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	04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure foods were stored in a manner to prevent spoilage and freezer burn and failed to ensure food items in 6 out of 6 kitchenettes were sealed, labeled and dated. This had the potential to affect all residents who reside in the facility. Findings include:An observation on 4/7/26 at 3:22 p.m., the 2nd floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles, hot dog buns and a container of red and white substance. Nursing assistant (NA)-H verified these items and stated all items should have been sealed, dated and labeled.An observation on 4/8/26 at 8:16 a.m., the 3rd floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, pepperoni, english muffins, omelets and bacon. NA-G verified these items and stated all items should have been sealed, dated and labeled.An observation on 4/7/26 at 2:29 p.m., the 4th floor kitchenette was reviewed. The freezer had undated, opened packages of omelets, pancakes, french toast, corn dogs, bacon, sausages, Toaster Strudel, and [NAME] Castle burgers. Additionally, the refrigerator had an undated bowl of noodles, undated Tupperware container of beans, and a bag of opened carrots that were expired on 3/25/26 . NA-F verified these items and stated all items should have been sealed, dated and labeled.An observation on 4/7/26 at 2:13 p.m., the 5th floor kitchenette was reviewed. The freezer had undated, opened packages of french toast, waffles, bacon, and omelets. NA-A verified these items and stated all items should have been sealed, dated and labeled.An observation on 4/8/26 at 7:44 a.m., the 6th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, french toast, bagels and meat patties. NA-E verified these items and stated all items should have been sealed, dated and labeled. An observation on 4/8/26 at 7:27 a.m., the 7th floor kitchenette was reviewed. The freezer had undated, opened packages of bacon, pancakes, waffles and french toast. NA-D verified these items and stated all items should have been sealed, dated and labeled.During interview on 4/8/26 at 12:28 p.m., chef manager (CM) expected any opened food items were sealed, dated and labeled. The kitchenettes had Ziplock bags, markers and deli containers with lids for storage use. CM further stated the kitchenettes were overseen by a multidisciplinary team. The CM oversaw education, ordered, stocked supplies and provided stocking sheets for staff. The nursing department oversaw the NAs. During interview on 4/9/26 at 12:40 p.m., administrator stated they expected all staff to handle and store food properly. Additionally, any opened items were to be labeled, dated and sealed. The rationale for proper food storage decreased the risk of food borne illness.A facility policy titled Episcopal Homes Refrigerator and Food Storage, directed staff to ensure opened freezer foods are sealed to prevent freezer burn and spoilage. Furthermore, all foods must be sealed, labeled and dated.

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 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 glove use and hand hygiene for 1 of 1 resident (R19) during personal cares. The facility further failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R19) who had a nephrostomy tube and for 1 of 1 resident (R4) who had a catheter and was receiving catheter cares. The facility also failed to ensure 1 of 1 resident (R54) on droplet precautions was wearing a mask when out of her room. This had the potential to affect all 10 residents residing on the 3rd floor. Findings include: Hand Hygiene/Glove Use R19's significant change Minimum Data Set (MDS) dated [DATE], indicated R19 had intact cognition, was dependent on staff for toileting and personal hygiene, and was always incontinent of urine and frequently incontinent of bowel. R19's diagnoses included chronic kidney disease, anxiety, and need for assistance with personal care. R19's care plan revised 4/6/26, indicated R19 required assistance of one for personal hygiene and substantial to total assistance for toileting. During observation on 4/7/26 at 10:05 a.m., nursing assistant (NA)-A entered R19's room and offered a brief change. R19 stated that she did need to be changed and cleaned. NA-A donned