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	03/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and record review, the facility failed to ensure provider notification occurred when a skin altercation was identified for 1 of 1 residents (R24) reviewed for surgical incision care. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of kidney failure, diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a non-adherent dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted to be black, necrotic, and foul smelling. Nurse practitioner (NP)-A assessed and sent R24 to the hospital for further evaluation and R24 had ssurgery for toe amputation. R24's provider order dated 2/21/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. A review of R24's electronic medical record (EMR) from 2/28/25- 3/5/25, lacked indication R24's surgical incision had any changes or R24's provider or surgical team were notified. (continued on next page)

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

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	03/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 3/5/25 at 2:07 p.m., registered nurse (RN)-E stated a nursing assistant (NA) notified them of the toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified on Monday 2/10/25. RN-E stated when first notified, there was a small black area on the side of the toe. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black tissue and the entire top of R24's foot was discolored and dark. When interviewed on 3/5/25 at 3:44 p.m., NP-B stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to bee seen that day and NP-B was asked to assess the toe when they had a chance. NP-B reviewed documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. Furthermore, NP-B expected staff to notify the providers when the toe was first noticed so treatment/monitoring orders would be placed or to send R24 in for further evaluation right away. NP-B stated for surgical incisions, the surgical team should be notified of any complications. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified for a resident, staff were expected to at least put a progress note in and update the provider and family. RN-D stated any changes to the surgical incision should also have been documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention. RN-D verified R24's provider and family were not notified at the time the skin was noted or when changes to the surgical incision were noted. When interviewed on 3/6/25 at 11:37 a.m., the Director of Nursing (DON) stated when a skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated, R24's provider should have been notified when the toe was first seen and when changes to the surgical incision were noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound changes since that appointment until 3/6/25. A facility policy titled Change in Condition revised 5/4/22, directed staff to promptly notify the residents provider or on call provider when there was a need to alter the resident's medical treatments.

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	03/06/2025

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 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** 44647 Based on observation, interview and record review, the facility failed to comprehensively assess a new skin alteration and changes in a surgical incision for 1 of 1 residents (R24) who developed gangrenous toe that required surgical treatment. Furthermore, the facility failed ensure coordination of care for a hospice patient with a change in condition for 1 of 1 residents (R25) reviewed for hospice. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of kidney failure, required dialysis (treatment to filter the blood), diabetes, and vascular disease. Furthermore, R24 was at risk for skin breakdown. R24's care plan revised 11/15/24, indicated R2 had an unstageable right heel ulcer. Staff were directed to follow policies/procedures for prevention and treatment and prevention of wounds. Staff were also directed to monitor, document and report as needed any skin changes. R24's nursing progress note dated 2/8/25 at 2:11 p.m., indicated R24 had a blackened malodorous (foul smelling) right little toe. The toe was covered with a dressing and indicated the nurse practitioner will be updated on 2/10/25. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/9/25 at 9:31 p.m., indicated R24's right pinky toe looked gangrenous (infected) and the nurse manager would assess on 2/10/25 for further management. The note lacked indication of family or provider notification of R24's toe. R24's nursing progress note dated 2/10/25 at 12:40 p.m., indicated R24's right pinky toe noted to be black, necrotic, and foul smelling. Nurse practitioner (NP)-B assessed and sent R24 to the emergency room (ER) for further evaluation. R24's medical record lacked indication a comprehensive assessment of R24's toe had been completed or documented prior to sending to the ER for further evaluation. R24's hospital progress note dated 2/10/25 at 10:09 a.m., indicated R24 had ischemic (insufficient blood flow) changes to the right 5th toe and had full thickness dry gangrene (condition where decreased blood flow causes tissue death) to the 5th toe that extended over the 5th metatarsal head (top or start if the bone in the midfoot). R24 will require at least a partial foot amputation. R24's hospital progress note dated 2/13/25 at 6:17 a.m., indicated R24 had a metatarsal amputation (procedure to remove the toes and part of the mid-foot) of the right foot. The incision and flap were well healing thus far however R24 was high risk for the surgical flap to fail due to vascular disease. (continued on next page)

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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's hospital discharge order dated 2/19/25, directed staff to perform dressing changes to R24's right foot surgical wound twice daily. R24's weekly skin audit dated 2/19/25, indicated R24 had a surgical incision and did not indicate any complications or concerns with the incision. R24's weekly skin audit dated 3/5/25, indicated R24 had a surgical incision on the right foot. The audit did not indicate any complications or concerns with the incision. A review of R24's electronic medical record (EMR) from 2/28/25- 3/4/25, lacked indication R24's surgical incision had any changes or complications. An observation on 3/5/25 at 12:59 p.m., registered nurse (RN)-E entered R24's room to perform wound cares. After performing hand hygiene and donning gloves and gown, RN-E removed the ace bandage from R24's right foot and cut loose the kerlix wrap. Gauze on the top of the foot was then removed and the surgical incision was visualized. There was scant bloody draining on the gauze removed and sutures in place. The incision did not appear fully approximated was foul smelling. There was dark black tissue along the incision site and R24's foot had a darkening color through the top of it almost to the ankle. RN-E verified the black tissue around the surgical incision and discoloration of R24's foot. When interviewed on 3/5/25 at 2:07 p.m., registered nurse RN-E stated initially, a nursing assistant (NA) notified them of a black area of the 5th toe during cares on 2/8/25. RN-E stated the toe was monitored over the weekend and nurse practitioner (NP)-B and family were notified the following Monday (2/10/25). RN-E stated when R24's right little toe was first observed, there was a small black area on the side of the toe. RN-E had documented a progress note and verified there was not a discription of size or measurements of the area. RN-E verified the note and stated to monitor for increased size, measurements and location would have been helpful to be able to tell how it was progressing. When completing the dressing change today, RN-E stated the surgical wound looked much worse than the last time they worked with R24 on 2/28/25. RN-E verified there was a lot of black tissue and the entire top of R24's foot was discolored and dark. RN-E was not aware of when R24's surgical incision had started to worsen and verified there was no documentation or assessment of it. When interviewed on 3/5/25 at 3:44 p.m., NP-B stated they provide regulatory visits on Mondays and was first notified of R24's right little toe then. NP-B further stated R24 was not on the list to bee seen that day and was asked to assess the toe when I had a chance. NP-B reviewed documentation and verified no calls had been place to the on-call service for R24 since January and there was no notification when the black part of the toe was first discovered. NP-B stated there was a low threshold for sending R24 to the ER for evaluation due to R24 having vascular disease and poor healing for thier heel wounds. NP-B stated for surgical incisions, typically, the surgical team would be notified of any complications or changes. (continued on next page)

