

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 05/19/2025
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an allegation of abuse was reported immediately to the state agency and administrator of the facility, but not later than two hours after the allegation is made for 1 of 3 residents (R1) reviewed for abuse. R1 reported to multiple staff members the care she received was rough causing pain, staff yelled at her, and a staff member heard another staff member yelling at R1.</p> <p>Findings include:</p> <p>The facilities grievance log dated 1/1/25 - 5/16/25 did not indicate any grievances about R1.</p> <p>R1's re-admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score indicated a 99 meaning unable to complete. R1 was dependent upon staff for toileting hygiene, bathing, lower body dressing, and moving from a lying to a sitting position on the side of her bed. R1's pertinent diagnoses were hypovolemia (deficiency of volume of blood in the body), cirrhosis of the liver (scar tissue in the liver), unspecified dementia, unspecified severity without behaviors/psychosis/anxiety and an unspecified personality disorder.</p> <p>Upon interview on 5/16/25 at 1:58 p.m. R1 stated staff was always rough with her when repositioning her. A couple of weeks ago a nursing assistant (NA)-F entered her room the one who always yells at me, and was yelling at R1 telling her she had to go to bed and have her incontinence pad changed. Then NA-G came in to assist the NA-F and they jerked her around like she was a rag doll. This caused pain for the next days. R1 reported the incident to other staff members who she trusted. R1 stated she remembers incidents but does not recall the dates. She had lost the ability to write down dates and times because she was compromised on the right side of her body.</p> <p>Upon interview on 5/16/26 at 2:20 p.m. NA-A stated a few weeks ago she heard a serious confrontation of yelling between NA-B and R1. NA-A walked away from the situation as she did not want to get involved because she had a recent confrontation with NA-B as well. NA-A reported the yelling to licensed practical nurse (LPN)-A the nurse manager. NA-A referred to the yelling as verbal abuse and stated she did what she was supposed to and reported to the nurse manager.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Upon interview on 5/16/25 at 2:45 p.m. NA-C stated R1 had aggressive behaviors because she would yell at staff, she had never heard staff yell back at R1. R1 told NA-C that a NA-F yelled at her. NA-C did not report the yelling allegations because she did not hear it firsthand. R1 always complained of rough cares and the nurses knew about R1's rough care concerns because R1 complained of rough cares to the nurses when they were assisting R1 with the nursing assistance.</p> <p>Upon interview on 5/16/25 an anonymous staff member stated R1 reported to them that the evening staff was rough with her, and she did not feel safe. R1 had cognitive deficits, so she is not the most accurate historian for reporting the dates. R1 did have the ability to accurately report occurrences and when negative occurrences happened at the facility and R1 tended to have more behaviors to defend herself. R1 told the staff member that two staff members were so forceful with her that she was frightened and felt pain for several days. R1 described one staff member who always yelled at her. The anonymous staff member stated they were aware that allegations of abuse are to be reported to the state agency within two hours. The staff member did report the allegations to the state agency in two hours but was not reporting on behalf of the facility. The staff member did not report the allegations to the facility because there had been enough instances where the facility had not investigated allegations, reported to the state agency, or taken any action. The staff member felt education about cares needed to be articulated to the staff and a level of trust needed to be displayed by the management team.</p> <p>Upon interview on 5/19/25 at 8:45 a.m. NA-D stated R1 told her that there is a huge difference between day and night shifts. The night shift performs their cares rough and argue with R1. NA-D did not hear any staff arguing with R1. She stated she reported to LPN-A R1 had complained of rough cares. NA-D stated nobody had followed-up with her after she reported the rough cares.</p> <p>Upon interview on 5/19/25 at 9:03 a.m. NA-E stated R1 mentioned that NA-F had yelled at her a few weeks ago, but he disregarded it because R1 was always yelling at staff herself and always complaining.</p> <p>Upon interview on 5/19/25 at 10:02 a.m. trained medication assistant (TMA)-A stated R1 had gotten angry at all staff. R1 complains of rough cares, but nothing specific is mentioned. TMA-A stated she reported rough cares to the supervisor multiple time over the past months.</p> <p>Upon interview on 5/19/25 at 10:15 a.m. LPN-A, nursing manager stated no staff member reported any specific concerns regarding R1. She stated she heard rumors that someone had pushed R1 over too hard. She did not investigate the rumors. She recalled NA-A had a complaint about NA-B yelling but could not recall the details.</p> <p>Upon interview on 5/29/25 at 1:07 p.m. the administrator stated her expectation would be for staff to report yelling and rough cares to their immediate supervisor and that supervisor to report any abuse allegations to the director of nursing or administrator.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Reporting and Investigation Procedure dated 11/15/23 indicated any employee, family member, volunteer or resident who suspects that an incident of maltreatment has occurred shall immediately report such incident to either the nurse on the station where the alleged incident occurred or to the employee/volunteer's immediate supervisor. NOTE: (NHA Notification Policy for immediate reporting requirement to facility administrator). Anyone who has reason to suspect that an incident of abuse or neglect has occurred has the right to make a report to the Office of Facility Health Complaints at the MDH. Incidents that must be reported to immediately to MDH:</p> <ul style="list-style-type: none"> -Mistreatment -Neglect -Abuse - Inclusive of Resident-to-Resident Abuse and Self Abusive Behavior -Sexual Abuse -Injuries of an unknown source 		