STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to promote dignity while providing care for 3 of 4 residents (R1, R2, R3) reviewed who required assistance with activities of daily living. Findings include: R1R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, and required supervision or partial assistance to move from a seated to lying position. R1's Record of Customer and Family Concern form dated 10/6/25, completed by social worker (SW)-A indicated family member (FM)-A reported a conversation she overhead between R1 and nursing assistant (NA)-B, in which NA-B stated to R1, What in the hell are you doing? You can't be sitting like that. To FM-A, it sounded like NA-B was repositioning R1 in bed and FM-A overheard R1 say to NA-B, Get your hands off of me, and it sounded like R1 was being man-handled by NA-B. The form further indicated R1 was interviewed by SW-A, and stated he got into a yelling match with NA-B, and NA-B threw R1's legs against the wall. R1 requested not to work with NA-B again.During an interview on 12/15/25 at 10:46 a.m., FM-A stated she filed a complaint with the facility weeks prior about NA-B. R1 set his phone down without hanging up. FM-A heard staff enter the room, staff asked what R1 was doing, and stated, Get your ass to bed. Then FM-A heard a crash. FM-A stated R1 told her staff spun him around in bed and hit R1's legs on the wall. FM-A yelled at NA-B through the phone and told NA-B to get his hands off R1 and leave the room. FM-A stated she knew R1 was not happy at the facility. During an interview on 12/17/25 at 10:58 a.m., the administrator stated R1's allegation was that staff was going too fast with him. If a resident was upset with their interaction with staff, it was a customer service issue. R2R2's quarterly MDS dated [DATE], indicated moderate cognitive impairment, and use of a wheelchair for mobility. R2's care plan dated 7/23/25, indicated a self-care deficit for ADLs related to limited mobility, impaired balance, and weakness. R2 required assistance of one staff for toileting, transfers, was at risk of pressure injury related to incontinence, and encouraged call light use to request assistance.R2's Record of Customer and Family Concern Form dated 11/3/25, indicated SW-A, director of nursing (DON), and administrator were notified by FM-B on 11/3/25 at 12:04 p.m., by email regarding the incident on 11/1/25 around 8:00 p.m. FM-B stated she was on the phone with R2, and overheard a conversation between NA-A and R2 in response to R2's request for an incontinence brief change. NA-A told R2, staff no longer toilet residents on demand, and R2 needed to wait for rounds to be changed. The NA-A said, I told you the consequences, get in the chair. NA-A then transferred R2 to her wheelchair. R2 asked NA-A for her phone and NA-A told R2, she would not need her phone where she [R2] was going. NA-A wheeled R2 out of the room. FM-A called the facility and learned R2 was sitting by the nurses' station.R2's progress note dated 11/1/25 at 10:25 p.m., indicated R2 had a miscommunication with the caregiver when the caregiver was providing care. R2 was soaking wet in bed, and the caregiver got her out of bed to take her to the shower room so the caregiver could change the incontinence brief and wash her because R2 had urine up her back. The resident construed the caregiver wanted to punish her for voiding in bed and called her daughter who expressed displeasure and talked to the supervisor. During an interview on 12/16/25 at 2:05 p.m., NA-A stated on 11/1/25 R2 used her call light several times and reported she was wet. NA-A told R2 she was doing rounds and would come to her when it was her turn, NA-A left R2's room, and continued rounds. NA-A stated R2 kept turning on her light, and when R2 activated her call light again around 8:00 p.m., R2 was sitting on the edge of the bed, so NA-A put R2 in a wheelchair wearing her brief and nightgown and wheeled R2 to an area by the nurses' station, but acknowledged R2 typically wore her clothes and underwear, not a brief and nightgown, in the dayroom. NA-A further stated she could not help R2 because she was caring for another resident. NA-A acknowledged R2 asked for her phone, but NA-A couldn't find it, and later found the phone under R2's pillow. NA-A stated the DON and nurse manager told her not to work with R2 anymore, but NA-A didn't know why and stated, Sometimes [R2's] daughter is on the phone and maybe she heard the conversation. NA-A acknowledged R2 sat by the nurses' station in a wet brief and nightgown while NA-A finished caring for another resident and re-made R2's bed, and then NA-A returned to assist R2. During an interview on 12/16/25 at 2:32 p.m., licensed practical nurse (LPN)-A stated NA-A should not have put R2 in a chair by the nurses' station wet, in her pajamas as it was a public space. R2 always had her phone and if she was taken from her room without it, she would be upset.During an interview on 12/16/25 at 3:15 p.m., LPN-B stated if a NA told a resident they were not allowed to use the call light or put the resident in a public place while wet, the resident would be anxious and afraid to use a call light again and would likely feel