gloves and put the head of the bed flat, lifted R19's gown and removed her brief which was dirty with bowel movement (BM). NA-A wiped R19's bottom of the BM and completed peri care. Without changing gloves, NA-A placed a new brief, pulled R19's gown down, repositioned her legs by grasping her feet, and adjusted the bed using the bed controls. During interview on 4/7/26 at 10:12 a.m., NA-A stated she did not change gloves after cleaning the BM and was not aware she needed to do so. During interview on 4/7/26 at 1:55 p.m., registered nurse (RN)-A stated gloves should be removed and hand hygiene completed after performing peri care. During interview on 4/8/26 at 10:23 a.m., licensed practical nurse (LPN)-A stated expectation for staff to change gloves and perform hand hygiene after performing peri care and before moving on to other resident care. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated staff were expected to change gloves and perform hand hygiene when going from dirty to clean areas during resident care. EBP R19 R19's significant change MDS dated [DATE], indicated R19 had intact cognition, was dependent on staff for most activities of daily living (ADLs), and had an indwelling catheter (nephrostomy tube). R19's diagnoses included chronic kidney disease, obstructive uropathy (blockage in the urinary system that impedes urine flow), and need for assistance with personal care. R19's care plan focus initiated on 9/5/25, indicated R19 had a nephrostomy tube for right kidney and instructed staff to perform nephrostomy tube care as ordered. R19's need for EBP related to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	presence of a nephrostomy tube was added on 4/7/26. During observation on 4/6/26 at 2:54 p.m., R19's doorway lacked signage indicating R19 required any infection control precautions. During observation and interview on 4/7/26 at 9:10 a.m., R19's doorway lacked signage indicating R19 required any infection control precautions. R19's full nephrostomy bag was visible and lying on top of her sheet. R19 stated staff were responsible for emptying the nephrostomy bag. During observation on 4/7/26 at 10:05 a.m., NA-A entered R19's room, donned gloves but did not don a gown. NA-A performed personal cares; a brief change, peri care, and resident repositioning without using EBP. During observation and interview on 4/7/26 at 12:04 p.m., R19's room had a sign indicating EBP and there was an isolation cart outside her room containing gloves. The sign instructed staff to perform hand hygiene, and don gloves and gown when entering to perform any high-contact resident care activities. NA-A stated while looking at the sign that a gown was only required when there was contact with the resident. NA-A stated was not aware R19 required EBB before now, and stated should have been wearing a gown this morning while preforming cares. During interview on 4/7/26 at 1:55 p.m.,RN--A stated residents with indwelling devices such as nephrostomy tube should be on EBP. RN-A further stated staff should wear gown and gloves when emptying nephrostomy bag, changing the dressing around the tube, and during any high contact care. During interview on 4/8/26 at 10:23 a.m.,LPN-A stated EBP should be in place for any resident with a nephrostomy tube. LPN-A could not explain why R19 had not been on EBP prior to yesterday (4/7/26). LPN-A further stated staff should follow EBP when working with R19 during nephrostomy care and all other high-contact care. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated residents with a nephrostomy tube should be on EBP and could not explain why R19 was not on EBP prior to yesterday. R4 R4'a quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of quadriplegia (paralysis of all four limbs), flaccid neuropathic bladder (type of bladder dysfunction characterized by an inability to contract properly, leading to urinary retention and overflow incontinence), and a need for assistance with personal care. It further indicated R4 had an indwelling catheter and was dependent on staff for toileting. During interview on 4/6/25 at 5:50 p.m., R4 stated some staff wear personal protective equipment (PPE) when they perform catheter cares and some don't. This concerned her as she had been having a lot more urinary