



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 2, 2025

Administrator
Gracepointe Crossing Gables
1601 RIVERHILLS PARKWAY NORTHWEST
CAMBRIDGE, MN 55008

RE: CCN: 245432

Cycle Start Date: September 4, 2025

Dear Administrator:

On November 11, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in blue ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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September 15, 2025

Administrator
Gracepointe Crossing Gables
1601 RIVERHILLS PARKWAY NORTHWEST
CAMBRIDGE, MN 55008

RE: CCN:245432

Cycle Start Date: September 4, 2025

Dear Administrator:

On September 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 4, 2025, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 4, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

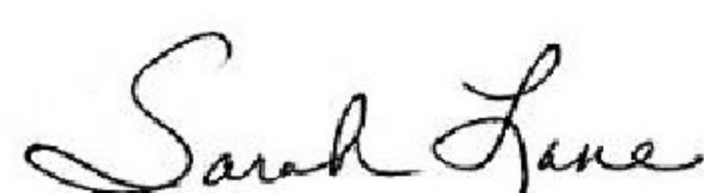
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2025	
NAME OF PROVIDER OR SUPPLIER Gracepointe Crossing Gables				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST , CAMBRIDGE, Minnesota, 55008			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 9/2/25 to 9/4/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			09/19/2025	
F0000	INITIAL COMMENTS On 9/2/25 to 9/4/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54323400C (2605020). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			09/19/2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.		F0641	An MDS modification was completed and submitted for R4's 7-15-25 and 9-3-25 MDS'. The modification changed MDS section N0350.Insulin from 1 day to 0 days. A full facility audit was completed to ensure that no other MDS' had MDS section N0350.Insulin miscoded. None were found.		09/16/2025	

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 reverse for further 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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F0641 SS = D	Continued from page 1 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure the minimum data set (MDS) assessment was correctly coded for 1 of 5 residents (R4) in the sample reviewed for unnecessary medications. Findings Include: R4's PointClickCare (PCC) (electronic medical record) diagnosis listing documented resident had the diagnoses of type 2 diabetes, morbid obesity due to excess calories and intestinal bypass. R4's last comprehensive minimum data set (MDS) assessment dated 9/3/25, indicated resident moderately cognitively impaired and was independent with activities of daily living (ADLS). A review of R4's PCC Physician Orders, last updated 9/4/25, R4 was prescribed the following medication: Trulicity Subcutaneous Solution Auto-injector 1.5	F0641	Continued from page 1 All staff responsible for coding the MDS were reeducated that Trulicity is a GLP-1 Agonist, not insulin and therefore should not be coded as insulin on the MDS. The facility will monitor and sustain correction by completing audits on all MDS' weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 9/16/25 This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	

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F0641 SS = D	Continued from page 2 MG/0.5ML (Dulaglutide) Inject 1.5 mg subcutaneously in the evening every Tue related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE (E11.22)Prescription date of 6/24/25 This medication is a GLP-1 (glucagon-like peptide-1), a hormone naturally produced in the intestines that plays a crucial role in regulating blood sugar levels. A review of the last two MDS assessments, both coded as Comprehensive MDS assessment, dated 7/15/25 and 9/3/25 were noted to have incorrect coding in Section N (Medications). It was noted in Section N of both assessments, R4 was marked as have received 1 injection of insulin. However, in review of the Eli Lilly and Company medication instruction sheet (last revised 9/2018 and found online at www.trulicity.com), informed the consumers Trulicity was not an insulin (used by diabetics to control blood sugar levels), but rather a medication used "as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus." In review of the medication reference guide, entitled Drugs.com, indicated the following."No, Trulicity is not a form of insulin.Trulicity mimics the effects of GLP-1 a naturally occurring hormone that stimulates insulin secretion.Trulicity is only suitable for people with type 2 diabetes who still have functioning insulin-producing cells in their pancreas.Trulicity is given by subcutaneous injection, once a week."In review of another medication reference guide, PDR (Physician's Drug Reference). which can be found at pdr.net, indicated the following: "GLP-1 is an important, gut-derived, glucose homeostasis regulator that is released after the oral ingestion of carbohydrates or fats. In patients with type 2 diabetes, GLP-1 concentrations are decreased in response to an oral glucose load. GLP-1 enhances insulin secretion; it increases glucose-dependent insulin synthesis and in vivo secretion of insulin from pancreatic beta cells in the presence of elevated glucose." During interview on 9/4/25 at 10:15 a.m., the director of nursing (DON) and a Corporate registered nurse ((RN)-Corp stated that the corporation data inputs and completed all resident MDS assessments offsite. The unit managers for each unit completed individual resident nursing assessment which aided the offsite nurses to complete the MDS assessment. If the offsite nurses have a question the facility is emailed for clarification. The onsite MDS coordinator main role was to monitor MDS scheduling for all the units and to		F0641				

