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	11/20/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and document review, the facility failed to follow professional standards when a staff crushed delayed release medications and crushed pill capsules with other medications instead of opening and emptying the pill capsules for 1 of 3 (R2) residents reviewed for medication administration.Findings include: R2's face sheet dated 10/16/25 indicated R2 was admitted to the facility on [DATE] and had diagnoses of severe vascular dementia without behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, dysphagia, epilepsy, chronic kidney disease stage 1 through 4 and depression.R2's quarterly minimum data set (MDS) assessment dated [DATE] indicated R2 was severely cognitively impaired and was dependent on staff for all activities of daily living.R2's October 2025 medication administration record (MAR) included physician orders for-Aspirin Enteric Coated Low Dose Oral Tablet Delayed Release 81 milligrams (aspirin). Give 81 milligrams by mouth one time a day related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Start date 3/29/25. Trained medication assistant (TMA)-A documented the morning dose on 10/16/25 as administered.-Pantoprazole Sodium Oral Tablet Delayed Release 20 milligrams. Give 40 milligrams by mouth one time a day for reflux disease total dose 40mg. Start date 3/29/25. TMA-A documented the morning dose on 10/16/25 as administered.-Sertraline Hydrochloric Acid Oral Tablet 100 milligrams. Give 1 tablet by mouth one time a day for depression related to depression. Start date 3/29/25. TMA-A documented the morning dose on 10/16/25 as administered.-Divalproex Sodium Oral Tablet Delayed Release 125 milligrams. Give 750 milligrams by mouth two times a day related to other seizures. Start date 3/28/25. TMA-A documented the morning dose on 10/16/25 as administered.-Acetaminophen Oral Tablet 500 milligrams. Give two tablets by mouth three times a day for pain. Start date 6/6/25. TMA-A documented the morning dose on 10/16/25 as administered.-Crush medications: if indicated by prescriber's order. May mix in a small substance (apple sauce, pudding, jelly) every shift for medication administration related to dysphagia following cerebral infarction. Start date 3/28/25. TMA-A documented a check mark for the morning of 10/16/25.On 10/16/25 at 8:45 a.m., TMA-A was observed preparing and passing medications to R2. TMA-A used hand sanitizer and wore gloves when handling the medications. TMA-A placed the following medications into a small plastic bag after verifying the orders:-Aspirin Enteric Coated Low Dose Oral Tablet Delayed Release 81 milligrams, 1 tablet-Pantoprazole Sodium Oral Tablet Delayed Release 20 milligrams, 2 tablets-Sertraline Hydrochloric Acid Oral Tablet 100 milligrams, 1 tablet-Divalproex Sodium Oral Tablet Delayed Release 125 milligrams, 6 capsules-Acetaminophen Oral Tablet 500 milligrams, 2 tabletsTMA-A used the pill crusher to crush all the medications in a small plastic bag. TMA-A then used a plastic spoon to try and remove the shredded capsule pieces from the bag. TMA-A attempted to crush the medications again. Some small pieces of capsule were still visible in the bag. TMA-A poured the medication powder into a medication cup and mixed with applesauce, entered the room and administered the medications to R2 by mouth with a spoon. R2 was able to swallow and finish the medications with applesauce. At 9:09 a.m., TMA-A was asked why she crushed the capsules. She stated it was hard to take apart capsules with gloves on, so she usually crushes them instead.During (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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 10/16/15 at 1:00 p.m., TMA-A stated the facility has given her education on delayed release medications. She stated she was aware R2 had delayed release medications, and they shouldn't have been crushed or opened. TMA-A stated she could not remember what delayed release medications meant.During an interview on 10/16/25 at 1209 p.m., licensed practical nurse (LPN)-A stated there was recent education on medication administration. The education was about making sure dosages that are being given match the prescriber's order. LPN-A stated the physician should be called to determine if it is okay to open a delayed release capsule medication.During an interview on 10/16/25 at 1:08 p.m., TMA-B stated he would not crush capsule medications, he would open the capsule and empty it. TMA-B was unable to explain the purpose of delayed or extended-release medications or any concerns that would accompany crushing or opening delayed release medications.During an interview on 10/16/25 at 1:19 p.m., registered nurse (RN)-A stated the facility provided education on delayed release medications. Staff should check with the prescribing physician about opening a delayed release capsule. Capsules shouldn't be crushed. When asked about crushing delayed release medications, RN-A stated the medication effects could hit the patient quickly rather then slowly.During an interview on 10/16/15 at 12:26 p.m., a pharmacist stated that she was concerned that the pharmacy had it documented the Divalproex Sodium was being given in tablet form and not capsule form. The facility staff should not be crushing capsules, staff should be twisting the capsules to open them and sprinkle the powder out. If a medication was delayed or extended release and was being crushed, there could be a concern about dose dumping and the patient would be receiving the medication all at once. The facility's order for R2 about crushing medications for dysphagia would not apply.During an interview on 10/16/25 at 1:50 p.m., the director of nursing (DON) stated she would be concerned if she witnessed nursing staff crushing a pill capsule instead of opening it. The best practice is to open the capsule. If it was a medication that shouldn't be crushed, staff should clarify the order. There would be concerns with crushing delayed release medication such as a faster response. Nursing staff have been given training on administering delayed release medications and must pass competencies.The facility policy, Administration of Medication, last revised 6/25/25 directs the person administering medications must ensure that the right medication, right dose, right time and right method of administration are verified before the medication is administered.The facility policy, Medication Crushing Guidelines, undated, directs the nurse administering the medications should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form if possible. The policy further directs that timed release tablets are designed to release medication over a sustained period and to achieve prolonged medication action. These medications should not be crushed. Enteric coated tablets are designed to pass through the stomach whole and dissolve in the intestinal tract to prevent destruction of the medication by stomach acid, prevent the medication from irritating the stomach lining or to achieve prolonged action from the medication.