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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medications were stored appropriately, securely, and not expired for 3 of 5 medication carts reviewed for medication storage. This had the potential to affect all the residents who received medications from those carts or resided in or visited the area of the facility in which those medication carts were located. In addition, the facility failed to ensure a medication for one resident (R8) was not left at the bedside of a different resident (R87), contributing to inappropriate medication storage practices for the facility.Findings include:Unsecured medications R4's provider order dated 4/2/26, indicated, Insulin Aspart Subcutaneous Solution Pen-injector 100 unit/ml [Insulin Aspart] (short acting insulin used to treat diabetes). R4's order dated 4/28/26, indicated, Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml [Insulin Glargine] (long-acting insulin used to treat diabetes). R122's provider order dated 4/13/26, indicated, Insulin Lispro [1 unit dial] Subcutaneous Solution Pen-injector 100 unit/mil [Insulin Lispro]. R122's provider order dated 4/6/26, indicated, Acetaminophen Oral Tablet 500 mg. During continuous observation on 5/6/26 at 2:04 p.m., one medication cart located outside the transitional care unit (TCU) team room and adjacent to a common area with a television, sofa, table and several chairs, had a small med cup with two white pills sitting beside a large bottle of Tylenol. No staff were seen in the area. -At 2:09 p.m., registered nurse (RN)-I went to the med cart and gathered medications from the cart and walked away, leaving the two pills and bottle of Tylenol sitting unsecured on the med cart. -At 2:15 p.m., RN-I walked back to the cart, charted in the computer and at 2:19 p.m., walked away from the cart, again leaving the medication unsecured on top of the medication cart. -At 2:21 p.m., RN-I returned to the med cart, retrieved the cup with the two pills and disposed of them in the TCU team room. During interview on 5/6/26 at 2:22 p.m., RN-I stated she did leave the med cup with the two pills, which were Tylenol (acetaminophen), and the container of Tylenol out on the med cart unsecured. RN-I stated she prepared the medication and then discovered R122 was in therapy when she (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