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F0641 SS = D	Continued from page 3 ensure the assessments are completed in required time frames. DON further stated the interdisciplinary team also gets together and reviews each resident prior to the completion and submission of the current MDS being assessed for. Both staff members indicated training may be at hand when it came to GLP-1 medication. In review of a facility policy, entitled: Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission (last modified March 2025) indicated the following:"3. c. An accurate assessment requires collecting data and information from multiple sources. These sources must include the resident, and direct care staff on all shifts, and should also include the resident's clinical record, physician, and family, guardian or significant other as appropriate or acceptable. Documentation in clinical record must support the items coded on the MDS.		F0641				
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide a palatable diet by serving cold food at a temperature over 40 degrees. This had the potential to affect 17 residents who resided in the memory care unit. Findings include: During observation on 9/3/25 at 12:10 p.m., the dietary aid (DA)-A on the first floor kitchenet had started to serve the assisted living facility (ALF). The nursing home residents were scheduled to be served starting at 12:30 p.m. The ALF and nursing home (NH) hot food was in the steam table, and the dessert for the ALF and NH was a fruit salad served in individual bowls on trays on top of the counter. Facility's temperature log indicated the fruit salad's temperature was 38 degrees		F0804	Employee involved received immediate re-education and corrective action. All desserts still present were discarded. Education for all Culinary staff was initiated, and adjustment was made to the serving process in that kitchen going forward to avoid delays in serving that may contribute to temperatures outside of the recommended ranges. The facility will monitor and sustain correction by completing temperature audits weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Care Center Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 10/1/25 This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.		10/01/2025	

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F0804 SS = E	Continued from page 4 at 11:50 am. During observation on 9/3/25 at 12:47 p.m., DA-A started to serve lunch to the nursing home residents on the 1st floor. The dessert served in bowls were on top of the counter. During observation and interview on 9/3/25 at 1:21 p.m., after all the residents were served a food tray which included the fruit salad, testing was conducted on one tray with the culinary director assistant (CAD). The CAD used a facility's food thermometer to check the temperature of the foods. The fruit salad's temperature was 62 degrees Fahrenheit. The CAD stated the fruit salad was plated at 11:45 a.m., and they were not put in the refrigerator. CAD stated, "I would like cold foods to be served at 38 to 40 degrees, 60 degrees is too high for the fruit salad." During interview on 9/4/25 at 7:35 a.m., the CAD stated the fruit salad was prepared at the facility. The recipe included the following ingredients, canned fruit cocktail, marshmallow, whipped topping, maraschino cherries, and vanilla pudding. During interview on 9/4/25 at 9:03 a.m., DA-A stated yesterday, she placed the individual bowls of fruit salad on the counter. DA-A stated the fruit salad was a cool item and it was not refrigerated. During interview on 9/4/25 at 9:08 a.m., the culinary director (CD) stated the fruit salad was a cold item. CD stated the fruit salad at 60 degrees could cause foodborne illnesses. During interview on 9/4/25 at 12:51 p.m., the director of nursing (DON) stated her expectation for cold food was not to sit on the counter for an extended period because the food will warm up. DON stated the concern about serving the cold food at a temperature over 40 or 41 degrees had the potential to cause foodborne illnesses. The Nutrition and Culinary Services Department, Menu item: Fruit Salad recipe indicated should be stored in the refrigerator at 41 degrees or lower. The Time/Temperature Control for Safety Food dated 2/15/23 indicated, the temperature danger zone was 41 and 135 degrees. This document also indicated maintaining cold food at 41 degrees or below.		F0804				
F0880 SS = E	Infection Prevention & Control		F0880	The employee found not properly disinfecting the glucometer was reeducated and competency tested on		10/01/2025	

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F0880 SS = E	Continued from page 5 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	Continued from page 5 cleaning of the glucometer. All staff responsible for using a glucometer were reeducated on the facility's Blood Glucose Monitoring Disinfection Policy. The employee found not properly doffing/donning PPE and hand washing was reeducated and competency tested on handwashing and proper PPE use. All staff that use PPE in residents' rooms were reeducated on proper PPE use and handwashing. The facility will monitor and sustain correction by completing glucometer disinfection, PPE use, and handwashing audits weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 10/1/25 This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	

