decision making skills, anxiety, behaviors, and impaired judgment. The evaluation indicated R3 was at risk for falls due to behavioral issues, physical limitation, and improper balance at times. R3's incident note dated 6/29/2023 indicated R3 used her recliner remote control putting the recliner in the highest position and slid out of the	F 656	Care Plan Plan of correction for residents cited with this survey: On 8/23/23 care plan and care sheets were reviewed and updated to reflect current fall interventions. CNA's on that unit were educated on R3's fall interventions, care plan/care sheet changes, rounding during NOC shift, checked and changed per individualized plan of care. Plan to address/prevent this deficiency for other residents: Facilities policy on care planning reviewed and remains current. Facility will continue to update individualized care plans with changes to reflect current needs and at minimum quarterly with MDS schedule. Direct care staff will be alerted to care plan changes. Education with nurse managers on updating care plans with be completed. Plan to monitor: Audits will be completed of all residents fall care plan and interventions during the MDS assessment period to ensure that interventions remain appropriate and are followed by the staff. Results of findings will be documented and reviewed with IDT and monitored at the facility QA meeting. Responsible for maintaining compliance: Director of Nursing or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 3 chair at approximately 7:15 a.m. R3 put on her call light for assistance, staff responded and found R3 lying on the floor. R3 required the assistance of emergency services to assist with transferring R3 from the floor. R3 had a skin tear on her left lower leg from the fall. R3 was taken to the hospital for evaluation, returning the same day with no additional concerns. R3's care conference note dated 7/12/23 indicated there was a discussion regarding the recliner remote control and it was okay to put it on the ground, making it inaccessible, so R3 does not fall. R3's care plan was not updated to reflect the fall intervention from the care conference on 7/12/23. R3's Fall Incident report dated 8/23/23 at 7:05 a.m. indicated R3 was found lying face down but more on her left side. The report indicated R3 was "toying" with her recliner remote control and the recliner was raised to a very high position. The report indicated R3 had a bruise to the left side of her face and hand and was taken to the hospital. The report noted R3 usually slept in her recliner. R3 was last observed in her recliner was at approximately 6:00 a.m. R3's progress note dated 8/23/23 indicated staff received a call from the hospice service provider that R3 would be admitted to their services. The note indicated the hospice staff stated R3 did not have a fracture per FM-A. The note indicated staff checked the recliner connections and the recliner remote did not appear to be working. The note indicated staff called FM-A and discussed the use of the bed, the recliner not working, and changes to the care plan. The note indicated staff	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 4 would provide frequent visual checks on the evening shift, and every one hour visual/safety checks. R3's care plan interventions dated 8/23/23 instructed staff to ensure recliner remote was out of sight once R3 was in the recliner. The intervention instructed staff to ensure call light was within reach, and the family consented to the intervention. The intervention instructed staff to provide safety checks approximately every one hour and to document the times in R3's room. R3's hospital recorded dated 8/23/23 indicated R3 was transported to the emergency department due to a fall. The hospital records indicated R3 had some injuries to the wrist with the use of a temporary splint and given the potential discomfort to R3 with her lymphedema ad goals of care this was decided against. During the hospital visit, R3 was found to have low oxygen levels which was determined to be caused by atypical pneumonia, with discussion of antibiotics and admission to the hospital but decided against this given R3's goal of care. The hospital records indicated R3 was set up with palliative care at the facility. R3 was transferred back to the facility from the hospital. During an interview with the hospice clinical director (HCD) on 2/29/24 at 1:24 p.m., the HCD stated R3 was admitted to hospice on 8/24/23 with a primary diagnosis of acute respiratory failure with hypoxia. HCD stated she saw in her admission assessment that she had a fall with no fractures, and she had pneumonia. During an interview with FM-A on 2/29/24 at 2:18 p.m., FM-A stated she received a call around 7:00	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 5 a.m. on 8/23/23 from the facility stating that R3 had fallen, and the paramedics had been called. FM-A stated the hospital thought R3 may have had congestive heart failure due to edema and recommended hospitalization, but FM-A had declined the hospitalization due to R3's age. FM-A stated the hospital then gave her a referral for palliative care. FM-A stated the family was already talking about putting R3 on hospice before the fall. FM-A stated if R3 had not fallen on 8/23/23 she would not have died on 9/9/23. FM-A stated when herself and the facility staff met for a care conference, they had talked about R3 not having access to the remote on her recliner and someone had forgotten to put that intervention in her care plan. FM-A stated R3 should not have had access to the remote that was connected to the recliner in her room. During an interview with the DON on 3/1/24 at 1:04 p.m., the DON stated R3 fell on 8/23/23. The DON stated R3 was found to have utilized the remote on her recliner to get it in an upright position. The DON stated the remote was supposed to be out of reach from R3 per a care conference. The DON stated R3 had slept in her recliner and did not utilize her bed. The DON stated that R3's fall from 8/23/23 was avoidable because R3's care plan was not followed. Surveyor asked facility for a policy and procedure on the use of electric recliners in the facility and none was provided.	F 656		

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 03/04/2024

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 2/29/24, 3/1/24, and 3/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of	2 000		

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

Electronically Signed | 03/21/24

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 03/04/2024

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

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. H56251324C (MN00100550) and H56259136C (MN00100215) The following complaints were reviewed. H56259852C (MN00096352) with a licensing order issued at 0656. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30004	A. BUILDING: _____ B. WING _____	C 03/04/2024