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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attempted to administer the medication. RN-I stated the medication was just Tylenol, but she still should not have left it sitting out since anyone walking by could have grabbed it. During observation and interview on 5/7/26 at 9:02 a.m., a tote sat next to the TCU medication cart and contained a clear plastic graduated cylinder with three insulin pens inside. The three insulin pens were not in individual plastic bags and were touching each other. There were no staff around and the tote was sitting between the med cart and the TV in the small common area. RN-I approached the cart and was asked about the insulin pens. RN-I stated insulin pens were normally stored in the top drawer of the med cart, she opened the top drawer and exposed several other insulin pens stored appropriately. RN-I stated the insulin pens should not be left out in the open and unsecured since anyone could have walked by and grabbed one. RN-I further stated the insulin pens were normally in individual plastic bags and confirmed the three that were out were not in bags and were touching each other. RN-I stated the pens should not have been stored like that. RN-I identified one of the pens were Lispro and was labeled for R122. RN-I identified the other two pens as Aspart and Lantus (Glargine) and stated they were labeled for R4. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated expectation for medications to be stored in the med carts and not left out unsecured which could allow residents, visitors or other staff to grab them. In addition, RN-A stated insulin pens should be stored in the top drawer of the med carts and not in the transport totes. Resident insulin pens should not be stored in direct contact with other resident's insulin pens to reduce the risk of cross contamination. R34's quarterly MDS dated [DATE], identified severely impaired cognition, diagnoses of diabetes mellitus and non-Alzheimer's dementia. R34 received insulin injections seven out of seven days in the lookback period. R34's nursing progress note dated 12/13/25 at 14:39 (2:39 p.m.), identified due to persistent increased blood sugars this day the nurse practitioner was updated and gave a one-time order for six units of insulin aspart (rapid-acting insulin). R34's corresponding Medication Administration Record (MAR) dated 12/13/25, identified the insulin aspart was given as ordered one time. R34's Physician's Orders form dated 3/26/26, identified to discontinue Lantus insulin (long-acting insulin also known as insulin glargine) R34's corresponding MAR dated 3/1/26 through 3/31/26, identified insulin glargine give four units subcutaneously (between the skin and muscle) one time daily related to type two diabetes. The order included a start date of 1/22/25 and discontinue date of 3/26/26. During an interview and observation on 5/7/26 at 10:50 a.m., registered nurse (RN)-E reviewed the insulin storage for the household. Included was an insulin aspart pen with a handwritten label including R34's name, which was not dated when opened. RN-E verified the insulin aspart was not a current order. Additionally, a Lantus insulin pen with a faded pharmacy label on it including R34's name was present. RN-E reviewed R34's orders and found the Lantus was discontinued on 3/26/26, neither pen should be in the insulin storage and usually, when a medication was discontinued, they would be removed from storage and given to the clinical manager to dispose. During observation on 5/7/26 at 10:28 a.m., an unattended medication cart was observed on the May (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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit. On top of the medication cart, there was a bottle of acetaminophen 500 milligrams tablets, and a teriparatide injection 560 micrograms over 2.24 milliliters. During continuous observation between 10:28 a.m. and 10:42 a.m., four staff members and a family member walked by the medication cart. During interview on 5/7/26 at 10:42 a.m., licensed practical nurse (LPN)-B stated she gave a shot to a resident before she went to check on another resident. LPN-B stated she needed to put the injectable medication in the refrigerator in the nurse's station and lock the bottle of Acetaminophen in the medication cart, but she forgot to do it. LPN-B added I just forgot to put away the medications, somebody could have grabbed the medications. Medication left in wrong resident's room R87's admission MDS dated [DATE], identified R87 had intact cognition and required substantial to maximal assistance for most activities of daily living (ADLs). R87's diagnosis included neovascular secondary angle closure glaucoma (severe glaucoma involving blood flow to the eye resulting in increased intraocular pressure and potential vision loss) affecting the left eye. R87's provider orders did not indicate Diclofenac (topical pain gel). R8's provider orders dated 11/29/25, indicated, Diclofenac Sodium External Gel 1% .Topical. During observation and interview on 5/4/26 at 5:41 p.m., R87 sitting in recliner with a bedside table in front of him. There was a bag with a tube of Diclofenac gel sitting on the table. R87 stated did not know what that medication was or what it was used for. With further inspection, the prescription label on the tube of medication indicated it was for a different resident (R8). R87 could not explain why it was left on his table. Licensed practical nurse (LPN)-D entered room and was asked about the medication. LPN-D picked up the bag, looked at the label and stated it belonged to a different resident and then set it back down on R87's table. LPN-D stated it must have been left there by the day shift and could not explain why it was in the wrong resident's room. During interview on 5/4/26 at 5:51 p.m., LPN-A entered R87's room and stated the medication must have been accidentally left on the table earlier in the day and could not otherwise explain why. During follow up interview on 5/6/26 at 1:48 p.m., LPN-A stated would not expect a medication for one resident to be left in a different resident's room. LPN-A stated medication should be stored securely and only left at the bedside of the correct resident if the resident was assessed safe to self-administer medication and safely store the medication at the bedside. During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated expectation for all medications to be securely stored in medication carts and not left out unsupervised and would not expect medications for one resident to be left in a different resident's room. DON further stated insulin pens should be stored in the top drawer of the locked medication cart and should not be stored in the tote that was used to transport the insulin pens to the resident room for administration. DON stated each insulin pen should be stored in a separate plastic bag designated for each individual resident and should never be stored together, unprotected from other resident's insulin pens which could cause cross contamination. In addition, DON stated that insulin pens should be discarded when expired. Facility policy Medication Storage Policy dated 1/1/2015, indicated lockable medicine carts, (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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cabinets, and drawers were provided for proper storage of medications. The policy lacked reference to expired medications. Facility policy Bedside Medication Storage, undated, indicated medications were stored at the bedside only when the resident was assessed safe for self-administration and storage of medication. The policy further indicated, All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage.

