STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home the Gardens	1860 University Avenue West 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R2) who were reviewed for falls. Findings include: R2's face sheet dated 3/27/25, identified diagnosis of Parkinson's disease, dementia, and kidney disease. R2's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment, maximum assistance for bed mobility, dependent for transfers, and two or more falls since admission without injury. R2's fall focus care plan dated 11/13/24, identified at risk for falls. Goal of will not sustain serious injury. Interventions added as followed: -11/13/24 to place call light within reach and encourage to use it -12/11/24 ensure R2's phone is close to her bed where can be easily reached. -12/23/24 R2 sometimes wakes up confused and agitated, she will scream and attempt to get out of bed on her own, staff to provided reassurance and redirection until calmed. -12/26/24 R2 sometimes wakes up confused and attempts to climb out of bed, staff to inquire about toileting needs and assist to bathroom when necessary. -3/24/25 staff to avoid having R2 in living room -3/21/25 staff to sit with resident for five to ten minutes when restless and provide reassurance such as I am here to help, you are safe, it is okay, how can I help you. Review of R2's nursing assistant care sheets on 3/26/25 identified fall risk and interventions: place call light within reach, mobility bar in place, phone kept at bedside, staff to sit with R2 for ten-15 minutes when restless and avoid having R2 in living room. (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: 245625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER: Episcopal Church Home the Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE: 1860 University Avenue West 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's incident report dated 12/21/25 at 2:06 a.m., identified R2 was found on floor in her room. New intervention for staff to provide reassurance and redirection until calmed. R2's care plan revised on 12/23/24 to provider reassurance until calmed. R2's incident report dated 1/2/25 at 4:46 a.m., identified R2 was found sitting on floor in her room. New intervention of frequent visual checks. R2's care plan did not identify intervention of frequent visual checks. R2's incident report dated 1/18/25 at 3:00 a.m., identified R2 was found lying on floor in room near bed. New intervention to check on every hour when awake and ask if she needs help. R2's care plan did not identify every hour checks. R2's incident report dated 1/24/25 at 7:33 a.m., identified R2 was found on floor near her bed. New intervention of staff to increase safety checks. R2's care plan did not identify safety checks. R2's incident report dated 2/16/25 at 10:30 a.m., identified R2 was found on floor on knees on side of bed. New intervention of staff to provide reassurance to R2 every shift. During an interview on 3/26/25 at 1:39 p.m., nursing assistant (NA)-C stated they do frequent checks for R2, but were not instructed on a specific timeframe on how often to check on her. NA-C stated staff did not document in R2's chart when they checked on her. During an observation and interview on 3/26/25 at 1:38 p.m., R2 was lying in bed with her call light within reach, bed in lowest position and a fall mat placed on the floor on the right side of her bed. NA-D stated R2 was high risk for falls, and they had been placing a fall mat next to her bed to protect her if she fell, however, NA-D verified the fall mat had not been added to the nursing assistant care sheet. NA-D stated if unfamiliar staff were working with R2 and were not aware of the fall mat, they could forget to place it on the floor. Review of R2's care plan on 3/26/25 did not identify fall mat to be placed next to bed. During an interview on 3/26/25 at 1:55 p.m., licensed practical nurse (LPN)-B stated R2's care plan did not identify any safety checks or fall mat and stated, It should have been added. During an interview on 3/26/25 at 3:08 p.m., director of nursing (DON) stated her expectation would be for any new fall intervention to be added to the care plan in a timely manner to reduce future falls. On 3/26/25 requested facility's care planning policy and did not receive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Episcopal Church Home the Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 University Avenue West 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 comprehensively assess and monitor a skin tear (a traumatic wound that occurs when the top layer of skin separates from the underlying layers) for 1 of 1 resident (R3) reviewed for injury of unknown origin. Findings include: R3's face sheet dated 3/26/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), chronic obstructive pulmonary disease (a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs). R3's care plan dated 1/22/25, identified R3 had actual impairment to skin integrity related to a healing skin tear on right upper arm. No other areas of skin impairment were identified. R3's admission nursing assessment dated [DATE], identified skin tear on right forearm measuring 3.2 centimeters (cm) x 1.2 cm. and included the skin tears need attention. R3's physician orders dated 2/4/25 to 2/20/25, identified an order for right arm skin tears (location of the skin injuries on the arm was not specifically identified): cleanse with normal saline. Apply skin sealant to intact periwound skin, let dry. Cover with non-adherent dressing and secure with roll gauze, tubular stockinet. Until resolved or new treatment. Review of the corresponding treatment administration record (TAR) indicated there were no treatments completed to R3's right arm between 2/21/25 to 3/26/25. R3's weekly skin body audit dated 2/23/25, identified bruising on right and left arm, however, did not have any measurements, description of bruise, or an open area on right forearm. R3's weekly skin body audit dated 3/9/25, identified bruising on left arm, however, did not have any measurements, descriptions, or an open area on right forearm. R3's skin body audit dated 3/25/25 at 9:02 p.m., identified a resolving open area on right forearm measuring 2.0 centimeters (cm) x 1.0 cm x 0.1 cm. During an interview on 3/25/25 at 5:14 p.m. nursing assistant (NA)-A stated the wound on R3's right forearm has been present since she came back from hospital, and it did not appear to be getting any smaller. During an interview on 3/25/25 at 5:16 p.m., NA-B stated R3's wound on her right forearm has been present since a return from the hospital in February and the nurses are not doing a treatment to the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Episcopal Church Home the Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1860 University Avenue West 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	During an observation and interview on 3/25/25 at 2:49 p.m., R3 was seated in her wheelchair and had an open area on her right lower arm. Open area was oblong in shape, approximately 2.0 cm x 2.0 cm., base of wound was covered with slight yellow material, appeared dry, and did not have a dressing on the wound. R3 stated that wound had been there for a while, and stated she was not getting a treatment to the wound. Licensed practical nurse (LPN)-C entered R3's room and identified the wound did not have a physician ordered treatment order or nursing directive to monitor the wound. During an observation and interview on 3/25/25 at 3:08 p.m., LPN-B identified R3 had 2.0 cm x 1.0 cm x 0.1 cm wound on her right forearm. LPN-B described the wound as a non-healing skin tear with rolled edges and a slightly reddened center. R3 did not have a current order for treatment/monitoring for the wound. R3 only had an order for treatment of the skin tear on her right forearm after a re-admission on [DATE] from the hospital and it was discontinued on 2/20/25. LPN-B indicated according to the record there was not a comprehensive assessment related to the right forearm wound and the record did not include a reason why the treatment was stopped. LPN stated R3 had weekly skin check done on 2/3/25 upon re-admission, however, after that the skin checks were not being done consistently. The next skin check that was completed was not until 2/23/25, which did not identify the open area on the right forearm. A skin check did not get completed again until 2/23/25, and did not identify open area on right forearm. LPN-B stated all skin tears should have a weekly assessment to determine if they are healing. During an interview on 3/25/25 at 5:00 p.m., director of nursing (DON) stated her expectation would be for weekly skin assessments to be completed for all residents, and any new skin concern the nurses should report to the physician and have a treatment put in place until healed. Review of the facility's Skin Care Policy dated 1/2015, identified expected outcomes: -Assessment of potential skin problems are completed upon admission, on a routine basis, and as needed. -The healing of pressure injuries or other skin conditions that are present is promoted (including prevention of infection to the extend possible). -Prevention of the development of additional pressure ulcers or other skin problems is promoted.