

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/22/2026
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide supervision to necessary prevent elopement for 1 of 1 resident (R1) who required continuous care and supervision, resided on a semi-locked unit and left the facility without their knowledge. This resulted in an Immediate Jeopardy (IJ) for R1. The Immediate Jeopardy (IJ) began on 7/9/26, when R1 was visiting another resident outside the semi-locked unit on the first floor between 8:30 a.m. and 9:30 a.m. At approximately 9:30 a.m., assisted living campus administrator (ACA) noticed R1 was walking alone outside the facility in the parking lot heading towards a busy avenue. The Administrator and Director of Nursing (DON) were notified of the IJ on 7/21/26 at 5:15 p.m. The immediacy was removed on 7/22/26 at 1:00 p.m., 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: R1's annual [NAME] Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired, and had no episodes of wandering. There was no information for resident to be at significant risk of getting to a potentially dangerous place of stairs or outside of the facility. R1 had worsening behaviors of care rejection and wandering compared to prior assessment. R1's MDS further indicated she was independent with activities of daily living including dressing and mobility with a walker and had a wander/elopement alarm that was used daily. R1's Elopement Risk Evaluation (ERE) dated 6/01/26, indicated R1 had not made attempts to elope from current living situation although a recent attempt to elope was successful. The evaluation further indicated R1 was found sitting outside on one of the green benches nearest to Arby's fast-food restaurant with her walker in front of her. Resident was spotted by her family member (FM)-B while driving to come and see her. FM-B brought her back to the nursing facility. The director of nursing (DON) and social worker were updated. R1's care plan dated 6/12/26, indicated R1 had impaired cognitive function or impaired thought processes and was at risk for falls due to impaired memory, mobility balance and vision impairment. The care plan indicated a wander guard was placed on lower part of r1's four wheeled walker (4WW) related to an elopement. R1's Psychiatric Evaluation dated 6/30/26, indicated R1 had major depressive disorder and generalized anxiety disorder. The evaluation indicated R1 reported she was doing fine, there was nothing wrong with her and she had no issues but can be forgetful at times, outside of that she had no concerns. The evaluation further indicated R1 was cognitively below average; her insight and judgements were below average. The Evaluation indicated It is interesting that facility is concerned about her elopement status noting that she is allowed to leave the memory care unit and visit her [FM-A] on a daily basis on a different unit. If the facility feels concerns regarding her eloping, I recommend not allowing her to leave the memory care unit which would substantially decrease the chance of eloping. R1's (ERE) dated 7/09/26, indicated R1 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245452 If continuation sheet Page 1 of 8

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had made elopement attempts from current living situation and had made 1-2 attempts previously and was successful. The Evaluation indicated R1 had short term and long-term memory loss and was found walking towards university avenue around the Garden assisted living facility. R1's care plan dated 7/9/26, included an elopement focus related to R1's desire to visit family member (FM)-A who was also a resident in the facility on the first floor. Interventions added included 1:1 staff as staffing allowed, hourly checks for three days, monitoring R1's location when she was not in common areas and documenting wandering. Attempt diversion, provider notification for medication changes as needed, and checking wander guard placement and functionality every shift. A Facility Reported Incident (FRI) dated 7/10/26, indicated on 7/09/26 at 9:35 a.m., R1 ate her breakfast on the semi-locked unit and requested to visit FM-A on the first floor which was not a locked unit in another area of the facility. At approximately 8:30 a.m., facility staff assisted R1 to FM-A and she remained with FM-A for an undetermined amount of time. Between approximately 8:30-9:35 a.m., R1 left FM-A, was unaccompanied and exited the building without the staff knowledge. R1 was found, unsupervised, in the