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	05/07/2026

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene for 1 of 1 resident (R21) during incontinence cares and for 1of 1 resident (R29) during meal service which had the potential to affect all 14 residents in that household. The facility further failed to ensure appropriate personal protective equipment (PPE) was being worn for 1 of 2 residents (R115) on enhanced barrier precautions (EBP). Findings include: Incontinence Care R21's admission Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition, was always incontinent of bowel and bladder, and dependent on staff for toileting and lower body dressing. R21 had diagnoses of non-Alzheimer's dementia and acute cystitis with hematuria (bladder inflammation with blood in the urine). R21 was taking an antibiotic with an indication identified. R21's Urinary Incontinence Care Area Assessment (CAA) dated 3/10/26, identified an admission following hospitalization due to having a UTI (bladder infection) with no complications noted. R21 was always incontinent of B&B (bowel and bladder) during the reference period. Staff were directed to continue to provide assist with peri care after each incontinent episode. R21's ADL (activities of daily living) care plan dated 3/31/26, identified one staff was required for toileting. During an observation on 5/4/26 at 4:54 p.m., nursing assistant (NA)-D brought R21 who was in her wheelchair, to her bedroom. NA-C entered shortly thereafter. NA-D and NA-C assisted R21 into her bed using a full body mechanical lift. While R21 was laying on her back, NA-C put on gloves, opened R21's incontinence brief and using wet wipes, cleaned up bowel movement from R21's groin at the front of the brief, and tucked the soiled wet wipes into the brief. R21 was assisted to roll on her side and NA-C cleaned up the rest of the bowel movement from R21's buttocks and tucked the soiled wet wipes into the brief. NA-C removed the soiled brief containing the soiled wipes, rolled it all up and put in the garbage. With the soiled gloves still on, NA-C put a new brief under R21, opened a jar of emollient ointment, and using the same soiled gloves, scooped out the ointment and applied it to R21's backside. Then NA-C removed her soiled gloves and put them in the garbage can. R21 was assisted to roll on her back, and the new brief was fastened. NA-C exited the room to dispose of the garbage.NA-C had contaminated the outside of R21's brief and the emollient jar by handling the items with soiled gloves. During an interview on 5/4/26 at 5:02 p.m., NA-C stated her gloves should have been changed right after incontinence cares. NA-C also said it was a mistake to go into the emollient jar with soiled gloves as the emollient was used on R21's legs also. During an interview on 5/4/26 at 6:25 p.m., NA-D stated gloves should be changed right after incontinence cares, disposed of, and new ones put on before touching anything else. During an interview on 5/4/26 at 6:27 p.m., registered nurse (RN)-F stated he expected gloves to be changed, hand hygiene performed right after incontinence cares and before touching anything else. RN-F stated he would have to dispose of the emollient jar as it may be contaminated with feces which could contribute to UTI. (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	05/07/2026

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 - Some	R29 R29's annual MDS dated [DATE], indicated severely impaired cognition, diagnoses of dementia, and no rejection of care behaviors noted. It further indicated R29 required assistance from staff with personal hygiene. R29's care plan dated 4/22/26, indicated R29 demonstrated ADL self-care performance deficit related to decreased cognition/confusion, impaired mobility. Non-compliant in waiting for assistance with an intervention requiring moderate to maximal assist of 1. During observation on 5/5/26 at 1:05 p.m., R29 was sitting in a chair in the dining room. The fingernails on both hands were approximately two inches long and had brown matter caked underneath them. During observation on 5/6/26 at 11:25 a.m., R29 was sitting at the dining room table drinking juice and waiting for lunch. The fingernails on both hands were approximately 2 inches long and had brown matter caked underneath them. At 11:45 a.m., NA-A set her lunch plate in front of her but did not offer to wash R29's hands or use hand sanitizer before she started eating. R29 proceeded to pick up her roll and eat it with her hands. Then she would pick up pieces of food (salad) off of her plate with her fingers and eat it. At 12:11 p.m., NA-A gave R29 ice cream for dessert. She ate the ice cream with a spoon, but when the ice cream was gone, she stuck her fingers in the cup and then proceeded to lick them. She then used her hands to brush the crumbs from her lunch off the table onto the floor. At 12:33 p.m., R29 left the table in her wheelchair and headed down the hallway towards her room. NA-A did not offer to wash R29's hands or use hand sanitizer when she was finished eating. During observation on 5/7/26 at 7:36 a.m., R29 was sitting in the dining room eating oatmeal and was using a spoon. The fingernails on both hands were approximately 2 inches long and had brown matter caked underneath them. When she had finished eating her oatmeal, she stuck her fingers in the bowl and then licked her fingers. NA-A asked R29 if she was done with her oatmeal and then took the bowl away. R29 picked up her spoon and started eating her yogurt with a spoon. At 8:23 a.m. R29 was sitting at the table eating orange slices. When she was finished, she started to fall asleep. NA-A asked her if she wanted to go back to her room to take a nap. NA-A assisted R29 to stand up and grab her walker and she headed back down the hallway towards her room. NA-A did not offer to wash her hands or use hand sanitizer. During observation and interview on 5/7/26 at 8:50 a.m., NA-B stated NAs were responsible for ensuring the residents hands and fingernails were clean and they were expected to wash the resident's hands (or use hand sanitizer) before and after meal service. NA-B verified R29's fingernails were long and had brown matter underneath them that appeared to have been there for a while, stating R29 often eats with her hands. During interview on 5/7/26 at 8:57 a.m.NA-A stated nursing assistants were responsible for ensuring resident's hands and fingernails were clean stating they have manicure sticks they can use on the resident's shower day, or they can wash them and clean underneath the nails if needed. NA-A further stated the NAs were also responsible for offering to wash the resident's hands or use hand sanitizer after meal service. During interview on 5/7/26 at 9:10 a.m., RN-B stated nursing staff (NAs and nurses) should be offering to clean the resident's nails at least once a week on their bath day and as needed, or they (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	05/07/2026