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to develop a care plan for one of one resident (R3) reviewed for care plans when interventions were not put into the care plan following a care conference that led to a fall. Findings include: R3 was admitted to the facility on 6/13/22 with a primary diagnosis of dementia. Additional diagnoses included osteoarthritis, abnormalities of gait and mobility, pain, muscle weakness, morbid obesity, difficulty walking, reduced mobility, Alzheimer's Disease, fecal urgency,	2 565	Corrected	3/29/24

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2 565	Continued From page 3 urinary incontinence, and incontinence of feces. R3's care plan dated 9/13/22 indicated R3 was at high risk for falls related to cognitive impairment, difficulty remembering to use walker, and incontinence. Interventions placed included making sure the call light is within reach, encourage the use of her call light for assistance, and evaluate and treat pain as needed. R3's Fall Risk Evaluation dated 6/2/23 indicated R3 had a history of falls. The evaluation indicated R3's predisposing fall risks included balance issues, decline in functional status, impaired balance, needed to rock body to push off chairs to stand, gait problems, required assistance to use restroom, impaired vision with correct lenses, fear of falling, a decline in decision making skills, anxiety, behaviors, and impaired judgment. The evaluation indicated R3 was at risk for falls due to behavioral issues, physical limitation, and improper balance at times. R3's incident note dated 6/29/2023 indicated R3 used her recliner remote control putting the recliner in the highest position and slid out of the chair at approximately 7:15 a.m. R3 put on her call light for assistance, staff responded and found R3 lying on the floor. R3 required the assistance of emergency services to assist with transferring R3 from the floor. R3 had a skin tear on her left lower leg from the fall. R3 was taken to the hospital for evaluation, returning the same day with no additional concerns. R3's care conference note dated 7/12/23 indicated there was a discussion regarding the recliner remote control and it was okay to put it on the ground, making it inaccessible, so R3 does not fall.	2 565		

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2 565	Continued From page 4 R3's care plan was not updated to reflect the fall intervention from the care conference on 7/12/23. R3's Fall Incident report dated 8/23/23 at 7:05 a.m. indicated R3 was found lying face down but more on her left side. The report indicated R3 was "toying" with her recliner remote control and the recliner was raised to a very high position. The report indicated R3 had a bruise to the left side of her face and hand and was taken to the hospital. The report noted R3 usually slept in her recliner. R3 was last observed in her recliner was at approximately 6:00 a.m. R3's progress note dated 8/23/23 indicated staff received a call from the hospice service provider that R3 would be admitted to their services. The note indicated the hospice staff stated R3 did not have a fracture per FM-A. The note indicated staff checked the recliner connections and the recliner remote did not appear to be working. The note indicated staff called FM-A and discussed the use of the bed, the recliner not working, and changes to the care plan. The note indicated staff would provide frequent visual checks on the evening shift, and every one hour visual/safety checks. R3's care plan interventions dated 8/23/23 instructed staff to ensure recliner remote was out of sight once R3 was in the recliner. The intervention instructed staff to ensure call light was within reach, and the family consented to the intervention. The intervention instructed staff to provide safety checks approximately every one hour and to document the times in R3's room. R3's hospital recorded dated 8/23/23 indicated R3 was transported to the emergency department	2 565		

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2 565	Continued From page 5 due to a fall. The hospital records indicated R3 had some injuries to the wrist with the use of a temporary splint and given the potential discomfort to R3 with her lymphedema ad goals of care this was decided against. During the hospital visit, R3 was found to have low oxygen levels which was determined to be caused by atypical pneumonia, with discussion of antibiotics and admission to the hospital but decided against this given R3's goal of care. The hospital records indicated R3 was set up with palliative care at the facility. R3 was transferred back to the facility from the hospital. During an interview with the hospice clinical director (HCD) on 2/29/24 at 1:24 p.m., the HCD stated R3 was admitted to hospice on 8/24/23 with a primary diagnosis of acute respiratory failure with hypoxia. HCD stated she saw in her admission assessment that she had a fall with no fractures, and she had pneumonia. During an interview with FM-A on 2/29/24 at 2:18 p.m., FM-A stated she received a call around 7:00 a.m. on 8/23/23 from the facility stating that R3 had fallen, and the paramedics had been called. FM-A stated the hospital thought R3 may have had congestive heart failure due to edema and recommended hospitalization, but FM-A had declined the hospitalization due to R3's age. FM-A stated the hospital then gave her a referral for palliative care. FM-A stated the family was already talking about putting R3 on hospice before the fall. FM-A stated if R3 had not fallen on 8/23/23 she would not have died on 9/9/23. FM-A stated when herself and the facility staff met for a care conference, they had talked about R3 not having access to the remote on her recliner and someone had forgotten to put that intervention in	2 565		

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2 565	Continued From page 6 her care plan. FM-A stated R3 should not have had access to the remote that was connected to the recliner in her room. During an interview with the DON on 3/1/24 at 1:04 p.m., the DON stated R3 fell on 8/23/23. The DON stated R3 was found to have utilized the remote on her recliner to get it in an upright position. The DON stated the remote was supposed to be out of reach from R3 per a care conference. The DON stated R3 had slept in her recliner and did not utilize her bed. The DON stated that R3's fall from 8/23/23 was avoidable because R3's care plan was not followed. Surveyor asked facility for a policy and procedure on the use of electric recliners in the facility and none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		