tract infections (UTI) recently. During observation on 4/8/26 at 9:59 a.m., R4 put on her call light and nursing assistant (NA)-C answered it. R4 and NA-C went into the bathroom where NA-C was emptying R4's catheter bag into a graduated cylinder and then emptied the graduated cylinder into the toilet. NA-C was wearing gloves but wasn't wearing a gown. During interview on 4/8/26 at 10:10 a.m., NA-C verified R4 was on EBP and the sign on the door indicated they should have been wearing a gown when performing catheter cares, stating they forgot to put one on but should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54 R54's quarterly MDS dated [DATE], indicated intact cognition and diagnoses of dementia and chronic obstructive pulmonary disease (COPD). It further indicated R54 required staff assistance with mobility. R54's physician's order, indicated ok for polymerase chain reaction test (test to determine if a certain virus is present) one time only for respiratory symptoms until 4/7/26. R54's progress note dated 4/6/2026, indicated R54 continues not to feel well. Cough noted from 4/3/26 continues. Lungs sounds, crackles lower left and inspiratory wheeze. Call placed to nurse practioner (NP) office for new orders. During observation 4/6/26, at approximately 12:30 p.m., R54 was in the therapy room riding a stationary bike. The physical therapist (PT)-A was also in the room standing beside her. Neither R54 nor PT-A were wearing masks or eye protection. At approximately 1:00 p.m. R54, PT-A, and LPN-C were in the therapy room and LPN-C was handing R54 and PT-A masks to wear. A few minutes later, PT-A brought R54 out of the therapy room and into her room via her wheelchair and then exited her room. Once outside the room, PT-A used hand sanitizer but did not remove their mask. The sign on the wall beside R54's door indicated she was on droplet precautions, and everyone must clean their hands (including before entering and when leaving the room), make sure their eyes, nose, and mouth are fully covered before room entry, and remove face protection before exiting the room. During interview on 4/6/26 at approximately 1:10 p.m. PT-A verified R54 was on droplet precautions but didn't know why. PT-A further verified the sign on the wall next to R54's door and stated I assume so when asked if they should be following the directions indicated on the sign. They also verified they should have been wearing eye protection and changing masks upon leaving R54's room. During interview on 4/6/26 at 6:15 p.m. R54 was sitting in her recliner in her room and she was coughing. She stated some of the staff wear PPE when they are providing cares and some don't, it just depends. During interview on 4/7/26 at 1:14 p.m., LPN-C stated R54 had been put on droplet precautions because she was having cold symptoms last week but R54 told her she didn't feel sick. Then they called the nurse practitioner again this week because R54 told her she wasn't feeling well and LPN-C wanted to do more in-depth testing. LPN-C stated R54 was permitted to leave her room if she was wearing a mask and verified neither R54 nor PT-A had been wearing masks during therapy on 4/6/26 and they had given them both masks to wear. During interview on 4/8/26 at 1:32 p.m. the DON/Infection Preventionist (IP) stated R54 was symptomatic and placed on droplet precautions. She should not leave the room but if someone on droplet precautions does have to leave the room, they should wear a mask and if staff were working with them (therapy) they should also be wearing a mask and eye protection. Facility policy Hand Hygiene dated 10/2/24, indicated, Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy Enhanced Barrier Precautions dated 10/2024, indicated criteria for implementing EBP included, Presence of wounds and/or indwelling medical devices, even if there is no known infection or colonization with an MDRO [multidrug-resistant organism]. The facility policy on droplet precautions dated 10/2/24, indicated to limit the movement and transportation of the elder to essential purposes only, the elder should wear a mask when out of their room. Provide meals, therapies, and activities in the elder's room whenever possible during the acute phase of illness with consultation with the IP.