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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 3/6/25 at 10:05 a.m., RN-D stated when a skin alteration was first identified was noted for a resident, staff were expected to at least put a progress note in and update the provider and family. An assessment should be completed for anything newly found. RN-D stated any changes to the surgical incision should also be documented and the provider notified. RN-D was not aware of when the changes to R24's surgical incision started and verified there was no documentation of it. RN-D had emailed NP-B about the worsening surgical incision on 3/5/25 after RN-E brought it to their attention but had forgotten to document the communication. RN-E was not sure if R24's surgical team were notified. When interviewed on 3/6/25 at 11:37 a.m., the Director of Nursing (DON) stated when any skin alteration was found, a body audit assessment should be completed and the provider notified as warranted. DON further stated with surgical incisions or already identified wounds, staff were expected to document any signs of poor healing, what it looks like, smells, suture problems, and take measurements if needed. R24's provider should have been notified when the toe was first seen and when changes to the surgical incision was noted. When interviewed on 3/6/25 at 2:15 p.m., RN-F verified R24 was last seen in clinic with the surgical team on 2/24/25. RN-F further stated there was not any notification of any wound changes since that appointment until today. A facility policy for non-pressure wound care was requested however was not recieved. 49617 R25 Hospice Collaboration R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had severely impaired cognition and was on hospice care. The MDS identified her diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), hemiplegia or hemiparesis (one-sided weakness or paralysis), a seizure disorder, and intellectual disabilities (developmental conditions affecting cognitive functioning and adaptive behavior). Additionally, the MDS reported she was taking an anticonvulsant medication. R25's care plan dated 7/15/24, identified she was on hospice related to a terminal illness and indicated staff would follow the hospice and facility coordinated plan of care. Additionally, the care plan indicated hospice nursing care would coordinate with and supplement facility-provided nursing care, and hospice, family, and providers would be informed of all R25's changes on condition. A progress note dated 9/9/24, indicated seizure activity noted this AM. A progress note dated 11/2/24, indicated the hospice nurse was updated about R25's seizure activity but that she had returned to normal without medication. A progress note dated 12/16/24, indicated she had seizure activity. A progress note dated 12/21/24, indicated R25 had a seizure while hospice nurse was around, she handled it. (continued on next page)

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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 1/3/25, indicated a seizure noted around 11:25 am this morning. A provider progress note dated 2/6/25, indicated staff reported no concerns during the provider's visit, and under the assessment and plan for R25's seizure disorder, the provider wrote, chronic. Last reported seizure was in August 2024, with no new orders given. During interview on 3/5/25 at 8:42 a.m., R25's hospice case manager (HCM) verified responsibility over her case management and stated the hospice team was responsible for all her medications except her Keppra, (an anticonvulsant medication used to treat seizures), that's the only one we don't cover. HCM stated R25's Keppra was monitored by her primary provider. HCM recalled R25 had a seizure at least once a month and stated she would get a loading dose of lorazepam (a rescue medication used to rapidly stop seizures) before facility staff would update HCM. HCM stated there had been no contact with the hospice providers by R25's primary providers regarding her seizures or medication changes. HCM stated during weekly hospice visits, I check with the nurses, sometimes I will check with the nurse manager as well, and indicated they also sent weekly reports to the facility with updates to her plan of care. HCM stated, as far as I am aware, the [primary] provider is updated on her seizure activity and her overall health status. During interview on 3/6/25 at 9:37 a.m., consultant pharmacist (CP) stated for the Keppra medication, therapeutic lab levels were rarely drawn because it is so safe. CP indicated it would be provider-driven that a lab level be drawn and stated, I would expect if a resident was seizing, I would be making sure the provider was aware, seeing what they're saying; is there a reason the provider wasn't saying anything? I would expect if a resident was having seizures, that the provider would be reviewing the medication and the dose to adjust that. CP was unaware of R25's documented seizure activity and questioned if she had seizures. During subsequent interview on 3/6/25 at 10:31 a.m., CP directed attention to a provider note dated 2/6/25, and stated because the provider wrote in their assessment and plan they were monitoring R25's chronic seizures, that means they are looking at it and reviewing and stated historically, providers would only do labs if there was a negative outcome. However, if there were no seizures or negative outcomes, the lab isn't really required. During interview on 3/6/25 at 10:44 a.m., registered nurse (RN)-A stated when a resident was on hospice, we call them first. RN-A stated for R25, most of her medications were managed by hospice except for her Keppra. RN-A explained when R25 had a seizure, they first assessed her and ensured her safety, then administered her lorazepam medication and updated her hospice team. RN-A stated there was not a liaison between the hospice team and R25's primary care provider who managed her Keppra medication. RN-A stated the floor nursing staff communicated with the nurse manager and it would go up from there. RN-A stated the hospice team was good at communicating with the floor staff if there were concerns or changes to her plan of care and we communicate that with our team. (continued on next page)

