

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Episcopal Church Home of Minnesota		STREET ADDRESS, CITY, STATE, ZIP CODE 1879 Feronia Avenue Saint Paul, MN 55104	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to monitor and assess for presence of signs/symptoms of urinary tract infections and for antibiotic effectiveness and/or adverse reactions for 2 of 3 residents (R1, R2) reviewed for change of condition. Findings include R1's discharge Minimum Data Set (MDS) dated [DATE] indicated impaired cognition, with diagnoses included lumbar (lower back) vertebra fracture and encephalopathy (confusion). R1 was frequently incontinent of bowel and bladder and needed assistance of 1 person with activities of daily living. R1's health status notes dated 9/5/25 indicated an order was obtained for a urinalysis with culture (UA/UC) but R1's family member (FM-A) did not want to wait for the facility to complete the order. FM-A had R1 tested at an outside medical facility. R1 returned with a diagnosis of UTI with an order for oral antibiotic medication. In review of R1's record there it was not evident R1 was monitored and/or evaluated for presence of/increase in/or decrease of urinary tract infection symptoms aside from vital signs such as increased incontinence, retention, burning during and/or after urination, presence of foul odors, discoloration, frequency, and urgency. Additionally, there was also no consistent documentation for monitoring the side effects of the antibiotic. R1's skilled charting note dated 9/6/25 indicated R1 started taking an antibiotic for UTI. R1's skilled charting note dated 9/7/25 indicated R1 was taking antibiotics for UTI. Vital signs were within R1's baseline. R1's skilled charting note dated 9/8/25 did not address urinary or antibiotic status. R1's provider notes dated 9/8/25 indicated an abnormal urinalysis with empiric (treatment when a healthcare provider suspects an infection but lacks complete information) treatment with oral antibiotic. R1 had reported to provider a little burning with urination. R2's care area assessments (CAA) dated 12/19/24 indicated R2 had triggered for a urinary incontinence CAA and indicated urinary incontinence would be addressed in the care plan. R2's quarterly MDS dated [DATE] indicated intact cognition with diagnoses included congestive heart failure and depression. R2 was continent of bowel and frequently incontinent of bladder. R2's care plan dated 9/17/25 did not include a bowel/bladder focus that addressed the incontinence. R2's health status notes dated 9/17/25 indicated an order was received for a UA/UC. The test was completed and R2 was diagnosed with a UTI and given an order for oral antibiotics for 5 days (through 9/22/25). The notes do not indicate what UTI symptoms R2 was displaying. R2's health status note dated 9/17/25 at 9:50 p.m., indicated R2 had received her first dose of antibiotic but lacked information regarding signs or symptoms of UTI or reaction to oral antibiotic. In review of R1's record between 9/17/25 through 9/22/25 it was not evident R1 was monitored and/or evaluated for presence of/increase in/or decrease of urinary tract infection symptoms aside from vital signs such as increased incontinence, retention, burning during and/or after urination, presence of foul odors, discoloration, frequency, and urgency. Additionally, there was also no consistent documentation for monitoring the side effects of the antibiotic. It could not be ascertained if R1's urinary symptoms had resolved and/or if the antibiotic was effective after the 5 day antibiotic course. R2's health status note dated 10/1/25 indicated R2 had been experiencing feelings of burning on urination and increased urinary frequency. A UA/UC order was obtained and the test completed. R2's EMR did not include health status notes on 10/2/25. R2's health status note dated 10/3/25 indicated R3 had started an antibiotic for UTI. R2's EMR lacked health status notes on 10/4/25, 10/5/25, 10/6/25 and 10/7/25. R2's health status note dated 10/8/25 indicated R2 had felt unwell that morning and had an unusual for her incontinent episode of loose stool. During an interview on 10/10/25 licensed practical nurse (LPN)-A stated after a resident has been diagnosed with a UTI a health status note should be written every shift with vital signs and whether or not the resident is experiencing any UTI symptoms. If the resident is on an antibiotic, the note should include any reaction to the antibiotic. Some possible side effects of an antibiotic include stomachache, diarrhea and not feeling well. During an interview on 10/10/25 at 12:04 p.m., registered nurse (RN)-A stated after a resident has been diagnosed with a UTI a nurse's note should be written every shift with the resident's vital signs, UTI symptoms the resident was experiencing, any adverse side effects from the antibiotic, and a resident's intake and output. During an interview on 10/10/25 at 12:34 p.m., RN-B stated after a resident has been diagnosed with a UTI, they should be monitored for improvement of UTI symptoms, vital signs, and anything else the provider ordered. Improvement in symptoms or reaction to antibiotic would be difficult to determine without looking at previous health status notes. RN-B confirmed there was no information regarding R2's signs or symptoms of UTI or reaction to oral antibiotic. During an interview on 10/10/25 at 12:53 p.m., RN-C stated when requesting an order for a UA/UC, the nurse should</p>		