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	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home the Gardens	1860 University Avenue West Saint Paul, MN 55104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 3 of 3 residents (R1, R2, and R3) reviewed had a dignified existence when the three residents had been told to use an incontinent brief to toilet rather than staff assisting them to the bathroom.Findings include: Upon observation and interview on 8/14/25 at 8:40 a.m. R1 was struggling to find her call light as it was wrapped around her bed rail and hanging to a floor. A voice from her camera saw the surveyor and asked to assist R1 as she needed to use the bathroom. A nursing assistant could not be found in the hallway, so licensed practical nurse (LPN)-A was asked to come into the room at 8:44 a.m. LPN-A placed her call light within her reach. At 8:45 a.m. R1 pushed her call light. At 8:47 a.m. nursing assistant (NA)-B entered the room, turned off the light and told R1 she would return. At 9:07 NA-B returned with another NA and started morning cares on R1. R1 stated it was common practice for the nursing assistances to turn off her light and tell her they would be back, sometimes they do and sometimes they do not. They always tell me to just go in my pad. R1's care plan dated 3/20/25 indicated for toilet use R1 required the assistance of one staff member for the transfer. Assistance of one staff member with toileting tasks and changing in bed. Staff was to offer and assist R1 with toileting upon rising, before and after meals, before bed and as needed when R1 requested to use the toilet. Use assistance of two staff members as needed related to weakness. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone), chronic kidney disease, pain, and unspecified dementia. An audio and video recording dated 8/17/25 showed R1 waving her hands to an unidentified nursing assistant (NA) who was in her room speaking with a maintenance staff member. R1 was heard saying, wait I have to pee, I have to pee. The NA replied, I'm in another room now, just let loose if you have to pee, you have a brief on. R1 stated I already did let loose. The NA left the room. An email from family member (FM)-A dated 8/18/25 at 12:19 p.m. indicated the video footage had been taken at the end of the day shift on 8/17/25. The NA's partner had left early leaving the NA by herself. A woman down the hall was on the toilet when the NA was called to assist maintenance with a call light. The NA left R1 to help the other woman. R1 knows now just to go in pants. When R1 did get to the toilet she had explosive diarrhea. The smell was so awful. The mess was awful. FM-A should have taken pictures. FM-A cleaned poop from the side of the toilet and the toilet seat. Upon interview on 8/14/25 at 9:43 FM-A stated she had multiple videos of staff telling R1 to use her incontinent pad instead of taking her to the bathroom. This has been the reason for a lot of her falls, R1 trying to self-transfer to the bathroom and not have to urinate in her pad. R2's quarterly MDS dated [DATE] indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively impaired. R2 was totally dependent upon staff for dressing, bathing, toileting, and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs with cognitive functions and awareness. R2's care plan dated 2/27/25 indicated R2's required assistance of two staff members and assistance with the Sara Steady (mechanical lift) for toileting and to have a urinal at bedside. R2's care plan dated 3/19/25 indicated R2 sometimes experienced confusion, weakness, and inability to communicate needs. Staff was to encourage R2 to use his urinal or the bathroom and would provide him reassurance and redirection. Upon interview on 8/14/25 at 4:18 p.m. FM-C stated she could not recall the date, but she overheard an NA telling R2 to urinate in his pad. She reported this to the director of nursing DON and the NA was talked to. FM-C stated she watched the video camera in his room, and she does not see him being offered toileting or his urinal. She witnessed staff changing his pad and at times does not witness staff in his room at all overnight. They don't honor our request to have him taken to the bathroom. Upon interview on 8/18/25 at 9:40 a.m. R2 stated he did not like to urinate in his pad, but he has no choice. R2 would not elaborate on his statement. Upon observation and interview on 8/18/25 at 11:30 a.m. R3 and family member (FM-D) were in R3's room. R3 was in her recliner. R3 stated she waited for staff often and has had skin breakdown due to waiting in a wet brief, but not currently. She stated she not aware that she had the choice to use the toilet. She asked multiple times during the interview if she could use the bathroom instead of urinating in her brief. FM-D

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(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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide adequate supervision to reduce the risk of accidents for residents 2 of 3 (R1 and R2) reviewed for supervision. The facility did not assess and document the aimed use for the intent of alarms to be used temporarily to assess patterns and routines of the residents. R1 and R2's family requested the alarms following multiple falls and concerns about adequate supervision.Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's care plan dated 3/20/25 - 8/18/25 did not indicate any scheduled supervision of staff interventions for R1 including patterns or routines with the use of the position alarm. R1's fall log dated 3/20/25 - 8/18/25 included falls on 4/7/25, 5/13/25, 5/20/25, 5/27/25, 6/6/25, 6/27/25, 6/28/25 and 7/12/25. R1's care plan intervention related to potential for falls dated 5/15/25 indicated R1 forgets she cannot transfer or ambulate without assistance and will often attempt to transfer independently which leads to her falls. Signs placed by her bedside to remind her to use her call light to seek help. R1's care plan intervention related to potential for falls dated 5/17/25 indicated R1 believed she could crawl from her bed to the bathroom. Each shift reminds R1 to use her all light and to seek help and staff will point to her call light render posted by her bedside until she develops a habit to use her call light. R1's care intervention related to potential for falls dated 6/9/25 indicated R1 was experiencing increase in confusion and inability to remember to use the call light for help. Hospice was to evaluate her medications. R1's care intervention related to potential for falls dated 6/10/25 indicated R1 had the inability to understand her diminished physical mobility and therefor attempts to self-transfer. R1 would be toileted after each meal, at bedtime and upon rising in the morning to prevent her from self-transferring. R1's care intervention related to potential falls dated 6/27/25 indicated R1 was kneeling by her bedside with no call light on. Family reporting observing R1 on camera attempting to turn her television off. Staff will turn off her television at bedtime. R1's care intervention related to potential falls dated 6/30/25 indicated R1 was attempting to pick up her cell phone charger from the floor while in bed, which led to her rolling out of bed and landing on the floor. Staff was to be sure R1's cell phone charger was secured to her bed rail and in a reachable position. R1' care plan dated 7/2/25 indicated R1 had an alternation in mobility and a potential for injury related to a fall risk. Staff was to ensure bed/chair alarm was under R1 and check for alarm placement and function every shift. R1's care plan for potential fall intervention dated 7/14/25 indicated R1 was attempting to self-transfer from to the toilet without seeking support after lunch. Staff was to toilet R1 after each meal to prevent her from attempting to self-transfer. Upon interview on 8/14/25 at 8:40 a.m. R1 stated she was aware that she had the bed alarm, and she did not like it because she felt there was a resistance, and she had to lay still. She stated she did want the alarm because her family wanted her to have it because of so many falls so staff would hear the alarm and would come quickly. Upon interview on 8/14/25 at 9:43 a.m. R1's family member FM-A stated she heard another family at the facility used a bed alarm because they did not feel their family member was being supervised so FM-A decided to get one for R1. She stated it is so awful to watch an elderly family member struggle to get out of bed on their own when they needed something or to use the bathroom. At least if she had the alarm, she would get staffs attention to assist her. R2's fall log dated 2/18/25 - 3/18/25 indicated R2 had falls on 2/18/25, 2/20/25, 2/21/25, 3/5/25, 3/17/25, and 6/2/25. R2's care plan dated 2/27/25 indicated R2 was a fall risk. R2 was to have call light within reach. R2 needed prompt response. R2's family was to be educated about safety reminders and what to do if R2 falls. R2's fall risk care plan intervention dated 3/6/25 indicated R2 sometimes attempted to self-transfer without using his call light, staff was to perform hourly checks and asked elder if he needed help when awake. R2's fall risk care plan intervention dated 3/6/25 indicated staff would check R1's chair/bed alarm placement and function every shift. R2's quarterly MDS dated [DATE] indicated R2 had a BIMs score of 4 indicating R2 was severely cognitively impaired. R2 was totally dependent upon staff for dressing, bathing, toileting, and hygiene cares. He was dependent upon staff for all transferring in and out of bed. R2's pertinent diagnoses were coronary artery disease (damage or disease in the hearts major blood vessels), chronic pain, symptoms and signs

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	245625	A. Building B. Wing	08/18/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication, and mobility for 3 of 3 residents (R1, R2, and R3) reviewed for bed rails. In addition, R2 had side rails used in conjunction with an air mattress. Findings include: Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment. Recommendations for Health Care Providers Using Adult Portable Bed Rails retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm indicated Food and Drug Administration (FDA) guidelines (Recommendations for Health Care Providers about Bed Rails) 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Recommendations for Health Care Providers Using Adult Portable Bed Rails retrieved fromhttps://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails indicated be aware that not all bed rails, mattresses, and bed frames are interchangeable, and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. R1's care plan dated 3/20/25 indicated she had bilateral mobility bars at the head of her bed to enhance her participation in positioning and bed mobility. R1's Physical Device Review Comprehensive dated 6/22/25 indicated R1 had right and left mobility bars, a floor mat, and a low bed. The reason for the use of the devices was R1 was non-ambulatory, her level of consciousness fluctuated, she had poor bed mobility or difficulty moving to a sitting position displayed. The devices would be used whenever R1 wanted to relax in her recliner. Her ability to demonstrate the appropriate use was marked as N/A (non-applicable). The device helped her assist with bed mobility. The device was not considered to be a therapeutic intervention to achieve proper body position, balance, or mobility, but indicated it was used for positioning. The devices were not used for fall prevention. The risks vs. benefits where they enabled R1 to assist with bed mobility and repositioning herself in bed. The summary of device use was side rails would assist with mobility and repositioning while in bed. The recliner chair would be used to help R1 relax. No risk or benefits or any other education was documented as provided to R1 or representative. In addition, R1's medical diagnosis, size and weight, cognition, communication, and mobility were not assessed for the medical device evaluation or if R1 could remove the