assisted living parking lot by the ACA. The social services designee was notified and tried to redirect the resident who refused to re-enter the building. Staff remained with resident for three hours attempting to get her back into the building. R1 and staff ate at a nearby restaurant and finally returned to the facility campus. R1 was placed on 1:1 supervision for increased monitoring. In addition, the facility initiated further review of the resident's elopement risk, clinical condition, potential contributing medical factors, and the effectiveness of current interventions and an investigation was initiated. R1's Care Plan did indicate after the 7/19/26 incident it was revised on 7/21/26, and staff were now to assist FM-A to R1's room for visits and R1 was no longer to be taken off of her unit. R1 ERE dated 7/21/16, indicated R1 had made attempts to elope three times and was successful. The evaluation indicated she was able to walk to the ALF and did not go outside, another occasion she was found sitting on the green bench in front of the building and she was also seen in the parking lot by the ALF. The evaluation indicated she was at high risk for elopement and was on continuous 1:1 monitoring on all shifts by nursing staff. R1's Progress Notes (PN) indicated the following: 6/01/26, Resident was found sitting on green bench without supervision. Family member (FM)-B found resident while driving to facility and [NAME] resident back to the nurse's station. Care Plan revised on 6/12/26 to include a wander guard to lower part of walker. 6/09/26, Resident was found off the unit on 6/09/26 without supervision. Resident refused to return to unit. Chaplain was able to level with her and guided her back to the unit. Nurse Manager (NM)-A is working on getting a wander guard for her. Residents' family member (FM)-B is looking at touring a locked memory care unit on campus. 6/12/26, R1 cut off wander guard placed on her arm and brought it to the nursing station. States: I don't need this on my arm. 7/09/26, R1 was observed outside the facility this afternoon after visiting FM-A who resides in the facility in an unlocked unit. Writer spent time with resident accompanied her on a walk. Upon initial contact resident was mildly agitated and stated she did not want to come inside with writer. During the walk resident engaged in casual conversation. 7/19/26, R1 was downstairs visiting FM-A and took off to ALF, a Code Grey was called (meaning a resident had eloped) staff were able to get resident back to the unit resident was upset and agitated and difficult to redirect. During interview on 7/20/26 at 12:12 p.m., director of social services (DSS) stated they had a meeting last week to have R1 moved to a fully secured, locked unit and the plan was to talk to the family today and continue 1:1's until R1 moved to the locked unit. During interview on 7/20/26 at 12:26 p.m., NM-A stated R1 visited FM-A on the [NAME] Unit every day around 8:30 a.m. Staff assisted R1 to the unit. R1 eloped after she finished visiting since there really was no plan for R1's return to the semi-locked unit. On 7/09/26, was when R1 went through the (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ALF and exited through the doors. R1 was found in the ALF parking lot. NM-A stated after that occurred, R1 was placed on 1:1 staff supervision. During interview on 7/20/26 at 4:30 p.m., the administrator stated R1's confusion has increased lately they were not aware of why her confusion increased. R1 was placed on 1:1 staff since the incident occurred on 7/09/26, since she was found after not being seen for over five minutes of staff knowledge of her location. The administrator stated during camera review, they found out R1 went through the cafe door going into the assisted living, which was not wander guard secured, so the alarm did not sound alerting staff she had gone through the door. The administrator stated he was unaware the cafe door was not wander guard secured until after her elopement on 7/09/26. A company was coming out today (7/20/26) to look at the door to make sure it is secured. The Administrator further stated he was informed of R1's previous elopement. During interview on 7/20/26 at 7:33 p.m., R1's FM-B stated he was aware that in the past few months R1 had eloped at least two other times (before 7/9/26), and the last time he believed she traveled toward the ALF and got out through the front door. FM-B was aware R1 was outside for three hours and on that side of the building (ALF) her alarm will