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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 residents were safe for self-administration of medication (SAM) for 1 of 1 residents (R36) observed with a medication at the bedside. Findings include:R36's quarterly Minimum Data Set (MDS) dated [DATE], indicated R36 had intact cognition and required set up/clean up assistance to partial/moderate assistance for all self-care activities of daily living (ADLs). R36's diagnoses included multiple sclerosis (a disease affecting the nervous system and may cause weakness, numbness, and difficulty walking), chronic obstructive pulmonary disease (COPD), arthritis, and need for assistance with personal care. R36's care plan revised 12/8/25, indicated R36 had inability to manage self-care related to functional and cognitive decline. R36's care plan further indicated R36 had multiple sclerosis which affected ADL independence. The care plan identified R36 wanted to be involved in her care and medications, but instructed staff to administer medications as ordered. R36's care plan lacked specific information regarding self-administration of medications. R36's provider orders indicated the following:-11/02/23, R36 was ok to self-administer medications after set-up.-5/20/24, R36 required Ipratropium Bromide nasal solution 0.06% - 2 sprays in each nostril three times a day.-12/4/24, R36 required Fluticasone Propionate suspension 50mcg/act -2 sprays in each nostril every day. R36's medication administration record (MAR) dated 4/2026, indicated the Ipratropium Bromide nasal spray was scheduled for morning, evening, and bedtime. The MAR did not indicate this could be left at the bedside or could be self-administered. R36's MAR further indicated that the Fluticasone Propionate nasal spray was scheduled for 6:00 a.m. and was documented as given on 4/2 through 4/6 and 4/8. R36's SAM assessment dated [DATE], indicated R36 had No desire to self-administer. The SAM assessment further indicated the interdisciplinary team (IDT) did not feel the resident was safe for SAM. R36's provider progress noted dated 3/24/26 indicated under the Assessment/Plan that R36 provided unreliable information and could not complete assessments due to her history of and advanced dementia. During observation and interview on 4/8/26 at 8:16 a.m., licensed practical nurse (LPN)-B gathered R36's morning medications for administration which included nine oral medications and one nasal spray. LPN-B entered R36's room and administered the oral medications. LPN-B asked if he could administer her Ipratropium Bromide nasal spray and R36 picked up a bottle of that nasal spray from her side table and stated she had already used that this morning. R36 stated she self-administered the nasal spray at her bedside (Ipratropium Bromide) in the morning and occasionally in the afternoon if she felt she needed it. R36 initially stated she was not aware of a second nasal spray, but when LPN-A showed her the medication, which was stored in her locked in-room medicine cabinet, she thought it looked familiar. R36 could not recall using the Fluticasone Propionate this morning and thought she took that nasal spray in the afternoon. LPN-B stated R36 had been assessed as appropriate for self-administration of medications.During interview on 4/8/26 at 10:23 a.m., LPN-A stated R36 had memory issues and could not be trusted to provide accurate information regarding which medications she took and when. LPN-A reviewed R36's most recent SAM assessment and confirmed R36 had been assessed as not appropriate for SAM. LPN-A stated R36 had an order which indicated it was ok for SAM but stated R36 was no longer appropriate for SAM and should not have the nasal spray at the bedside. During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) stated in order for a medication to be left at the bedside for SAM, there had to be an order and an assessment. The SAM assessment should identify the medication and indicate that the resident understood when and how to administer it. DON further stated R36 was not appropriate for SAM and should not have any medications left at the bedside. A facility policy titled Self-Administration of Medication dated 11/13/17, indicated a resident could only be considered safe for SAM after an assessment and the IDT determined which medications would be safe for SAM. The policy further indicated the following:-The SAM assessment must include evaluation of the resident's (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ability to follow administration instructions including dose and time of administration. -A periodic re-evaluation should be completed based on cognitive changes.-A physician order would be obtained and must include which specific medications could be kept at the bedside.