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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 3/6/25 at 11:32 a.m., RN-B expected staff to update hospice first with any change in condition for a hospice resident and if it is anything they are not covering, hospice would refer that back to the providers here. RN-B stated because our providers are here so often, we do update them but stated it may be a more informal, verbal report. RN-B reviewed R25's progress notes and confirmed the documented seizure activity on the dates 9/9/24, 11/2/24, 12/6/24, 12/21/24, and 1/3/25. RN-B reviewed the provider progress note on 2/6/25, and confirmed the provider's documentation that R25 had no seizure activity since August 2024. RN-B was unsure why the provider note did not include the documented seizure activity from the progress notes. Per interview on 3/6/25 at 1:46 p.m., the director of nursing (DON) expected hospice to collaborate with the nurse manager immediately to determine a resident's plan of care once signed onto hospice. The DON stated the communication between the hospice team and primary providers should be going through the nurse managers, but stated there could be problems with that since the nurse managers are not always available. The DON expected nursing staff to communicate changes of condition with the hospice providers and if the hospice team was not managing that aspect of a resident's care, they should defer to the attending provider. The DON stated, we would encourage our nurses to be updating the providers, and the hospice team should also remind the nurses to update the primary provider. The DON reviewed R25's progress notes and confirmed the documented seizure activity and the provider progress note dated 2/6/25. The DON stated, this does seem tricky with the shared management. The DON stated although nurses were encouraged to update the primary providers, sometimes they would believe if they updated hospice, the work is done. During interview on 3/6/25 at 3:03 p.m., R25's nurse practitioner (NP)-A verified responsibility for the provider note dated 2/6/25, and stated there had been no updates from the facility regarding the seizure activity documented in her progress notes. NP-A stated, If I had been notified of the seizures, and they had been true seizures, I would have notified my MD [medical doctor], due to being new in the field. Furthermore, NP-A expected staff to provide verbal updates when on-site, then I could go back and review the notes. We rely heavily on those progress notes. Per interview on 3/7/25 at 7:47 a.m., with R25's medical doctor (MD)-B, there were no updates received about her seizure activity. MD-B stated, I am not typically involved in the hospice IDG communications. I don't believe we were updated about her seizure activity. MD-B expected an update from facility staff, however, stated I don't know that I would have changed anything with her care. MD-B denied concerns for her safety and stated her care was being managed fine. MD-B stated, I think we should have been updated and I think maybe this is a learning point for staff there. (continued on next page)

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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per Nursing Facility Services Agreement for Routine Hospice Care dated 3/20/23, the facility should ensure that all facility services are provided competently and efficiently in a timely manner. Facility services should meet or exceed the standards of care for providers of such services and should be in compliance will all applicable laws, rules, regulations, professional standards and licensure requirements. The agreement indicated hospice and facility should communicate with one another regularly and as needed for each particular hospice patient and each party was responsible for documenting such communications in its respective clinical records to ensure the needs of hospice patients were met 24 hours per day. Furthermore, the agreement indicated the facility should designate a member of the facility's interdisciplinary team who would be responsible for working with hospice to coordinate care provided by facility staff and hospice staff. The policy directed that team member to collaborate with hospice and coordinate with facility staff participating in the care planning process; communicate with hospice and other healthcare providers participating in the provision of care for the terminal illness and other conditions to ensure quality of care; and to ensure the facility communicates with the hospice medical director, the hospice patient's attending physician, and other practitioners participating in the provision of care to the hospice patient as needed to coordinate care provided by other physicians.

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	03/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** 42579 Based on observation, interview and document review, the facility failed to ensure a safe smoking environment was provided for 2 of 2 residents (R50 and R55) reviewed for smoking. Findings include: R50's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition, no rejection of care, and independent with eating and oral hygiene. Manual wheelchair was used independently. R50's Selfcare/Mobility Care Area Assessment (CAA) dated 12/19/24 identified a diagnosis of tobacco use. E50 has no impairment to extremities and was able to voice needs and used call light appropriately. The resident was often independent with ADLs (activities of daily living) and received assist as needed. R50's care plan dated 11/20/19, identified current smoking status. The care plan identified he was able to light his own cigarette, keep his lighter at the bedside, and smoke independently with use of a smoking apron. Staff were directed to encourage him to use his smoking apron. The plan of care lacked description of safe disposal of smoking materials. R50's Smoking Safety Screen dated 12/18/24, identified he smoked in the morning, afternoon and evening, could light own cigarettes, and a smoking apron was used for adaptive equipment. Plan of care included assure resident was safe while smoking. The safety screen lacked description of safe disposal of smoking materials. During an observation on 3/3/25 at 9:41 a.m., R50 self-propelled his wheelchair toward his room with his smoking apron on. R50 stated he was a smoker, but the ashtray (smoking materials disposal receptacle) kept being messed with so he had to put his cigarette butts out on the ground by stomping them with his foot. He said it had occurred for a month or so, off and on. During a tour of the designated smoking area and interview on 3/03/25 at 9:48 a.m., with maintenance staff (M)-A, there was no ashtray or container to dispose of smoking materials. Approximately 20 cigarette butts of various brands and colors were laying on the ground and on the dried grass and leaves about 15 feet from the facility entrance. M-A stated it was an ongoing problem where people would mess with or steal the ashtray. M-A stated the cigarette butts should be disposed of in an approved container for fire safety purposes. During an observation on 3/3/25 at 10:54 a.m., R50 was in his room getting ready to go outside for a cigarette. He removed two cigarettes from a full pack and put those two into an empty pack. R50 left his room with his smoking apron still on the bed. During an observation on 3/3/25 at 10:56 a.m., R50 told nursing assistant (NA)-A he was going outside for a smoke. NA-A did not remind R50 to put on his smoking apron. (continued on next page)