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F0880 SS = E	Continued from page 6 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure glucometers (a device used to monitor blood sugar levels) were appropriately disinfected between uses, for 1 of 4 residents (R85) in the sample who had a blood sugar check by a unit glucose meter. This had the potential to affect all four residents on 2nd Floor North unit who received scheduled blood sugar checks. In addition, the facility failed ensure personal protective equipment (PPE) was worn by staff while assisting 1 of 1 resident (R79) on contact precautions. Findings include: R85 R85's PointClickCare (PCC) (electronic medical record) diagnosis page documented resident had the following diagnoses: type 2 diabetes mellitus with unspecified complications, mild non-proliferative diabetic retinopathy without macular edema and morbid obesity due to excess calories. R85's Comprehensive Minimum Data Set (MDS), dated 8/3/25, indicated resident was moderately cognitively impaired and required partial to maximal assistance from staff to complete her			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2025	
NAME OF PROVIDER OR SUPPLIER Gracepointe Crossing Gables				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST , CAMBRIDGE, Minnesota, 55008			
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F0880 SS = E	Continued from page 7 activities of daily living (ADLS). In review of R85's PCC order summary report, resident had the following physician orders: 1. Insulin Glargine Subcutaneous Solution 100 UNIT/ML(milliliter) (Insulin Glargine) Inject 20 units subcutaneously in the morning 2. NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject 8 units subcutaneously one time a day for Hold insulin for BG < (less than) 120 or if not eating 3. Accu check before meals. Call if BS (blood sugar) less than 70 or greater than 450 three times a day for Diabetic Monitoring AM Is fasting check During observation on 9/3/25 at 1:01 p.m., licensed practical nurse (LPN)-A prepared to check R85's blood sugar before she received her noon meal in her room. LPN-A gathered the required supplies of the Accu-Check meter, a test strip, an prepackaged alcohol pad and needle lancet. LPN-A performed hand hygiene using alcohol hand gel and donned disposable gloves. Upon entering R85's room, LPN-A informed resident she was here to check her blood sugar level, prior to the noon meal and insulin injection. R85 indicated which finger she wished to be used and LPN-A prepped the finger, cleansing it with the alcohol pad. Once air dried, LPN-A used the lancet (device used to puncture the skin), obtained a droplet of blood and captured it on the Accu-Check test strip. A tissue was provided to R85 for her finger while the test calculated. R85's blood sugar level was 267. R85 stated she had just had some candy and it will go down shortly. Seeing the meal tray being delivered, LPN-A gave R85 her insulin. LPN-A Then left R85's room, returning to the medication cart and placed the glucometer on the medication cart, doffed her gloves and applied alcohol gel to her hands. LPN-A then open the medication cart, removed two more alcohol pads and wiped down the glucometer, placing it back into the medication cart. During interview on 9/3/25 at 1:24 p.m., LPN-A stated this unit only has one glucometer and is shared among all the diabetics on the unit. LPN-A stated they clean the device by wiping it down with alcohol pads and allow it to air dry between resident uses.		F0880				

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F0880 SS = E	Continued from page 8 During an interview on 09/3/25 at 1:33 p.m., LPN-B stated that each unit has bleach wipes which glucose meters are to be cleaned with before using with another resident. During an interview on 9/3/25 at 1:36 p.m., registered nurse (RN)-A, stated we use the alcohol wipes were used to clean the glucometer between residents. During an interview on 9/3/25 at 1:38 p.m., LPN-C stated "each diabetic resident on this unit has their own glucometer, we clean them when soiled. Each room had a container of bleach wipes." During an interview on 9/3/25 1:44 PM, LPN-D stated the unit only has one glucometer and they used bleach wipes on the devices between residents. The facility used the Assure Platinum brand of glucose meter, which has the following cleaning / disinfection instructions from the manufacturer: "To disinfect an Assure Platinum meter, you must first clean it with soap and water or 70-80% isopropyl alcohol, then disinfect using a lint-free cloth dampened with either a commercially available EPA-registered disinfectant wipe or a 1:10 bleach solution (1 part household bleach to 9 parts water). Always follow the manufacturer's instructions, use proper PPE, and be careful not to get liquid in the test strip or battery ports. Follow These Steps: 1. Prepare for a new patient: • Wash your hands thoroughly with soap and water. • Put on a new pair of clean gloves. • Use an auto-disabling, single-use lancing device for each patient. 2. Clean the meter: • Use a lint-free cloth dampened with a soap and water			F0880			