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report allegations of physical and verbal abuse immediately (within two hours) to the State Agency (SA) for 3 of 4 residents (R1, R2, R3) after family members and/or residents reported the alleged abuse. Findings include:R1R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition. R1's care plan dated 8/23/25, indicated a self-care deficit related to dementia and impaired mobility in which R1 required staff assistance to turn and reposition in bed. R1's Grievance Log entry dated 10/6/25, indicated a staff concern related to communication by the nursing assistant (NA) reported by both the R1 and family member (FM)-A. R1's Record of Customer and Family Concern form dated 10/6/25, completed by social worker (SW)-A indicated FM-A reported a conversation she overhead between R1 and NA-B, in which NA-B stated to R1, What in the hell are you doing? You can't be sitting like that. To the FM-A, it sounded like NA-B was repositioning R1 in bed and FM-A overheard R1 say to NA-B, Get your hands off of me, and it sounded like R1 was being man-handled by NA-B. The form further indicated R1 was interviewed by SW-A, and stated he got into a yelling match with NA-B, and NA-B threw R1's legs against the wall. R1 requested not to work with NA-B again. The form indicated the administrator and director of nursing (DON) were notified of the incident on 10/6/25 at 10:30 a.m. R1's SA Report dated 12/12/25, indicated concerns about R1 returning to the facility after hospitalization after R1 reported abuse at the facility, and FM-A had concerns about inappropriate behavior by staff at the facility. The facility did not file the SA report. During an interview on 12/15/25 at 10:35 a.m., SW-B stated she was not sure if a report was made to the SA about the potential abuse but hoped the facility had. R1 did not want to go back to the facility because of the abuse. During an interview on 12/15/25 at 10:46 a.m., FM-A stated she filed a complaint with the facility weeks prior about a NA-B. R1 would set his phone down and not hang up, and FM-A heard staff enter the room, asked what R1 was doing, and stated, Get your ass to bed, then FM-A heard a crash. FM-A stated R1 told her staff spun him around in bed and hit R1's legs on the wall. FM-A yelled at NA-B through the phone and told NA-B to get his hands off R1 and leave the room. FM-A reported the incident to SW-A. During an interview on 12/16/25 at 4:43 p.m. SW-A stated she received R1's grievance on 10/6/25, the process should have been to investigate the concern with full completion of the Record of Customer and Family Concern Form. The SW-A stated she took the initial verbal report for R1's incident from FM-A, interviewed R1, and interviewed the staff member alleged to have abused R1 who was NA-B, who denied the allegation. The SW-A acknowledged after reading the allegation, it could be considered abusive behavior by the NA. R2R2's quarterly MDS dated [DATE] indicated moderate cognitive impairment, and use of a wheelchair for mobility. R2's Grievance Log entry dated 11/3/25, indicated a care concern related to communication with a NA reported by FM-B. R2's Record of Customer and Family Concern Form dated 11/3/25 indicated the SW-A, DON, and administrator were notified by FM-B on 11/3/25 at 12:04 p.m., by email regarding the incident on 11/1/25 around 8:00 p.m. FM-B stated she was on the phone with R2, and overheard a conversation between NA-A and R2 in response to R2's request for an incontinence brief change, NA-A told R2 staff no longer toilet residents on demand, and R2 needed to wait for rounds to be changed. The NA-A said, I told you the consequences, get in the chair, and NA-A transferred R2 to her wheelchair. R2 asked NA-A for her phone and NA-A said R2 would not need her phone where she was going, and NA-A wheeled R2 out of the room. FM-A called the facility and learned R2 was sitting by the nurses' station. R2's call light log indicated the call light was activated on 11/1/25 at 5:31 p.m., 6:11 p.m., 7:08 p.m., 7:13 p.m., 7:17 p.m., 7:29 p.m., 7:48 p.m., 8:17 p.m., and 8:35 p.m. R2's care plan dated 7/23/25, indicated a self-care deficit for ADLs related to limited mobility, impaired balance, and weakness. R2 required assistance of one