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	03/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/3/25 at 11:02 a.m., R50 reached the designated smoking area and started a cigarette. at 11:20 a.m., he extinguished the cigarette by rolling the butt between his fingers until the ash fell out on the ground. His pants had several small holes that resembled old burn holes in the groin area of his pants. R50 had not ashed on himself during this smoking observation. There continued to be no smoking material disposal receptacle available. During an interview together on 3/3/25 at 11:24 a.m., NA-C stated R50 needed a smoking apron on, he had it on earlier in the morning but she did not check if he had it on for his 11:02 a.m., cigarette. NA-A stated he needed the apron on because ash would fall off and burn his clothing, and R50 was independent with managing his smoking apron. She also agreed she did not check if he had his smoking apron on for his 11:02 a.m., cigarette. During an interview on 3/3/25 at 11:29 a.m., the assistant director of nursing (ADON) said lack of a smoking receptacle was a fire hazard and he would go speak to maintenance now. During a follow up interview on 3/3/25 at 1:47 p.m., the ADON stated he talked to the administrator and was told the smoking materials disposal receptacles by the designated smoking area kept getting stolen . The ADON stated a new smoking disposal receptacle was ordered. 42586 R55 R55's quartely Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of type II diabetes, chronic obstructive pulmonary disease (COPD), and tobacco use. It further indicated R55 required set up assistance with most activities of daily living (ADLs) and was independent with mobility. During interview on 3/4/25 at 3:29 p.m., R55 stated he was on smoking restrictions because of dental surgery, but he didn't always follow it. He further stated he put his cigarette butts out on the sidewalk or on the side of the garbage can outside and threw them away in the trash can. He stated they (facility) just got a smoking receptacle yesterday but they hadn't had one in a while before then. During an interview on 3/6/25 at 8:05 a.m., the administrator stated maintenance was here on the weekends and should have checked to see if the smoking area was in safe condition during daily rounds. Additionally, nursing should ensure smoking aprons were in place if that was what the smoking safety screen identified. During an interview on 3/6/25 at 8:52 a.m., the director of maintenance services (DMS) stated every morning staff would do a walk through and clean up the grounds. He said checking for a smoking materials disposal receptacle was also part of their process but not documented. The facility's smoking policy dated 5/28/24, identified no smoking of any kind allowed on campus grounds, all smoking at least 25 feet from entrance on city sidewalk, smoking waste and materials must be cleaned up and kept free from sight from others. The Life Safety Code, state fire code, and MN (Minnesota) clean indoor air act would be followed.

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	03/06/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review, the facility failed to ensure a dialysis fistula site was maintained according to professional standards of care for 1 of 2 residents (R24) reviewed for dialysis. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of kidney failure, diabetes, and vascular disease. Furthermore, R24 required dialysis (treatment to filter the blood when in kidney failure). R24's provider and nursing orders reviewed on 3/5/25, lacked indication of where R24's fistula was located or if R24 had restrictions for blood pressure on their left arm. R24's care plan revised 9/20/24, indicated R24 required dialysis 3 times a week. R24's care plan lacked indication R24 had restrictions for blood pressure on their left arm. An observation on 3/5/25 at 10:23 a.m., trained medication assistant (TMA)-A entered R24's room to provide medication. R24 was sitting in their wheelchair and was very sleepy. Registered nurse (RN)-E requested vital signs. TMA-A obtained a vital sign machine and re-entered R24's room. TMA-A placed a blood pressure cuff on R24's left arm above the elbow and obtained a blood pressure. When interviewed on 3/5/25 at 2:03 p.m., TMA-A verified the blood pressure was taken on the left arm and was not aware of any restrictions for taking blood pressures for R24. TMA-A was not sure if a blood pressure could be taken on the same arm as a dialysis fistula site and would need to verify with the nurse. When interviewed on 3/5/24 at 2:07 p.m., RN-E stated TMA-A should not have taken the blood pressure on R24's left arm. RN-E further stated R24 was wearing a sweatshirt and TMA-A may not have noticed it. When interviewed on 3/6/25 at 10:05 a.m., RN-D stated blood pressures should not be taken over the fistula site or on the arm of the fistula site. RN-D further stated the order for blood pressures had not been ordered for R24 but was now placed. RN-D stated care sheets were not used on the short term stay unit as residents discharged and admitted frequently. However, the information was included on the nurse 24-hour sheet which nurse and TMA's have access to. RN-D stated there was only a verbal process for nursing assistants and a better process of communication may be needed. When interviewed on 3/6/25 at 11:43 a.m., the Director of Nursing (DON) expected staff to take blood pressures on the opposite arm of the fistula for residents with dialysis. This should be included in the orders, included on the 24-hour sheet for the nurses and TMAs, and reported to the NAs. A facility policy titled Dialysis dated 1/1/15, directed staff to follow all provider orders for dialysis. The policy did not address any standards of care for dialysis residents.