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 - Some	can soak their hands and clean underneath their nails. This is important to prevent germs from spreading. EBP R115's census identified he was admitted on [DATE]. R115's in-house nurse practitioner (NP) initial intake document dated 5/1/26, identified diagnoses of cellulitis, abscess of right lower extremity (RLE) and history of sepsis. R115 had a right lower extremity wound which was really weepy and required a towel underneath the leg to absorb drainage. A wound consult was ordered. R115's wound care orders dated 4/30/26, identified clean leg with antimicrobial cleansing solution, dry well, apply skin prep to peri-wound, xeroform (protective wound dressing) to wound bed, cover with non-adherent gauze, add ABD pad (consists of a soft outer nonwoven layer and fluff filler to absorb and disperse fluid) as needed if drainage, secure with kerlix (gauze). R115's care plan dated 4/30/26, identified actual impairment to skin integrity of bilateral lower extremity wound with interventions to follow facility protocols for treatment of injury. The care plan lacked EBP interventions. During an observation on 5/4/26 at 11:36 a.m., R115 was seated in his wheelchair. His RLE was wrapped in gauze up to the knee, covered with a grip sock and elevated on a folding chair. R115 stated he had an infection while in the hospital. He had a lower leg wound that had a once weekly dressing change, however it was recently changed to daily dressings as the weekly one would get too saturated and leak. During an observation and interview on 5/4/26 at 11:50 a.m., nursing assistant (NA)-E entered R115's room with a mechanical standing lift to complete a transfer. NA-E did not put on any PPE for the transfer. After NA-E exited the room, she was asked if R115 required EBP and she R115 was not on precautions, because there was no bin outside the room of PPE and no signage near the door. NA-E stated that was the reason she did not put a gown on to help R115 with his transfer. During an interview on 5/4/26 at 11:58 a.m., NA-F stated if a resident was on EBP a gown should be on for all high contact cares. Additionally, a sign and bin would be outside each room. NA-F looked at R115's room and said there was no PPE bin or signage for EBP and was unsure if EBP was in place. During an interview on 5/4/26 at 12:20 p.m., RN-G who was working with R115 today, stated if a resident was on EBP they needed a gown and gloves on for all direct care, including transfers. Though RN-G had been working with R115 today, she was unsure if he was on EBP and wanted to check with the nurse manager. During an interview and observation on 5/4/26 at 12:25 p.m., RN-G returned with a printed EBP instructions sign for R115's doorway and said he should be on EBP due to the wound. RN-G stated the wound was weeping fluid today when the nurse practitioner changed the dressing. During an interview on 5/4/26 12:26 p.m., RN-A stated R115 should have EBP in place as he was admitted with a wound. Each room on EBP should have their own bin and signage directing staff to follow EBP PPE precautions. (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	05/07/2026

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 - Some	During an observation on 5/4/26 at 12:30 p.m., NA-F placed a full PPE bin outside of R115's room. During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated gloves should be changed immediately after incontinence cares, hand hygiene should be completed and new gloves put on if needed, and a resident with a weeping wound should be placed on enhanced barrier precautions for infection control purposes. During interview on 5/7/26 at 10:08 a.m., DON stated if a resident's fingernails are dirty the nursing staff are expected to clean them. They are also expected to be offering to wash the residents' hands or use hand sanitizer if they are visibly soiled after meal service. A facility policy regarding hand hygiene dated 10/2/24, indicated hands must be washed with soap and water if they are visibly soiled. Alcohol based hand sanitizer may be used for hand hygiene unless hands are visibly soiled. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, andcontaminated items, whether gloves are worn; immediately before and after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other elders, personnel, equipment and/or the environment. Hand hygiene is essential in order to prevent the transmission of infectious agents.