staff for toileting, transfers, was at risk of pressure injury related to incontinence, and encouraged call light use to request assistance. R2's progress notes dated 11/1/25 at 10:25 p.m., indicated R2 had a miscommunication with the caregiver when the caregiver was providing care. R2 was soaking wet in bed, and the caregiver got her out of bed to take her to the shower room so the caregiver could change the incontinence brief and wash her because R2 had urine up her back. The resident construed the caregiver wanted to punish her for voiding in bed, and called her daughter who expressed displeasure and talked to the supervisor. The facility lacked a SA report for the alleged abuse. During an interview on 12/15/25 at 2:48 p.m., the anonymous reporter (AR)-A stated R2 called FM-B and reported a concern about having to use the bathroom but was afraid to use the call light because NA-A told her if she

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to immediately respond, investigate timely, and implement resident protections for 2 of 4 residents (R1, R2) following an allegation of verbal, mental and physical abuse of R1 and an allegation of mental abuse and neglect of care of R2, that were both reported to the facility.The immediate jeopardy began on 10/6/25 at 10:30 a.m. when R1's family member (FM)-A reported to social worker (SW)-A an allegation of staff to resident mental and physical abuse. Additionally, on 11/3/25, R2's FM-B reported an allegation of staff to resident mental abuse and neglect of care. The facility failed to report timely the incidents to the State Agency (SA), conduct a thorough investigation, and to implement resident protections to ensure other vulnerable residents at risk of abuse were safe during the investigation.The administrator and assistant director of nursing (ADON) were notified of the immediate jeopardy at 5:07 p.m. on 12/17/25. The immediate jeopardy was removed on 12/18/25, but noncompliance remained at the lower scope and severity level D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include:R1R1's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition. R1's care plan dated 8/23/25, indicated a self-care deficit related to dementia and impaired mobility in which R1 required staff assistance to turn and reposition in bed.R1's Grievance Log entry dated 10/6/25, indicated a staff concern related to communication by the nursing assistant (NA). Concern was reported by both the R1 and FM-A.R1's Record of Customer and Family Concern form dated 10/6/25, completed by SW-A indicated FM-A reported a conversation she overhead between R1 and NA-B, in which NA-B stated to R1, What in the hell are you doing? You can't be sitting like that. To the FM-A, it sounded like NA-B was repositioning R1 in bed and overheard R1 say to NA-B, Get your hands off me! FM-A stated it sounded like R1 was being, man-handled by NA-B. The form further indicated R1 was interviewed by SW-A, R1 stated he got into a yelling match with NA-B, and NA-B threw R1's legs against the wall. R1 requested not to work with NA-B again. The form indicated the administrator and DON were notified of the incident on 10/6/25 at 10:30 a.m. The form lacked indication other staff or residents were interviewed during the investigation, measures were taken to protect residents during investigationR1's progress notes dated 9/15/25 to 12/15/25, lacked mention of the incident described in the Grievance Log on 10/6/25, but indicated R1 was transferred to a hospital on [DATE]. State Agency Report dated 12/12/25, indicated R1's concerns about returning to the facility from hospitalization after R1 reported abuse at the facility, and because FM-A had concerns about inappropriate behavior by staff at the facility. During an interview on 12/15/25 at 10:46 a.m., FM-A stated she filed a complaint with the facility weeks prior about NA-B. R1 set his phone down without hanging up. FM-A heard staff enter the room, staff asked what R1 was doing, and stated, Get your ass to bed. Then FM-A heard a crash. FM-A stated R1 told her staff spun him around in bed and hit R1's legs on the wall. FM-A yelled at NA-B through the phone and told NA-B to get his hands off R1 and leave the room. FM-A stated she knew R1 was not happy at the facility. FM-A reported the incident to SW-A. During an interview on 12/16/25 at 4:43 p.m. SW-A stated she received R1's grievance on 10/6/25, when FM-A called her to make a report. The process should have been to investigate the concern with full completion of the Record of Customer and Family Concern Form. The SW-A stated she took the initial verbal report for R1's incident from FM-A, interviewed R1, and interviewed the staff member alleged to have abused R1. NA was identified as NA-B, who denied the allegation. SW-A stated the best practice would have been to interview other residents and suspend NA-B immediately, but acknowledged she had not done that, and left the process up to the nurse manager. The SW-A further acknowledged after reading the allegation, it could be considered abusive behavior by NA-B.R2R2's quarterly MDS dated [DATE] indicated moderate cognitive impairment, and use of a wheelchair for mobility. R2's care plan dated 7/23/25, indicated a self-care deficit for ADLs related to limited mobility, impaired balance, and weakness. R2 required assistance of one staff for toileting, transfers, was at risk of pressure injury related to incontinence, and encouraged call light use to request assistance. R2's Grievance Log entry dated 11/3/25, indicated a care concern related to communication with a NA reported by FM-B.R2's Record of Customer and Family Concern Form dated 11/3/25 indicated the SW-A, DON, and administrator were notified by FM-B on 11/3/25 at 12:04 p.m., by email regarding the incident on 11/1/25 around 8:00 p.m. FM-B stated she was on the phone with R2, and overheard a conversation between NA-A and R2 in response to R2's request for an incontinence brief change. NA-A told R2 staff no longer toilet residents on demand, and

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and document review, the facility failed to ensure annual performance reviews were completed for 4 of 5 nursing assistants (NA-A, NA-B, NA-C, and NA-D) whose personnel files were reviewed. This deficient practice had potential to affect all residents who currently resided in the nursing home and who could receive care from this staff. Findings include:The following nursing assistant (NA)'s personnel records were reviewed for annual performance reviews and identified the following:NA-A was hired on 7/12/13. NA-A's last performance review was dated 10/4/22.NA-B was hired on 2/5/21. NA-B's last performance review was dated 2/5/23.NA-C was hired on 5/24/22. NA-C's last performance review was dated 7/18/23.NA-D was hired on 8/20/21. The facility was unable to provide documentation NA-D had received a performance review.During an interview on 12/18/25 at 5:31p.m., the administrator stated performance reviews should be completed by nurse managers on an annual basis. The director of nursing (DON) oversaw the completion of the performance reviews. Administrator confirmed documentation of more recent performance reviews could not be located for NA-A, NA-B, NA-C and NA-D.The DON was unavailable for interview.The employee handbook informed the facility will provide annual reviews of work performance on or around an employee's anniversary date of employment.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 3 of 5 nursing assistants (NA-A, NA-C, NA-D) reviewed for annual training.Findings include:The following nursing assistants (NA)'s personnel files were reviewed for annual training and identified the following:NA-B's Relias education (facility's computer-based education system) indicated on 12/18/25, NA-B had 8.6 hours of the required 12 hours of training in the last 12 months.NA-C's Relias education indicated on 12/18/25, NA-C had four hours of the required 12 hours of training in the last 12 months.NA-D's Relias education indicated on 12/18/25, NA-D had zero hours of the required 12 hours of training in the last 12 months.During an interview on 12/18/25 at 4:00 p.m., staff development (SD) stated annual education should be completed in person during a staff's anniversary month. If a staff person does not attend in person, they would be assigned online training. At the end of the year calendar year, SD reviewed all staff education for completion and assigned online training as needed. A staff person would have 30 days to complete the online training. SD confirmed NA-A, NA-C and NA-D had not completed the require annual training in the last 12 months and had not been assigned the online training.During an interview on 12/18/25 at 5:31 p.m., administrator stated all staff are required to attend in-person annual training. In-person trainings were held monthly, and it was the responsibility of the staff development department to let staff members know what month they needed to attend. The annual training should be completed annually. The Nurse Aide In-Services and Training policy dated 1/20/2024 instructed nurse aides will complete a minimum of 12 hours of in-service annually and complete all required training within established timeframes. Completion of orientation, annual in-services, and additional training was documented and maintained in the employee personnel file. The facility would monitor compliance with training requirements and address gaps as needed.