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	03/06/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on interview and document review the facility failed to ensure antifungal medications without an end date were monitored and evaluated for the appropriateness of continued use for 2 of 2 residents (R17, R27) reviewed who were prescribed antifungal medications. Findings include: R17 R17's quarterly Minimum Data Set, dated dated dated [DATE], identified intact cognition, no rejection of care, diagnoses of type two diabetes mellitus with diabetic chronic kidney disease and candidiasis (fungal infection) of skin and nail. Skin interventions included application of ointments/medication other than to feet. R17 was dependent on staff for toileting hygiene and required substantial to maximal assistance for showering and bathing. R17's annual Care Area Assessment (CAA) dated 9/5/24, triggered for potential for pressure ulcers, however identified no current skin issues were present, staff were directed to observe for changes and update MD (medical doctor) PRN (as needed). R17's care plan dated 9/15/23, identified a potential for alteration in skin integrity related to immobility, diabetes, morbid obesity, bowel and bladder incontinence. Nursing staff were directed to monitor skin with cares and report changes and monitor/document/report signs/symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. The care plan lacked instructions for care to fungal infections of the skin. R17's active Order Summary dated 3/6/25 identified: effective 6/24/24, clotrimazole external cream 1% (antifungal medication). Apply to affected area topically two times a day related to candidiasis of skin and nail. The order had no end date. The Clotrimazole Product Monograph Dosing Considerations dated 9/16/22, identified clinical improvement with relief of pruritus, usually occurred within the first week of treatment. The symptoms of jock itch, ringworm and diaper rash usually resolved within two to four weeks. If the signs and symptoms of the infection were not resolved after four weeks of treatment with clotrimazole topical, a physician should be consulted. If a cure is not mycologically confirmed, treatment should, as a rule, be continued for two weeks after all clinical symptoms have disappeared. Candida infections are generally treated for only two weeks. R17's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified clotrimazole cream was documented as applied twice daily over the past year to the groin area while resident was in the facility. The original start date of the medication was identified as 12/29/23. R17 had received the medication routinely for one year and approximately two months. R17's weekly skin assessments dated 11/23/24 through 3/1/25, identified no candidiasis or skin deficits. (continued on next page)

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	03/06/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's primary care provider visit notes dated 1/30/25, 1/6/25, 11/18/24, 11/4/24, 9/9/24, 8/1/24, 7/22/24, 6/10/24, 4/4/24, 3/5/24, 3/14/24 and 1/3/24, lacked a review for continued use of clotrimazole and lacked mention of any candidiasis skin concerns. During an observation on 3/3/25 at 8:55 a.m., R17 was in bed with a hospital gown on. Feet, nails, and other exposed skin shows no signs of fungal infection. During a phone call to nurse practitioner (NP)-A's office (R17's primary care provider) on 3/5/25 at 3:13 p.m., registered nurse (RN)-C, who was NP-A's primary nurse, stated antifungal medications should always have an indication for use and length of time to use. Typically, clotrimazole was prescribed twice daily for a 14-day course and then reassessed. RN-C reviewed medications on R17's chart and stated clotrimazole was not on their medication list, even though it was on the facility's medication list, apparently had not been reconciled. RN-C stated she would leave instructions for NP-A to review clotrimazole and ensure it was still appropriate as an active order. R17's telephone order (TO) to nursing dated 3/5/25, identified discontinue clotrimazole cream if resident having no more rash. The medication was documented as discontinued from the active orders. During an interview on 3/6/25 at 8:30 a.m., nursing assistant (NA)-A stated R17 had no current skin conditions. R27 R27's quarterly MDS dated [DATE], identified severely impaired cognition, no rejection of care, and diagnoses of dementia with agitation. Skin concerns included two venous/arterial ulcers and MASD (moisture associated skin damage). Application of ointments/ medications other than to feet were used and R17 was on hospice care. Substantial/maximal assistance was provided from staff for bathing and showering and R17 was dependent on staff for lower body dressing and hygiene. R27's significant change CAA dated 11/22/24, identified actual pressure ulcers (PU) one unstageable PU, one stage 2, and one vascular ulcer. R27 was newly enrolled in hospice and had additional diagnoses of type two diabetes mellitus and PVD (peripheral vascular disease). R27 was incontinent, staff performed pericare after each incontinent episode and changed product PRN to keep skin clean and dry. Staff were directed to continue to treat and observe for changes and update MD PRN. There was no documentation of fungal infections of the skin. R27's care plan dated 5/20/24, identified a potential/actual impairment to skin integrity related to impaired mobility, bowel/bladder incontinence and chronic vascular injury to their left lower leg. R27 refused to lay in a bed. The care plan indicated they refused to have a bed in their room for wound treatments and brief changes. Nursing staff were directed to monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD/NP. The care plan lacked instructions for care to fungal infections of the skin. R27's active Order Summary dated 3/6/25, identified three different orders for antifungal medication application: (continued on next page)

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	03/06/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Effective 4/19/22, apply nystatin powder twice daily to reddened areas under breast and groin. Nursing assistant may apply during cares. The order had no end date. 2. Effective 4/15/23, left to right abdominal folds, dust area between folds with nystatin powder and lightly rub in one time a day for preventing abdominal breakdown. Brush off extra. The order had no end date. 3. Effective 2/17/25, Zeasorb-AF external powder 2 % (miconazole nitrate topical). Apply to pannus folds topically two times a day for rash. The order had no end date. The undated Nystatin Topical Powder package insert identified indications for use included skin infections caused by candida albicans and other susceptible candida species. Patients were directed to apply to candidal lesions two or three times daily until healing was complete. R27's Medication Administration Records and Treatment Administration Records (MAR and TAR) dated 3/1/24 through 3/5/25, identified nystatin powder was documented as applied as ordered over the past year to the groin area while resident was in the facility. The original start date of the medication was identified as 12/29/23. R17 had received the medication routinely for two years and approximately eleven months. on 2/17/25, Zeasorb-AF was added and used in conjunction with the nystatin. R17's primary care provider visit notes dated 1/31/25, 11/18/24, 9/3/24, 7/15/24, 5/29/24, and 3/4/24, lacked a review for continued use of nystatin and lacked mention of any candidiasis skin concerns. R27's wound care consults dated 1/23/25 and 12/5/24 lacked mention of ongoing use of nystatin or conditions under breasts or groin. During an interview on 3/04/25 at 4:15 p.m. NA-B stated she worked with R27 routinely. Nystatin powder was in her room and the groin was improving to a pink color only. The resident refused to allow observation of the application site. During an interview on 3/5/25 at 3:47 p.m., NP-B stated nystatin, and antifungals could be used if symptoms were active. NP-B stated there was no clinically significant risk of antimicrobial resistance due to prolonged use. However, NP-B stated they relied on the nurses to let providers know on skin conditions so they could taper down medications as needed. NP-B stated R27's care and topicals were now managed by hospice. During an interview on 3/06/25 at 10:32 a.m. hospice RN case manager (HCM) stated hospice started R17's Zeasorb on 2/17/25, because they nystatin was not effective. The HCM stated the two orders for nystatin should have been discontinued when the Zeasorb powder was started, and she would have the hospice physician update the orders. R27's telephone order (TO) to nursing from the hospice physician dated 3/6/25, identified to discontinue nystatin and continue Zeasorb powder to rashes. (continued on next page)