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	05/07/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medication was administered safely for 2 of 2 (R68, R117) who had been assessed as unable to safely self-administer medications.Findings include: R117 R117's care plan dated 4/27/26, indicated R117 had an ADL self-care deficit related to a functional ability decline due to right scapula and rib nonunion (unhealed fracture). The care plan further indicated R117 had altered respiratory status and difficulty breathing related to COPD (chronic obstructive pulmonary disease) and OSA (obstructive sleep apnea). R117's provider orders dated 4/26/26, indicated Calcium Carbonate Antacid Oral Tablet Chewable 1000 MG.Give 1 tablet by mouth one time a day for Supplement. R117's provider orders lacked evidence of Symbicort (budesonide/formoterol) inhaler. R117's electronic medical record (EMR) lacked evidence of orders allowing SAM and medications to be left at bedside. R117's SAM assessment dated [DATE], indicated R177 did not desire to self-administer medications and agreed to have medications administered by the facility. During observation and interview on 5/4/26 at 1:42 p.m., R117 was in their room in recliner with a bedside table adjacent to the chair. There was an unlabeled inhaler and also a small medicine cup with 2 chewable disks inside. R117 stated she used the inhaler on occasion and would take those chewable tablets later. During observation and interview on 5/4/26 at 1:56 p.m., licensed practical nurse (LPN)-C confirmed the medications on R117's bedside table included a Symbicort inhaler and two Tums. LPN-C stated R117 was not assessed as safe for SAM and those medications should not have been left at the bedside. LPN-C stated if a resident refused to take a scheduled medication when offered, it should be removed and not left at the bedside. During interview on 5/6/26 at 1:48 p.m., LPN-A stated would not expect medications to be left at the bedside unless the resident was assessed as safe for SAM. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated in order for medications to be left at the bedside, the resident must be assessed as safe for SAM. RN-A stated R117 had not been assessed as safe for SAM and therefore, the medication should not have been left at her bedside. During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated medications should not be left at the bedside unless the SAM assessment was completed indicated the resident was safe for SAM. Facility policy Bedside Medication Storage, undated, inidcated, All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside (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	05/07/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	storage. R68 R68's quarterly MDS dated [DATE], indicated R68 was cognitively intact, had no hallucinations or delusions. MDS indicated R68 was set up assistance with activity of daily living and supervision with mobility. MDS indicated diagnoses of chronic obstructive pulmonary disease, cellulitis of lower limbs, and left knee surgery. A review of R68's orders indicated the following: -On 1/26/26, R68 may not self-administer medication. -On 3/6/26, required a topical analgesic external gel 4% apply to affected areas. R68's care plan revised on 4/3/26, indicated she was at risk for impaired comfort related to pain. Interventions directed staff to give pain medication as ordered, monitor effectiveness of pain interventions, provide non-pharmacological measures and report unrelieved pain and condition of change to primary care provider. R68's SAM assessment dated [DATE], indicated R68 was not safe to self-administer medications. Furthermore, the comment section indicated R68 hoarded and used multiple over the counter medications. During observation on 05/04/2026 at 5:29 p.m., R68 had Biofreeze (topical analgesic) roll-on located in a bin on bedside table in her room. R68 was sitting in chair and stated she puts it on by herself. During observation on 05/05/2026 at 9:49 a.m., R68 had Biofreeze located in a bin on bedside table in room. During observation on 05/06/2026 at 10:53 a.m. R68 had Biofreeze located in a bin on bedside table in room. Nursing assistant (NA)-I confirmed that there was Biofreeze in R68's room as R68 applied it when it was needed. During interview on 5/6/26 at 11:45 a.m., LPN-B stated residents' medications should be locked up. Additionally, an assessment for SAM was required and order from the physician was necessary for residents to self-administer medications. Facility policy Self-Administration of Medication dated 11/13/17, indicated residents could only self-administer medications after the IDT (interdisciplinary team) had determined which medications could be safely self-administered. The policy further indicated, if a resident was found safe for SAM per the licensed nurse assessment and IDT determination, a provider order would also need to be obtained which would specify which medications could be kept at the bedside. During interview on 5/6/26 at 1:28 p.m., RN-H stated for residents to self-administer medications was a physician order was required. The resident needed to be cognitively able to safely take the medication, know the name of medication, and how often to take it. During interview on 5/7/26 at 10:22 a.m., director of nursing (DON) stated they expected residents (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	05/07/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who self-administered medications to have a physician's order. The resident needed to be cognitively able to understand the medication and its use. Additionally, a SAM assessment was to be completed quarterly for residents to help determine if they were safely able to self-administer medications.