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F0880 SS = E	Continued from page 9 solution or a 70-80% isopropyl alcohol solution. • Clean the exterior of the meter, wiping off any dirt, blood, or other bodily fluids. 3. Disinfect the meter: • Use a different lint-free cloth dampened with either: • An EPA-registered disinfectant detergent or germicide. • A solution of 1 part household bleach (5-6% sodium hypochlorite) to 9 parts water (a 1:10 dilution). • Wipe down the meter thoroughly with the disinfectant solution." In review of the facility policy, entitled: Blood Glucose Monitor Disinfection (modified November 2022) documented the following for disinfecting glucometers between residents: "Policy for Glucometer Use Between Multiple Residents: After the completion of blood glucose testing discard the test strip per policy. Wash hands or use waterless hand sanitizer. Apply a clean pain of gloves. If any visible soiling of the glucometer, first clean the glucometer with an alcohol wipe. Disinfect the glucometer using a bleach based disinfectant wipe. This product will be effective for devices that have come in contact with C-Diff and/or Norovirus. a. Disinfectant Sani-Cloth Bleach Wipe (Item # P54072) meets this requirement. Do not clean inside the battery compartment, code chip port or test strip port. The glucose monitor must be disinfected for 4 minutes using wipes and then thoroughly dried prior to use between clients. Remove gloves. Wash hands or use waterless hand sanitizer."		F0880				

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F0880 SS = E	Continued from page 10 R79 R79's quarterly Minimum Data Set (MDS) dated 7/9/25, indicated diagnosis of Alzheimer's, diabetes, non-traumatic brain dysfunction, and coronary artery disease (CAD). R79 had impaired cognition. R79 had a diagnosed of shingles. An observation on 9/3/25 at 1:20 p.m., nursing assistant (NA)-A was observed bringing a lunch tray to R79's room. R79's room had a sign posted outside the door indicating to staff contact precautions (gown and gloves worn for all interactions with patient [resident] and their environment to prevent pathogen transmission). NA-A place the lunch tray on the bin outside the room that had PPE in. The bin had no clean gowns. NA-A went into R79's room and took a soiled gown out of the white laundry basket in R79's room and put it on and put on clean gloves. NA-A brought the lunch tray to R79 and assisted R79 with the meal. NA-A stayed in the room while R79 ate. At 1:32 p.m., NA-A brought the tray to the counter in R79's room and took off the gloves and gown, placed the gown in the white laundry basket in R79's room. NA-A washed her hands with soap and water and brought the meal tray out of the room towards the dining area. An observation on 9/3/25 at 1:33 p.m., NA-A went into R79's room to get previous meal trays from the counter and did not put on PPE when she entered. NA-A organized both trays to one and left room with the meals trays and went towards the dining area. NA-A did not put PPE on, hand sanitize or wash her hands when entering or exiting R79's room. On 9/3/25 at 1:34 p.m., NA-B stated R79's was diagnosed with Shingles and was on contact precautions. NA-B stated staff needed to wear gowns and gloves when going into R79's room to do cares. NA-B staff were not to take gowns out of the white laundry basked in the room to wear as they were soiled. NA-B stated staff did not need to wear gown or gloves when just going into pick up trays from previous meals. On 9/3/25 at 1:37 p.m., NA-A stated she took the gown out of the white laundry basket from R79's room and did not know if they were clean or not and then put the gown on to go into R79's room. NA-A stated she should		F0880				