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	03/06/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:46 a.m., licensed practical nurse (LPN)-A stated skin assessments were completed on resident's bath days. If no skin concerns were found, then none were documented. LPN-A stated she would typically notice if an antibiotic did not have an end date, and reach out to the provider, but was not the current practice for topical antifungals. During an interview on 3/06/25 at 9:28 a.m., the facility's consultant pharmacist (CP) stated topical antifungals would typically be discontinued once the skin concerns were healed and expected the facility nurses to update the primary care provider for review of ongoing use. The CP stated there was not a risk for antimicrobial resistance related to ongoing use. During an interview on 3/6/25 at 11:35 a.m., the director of nursing (DON) stated if skin conditions were resolved or not improving regarding topical antifungals, the nurses should notify providers, so the medication was not used if not necessary. The facility policy for Unnecessary Medications dated 8/7/12, identified the RN manager or designee reviews each resident's medication regimen (in addition to the Pharmacist's monthly drug regimen review) to assure there were no excessive dosages, duplicative therapy, excessive durations, inadequate monitoring for side effects or other parameters or inadequate indications for use.

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	03/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49617 Based on observation, interview and document review, the facility failed to ensure frozen food items were stored in a manner to prevent cross contamination in 2 of 3 unit kitchenettes reviewed. Findings include: During observation on 3/5/25 at 10:49 a.m., the second-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened plastic bag of frozen, pre-cooked bacon that was not sealed but was dated 3/3. Additionally, there was a resealable gallon-sized bag of frozen, pre-cooked sausage links that was dated 3/3. There was also a sealed plastic bag of frozen, pre-cooked pancakes that had a thick layer of white, ice crystals inside on the pancakes. Nursing assistant (NA)-J reviewed the items in the freezer and confirmed the dates and stated the unit usually went through the food items in 3 days per policy. When asked about the opened bags of bacon and sausage links, NA-J stated someone from the main kitchen came each morning and went through the freezer and removed undated and old food items. During observation on 3/5/25 at 1:32 p.m., the first-floor kitchenette was reviewed. In the kitchenette's freezer, there was an opened and unsealed bag of frozen, pre-cooked bacon. The bag was dated 3/4 but not able to be resealed in it's original packaging, leaving the bacon open to air in the freezer. Per interview on 3/5/25 at 1:43 p.m. with culinary supervisor (CS), kitchen staff were expected to remove outdated food items or items that look bad. CS confirmed kitchen staff rounded on the unit kitchenettes in the morning and looked through the freezers and refrigerators to replenish what the units needed. CS also expected everything in the fridge and freezer to be covered or sealed. During follow-up tour and interview on 3/5/25 at 2:41 p.m., CS and culinary manager (CM) verified the opened food packages in the second-floor kitchenette freezer. CM confirmed kitchen staff rounded each morning on the unit kitchenettes to replenish food items and stated someone should have removed the bacon, sausage links, and pancakes. Additionally, CM stated nursing staff utilized the kitchenettes and were also expected to remove outdated and opened items. CM stated, the expectation would be if you're seeing something that is unlabeled or opened and you weren't sure how long it had been open or it did not have a bag, you should take it out or call the kitchen at least if you have questions. CM stated food items that were stored improperly posed the risk of cross-contamination and infection control. Per interview on 3/6/25 at 1:41 p.m., the administrator expected food to be labeled and sealed appropriately to prevent cross contamination. Per facility policy titled Episcopal Homes Refrigerator and Food Storage Policy and Procedure dated 11/24, all food products not in their original containers would be placed in approved, seamless, tightly sealed containers. Staff were directed to properly re-seal packages of frozen foods to prevent freezer burn and spoilage.

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	03/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure hand hygiene was performed for 2 of 3 residents (R24, R84) observed during personal cares and 1 of 1 residents observed during wound cares. Furthermore, the facility failed to ensure transmission-based precautions (TBP) were followed for 1 of 3 (R24) residents observed for TBP. Findings include: R24 R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact and had diagnoses of kidney failure that required dialysis, diabetes, and vascular disease. Furthermore, R24 had a pressure wound, required assistance of two staff for toileting, and was frequently incontinent of bladder. R24's hospital provider note dated 2/18/25 indicated R24 had a history of Methicillin Resistant Staphylococcus aureus (MRSA); a multi-drug resistant bacteria. The note further indicated cultures from R24's right foot infection had MRSA growth. R24's care plan revised 2/20/25, indicated R2 had a right foot surgical incision and directed staff to follow facility policies/procedures for treatment. R24's care plan further indicated R24 required assistance with toileting. R24's Electronic Medical Record (EMR) lacked indication R24 required TBP or enhanced barrier precautions (EBP). An observation on 3/3/25 at 7:54 a.m., R24 was sitting up in their recliner. Outside R24's room on the door frame was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. An observation on 3/5/25 at 7:54 a.m., R24 was sitting up at the edge of their bed. Outside the room was a sticker that said EBP. Hanging under R24's name plate was a sign that said Enteric Contact Precautions and directed all staff who enter to don a gown and gloves and wash hands with soap and water upon exit. At 7:56 a.m., trained medication assistant (TMA)-A entered R24's room without donning a gown or gloves and provided medications. When interviewed on 3/5/25 at 7:59 A.M., TMA-A verified the EBP sticker outside the door and the sign for Enteric Contact Precautions. TMA-A was not sure which precautions R24 needed and would need to talk to the nurse. TMA-A further stated a gown and gloves were needed when working with R24's wounds or ostomy. TMA- verified with the registered nurse (RN)-E R24 was on EBP. When interviewed on 3/5/35 at 8:05 a.m., RN-D stated R24 required EBP and only required gown and glove for personal cares, wound cares and hygiene. RN-E verified the sign for enteric contact precautions and further stated I don't even know what that is. (continued on next page)

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	03/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 3/5/25 at 8:10 a.m., nursing assistant (NA)-D entered R24's room to provide morning cares. NA-D performed hand hygiene, donned gown and gloves before entering. A warm basin of soapy water was placed on R24's bedside table. With several washcloths inside the basin. NA-D washed R24's legs and left foot. NA-D placed the washcloth back into the basin of soap and water. R24's brief was unfastened and was wet. NA-D tucked the brief under R24 and then grabbed a washcloth from the basin of soapy water and cleaned R24's peri area. The washcloth used to clean R24's peri area was then placed back into the same basin of soapy water. The basin of soapy water was brought over to R24's bathroom sink. The water was emptied into the sink, leaving the washcloths in the basin. Without glove exchange and hand hygiene, NA-D then refilled the basin with soapy water and took the basin with the same washcloths over and placed on R24's bedside table again. R24 was assisted with turning to the left side and NA-E took a washcloth out of the basin to wash R24's back, right arm and underarm area. The washcloth was placed back into the basin of soapy water. R24 was then assisted to turn to their right. R24's brief was tucked down and a washcloth was obtained from the soapy basin of water. R24's bottom was cleaned and R24 was assisted to their back. NA-D then took the basin of soapy water and emptied into the sink, this time including the washcloths. NA-D filled the bucket with soapy water and obtained clean washcloths on R4's bathroom sink and brought to the bedside table. Without glove exchange or hand hygiene, NA-D took a washcloth out of the basin and washed R24's chest and abdomen. NA-D put the washcloth into the bathroom sink before obtaining a second one from the basin and assisting in washing R24's face. The bucket was then emptied, and all wet washcloths were then placed into the bucket. NA-D then removed gloves and threw them in the garbage. Without hand hygiene, NA-D took obtained clothing for R24 and guided the legs into the pants. NA-D then obtained a clean brief and placed it next to R24 before assisting with turning to place it on. The soiled brief was still tucked under, however was removed and placed in the garbage. NA-D assisted R24 with a shirt and sweatshirt. NA-D then removed gloves and without performing hand hygiene prepared a lift and wheelchair while waiting for help to transfer R24 to the wheelchair. When interviewed on 3/5/25 at 8:47 a.m., NA-D verified they did not perform hand hygiene after glove removal and was supposed to. NA-D further stated the soiled washcloths were placed back into the basin of water because the sink was farther away and the basin was just closer at that time. NA-D acknowledged the washcloths. NA-D verified the enteric isolation sign outside R24's room and stated R24 was not infected and only required EBP. An observation on 3/5/25 at 1:00 p.m., RN-E was in R24's room donned in a gown and gloves preparing items for R24's dressing change to the right heel and right foot surgical incision. Once set up, RN-E washed hands and donned new gloves. RN-E removed the ace bandage and kerlix from R24's right foot. The gauze over the surgical dressing was removed and an adaptic dressing removed from the heel. RN-E obtained a clean gauze and cleaned R24's heel with wound cleaner. Then took Aquaphor ointment and applied to R24's foot avoiding surgical incision and heel. RN-E then removed their right glove and without hand hygiene, placed donned a new one. R24's heel wound was measured and Adaptec dressing applied. Without hand hygiene or glove exchange, Betadine swabs were then used over R24's surgical incision. The surgical incision was covered with gauze before wrapping R24's foot with kerlix and ace wrap. When interviewed on 3/5/25 at 2:07 p.m., RN-E verified they did not perform hand hygiene in between glove exchanges. RN-E stated that only needed to be done with certain circumstances such as picking up something from the floor. (continued on next page)