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	05/07/2026

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** Based on observation, interview and document review, the facility failed to ensure the primary care provider (PCP) was notified of a change in condition for 1 of 2 residents (R21) reviewed for a change of condition. Findings include: R21's admission Minimum Data Set (MDS) dated [DATE], identified she had severely impaired cognition, no behaviors or rejection of care and was dependent on staff for toileting, bed mobility, transfers and lower body dressing. Diagnoses included diabetes mellitus and non-Alzheimer's dementia. R21 was admitted with an unstageable pressure ulcer/injury, was at risk for developing pressure ulcers/injuries and did not have foot problems. Skin interventions included pressure reducing devices for bed and pressure ulcer/injury care.R21's pressure ulcer Care Area Assessment (CAA) dated 3/10/26, identified she was admitted with left heel unstageable PI (pressure injury), dressing applied, to be seen by the wound nurse.R21's care plan dated 3/31/26, identified she had a pressure ulcer related to immobility with interventions to administer treatments, monitor for effectiveness, provide education, monitor nutrition and pressure relieving mattress on bed. The care plan lacked notation of any toe concerns.R21's weekly Skin and Body Audit form dated 4/4/26, identified the tip of right first toe (the big toe) had ischemic (dark or dusky color indicative of insufficient blood flow) tissue measuring 1.2 centimeters (cm) long by 0.9 cm wide. R21's nursing progress note dated 4/4/26 at 14:43 (2:43 p.m.), identified an on-call senior care nurse practitioner was notified of the ischemic tissue on the tip of the right first toe with instructions to continue monitoring with an update to the PCP wound nurse on Monday (4/6/26).R21's consultant wound care nurse practitioner (NP)-B visit note dated 4/16/26, identified the unstageable pressure ulcer to the left heel was healed, no new skin issues were reported to NP-B and to reconsult with any new concerns. NP-B was not updated on the new skin alteration to the right first toe observed on 4/4/26.R21's consultant wound care NP-A visit note dated 5/5/26, identified a non-pressure wound of the right first toe and full thickness of unknown duration, at least greater than 14 days. The estimated time to heal was one to two months. Care goals included to decrease wound area, improve new tissue growth, prevent infection, close monitoring, debridement, education and off-loading. Wound measurements were 1.2 cm long by 1.8 cm wide. The wound measurements had increased in width by 0.9 cm since it was last measured on 4/4/26. New orders were issued to apply Betadine (an antiseptic) once daily and as needed.During an observation and interview on 5/4/26 at 4:54 p.m., nursing assistant (NA)-D brought R21 into her room. The top of R21's right first toe was exposed and black on the top slightly larger than a dime in size. NA-D stated R21 had a bruise on the top of her right first toe and was unsure how long the skin alteration was present and estimated a week or more. During an interview on 5/6/26 at 7:51 a.m., licensed practical nurse (LPN)-A stated yesterday, on 5/5/26, the wound provider NP-A debrided (medical removal of dead, damaged, or infected tissue from a wound to promote healing) R21's right first toe wound, and they were waiting for the wound provider's transcription of the visit.During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, electronic chart and 24-hour nursing report sheets and stated the order for 4/6/26 to update the PCP wound care provider should have been completed and was not. Because of the lack of notification, consistent monitoring was not completed of the necrotic right first toe.During an interview on 5/6/26 at 1:07 p.m., consultant wound care NP-A, stated as soon as a facility noticed a new skin alteration, they should contact the wound care team so they can examine during their next wound rounds and update their records. NP-A expected any directions for wound care should be followed. NP-B stated it was not a significant change in the past month to R21's right first toe wound and expected it to be treatable. NP-A was not concerned that the wound had increased in size since first noticed on 4/4/26, and stated sometimes wounds increase in size before they begin to improve and his assessment showed R21's wound was stable. NP-A stated if (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	05/07/2026

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	R21's skin alteration had been addressed on 4/6/26, as ordered, it could have decreased in size by this time. During an interview on 5/6/26 at 12:03 p.m., senior care NP-C stated their on-call service was notified of the new skin alteration on 4/4/26 with orders to monitor and update the wound provider next business day (4/6/26). NP-C wrote new orders for R21 regarding blood pressure on 4/6/26, however she was not personally updated by the facility of R21's new skin alteration on the right first toe, so it was not addressed in her orders. NP-C stated she relied on the nursing staff to provide updates on changes in condition, and no information about the right first toe alteration was in their records between 4/4/26 and 5/4/26.During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated the facility should have updated the PCP or wound provider on 4/6/26, as identified in the on-call order, and entered into the electronic medical record to ensure consistent monitoring of the skin alteration was completed to ensure follow up.On 5/7/26 at 12:17 p.m., a phone call was placed to NP-B to inquire about his last wound care visit with R21 on 4/16/26 and if he was updated on the new skin alteration on the right first toe.On 5/14/26 at 1:50 p.m., NP-B's medical liaison (ML) returned the previous phone call. The ML stated she reviewed the phone logs and records, and their service was not updated on 4/6/26 or any date thereafter, of R21's new skin alteration on the right first toe, and she would have expected their services to be updated to complete a new assessment and form a treatment plan.The facility's Change in Condition policy dated 5/4/22, identified to promptly notify the resident, his/her attending MD (medical doctor) or other person as indicated by the resident of changes in the resident's condition. The MD should be notified if there was a discovery of injury of unknown source and a need to alter the resident's medical treatment. Additionally, documentation should be entered in the medical record of all information related to the change in condition, the notifications and interventions.