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F0880 SS = E	Continued from page 11 have asked someone if the gowns in the white laundry basket were clean or not. NA-A stated she did not know where to get clean gowns from. NA-A asked another staff to get more clean gowns for R79's bin outside the room. On 9/3/25 at 1:53 p.m., registered nurse (RN)-A stated staff are to wear gowns and gloves when going into a resident's room with contact precautions. RN-A stated staff were to wash their hands or use hand sanitizer before and after going into a resident's room with contact precautions. RN-A stated clean gowns are kept in the bin drawer outside the resident's room, if there were no clean gowns in the bin then staff had to get them from the clean storage room. RN-A stated the white laundry basket in the room was for soiled gowns and staff should not take a gown out of there and wear when entering the residents room. RN-A stated staff should wear a gown and gloves to enter R79's room even when getting meal trays from the counter in the room. On 9/4/25 at 10:17a.m., RN-B stated R79 had shingles and needed contact precautions for staff and visitors. RN-B stated staff were to wash hands before entering or use hand sanitizer, wear gown and gloves when entering R79's room, take off gloves and gown when leaving room and wash hands or use hand sanitizer. RN-B stated staff are to place the soiled gown in the white laundry basket inside the resident room. RN-B stated staff are to get clean gowns from the bin outside of R79's room and not to take the gown from the white laundry basket and wear again as it was soiled. RN-B expected staff to wear gown and gloves whenever they entered R79's room. On 9/4/25 at 1:25 p.m., infection preventionist (IP) stated all staff had been trained on all precautions. IP stated the gowns in the white laundry basket were soiled and staff were not to re-wear them. IP stated the clean gowns were kept in the bin outside the resident's room. IP stated taking a gown from the white laundry basket was not the process of the facility. The facility policy Infection Prevention and Control Manual Transmission-Based Precautions undated, indicated contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment. In addition to standard precautions, contact precautions will be used to prevent the healthcare acquired spread of organisms		F0880				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/04/2025	
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F0880 SS = E	Continued from page 12 that can be transmitted by direct resident contact (hand or skin to skin contact that occurs when performing resident cares) or by indirect contact (touching) with environmental surfaces or contaminated resident care equipment.			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GRACEPOINTE CROSSING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 09/03/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, GracePointe Crossing was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:			K0000			09/19/2025

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 reverse for further 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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K0000	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Gracepointe Crossing is a 3 story building with a partial basement built in 2018 and was determined to be Type II(111) construction. The building plans and the building codes were reviewed under the 2012 Edition of the NFPA Life Safety Code after to 07/05/2015 the facility was inspected under new construction. The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas that is is monitored for automatic fire department notification. The facility has a capacity of 110 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101		K0353	Inspection was completed within regulated timeline. A copy of this inspection document was provided to the fire marshal on the day of the inspection visit.		09/04/2025	

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K0353 SS = E	Continued from page 2 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler/ standpipe system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 6.3.4.1, and 6.3.4.2. This deficient finding could have a patterned impact on the residents within the facility. On 09/03/2025 at 11:46 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for the five year sprinkler testing. The documentation for the five year sprinkler test was received via email after the survey was completed. An interview with the Environmental Services Director and the Care Center Administrator verified this deficient finding at the time of discovery.		K0353	Continued from page 2 a) Date sprinkler system last checked: 10/23/23 b) Who provided system test: Breth-Zenzen Fire Protection, LLC c) Water system supply source: Cambridge City Water Breth-Zenzen Fire Protection has a new format for their documentation. They entered the 2023 visit into this format, it was printed and placed in the life safety systems book. All documents from Breth-Zenzen Fire Protection will be in this format and placed in life safety systems book. Next 5-year inspection not due until 2028. Care Center Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 9/3/25			
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 This STANDARD is NOT MET as evidenced by:		K0761	Inspections were completed within regulated timelines. The inspection log found to have the incorrect date was immediately corrected and provided to the fire marshal. The door inspections were entered onto the correct form		09/04/2025	

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K0761 SS = F	Continued from page 3 Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. On 09/03/2025 at 10:13 AM, it was revealed by a review of available documentation that a fire door inspection has not been conducted within the last 12 months. An interview with the Environmental Services Director and the Care Center Administrator verified this deficient finding at the time of discovery.			K0761	Continued from page 3 with the correct date. The form was placed into the life safety systems book. The facility will monitor and sustain correction by completing door log audits monthly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Care Center Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 9/4/25		09/30/2025
K0920 SS = D Bldg. 02	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a isolated impact on the residents within the facility.			K0920	Fridge found to not be plugged into the wall was immediately corrected and plugged directly into the wall during the inspection visit. Full house audit was conducted to ensure all appliances were plugged directly into the wall and no further concerns were noted. Education on appliances being plugged directly into the wall started for those with appliances located in their offices. The facility will monitor and sustain correction by completing appliance audits on 5 fridges weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Care Center Administrator, or designee, will be responsible for ensuring ongoing compliance. Correction date for certification: 9/30/25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GRACEPOINTE CRO... B. WING		(X3) DATE SURVEY COMPLETED 09/03/2025	
NAME OF PROVIDER OR SUPPLIER Gracepointe Crossing Gables				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST , CAMBRIDGE, Minnesota, 55008			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0920 SS = D Bldg. 02	Continued from page 4 On 09/03/2025 at 11:16 AM, it was revealed by observation that a refrigerator were plugged into a power strip in the third floor staff office. The Environmental Services Director removed this deficient practice at the time of discovery. These deficient findings were verified by the Environmental Services Director and the Care Center Administrator at the time of discovery.			K0920			