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	03/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 3/6/25 at 10:05 a.m., RN- D stated when residents were on EBP, just the yellow sticker was outside their door on the frame. This directed staff to gown and glove for direct resident cares. If the resident was in full isolation precautions, the isolation sign would be placed outside their door and staff were expected to follow the directions on the sign. RN-D stated R24 was on contact for MRSA related to R24's surgical incision, but believed the infection was no longer active as R24 had completed the antibiotics. RN-D further stated they did not have a contact isolation sign, so enteric contact isolation was similar so that one was placed. RN-D stated staff should be following the isolation signs if in place. When interviewed on 3/6/25 at 11:00 a.m., the infection preventionist/Director of Nursing (DON) expected staff to follow the TBP or contact isolation signs that were placed for the resident. IF they were unsure, they should follow up. DON further expected staff to perform hand hygiene when moving from dirty areas to clean areas and after each glove removal. 42586 R84 R84's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia, delirium, and history of urinary tract infections (UTI). It further included R84 was dependent on staff for toileting, mobility, and was always incontinent of bowel and bladder. During observation on 3/5/25 at 1:03 p.m., NA-F and NA-G were transferring R84 from the wheelchair to bed. Once she was laying in bed, they removed the sling from underneath her in order to change her brief. NA-F removed R84's pants, put them in the dirty clothes basket, removed her brief and cleaned her peri area with a wipe while wearing gloves. Then NA-G assisted R84 to roll over and NA-F used a wipe to clean her bottom which had a small amount of bowel movement on it. Then NA-F put a new pair of pants on and proceeded to put R84's neck pillow around her neck, pull her sheet and blanket up to her chin, put a pillow under her head, and used the bed remote to adjust the bed without changing gloves. Once those tasks were complete, NA-F removed her gloves, used hand sanitizer, and exited the room. During an interview on 3/5/25 at 1:20 p.m., NA-F stated nursing staff should remove their gloves and wash their hands following a brief change. NA-F verified touching R84's blankets, pillow, neck pillow, and bed controller after changing her brief without removing her gloves or washing her hands. During an interview on 3/5/25 at 1:25 p.m., NA-G stated nursing staff should change gloves after a changing a brief, and wash their hands before touching anything else. During interview on 3/6/25 at 7:50 a.m., licensed practical nurse (LPN)-B stated after completing personal cares (specifically changing a brief), nursing assistants should remove their gloves, wash their hands, and apply new gloves before touching anything else. A facility policy titled Hand Hygiene revised 10/2/24, directed staff to perform hand hygiene after touching body fluids or contaminated items whether gloves are worn and immediately before and after glove removal. (continued on next page)

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	03/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Enhanced Barrier Precautions revised 10/2/24, directed staff to implement EBP when residents were infected or colonized with an MDRO, when contact precautions were not otherwise indicated.

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	03/06/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to ensure 2 of 5 residents (R59, R211) were offered and/or provided updated vaccinations for pneumococcal disease and 1 of 4 residents (R59) were offered and/or provided updated vaccinations for influenza in accordance with the Centers for Disease Control (CDC) vaccinations. Findings include: R59's significant change Minimum Data Set (MDS) dated [DATE], indicated R59 was admitted on [DATE], was currently [AGE] years old, had intact cognition and diagnosis of diabetes which put him at higher risk for pneumococcal diseases. It further indicated his influenza and pneumococcal vaccinations were not up to date and had not been offered. R59's immunization report undated, indicated R59 received the pneumococcal conjugate vaccine (PCV13) on 5/24/17. It further indicated R59's most recent influenza vaccination was administered on 10/26/2023. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 3/5/25, identified based on R29's age and vaccine history: Give one dose of PCV20 or PCV21 at least 1 year after PCV13. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. R59's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a signed declination or documentation of risk and benefits regarding the pneumococcal and/or influenza vaccination. R211 R211's significant change MDS dated [DATE], indicated R211 was admitted on [DATE], was currently [AGE] years old, had intact cognition and diagnoses of heart failure and hypertension. It further indicated his infuenza and pneumococcal vaccinations were not up to date. R211's immunization report (undated) lacked documentation of an influenza and pneumococcal vaccination. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 3/5/25, identified based on R211's age and vaccine history: Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 are used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising condtions such as cochlear implants, or cerebrospinal fluid leaks. R211's medical record lacked documentation he had received any pneumococcal vaccinations, a signed declination, or information regarding risks and benefits regarding the pneumococcal and influenza vaccinations. (continued on next page)

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	03/06/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/6/25 at 10:05 a.m. the director of nursing (DON)/infection preventionist (IP) stated when the facilty recieved a new admission, the health unit coordinator (HUC) was responsible for entering the vaccines into point clinck care (computer program). Then the nurse was responsible for ensuring there wasn't any contraindications, offering the resident the vaccines, and then administering them. The DON/IP further stated the facility offered the influenza vaccination to residents from September to April each year and they had a vaccine clinic in October. After that they offered vaccinations to new admits. If a resident refused a vaccination there should be a signed declination form which included the risk and benefits, and it should be documented in the residents medical record. She also verified they didn't have a Minnesota Immunization Information Connection (MIIC) report for R211. The facility's policy on influenza and pneumococcal vaccinations were requested but not received.

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	03/06/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to provide a COVID-19 vaccination timely to 1 of 1 resident (R211) who requested to be vaccinated. Findings include: R211's significant change Minimum Data Set (MDS) dated [DATE], indicated R211 was admitted on [DATE], had intact cognition and diagnoses of heart failure and hypertension. R211's immunization report (undated) lacked documentation of a COVID-19 vaccination. R211's medical record lacked a signed consent/declination form with risks and benifits for a COVID-19 vaccination. During interview on 3/3/25 at 10:43 a.m. R211 stated he had not been vaccinated in years. He asked someone (unknown) about getting the flu, COVID, pneumonia and Tetanus vaccination in the past, but they told him he could only get them at the care center. He still hadn't received any vaccinations. During interview on 3/6/25 at 10:05 a.m., the director of nursing (DON)/infection preventionist (IP) stated when the facilty recieved a new admission, the health unit coordinator (HUC) was responsible for entering the vaccines into point click care (computer program). Then the nurse was responsible for ensuring there wasn't any contraindications, offering the resident the vaccine, and then administering them. If a resident refused a vaccination there should be a signed declination form which included the risk and benefits, and it should be documented in the residents medical record. She also verified they didn't have a Minnesota Immunization Information Connection (MIIC) report for R211 and that he hadn't received the COVID-19 vaccination. The facility's policy regarding COVID-19 vaccinations was request but not received.