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure personal privacy was maintained for 1 of 1 residents (R19) observed during personal cares.Findings include:R19's annual Minimum Data Set (MDS) dated [DATE], indicated R19 had intact cognition, was dependent on staff for toileting and personal hygiene, and was always incontinent of urine and frequently incontinent of bowel. R19's diagnoses included chronic kidney disease, anxiety, and need for assistance with personal care. R19's care plan revised 4/6/26, indicated R19 required assistance of one for personal hygiene and substantial to total assistance for toileting. During observation on 4/7/26 at 10:05 a.m., nursing assistant (NA)-A entered R19's room and offered a brief change. R19 stated that she did need to be changed and cleaned. NA-A donned gloves and put the head of the bed flat, lifted R19's gown and removed her brief. NA-A did not close R19's door, which was open to the hallway. NA-A walked into the bathroom to obtain a new brief, while R19 waited, exposed from mid abdomen down. R19 was able to roll to her left side facing the window as her back side faced the door. While NA-A wiped R19's bottom physical therapist (PT)-A knocked once on the open door, did not wait for a response, and walked into R19's room as her bottom was exposed. PT-A stopped turned around and stated he would come back in a bit. NA-A completed peri care and placed a new brief. During interview on 4/7/26 at 10:16 a.m., NA-A stated she should have closed R19's door for privacy and agreed that PT-A had walked in and saw R19's exposed bottom. During interview on 4/7/26 at 10:18 a.m., R19 stated she wished the door would have been shut during peri care and was wondering why PT-A had just walked right in. During interview on 4/7/26 at 1:55 p.m., registered nurse (RN)-A stated resident doors should be closed during personal cares to protect their privacy. During interview on 4/8/26 at 10:23 a.m., licensed practical nurse (LPN)-A stated expected staff to close a resident's door during cares for privacy.During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) expected privacy to be maintained for all residents. Resident's door should be closed during brief changes and other personal cares.A facility policy titled Dignity dated 10/15/24, the facility was committed to providing care and services in such a way to maintain each resident's dignity, individuality, privacy, autonomy, and self-worth. The policy further indicated, Residents are provided privacy during personal care, bathing, dressing, toileting, and medical treatments. The policy further indicated, staff will knock and request permission before entering resident rooms whenever possible.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered and maintained as ordered by the provider for 1 of 2 residents (R15) reviewed for respiratory care. Findings include:R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 was cognitively intact, was dependent on staff for most self-care activities of daily living (ADLs), bed mobility and transfers. R15's diagnoses include chronic respiratory failure with hypoxia (low oxygen), chronic obstructive pulmonary disease (COPD), anxiety, and dyspnea (shortness of breath). R15's provider orders dated 7/29/25, included the following:-Oxygen via nasal cannula at 4 liters per minute (lpm) continuous for dyspnea. -Change cannula/mask and tubing, date and initial weekly every Tuesday evening.R15's shortness of breath interview and evaluation assessment dated [DATE], indicated R15 was oxygen dependent.R15's care plan dated 8/6/25, indicated R15 had orders for oxygen therapy related to diagnoses and R15's oxygen saturations would drop into the 80s when oxygen was removed. The care plan instructed staff to administer oxygen via nasal cannula as ordered. During observation and interview on 4/6/26 at 2:03 p.m., R15 was lying in bed with the oxygen tubing/nasal cannula wrapped up and hanging off the oxygen concentrator out of R15's reach. The oxygen concentrator was on and set to 3 lpm. R15 stated she was supposed to have her oxygen on at 5 lpm. R15 stated she did not currently feel she was in any respiratory distress but could not remember how long she was without oxygen. R15's oxygen tubing was not labeled as to when it had been last changed. During observation on 4/7/26 at 8:19 a.m., R15 was in bed sleeping with the nasal cannula positioned on her chin rather than in her nares. The oxygen concentrator was set to 3 lpm. The oxygen tubing was not labeled as to when it had been last changed. During observation on 4/7/26 at 8:21 a.m., nursing assistant (NA)-I entered R15's room and delivered her breakfast tray. R15 did not address the oxygen tubing positioned on R15's chin or setting. During observation and interview on 4/7/26 at 8:32 a.m., NA-I and NA-B entered R15's room to boost her up in bed for breakfast. R15's oxygen tubing was now lying to the side of her on the bed. Neither NA-I nor NA-B addressed the oxygen tubing or flow rate. After the NAs left the room, R15 stated she took the oxygen off for breakfast and would replace it once she was done eating. During observation and interview on 4/7/26 at 11:19 