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	05/07/2026

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** Based on observation, interview and document review, the facility failed to ensure a new skin alteration was comprehensively assessed and monitored consistently in accordance with nursing standards of practice, and that orders for monitoring and referral were entered into the electronic medical record (EMR) for 1 of 2 residents (R21) reviewed for new skin alterations. Findings include: R21's admission Minimum Data Set (MDS) dated [DATE], identified she had severely impaired cognition, no behaviors or rejection of care and was dependent on staff for toileting, bed mobility, transfers and lower body dressing. Diagnoses included diabetes mellitus and non-Alzheimer's dementia. R21 was admitted with an unstageable pressure ulcer/injury, was at risk for developing pressure ulcers/injuries and did not have foot problems. Skin interventions included pressure reducing devices for bed and pressure ulcer/injury care.R21's pressure ulcer Care Area Assessment (CAA) dated 3/10/26, identified she was admitted with left heel unstageable PI (pressure injury), dressing applied, to be seen by the wound nurse.R21's care plan dated 3/31/26, identified she had a pressure ulcer related to immobility with interventions to administer treatments, monitor for effectiveness, provide education, monitor nutrition and pressure relieving mattress on bed. The care plan lacked notation of any toe concerns or interventions.R21's weekly nurse Skin and Body Audit forms identified:-4/4/26, tip of right first toe (the big/great toe) had ischemic (dark or dusky color indicative of insufficient blood flow) tissue measuring 1.2 centimeters (cm) long by 0.9 cm wide.-Wound assessments were not obtained 4/8/26 through 4/13/26, due to R21's hospitalization.-4/21/26, no notation of the right first toe alteration.-4/25/26, hard dark tissue observed on the right first toe. The audit lacked measurements of the skin alteration.-5/2/26, cyanosis and bruising on the right first toe. The audit lacked measurements of the skin alteration.R21's nursing progress note dated 4/4/26 at 14:43 (2:43 p.m.), identified the on-call provider was notified of the ischemic tissue on the tip of the right first toe with instructions to continue monitoring with an update to the PCP wound nurse on Monday (4/6/26).R21's Medication Administration Record (MAR), Treatment Administration Record (TAR) and EMR dated 4/1/26 through 5/4/26, lacked orders to monitor ischemic tissue on the right first toe or to update the PCP wound nurse on 4/6/26. The on-call provider's orders given on 4/4/26, had not been transcribed into the EMR for staff to monitor and document, therefore no further measurements were obtained and the PCP wound nurse was not updated on 4/6/26, of the new skin alteration.R21's consultant wound care nurse practitioner (NP)-B visit note following hospitalization dated 4/16/26, identified an unstageable pressure ulcer to the left heel was healed, no new skin issues were reported to NP-B and to reconsult with any new concerns.R21's consultant wound care NP-A visit note dated 5/5/26, identified a non-pressure wound of the right first toe and full thickness of unknown duration, at least greater than 14 days. The estimated time to heal was one to two months. Care goals included to decrease wound area, improve new tissue growth, prevent infection, close monitoring, debridement, education and off-loading. Wound measurements were 1.2 cm long by 1.8 cm wide. The wound measurements had increased in width by 0.9 cm since it was last measured on 4/4/26. New orders were issued to apply Betadine (an antiseptic) once daily and as needed.During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, EMR and 24-hour nursing report sheets and stated the order on 4/4/26, to update the PCP wound care provider on 4/6/26, should have been completed and was not. Because the order was not transcribed into the EMR, consistent monitoring was not completed of the ischemic right first toe.During an interview on 5/6/26 at 1:07 p.m., consultant wound care NP-A, stated any directions for wound care should be followed. NP-B stated it was not a significant change in the past month to R21's right first toe wound and expected it to be treatable. NP-A stated if R21's skin alteration had been addressed on 4/6/26, as ordered, it could have decreased in size by this time. During an interview on 5/6/26 at 7:51 a.m., licensed practical nurse (LPN)-A stated he could not find documentation the wound had been (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	05/07/2026