not set off the door alarm. FM-B further stated he was aware at one time she had her alarm (wander guard) on her wrist and she cut that off so it was then placed on her walker. FM-B stated he thought it was okay for R1 to go to the ALF to the movie theater and to the pub but was unaware the door was not wander guard secured. During interview on 7/21/26 at 10:10 a.m., the DON stated on 7/19/26, while R1 was on 1:1's, during change of shift in the afternoon, after R1 visited FM-A on first floor, the staff were unable to locate her. The DON stated R1 was found several minutes later in the ALF. During interview on 7/21/26 at 4:00 p.m., the administrator stated he provided staff with a Staff Alert: Constant 1:1 Supervision sheet to prevent further incidents from occurring, similar to the incident on 7/19/26. The Administrator stated they will be educating everyone that will be assigned to the 1:1 with R1. Facility document, Staff Alert: Constant 1:1 Supervision sheet, WHAT THIS MEANS: R1 is on constant one-to-one supervision. Someone must have eyes on her every minute of every shift. The one-to-one does NOT stop at shift change. It must be handed off directly, person to person. Do not assume someone else is watching. If you are assigned, she is your responsibility until you hand off. AT SHIFT CHANGEDo a face-to-face handoff. Your relief must be standing with R1 before you leave. Say it out loud: You have eyes on R1 now. Get a clear yes back. Never walk away until the next staff member has visual contact. IF YOU NEED A BATHROOM OR BREAK Find another staff member to cover your one-to-one FIRST. Wait until they have eyes on R1 before you step away. When you return, take the one-to-one back with a clear verbal handoff. If you cannot find coverage, call the charge nurse immediately. Do not leave her alone even for a moment. WHY THIS MATTERS R1 has left the building unsupervised before and can move quickly. A gap of even a minute is enough for her to reach an exit. Constant eyes keep her safe. Questions? See the Charge Nurse or DON. Thank you for keeping R1 safe. Facility policy, Elopement/Missing Resident-Code Gray Policy reviewed 6/17/25, indicated Elopement Risk assessment will be completed upon admission, quarterly, and as needed in case of a significant change. If a resident is determined to have a history of wandering or is assessed to have a high potential for wandering outside the facility, the plan of care will identify specific actions and se guards. The IJ that began on 6/30/26 and was removed on 7/22/26 at 1:00 p.m., when R1 was reassessed for elopement risk, and the care plan was reviewed and revised to include interventions consistent with her current level of risk, a new locked magnetic door was added to the unsecured door on the semi-secured unit, ALF door was magnetically locked, 1:1 supervision was applied with no gaps, R1 was no longer allowed to leave the secured unit, staff were re-educated and a discharge was planned for R1 to a more secured locked unit on 7/24/26. Elopement/Missing Resident-Code Gray (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy reviewed 6/17/25, indicated Elopement Risk assessment will be completed upon admission, quarterly, and as needed in case of a significant change. If a resident is determined to have a history of wandering or is assessed to have a high potential for wandering outside the facility, the plan of care will identify specific actions and se guards. The IJ that began on 7/9/26. was removed on 7/22/26 at 1:00 p.m. when R1 was reassessed for elopement risk, and the care plan was reviewed and revised to include interventions consistent with her current level of risk, new locked magnetic door on secured unit, ALF door was magnetically locked, one to one supervision was applied with no gaps, R1 was no longer allowed to leave the secured unit, staff re-education and a discharge was planned for a more secured locked unit on 7/24/26.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to report an injury of unknown origin to the State Agency (SA) immediately, but not later than two hours, for 1 of 1 (R1) residents reviewed for resident safety. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired. R1's was independent with activities of daily living including dressing and mobility with a walker. The MDS indicated R1 had a fall since the prior assessment. R1's care plan dated 6/12/26, indicated R1 had impaired cognitive function and impaired thought processes. R1 was at risk for falls due to impaired memory, mobility balance and vision impairment. The care plan directed staff to anticipate and meet needs, be sure the R1's call light was within reach, encourage the R1 to use it for assistance as needed and to follow the facility protocol. A Facility Reported Incident (FRI) dated 7/21/26 at 3:17 p.m., indicated R1 was observed to have a bruise on the right eye socket that was not observed by the nurse at 10:00 p.m. on 7/20/26. It was first noted by the night nurse around 11:00 p.m. on 7/20/26, and at 7:00 a.m. on 7/21/26 by nursing assistant (NA)-A. There was increased swelling in size and further assessment showed a seven (7) centimeter (cm) by six (6) cm bruise and R1 reported pain on her right arm. The report indicated the nurse offered Tylenol and R1 declined and stated she was alright. The report further indicated on 7/20/26, in the evening, R1 had an agitation episode. R1 received scheduled evening medications and an as needed Lorazepam (anxiety medication) 0.5 milligrams (mg) with stable vital signs at baseline. R1's family member (FM)-B visited and she calmed down. Licensed practical nurse (LPN)-D saw the resident at 10:00 p.m., with no bruises and at 11:00 p.m., LPN-B noted the bruise on R1's head and offered Tylenol which R1 declined. Even though the bruise on R1's face was first noted on 7/20/26 at 11:00 p.m., it was not reported until the following day (7/21/26) at 3:17p.m. A progress note dated 7/22/26, indicated R1 was seen at the emergency department and when questioned she reported she had a fall during the night and complained of pain in right arm. Tylenol was given and a cold pack was placed to the bruise on side of R1's face. No fractures were present and R1 had a BIMS (Brief Interview for Mental Status) (test to determine cognitive status. A score of zero to seven indicates severe cognitive impairment) score of 2, which means severely cognitively impaired. Orders in place to monitor bruising on right side of face until healed/resolved. Orthostatic blood pressures reviewed appear with in normal limits. Intervention: staff to encourage resident to allow bathroom light to be left on at night. During interview on 7/22/26 at 3:55 p.m., the director of nursing (DON) stated nursing assistant (NA)-D worked the evening shift on 7/20/26, and she was the 1:1 with R1. The DON stated she was told by NA-D, R1 was having behaviors and had feces on the walls. NA-D noticed the bruise on R1's face at 11 p.m. LPN-A, the night nurse offered R1 Tylenol for pain and R1 refused. The DON stated they felt the bruising was from a fall, but they were not sure. The DON stated they did not immediately report the incident but after she thought about it, the DON felt they should have. Facility policy, Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Reporting and Investigating/Responding: 1. It is the policy of this organization that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unknownsource and misappropriation of resident property) are reported perFederal and State Law.2. The facility will ensure that all alleged violations involving abuse, neglect,exploitation or mistreatment, including injuries of unknown source andmisappropriation of resident property, are reported immediately, but notlater than 2 hours after the allegation is made, if the events that causedthe allegation involve a crime, abuse or resulted in serious bodily injury.3. The facility will ensure that alleged violations not involving serious injuryor a crime are reported no later than 24 hours if the events that causethe allegation do not involve abuse and do not result in serious bodily		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to comprehensively assess bruising for 1 of 1 resident (R1), and the facility was unable to ensure neurological checks (a critical assessment to identify any potential damage to the brain and nervous system) had been completed according per protocol. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired. R1 was independent with activities of daily living including dressing and mobility with a walker and had a wander/elopement alarm that was used daily. The MDS indicated R1 had a fall since the prior assessment. R1's care plan dated 6/12/26, indicated R1 had impaired cognitive function, impaired thought processes and was at risk for falls due to impaired memory, mobility balance and vision impairment. The care plan directed staff to anticipate and meet needs, be sure R1's call light was within reach, encourage R1 to use it for assistance as needed and follow the facility protocol. A Facility Reported Incident (FRI) dated 7/21/26 at 3:17 p.m., indicated R1 was observed to have a bruise on the right eye socket that was not observed by the nurse at 10:00 p.m. on 7/20/26. It was first noted by the night nurse around 11:00 p.m. on 7/20/26, and at 7:00 a.m. on 7/21/26 by nursing assistant (NA)-A. There was increased swelling in size and further assessment showed a seven (7) centimeter (cm) by six (6) cm bruise and R1 reported pain on her right arm. The report indicated the nurse offered Tylenol and R1 declined and stated she was alright. The report further indicated on 7/20/26, in the evening, R1 had an agitation episode. R1 received scheduled evening medications and an as needed Lorazepam (anxiety medication) 0.5 milligrams (mg) with stable vital signs at baseline. R1's family member (FM)-B visited and she calmed down. Licensed practical nurse (LPN)-D saw the resident at 10:00 p.m., with no bruises and at 11:00 p.m., LPN-B noted the bruise on R1's head and offered Tylenol which R1 declined. R1's Neurological Check list indicated the following: Vitals were taken on 7/22/26 at 9:35 a.m., (over 10 hours after the bruise was noted on R1's head) which indicated Temperature- 96.9, Pulse- 79, Respirations- 16 and Blood pressure- 153/95, neuros were within normal limits and R1 reported pain on the right area of the eye when touched. Facility document, Facilities Falls Follow Up, indicated If a fall is witnessed and did not hit head VS [vital signs] X 24 hours. If fall is unwitnessed VS x72 hours. If hit head VS and Neuro checks X 72hours. If confused and unwitnessed VS and Neuro checks x 72 hours. The Follow up indicated VS and Neuros should have been taken every 15 minutes x 1 hour, every 30 minutes x 1 hour, every hour x 4 hours, every shift x three (3) days and return to Nurse Leader when completed. During interview on 7/21/26 at 11:45 a.m., R1's Nurse Practitioner (NP) stated she was notified R1 was sent to the emergency room at 9:45 a.m. on 7/21/26, with bruising on the right side of her face and was unable to open her right eye, neuros and vitals were within normal limits. NP was not sure what occurred and was unsure if R1 had a fall. NP stated R1 was very frail. NP was concerned since R1 was on aspirin and Eliquis which are both blood thinners, NP stated the staff should have sent R1 in as soon as they noticed the bruising due to her high risk for bleeding and risk for a brain bleed. A progress note dated 7/22/26, indicated R1 was seen at the emergency department and when questioned she reported she had a fall during the night and complained of pain in right arm. Tylenol was given and a cold pack was placed to the bruise on side of R1's face. No fractures were present and R1 had a BIMS (Brief Interview for Mental Status) (test to determine cognitive status. A score of zero to seven indicates severe cognitive impairment) score of 2, which means severely cognitively impaired. Orders in place to monitor bruising on right side of face until healed/resolved. Orthostatic blood pressures reviewed appear within normal limits. Intervention: staff to encourage resident to (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allow bathroom light to be left on at night. During observation and interview on 7/22/26, at 12:20 p.m., R1 was in her room with family member (FM)-B sitting next to her. R1 had her food tray on her small table, and she was attempting to eat her food. A large bruise was noted on the entire right side of her face. When asked what happened R1 stated What do you think look at my face, she had word troubles stating what happened and when asked if she fell, she stated, no, and said she was sitting in a chair and her face went down and hit something. R1 was agitated and trying to give her food to FM-B. During interview on 7/22/26 at 3:55 p.m., the director of nursing (DON) stated nursing assistant (NA)-D worked the evening shift on 7/20/26, and she was the 1:1 with R1. The DON stated she was told by NA-D, R1 was having behaviors and had feces on the walls. NA-D noticed the bruise on R1's face at 11 p.m. LPN-A, the night nurse offered R1 Tylenol for pain and R1 refused. The DON stated they felt the bruising was from a fall, but they were not sure. Falls Policy for Episcopal Church Home effective June 2025, indicated All residents identified as being at risk for falls will receive individualized fall prevention interventions. The goal is to reduce fall incidence, prevent injury, and preserve resident dignity and independence.		