a.m., R19 in bed with the oxygen nasal cannula in her nares. The oxygen concentrator was set at 3 liters per minute. NA-B entered R15's room and stated R15 was on continuous oxygen at 4 lpm. When asked to confirm the flow rate, NA-B confirmed the flow rate was currently set at 3 lpm but should be on 4 and changed it to 4 lpm. During interview on 4/7/26 at 11:27 a.m., registered nurse (RN)-A stated R15 was on continuous oxygen and that staff should encourage her to keep it on at all times. RN-A further stated she thought the flow rate could be adjusted during the day but could not find any reference to those instructions in R15's electronic health record (EHR). RN-A confirmed R15's oxygen order was for continuous oxygen at 4 lpm. RN-A further stated oxygen tubing was changed weekly and should be labeled to identify when it had been changed last. RN-A further stated NAs should not adjust oxygen flow rate and that NA-B should have notified a nurse about R15's incorrect oxygen flow rate. During interview on 4/8/26 at 10:20 a.m., licensed practical nurse (LPN)-A stated the oxygen flow rate should match the provider order, and oxygen tubing should be labeled and dated. LPN-A further stated NAs should not adjust the flow rate but rather notify a nurse when found to be incorrect.During interview on 4/8/26 at 1:00 p.m., director of nursing (DON) expected R15's oxygen to be administered as ordered by the provider and tubing labeled and dated when to indicate when it was last changed. DON further stated NAs were not supposed to adjust oxygen flow rate and NA-B should have notified a nurse instead. A facility policy Safe Oxygen Use and Storage dated 8/28/20, indicated staff would take measures to ensure residents were educated and encouraged to use oxygen in a safe manner and any concerns would be reported to the RN.

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	04/09/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include:R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 had moderate cognitive impairment, was frequently incontinent of bowel, and was taking opioid medications during the seven-day lookback period. R10's diagnoses included adjustment disorder with mixed anxiety and depressed mood, chronic pain syndrome, and constipation. R10's care plan dated [DATE], indicated R10 used antidepressant medication and instructed staff to monitor adverse medication reactions such as constipation fecal impaction (when stool becomes hardened and stuck in the rectum due to long term constipation. The care plan further indicated R10 had chronic pain syndrome and instructed staff to give pain medications as ordered. R10's consultant pharmacy review (CPR) dated [DATE], indicated, The resident has orders for MiraLAX PRN [as needed] for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use [e.g. which to use first] or, if a duplication, consider discontinuing one of the above. The CPR had an undated handwritten note stating use MiraLAX first and was signed by an unidentified nurse practitioner.R10's CPR dated[DATE], indicated The resident has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above. The CPR had an undated handwritten note that indicated it was faxed to provider per licensed practical nurse (LPN)-A.R10's CPR dated [DATE] indicated, The resident has orders for MiraLAX PRN for constipation as well as docusate PRN for constipation. To ensure consistent administration and for state survey purposes, please set parameters for use or, if a duplication, consider discontinuing one of the above. The CPR had a handwritten note that indicated R10's medication administration record (MAR) was updated [DATE] by LPN-A.R10's monthly MARs dated 10/2025 through 2/2026, indicated, MiraLAX Oral Packet 17 GM.Give 17 gram by mouth every 24 hours as needed for Constipation. And Docusate Sodium Oral Capsule 100MG.Give 1 capsule by mouth every 24 hours as needed for Constipation. The monthly MARs lacked evidence of any instruction as to which medication to give first for constipation. During interview on [DATE] at 12:51 p.m., director of nursing (DON) expected R10's CPR would have been addressed timelier. DON stated the process for CPR was the clinical pharmacist would email the recommendations to the DON and each of the clinical nurse managers (CNM). The CNM who was responsible for the resident in the recommendation would forward to the provider if appropriate or address the recommendation if it was a nursing issue. DON further stated urgent recommendations should be addressed promptly, and less urgent ones should be addressed in one to two months at the most. During interview on [DATE] at 1:00 p.m., CP expected facilities to address the CPR within 30 days or so. CP stated should not have to issue the same recommendation without being addressed multiple times and would have expected R10's duplicate medications to have been addressed sooner than five months. Facility policy for pharmacy recommendation review was requested but was not provided.