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	measured or comprehensively assessed since it was first noticed on 4/4/26. LPN-A stated orders from the weekend on-call providers should be entered into the EMR.During an interview on 5/6/26 at 8:22 a.m., the assistant director of nursing (ADON) reviewed R21's paper chart, electronic chart and 24-hour nursing report sheets and stated the weekend order to monitor the wound and to update the PCP wound care provider on 4/6/26, should have been completed and was not.During an interview on 5/6/26 at 12:03 p.m., senior care NP-C stated in the case of new ischemic skin alterations in a toe, she would expect nursing staff to document at least daily assessments in the medical record of the condition, signs of infection, circulation in the feet, and to update the provider on any worsening. Part of determining the progress or lack of progress in a wound included skin measurements.During an interview on 5/6/26 at 12:45 p.m., the director of nursing (DON) stated that she expected staff to follow the facility policy to complete and document Skin and Body audits every week which would include measurements and progress of the wound. Additionally, providers should be updated on skin alterations to ensure proper follow up.The facility's Skin Care policy dated 3/2025, identified for an existing ulcer, the assessment would: Differentiate the type of ulcer (pressure-related versus non-pressure related) Determine the ulcer's stage Describe the ulcer's characteristics Determine if infection is present Assess pain Note any dressings and treatments that have occurred.Additionally, the comprehensive assessment would initiate care plan directives including daily monitoring of skin with cares, at least weekly documentation in conjunction with bath day, monitoring of the ulcer's characteristics, progress toward healing, and potential complications.

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	05/07/2026

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** Based on observation, interview, and document review, the facility failed to ensure a resident was safe to have a lift reclining chair for 1 of 1 resident (R92) reviewed for falls. Findings include:R92's admission Minimum Data Set (MDS) dated [DATE], identified R92 had severe cognitive impairment, had lower extremity impairment on one side of the body, had a history of falls, was dependent on staff for transfers, and received antipsychotic, antianxiety, antidepressant, and opioid medications. R92's diagnoses included dementia, disorientation, anxiety, muscle weakness, and right pubis fracture. R92's care plan printed 5/7/26, indicated R92 was HIGH risk for falls r/t [related to] impaired mobility, confusion, dementia and instructed staff to ensure call light was in reach and encourage R92 to use it. The care plan identified R92 had an ADL (activities of daily living) self-care deficit and required two staff to assist with transfers using a [NAME] steady (standing lift) as needed. The care plan did not identify R92 had a lift reclining chair. R92's physical device review dated 4/19/26, identified R92 used a low bed and a walker, however, did not identify an electric recliner chair or any other lift type reclining chair. During observation on 5/7/26 at 8:30 a.m., R92 was not in her room. The lift reclining chair was all the way up to an almost vertical position. During observation on 5/7/26 at 8:40 a.m., R92 transferred from standing with a walker to the lift chair with contact guard assistance by physical therapist assistant (PTA)-B. PTA-B used the lift chair remote to lower the chair to a seated position and then to a reclining position. PTA-B placed the lift chair remote and the call light both on the right side of R92's lap next to each other. During interview on 5/7/26 at 8:41 a.m., PTA-B was not aware of any assessment for safe use of the lift chairs. During interview 5/7/26 at 8:52 a.m., nursing assistant (NA)-H stated R92 required the [NAME] steady lift for transfers from nursing staff and therapy used the lift chair. NA-H stated was not aware if R92 know how to use the lift chair, but she did use the call light on occasion. NA-H stated R92's cognition fluctuated and was not sure she always knew she was pushing the call light. During interview on 5/7/26 at 9:01 a.m., occupational therapy assistant (OTA)-A was not aware of any sort of lift chair assessment for residents. During interview on 5/7/26 at 9:11 a.m., registered nurse (RN)-A stated only nursing staff were supposed to use the lift chair for resident transfers when therapy indicated it was safe for the resident. RN-A further stated instructions for safe use would be on the resident's whiteboard and would also be in the resident's care plan. During interview on 5/7/26 at 9:20 a.m., director of therapy (DT) stated therapist working with the resident would do an informal evaluation of the lift chair and was not aware of any formal assessment. DT further stated was aware of a fall from a lift chair involving a different unidentified resident in long term care some time ago. DT stated maintenance ended up disabling the lift function of the recliner as a result of the findings of that fall investigation. DT further stated periodic evaluations should occur with resident's use of physical devices since their cognition can change. During interview on 5/7/26 at 9:54 a.m., director of nursing (DON) stated the therapy department worked with residents who had lift chairs and was not aware of any formal assessment. DON stated was aware of previous fall from a lift chair when a resident accidently sat on the remote and unintentionally activated the lift function of the chair. DON stated R92 was cognitively impaired and could see her accidentally using the lift chair remote when she intended to push the call light. During follow up interview on 5/7/26 at 11:30 a.m., DON stated the electronic recliner was listed on physical device assessment form and was being used with other residents as a lift chair assessment and the facility would change the wording to indicate lift chair. DON further stated R92 should have had an assessment completed to determine if she was safe to have a lift chair. A facility policy on physical device assessments was requested but not provided.