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a system to reduce the risk of significant medication errors for transdermal opioid patches for 1 of 3 residents (R1) reviewed for medication administration. R1 was ordered by her hospice agency to have a transdermal opioid patch (narcotic medicated patch that slowly releases the medication into the body) placed on her skin every seven days. On two occasions the nursing staff failed to remove the old patch from her skin when the new patch was placed on her.Findings include: R1's hospice care plan dated 5/28/25 indicated buprenorphine (Butrans) 5 micrograms per hour (mcg/hr.) patch (an opioid patch used to treat opioid use disorder but also used for pain management) was to be applied once every week. Remove old patch prior to new patch application for chronic pain. R1's facility providers order dated 5/29/25 indicated Butrans transdermal patch 5 mcg/hr. Apply 1 patch transdermal one time a day every seven days for pain. The facility's order did not include to remove the old patch. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. R1's progress notes dated 8/1/25 - 8/18/25 did not provide any documentation regarding medication error monitoring or follow-up. R1's medication error on 8/1/25 or the error on 8/8/25 including any follow-up assessments. A facility report titled Record of Customer and Family Concern dated 8/1/25 indicated hospice staff reported that they found two pain patches on R1 during her weekly shower. The oldest patch was removed and the newest was left on. R1's vital signs were obtained and were within baseline, staff was to continue to monitor R1, no acute changes noted. The Administrator and the director of nursing (DON) were notified on 8/4/25. The staff member who provided care was interviewed and stated she did not see an old patch and always removed an old patch. The action taken was patch training conducted, staff demonstrate understanding of the patch removal. R1's care plan and treatment administrator were updated. R1's family was notified on 8/4/25. The form did not indicate hospice, or the facilities medical provider were notified to obtain an order for any assessments following the error. A facility report titled Medication Error Report dated 8/11/25 indicated on 8/8/25 R1's family member (FM)-A notified staff that R1 had two pain patches on her, one was dated 7/31/25 and the other was not dated. Both patches were removed, and a new patch was applied. Hospice was updated on 8/11/25 and the staff was to monitor R1. The form did not indicate who was notified at hospice and what the staff was to monitor, in addition hospice was notified three days after the error occurred. There was no documentation of initial interventions to assess R1. A typed form by the facility dated 8/12/25 indicated FM-A was assisting change R1 into her nightgown and found two pain patches on R1's body. The first patch was on the front of R1 and not dated, while the second was dated and placed on her back. FM-A requested both patches to be removed by the nurse based on the instruction of a family member who was a doctor. The form did not indicate any communicate with hospice. The intervention was patch training conducted, staff administrating medications will ensure that the old patch was removed prior to new patch administration. There were no documented interventions for the care of R1 following the error. Upon interview on 8/14/25 at 11:09 a.m. licensed practical nurse (LPN)-A the nurse manager stated R1 did have two patches placed on her body at the same time twice. He stated the first time. R1 had two patches on it was the hospice nursing assistant who notified him. He stated he did monitor R1 following the error on 8/1/25 however he did not document exactly what he monitored. The second time the error happened he was not certain if hospice was notified as he was not onsite that day and he was not certain of the immediate action taken by staff to care for R1. Upon interview on 8/14/25 hospice registered nurse (RN)-A at 12:26 p.m. stated she was not aware of the doubling of the patches on 8/1/25, but was aware of the 8/7/25 incident as FM-A notified her. She stated the facility should have obtained orders to assess R1 and maybe even have the hospice staff make a visit if necessary. Upon interview on 8/14 at 1:01 p.m. R1's family member (FM)-B stated the facility failed R1 twice. FM-B's spouse was a Medical Doctor, and he told the facility they needed to remove both patches and start a new one. The facility was not able tell FM-B what their system was for a transdermal patch error. FM-B watched on R1's room camera if the staff checked in and completed vital signs often on R1 following the error and no

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to establish a communication process between the facility and the hospice provider to ensure that the needs of a resident were addressed and met for 1 of 3 residents (R1) reviewed for hospice services. R1 did not receive the necessary care and services when she had the same medication error occur twice. In addition, the facility failed to have a designated member of the interdisciplinary team who was responsible to work with hospice to ensure residents receiving hospice services needs were met.Findings include: R1's hospice care plan dated 5/28/25 indicated buprenorphine (Butrans) 5 micrograms per hour (mcg/hr.) patch (an opioid patch used to treat opioid use disorder but also used for pain management) was to be applied once every week. Remove old patch prior to new patch application for chronic pain. R1's facility providers order dated 5/29/25 indicated Butrans transdermal patch 5 mcg/hr. Apply 1 patch transdermal (on the skin) one time a day every seven days for pain. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status was a 13 indicating R1 was cognitively intact. R1 was dependent upon staff for dressing, bathing, toileting, and hygiene cares. She was dependent upon staff for all transferring in and out of bed. R1's pertinent diagnoses were cerebral vascular disease (a group of conditions that affect blood flow and blood vessels in the brain), hypothyroidism (the thyroid gland doe does not produce enough thyroid hormone, chronic kidney disease, pain, and unspecified dementia. A facility report titled Record of Customer and Family Concern dated 8/1/25 indicated hospice staff reported that they found two pain patches on R1 during her weekly shower. The oldest patch was removed and the newest was left on. R1's vital signs were obtained and were within baseline, staff was to continue to monitor the elder, no acute changes noted. The Administrator and the director of nursing (DON) were notified on 8/4/25. The staff member who provided care was interviewed and stated she did not see an old patch and always removed an old patch. The action taken was patch training conducted, staff demonstrate understanding of the patch removal. R1's care plan and treatment administrator were updated. R1's family was notified on 8/4/25. The date of the training was 8/13/25 and 8/14/25. The form did not indicate hospice, or the facilities medical provider were notified. A facility report titled Medication Error Report dated 8/11/25 indicated on 8/8/25 R1's family member (FM)-A notified staff that R1 had two pain patches on her, one was dated 7/31/25 and the other was not dated. Both patches were removed, and a new patch was applied. Hospice was updated on 8/11/25 and the staff was to monitor R1. The form did not indicate who was notified at hospice and what the staff was to monitor, in addition hospice was notified three days after the error occurred. A typed form by the facility dated 8/12/25 indicated FM-A was assisting change R1 into her nightgown and found two pain patches on R1's body. The first patch was on the front of R1 and not dated, while the second was dated and placed on her back. FM-A requested both patches to be removed by the nurse based on the instruction of a family member who was a doctor. The form did not indicate any communicate with hospice. The intervention was patch training conducted, staff administrating medications will ensure that the old patch was removed prior to new patch administration. Upon interview on 8/14/25 at 11:09 a.m. licensed practical nurse (LPN)-A the nurse manager stated R1 did have two patches placed on her body at the same time twice. He stated the first time. R1 had two patches on it was the hospice nursing assistant who notified him. He stated since it was the hospice aid was part of the hospice she would report to her leaders. The second time the error happened he was not certain if hospice was notified as he was not onsite that day. LPN-A stated the facility did not have a hospice coordinator to report incidents to. Upon interview on 8/14/25 hospice registered nurse (RN)-A stated she was not aware of the doubling of the patches on 8/1/25, but was aware of the 8/7/25 incident as FM-A notified her. RN-A stated she did not know of a hospice coordinator at the facility, she just spoke with the nurse on each floor of any orders, updates or concerns she had. Upon interview on 8/14/25 at 1:35 p.m. the Administrator in training stated she was not certain if the facility had a hospice coordinator. She stated to ask the DON as she had been at the facility for a long time. Upon interview on 8/14/25 at 1:35 p.m. the DON stated the facility did not have one actual person as the coordinator, it was a team effort. The social worker worked on referrals and admissions and the nurse manager work with the hospice companies once they are onboard. The facilities contract with hospice dated 3/14/22 indicated:Facility Representative: Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice to coordinate care provided by Facility staff and Hospice staff to any Hospice Patient under Hospice's care. Such interdisciplinary team member

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	08/18/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 3 of 3 residents (R1, R2, and R3) reviewed. The bed manufacturer guidelines indicated to visually inspect the bed and accessories monthly and indicated to follow the FDA guidance.Findings include: Recommendations for Health Care Providers Using Adult Portable Bed rails dated 2/27/2023 retrieved on 8/14/25 from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, when evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.The manufacture user-service manual for Joerns Assist Device and Side Rails [NAME]-Care Models, undated, indicated Maintenance/Inspection Information: Visually inspect the assist handle and mounting bracket, and check for loose hardware monthly. Tighten loose hardware as stated in the installation instructions.Warning: Risk of Serious Injury or Death. Properly locate the mounting brackets. The gap between the head/foot panel and the assist device or side rail must be small enough to prevent a resident from getting their head or neck caught in this location (see the installation instructions for more information, if applicable). If multiple assist devices are needed, position them such that the gap between them is large enough that the trunk and hips can easily pass through. Make sure that raising or lowering the bed, or adjusting the sleep surface, does not create hazardous gaps. The assist devices or side rails should not be used if ANY openings within the bed system allow a resident to get their head or neck lodged within these openings. Failure to do so could result in serious injury or death.Warning: An optimal bed system assessment should be conducted for each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment