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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4M3S
Facility ID: 00292

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245120**
2. STATE VENDOR OR MEDICAID NO. (L2) **195487000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES EAST**
(L4) **548 FIRST AVENUE**
(L5) **CAMBRIDGE, MN** (L6) **55008**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/02/2007**
6. DATE OF SURVEY 08/29/2013 (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **90** (L18)
13. Total Certified Beds **90** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NEII 09/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/27/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/17/1967** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/27/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On June 14, 2013, an abbreviated standard survey was completed. As a result of this abbreviated standard survey, this Department notified the facility that the following enforcement remedy was being imposed: Mandatory Denial of Payment for New Medicare and Medicaid admissions effective September 14, 2013. The facility was also subject to a loss of NATCEP for two years from September 14, 2013.

This was based on deficiencies cited by this Department for an abbreviated standard survey completed on June 14, 2013 and failure to achieve substantial compliance at the time of the Standard survey completed on July 18, 2013.

On August 29, 2013, this Department completed a Post Certification Revisit and all deficiencies were found corrected effective August 29, 2013. As a result of the revisit findings, Mandatory Denial of Payment for New Medicare and Medicaid admissions effective September 14, 2013 was rescinded. The facility is no longer subject to a loss of NATCEP for two years.

Effective August 29, 2013, the facility is certified for 90 skilled nursing facility beds. Please refer to the CMS 2567B.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5120 December 27, 2013

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Dear Ms. Barthel:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 29, 2013, the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

September 5, 2013

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

RE: Project Number H5120035 and S5120023

Dear Ms. Barthel:

On August 2, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 14, 2013. (42 CFR 488.417 (b))

We also notified you that in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 14, 2013.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on June 14, 2013, and failure to achieve substantial compliance at the time of the Standard survey completed on July 18, 2013. The most serious deficiencies at the time of the abbreviated standard survey and the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 29, 2013, the Office of Health Facility Complaints and the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey completed on June 14, 2013 and the Standard survey completed on July 18, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey completed on June 14, 2013 and the Standard survey completed on July 18, 2013.

As a result of the PCR findings, this Department is recommending the following to the CMS Region V Office. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 14, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 14, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 14, 2013, is to be rescinded.

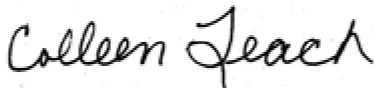
In our letter of August 2, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 14, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 29, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117   Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245120	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 55008

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**08/26/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**08/26/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**08/26/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	**08/26/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**08/26/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	**08/26/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	BF/cbl	09/06/2013	29249	08/29/2013
Reviewed By CMS RO				

Followup to Survey Completed on: 7/18/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245120	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 55008

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0309 Reg. # 483.25 LSC	08/29/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/14/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

AH Form Approved
2/4/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00292	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 55008

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	**08/29/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
6/14/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

September 5, 2013

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Re: Enclosed Reinspection Results - Project Number H5120035 and S5120023

Dear Ms. Barthel:

On August 29, 2013 an investigator from the Office of Health Facility Complaints and survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found at the time of the complaint investigation completed on June 14, 2013 and the standard survey completed on July 18, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00292	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 55008

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	08/26/2013	ID Prefix 20800 Reg. # MN Rule 4658.0510 Subp. LSC	08/26/2013	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	08/26/2013
ID Prefix 20915 Reg. # MN Rule 4658.0525 Subp. LSC	08/26/2013	ID Prefix 21805 Reg. # MN St. Statute 144.651 Sul LSC	08/26/2013	ID Prefix 21830 Reg. # MN St. Statute 144.651 Sul LSC	08/26/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/cbl	09/06/2013	29249	08/29/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/18/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4M3S
Facility ID: 00292

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245120**

2. STATE VENDOR OR MEDICAID NO.
(L2) **195487000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES EAST**
(L4) **548 FIRST AVENUE**
(L5) **CAMBRIDGE, MN** (L6) **55008**

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/02/2007**

6. DATE OF SURVEY **07/18/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited
1 TJC
2 AOA
3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **90** (L18)

13. Total Certified Beds **90** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

At the time of the Standard survey, the facility was not in compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Karlyn Pogatchnik, HFE NEII 08/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 08/23/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/17/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted
8/27/2013
ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5483

August 2, 2013

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

RE: Project Number S5120023

Dear Ms. Barthel:

On June 22, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on June 14, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 18, 2013, a standard 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 program. This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 14, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 14, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 14, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Gracepointe Crossing Gables East is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 14, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 14, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department’s informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

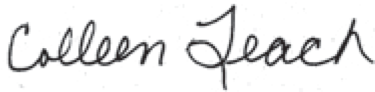
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

RECEIVED

AUG 1 4 2013

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

PRINTED: 08/01/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING MN Dept of Health St.Cloud B. WING	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	THIS PLAN AND RESPONSE TO THESE SURVEY FINDINGS IS WRITTEN SOLELY TO MAINTAIN CERTIFICATION IN THE MEDICARE PROGRAM. THESE WRITTEN RESPONSES DO NOT CONSTITUTE AN ADMISSION OF NONCOMPLIANCE WITH ANY REQUIREMENT NOR AN AGREEMENT WITH ANY FINDINGS. WE WISH TO PRESERVE OUR RIGHT TO DISPUTE THESE FINDINGS IN THEIR ENTIRETY AT ANY TIME AND IN ANY LEGAL ACTION. WE MAY SUBMIT A SEPARATE REQUEST FOR INFORMAL DISPUTE RESOLUTION FOR CERTAIN FINDINGS AND DETERMINATIONS	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified dining experience in the North Haven dining room-assistance section for 3 of 3 residents (R21, R3, R18) that received assistance during dining. Finding include: R21 diagnosis included Alzheimer's Disease. The quarterly Minimum Data Set (MDS) dated 05/14/13, indicated R21 had severe cognitive impairment and required total staff assistance to eat. The care plan dated 07/11/13, indicated R21," I require total assistance of one staff to	F 241	Dining room protocol has bee reviewed and is current. Education with staff on the dining room protocol and resident dignity is in process and will be ongoing. Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated.	8/19/13 HX accepted.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: Brandi Barthel, LNHA | TITLE: Care Center Administrator | (X6) DATE: 8/13/13

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.

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F 241	Continued From page 1	F 241		

eat."

R3 diagnosis included Alzheimer's Disease. The quarterly MDS dated 06/05/13, indicated R3 had severe cognitive impairment and required total *staff* assistance to eat. The care plan dated 12/05/12, indicated, "I require 1 staff participation to eat."

R18 diagnosis included Alzheimer's Disease. The quarterly MDS dated 01/23/13, indicated R18 had severe cognitive impairment and required supervision and set up help of tray to eat. The care plan dated 10/30/12, indicated R18," I require setup, supervision, cueing to continue eating, then phsyical [sic] assistance to finish my food at each meal..."

During an observation in the North Haven dining room on 07/15/13, at 5:31 p.m., nursing assistant (NA)-G was sitting next to R21 and assisting her with her meal. As she fed R21, NA-G said to NA-F who was assisting R3 to eat stated, "I think I am going to do a bed bath tonight because a bath did not go well." NA-F looked *over* at R21 arid said, [R21's name]. NA-G replied, "Yes." NA-F asked NA-G how many baths she had to complete. NA-G replied, "I have *five* to do tonight, [NA-G started stating resident's names], that she had to assist with bathing. During this conversation R21, R3 and R18 were all sitting at the table, while NA-F and NA-G discussed their tasks of bathing identifying specific resident. They did not engage these residents in a meal time conversation but instead identified their work tasks.

When interviewed on 07/18/13 at 10:25 a.m., household coordinator (HC)- J, verified the North

Dining room/dignity audits will be conducted on 20% of meals weekly for four weeks and reviewed at IDT. The facility QA&A committee will review audits to determine the need for ongoing monitoring.

The Clinical Administrator and/or designee are responsible for ongoing compliance.

Date certain for purposes of ongoing compliance is August 26, 2013

PRINTED: 08/01/2013
FORM APPROVED
OMB NO 0938-0391

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F 241	Continued From page 2 Haven assigned seating arrangements and the location of where R21, R3, R18 are seated in the dining room. When HC-J was notified of NA-G and NA-F discussion identifying resident's names and their bathing scheduled HC-J stated, "it is not acceptable and should not have occurred." The facility's "Dining Room Protocol", dated 04/29/10, indicated, the purpose: "to provide dignified, prompt meal service... initiate friendly conversation with residents at table."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION- RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who had pureed diets were provided choices regarding food preferences for 1 of 1 residents (R48) in the sample that received a pureed diet. Findings include: R48 had diagnosis of dementia. The quarterly Minimum Data Set (MDS) dated 5/23/13 identified the resident had severe cognitive impairment and needed extensive assistance with eating.	F 242	Resident R48 food preferences have been reviewed and tray ticket updated to reflect preferences. Upon admission, quarterly, and as needed resident's food preferences are reviewed and tray ticket created. Education with staff on resident choices is in process and will be ongoing. Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated. Meal satisfaction audits will be completed on 10% of residents weekly for four weeks. The facility QA&A committee will review audits to determine the need for ongoing monitoring.	

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F 242	Continued From page 3 R48's current plan of care dated 7/11/13 indicated to honor the residents food preferences and requests within the diet as ordered. The current nutritional assessment dated 5/21/13 indicated the resident liked orange juice, milk, ice cream, and peanut butter and jelly sandwichs. The assessment did not include any of the residents dislikes. During meal observation on 7/15/13 at 4:58p.m., R48 was being assisted by resident assistant (RA)-D with her supper meal. RA-D tried to give R48 a bite of pureed fish and R48 stated, "I don't like fish!" RA-D stated, "I know you don't like fish, but that's all they have tonight." Household coordinator (HC)-C was sitting across the table assisting another resident and asked RA-D why she didn't have something else to offer. RA-D stated, "I told the cook she didn't want fish; but they still gave it to her." R48 was observed throughout the entire meal until 5:48p.m., the resident did not eat any fish and was not offered a different main entree to eat. During interview on 7/18/13 at 8:21a.m. dietary manager (DM)-G stated staff should have provided an alternative to R48 on 7/15/13. She stated staff was suppose to have pureed chicken and hamburger as an alternative but did not do that. DM-G stated she was in the process of retraining her staff regarding providing all resident food choices. The facility provided a policy titled Mechanically Altered Diets dated 2/2011 which instructed "Staff will observe for adequate meal intake and offer/ make available alternative menu items."	F 242	The Clinical Administrator and/or designee are responsible for ongoing compliance. Date certain for purposes of ongoing compliance is August 26, 2013	

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F 282	Continued From page 4	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: ·Based on observation, interview and document review, the facility failed to provide restorative nursing services were completed as directed by the plan of care, for 3 of 3 residents (R81,R57 &R53) reviewed who had restorative nursing programs and failed to ensure a swallow program was followed during meals for 1 of 1 resident (R19) with a swallowing problem. Findings include: R81 did not receive her standing program as ordered. R81's diagnoses included pain in thoracic spine, lumbago and pathologic fracture of vertebrae. The quarterly Minimum Data Set (MDS) dated 4/25/13, identified R81 was cognitively intact and needed extensive assist of two with transfers. R81's care plan dated 6/22/13, indicatedR81 was on a restorative program to stand from wheelchair at handrail in private restroom. Minimal assist of one two times daily, five times from sitting to standing, stand 1-2 minutes each time.	F 282	Resident R81, R53, R54have been reassessed for restorative programs. Resident R19 was reassessed by speech therapy on 7/17/13 for swallowing and choking concerns. Restorative nursing programs have been re-evaluated by therapy. Education with staff on restorative nursing is in process and will be ongoing. Education with staff on specific eating guidelines/recommendations was completed on 7/18/13, 7/19/13 and ongoing. Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated. Resident care and care plan audits will be completed on 10% of residents weekly for four weeks. The facility QA&A committee will review audits to determine the need for ongoing monitoring. The Clinical Administrator and/or designee are responsible for ongoing compliance. Date certain for purposes of ongoing compliance is August 26, 2013	

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F 282	Continued From page 5	F 282		

R81's Physical Therapy (PT) Evaluation and Plan of Care dated 7/4/12, indicated R81 was seen for a standing program and use of stand lift to increase and maintain arm and leg strength. The PT eval also indicated R81 is very agreeable to therapy to walk and ease of transfer. The rehabilitation Daily flow sheet dated 7/17/12, indicated PT spoke to R81's son to discontinue therapy and he still wished for patient to be seen private pay for PT for ambulation and exercise. The Physical Therapy progress note dated 7/19/12, indicated R81 was discontinued from PT and placed on a functional maintenance program for standing with nursing staff. The program included, "nursing transfer program: stand from w/c {wheelchair} in the hallway at the rail 2x per day, 5x to sit to stand and for 1-2 minutes each time."

Review of the nursing transfer program data from 7/1/13 to 7/16/13 indicated the following:
7/01/13- a.m. Program did not occur
7/01113- p.m. activity did not occur
7/04/13 -a.m. activity did not occur
7/05/13- p.m. activity did not occur
7/7113- a.m. activity did not occur
7/8/13- a.m. activity did not occur
7/8/13- p.m. activity did not occur
7/10/13- a.m. activity did not occur
7/12/13-a.m. activity did not occur
7/13/13-a.m. activity did not occur
7/15/13-p.m. activity did not occur

On 7/17/13 at 11:06 a.m., R81 was observed to be sitting in her room in her wheelchair. R81 stated she is on a restorative program to sit and stand, which is to be done twice a day. R81 provided an activity calendar on her night stand and then stated "I write down each time my

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F 282	Continued From page 6	F 282		

program is done." R81 stated it is not done twice a day and stated, "they just have too much work to do and they just cant get it done". R81 also stated she receives PT two times a week per her son's request.

During interview on 7/16/13 at 1:25 p.m., with resident assistant (RA)-A who stated "there is days where I am just too busy and sometimes we just cant do it" RA-A further stated there is several days a week that I cant complete the restorative nursing.

R57 had a ambulation program that was not completed as ordered.

R57 was admitted 6/6/13 and had diagnoses which included abnormality of gait, difficulty in walking and muscle weakness. The admission MDS dated 6/19/13, indicated R57 was cognitively intact, needed extensive assistance with transfers, and did not walk in his room or corridor.

R57's care plan dated 6/19/13, included, "nursing walking program: Ambulate with CGA {contact guard assist} of 1 with 4 wheeled walker 100 plus feet 1-2 times/day. Try to ambulate towards the dining room".

R57's Functional Maintenance Program (FMP) dated 6/18/13, indicated R57 to be on "Nursing walking program: ambulate with CGA [contact guard assist] of 1 with 4 wheeled walker 100 plus feet 1-2 times/day. Try to ambulate towards the dining room".

F 282 Continued From page 7 F 282

Review of the FMP data indicated the following from 7/5/13 to 7/17/13:

7/5/13- resident did not ambulate (do documentation as to why)
7/7/13- resident refused to ambulate
7/11/13- resident refused to ambulate
7/13/13- a.m. resident did not ambulate do documentation p.m. resident did not ambulate and staff checked "not applicable".
7/14/13-a.m. resident did not ambulate do documentation p.m. resident did not ambulate and staff checked "not applicable".
7/16/13-resident did not ambulate do documentation p.m. resident did not ambulate and staff checked "resident refused

On 7/18/13 at 10:33 a.m., R57 was observed in the hallway to be ambulating with the staff in hallway. R57 returned to his room and stated, "I just got done walking and my ankle hurts, the staff come and get me when it is time to walk. R57 also stated he never refuses to walk but they don't do it all time them." R57 further stated, "I think it doesn't get done all the time because they are just to busy here to get it done". R57 further stated that this happens weekly that he is not ambulated.

During interview on 7/18/13 at 12:18 p.m., with the Rehab Supervisor, who stated "I was not aware that R57 was not ambulating on a daily basis, nursing staff should inform me if he is not." The Rehab Supervisor also stated that R57 does not refuse his therapy and did not think he would refuse his FMP.

R53 did not receive his ambulation program as ordered.

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F 282	Continued From page 8 R53 diagnoses included difficulty walking, abnormality of gait and acquired deformity of ankle and foot R53's quarterly MDS dated 6/28/13 indicated he was severely cognitively impaired and needed extensive assistance of one with ambulation. R53's current care plan dated 7/11113, included, "I have a restorative ambulation program. I use a walker with my program. I often refuse to walk and say that I am unable to anymore." R53 therapy recommendations/FMP dated 1/07113 included, "nursing walking program: 25-50 feet with minimum assist of 1 with 2 WW (wheeled walker). Assist of 1 with w/c to follow 2 times per day. Cue resident to pick up feet while walking especially right fooL" Review of the FMP data from 7/5/13 to 7/17/13 indicated: 7/05/13- resident did not ambulate no reason provided 7/07/13- resident did not ambulate no reason provided 7/08/13- resident did not ambulate no reason provided 7/16/13- resident did not ambulate no reason provided During interview on 7/16/13 at 1:25 p.m. with NA-B, who stated they are so busy on the floor they just cant get everything done NA-B further stated the resident walking programs and restorative programs are not being completed due to staffing. NA-B further stated this has been going on for several months.	F 282		

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(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
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During interview 7/18/13 at 11:00 a.m., with NA-A, who stated there is days he is just too busy and can't get his work done. NA-A then stated sometimes he is unable to complete his restorative nursing.

During interview on 7/18/13 at 12:18 p.m., with the rehab supervisor, she stated R81 is on a sit to stand restorative program and she was not aware that R81 had not been receiving her program as ordered, the rehab supervisor also stated that R53 does refuse to walk at times and then stated if the staff are not able to ambulate R53 they need to document why and if he refuses they need to re-approach him and re-attempt. The rehab supervisor also stated the clinical coordinators or the house hold coordinators complete weekly audits and are to be informing her of programs not completed or resident refusals. The Rehab supervisor then stated that R81,R57 &R53 have not had a decline in there mobility.

During interview on 7/18/13 at 1:20 p.m., with the Director of Nursing (DON) and the clinical coordinator verified the findings of the FMP's. The DON stated the programs should be completed according to there plan of care.

R19 had diagnosis of end stage Alzheimer's disease and was receiving end of life hospice care. The annual Minimum Data Set (MDS) dated 5/2/13, identified R19 had severe cognitive impairment, was an ex1ensive assist with all activities of daily Jiving (ADL's), and had no swallowing or choking problems.

R19's care plan dated 7/11/13, indicated the resident had swallowing problems and had

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F 282	Continued From page 10 specific eating guidelines related to severe dysphagia [difficulty swallowing] per hospice directives: "Feed patient only when fully alert; Hold my head upright when feeding; must sit upright, 90 degrees; require supervision; reduce distractions; take your time, slow rate of intake, allow resident to eat slowly, check for oral residue, smaller, frequent meals; small amounts, 1 teaspoon bites/sips; verify a swallow with each bit or sip eating; if patient is holding food/liquid in mouth try tactile cue with spoon/ spouted cup tip to trigger swallow; use spouted cups; give verbal cues (ex. ready) prior to presentation of food; pay attention to patient warning signs such as pulling head away, holding food/liquid in mouth with no swallow; trouble breathing, coughing/choking=discontinue feeding." During dining observation on 7/15/13 at 5:11 p.m., R19 was being assisted with her meal by household coordinator (HC)-C. R19 was sitting in a geri chair with multiple pillows propped around her. R19 was leaning towards the left and had a neck pillow behind her neck. Her neck was hyperextend back. At 5:11 p.m., HC-C gave R19 a drink of thickened water out of a spouted cup without saying anything to the resident; R19 did not place her lips around the cup and her eyes were closed. R19 began to cough and gag on the thickened water for approximately 10 seconds. HC-C asked another (unknown) staff member to assist in repositioning R19 in her geri chair. The staff assisted R19 to sit in an upright position in the geri chair, however, the neck pillow was still directly behind her neck with her neck was hyperextend back. At 5:13p.m. HC-C gave R19 another drink of thickened water, again, R19 began to cough and choke on the water. At 5:17 p.m., R19 was given a drink of thickened apple	F 282		

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juice, the resident began to cough again. Throughout the meal observation form 5:11 p.m. to 5:28p.m., R19's neck remained hyperex1end and was not repositioned.

During meal observation on 7/16/13 at 12:55 p.m., R19 was being fed by resident assistant (RA)-B. R19 was sitting in her geri chair with the neck support pillow behind her neck, her neck was hyperex1end back, she was leaning to the left and her mouth open. RA-B gave R19 a drink of thickened water. The resident began to cough and gasp for air. Her eyes got wide and began to water, with her face turning red. RA-B asked another (unknown) RA to assist in sitting R19 up in her geri chair. The RA's held the resident straight up in her wheelchair while R19 continued to cough and gasp for air. This continued until 1:00 p.m. when RA-B told the other RA to get the nurse. Registered nurse (RN)-A assisted sitting R19 upright in her geri chair. At 1:01 p.m. RN-A gave R19 a drink of thickened water from the spouted cup and proceeded to feed the resident until1:11 p.m. The resident was positioned according to speech recommendations and was being prompted by the RN. No chockIng or coughing was noted during the observation of RN-A feeding the resident At 1:12 p.m. household unit coordinator (HUC)-1 sat by R19 and continued to feed her, without any incidents. The resident did not have anymore choking episodes after 1:11 p.m., however, R19 did cough several times.

During interview on 7/17/13 at 12:35 p.m. MDS coordinator registered nurse (RN)-F verified the observations made of R19 being assisted with eating on 7/15/13 and 7/16/13 were not according to the care plan.

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F 309 SS;D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R19) with swallowing problems was provided adequate assistance with eating as assessed to ensure resident was being fed correctly. Findings include: R19 had diagnosis of end stage Alzheimer's disease and was receiving end of life hospice care. The annual Minimum Data Set (MDS) dated 5/2/13 identified the resident had severe cognitive impairment, was an extensive assist with all activities of daily living (ADL's), and had no swallowing or choking problems. Upon review of !tie most recent speech evaluation, completed by the hospice speech therapist on 7/12/12, the recommendations listed on the care plan were made by the speech therapist. The speech therapist identified R19 had "severe dysphagia." The progress notes written by the hospice speech therapist dated 7/12/13 indicated, "Patient with history of severe dysphagia. Current diet of puree textures and honey thick liquids via spouted cup. Patient	F 309	Resident R19 was reassessed by speech therapy on 7/17/13 for swallowing and choking concerns. Resident R19 care plan was updated. Education with staff on specific eating guidelines/recommendations was completed on 7/18/13, 7/19/13 and ongoing. Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated. Resident care and care plan audits will be completed on 10% of residents weekly for four weeks. The facility QA&A committee will review audits to determine the need for ongoing monitoring. The Clinical Administrator and/or designee are responsible for ongoing compliance. Date certain for purposes of ongoing compliance is August 26, 2013	

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F 309	Continued From page 13 referred for swallowing evaluation due to recent chocking episode on 7/11/12 requiring Heimlich maneuver intervention. Patient seen for speech therapy evaluation on this date to assess swallowing status and provide recommendations for swallowing techniques to increase swallowing safety. Patient observed during lunch meal time with RN feeding patient. RN familiar with patient feeding routine. RN holding patient head upright at 90 degrees angle to increase safety of swallow. Food and liquid presented via spouted cups, small amounts. Patient presented with reduced mastication bolus control, and bolus transit time. Laryngeal elevation observed with each swallow however reduced. Patient demonstrated increased fatigue and swallowing difficulty as meal progressed, with increased holding of food/ liquid and significantly delayed swallow time. Immediate cough once with honey. Immediate cough once with puree and delayed cough twice...feeding discontinued due to increased difficulty managing food/liquid intake and signs and symptoms of aspiration/ penetration. Patient consumed approximately 25% of meal. Patient presents with severe oral pharyngeal dysphagia." The recommendations were listed as in the care plan. After the recommendations the speech evaluation further indicated, "RN and RN manager educated on results of evaluation and recommendations. Provide with written handout of recommended strategies for increased safety of oral intake. Ongoing speech therapy is not recommended at this time due to evaluation completed and swallowing strategy education completed. Please contact Hospice RN with any additional concerns." R19's care plan dated 7/11113, indicated the resident had swallowing problems and had	F 309		

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specific eating guidelines related to severe dysphagia [difficulty swallowing] per hospice directives: "Feed patient only when fully alert; Hold my head upright when feeding; must sit upright, 90 degrees; require supervision; reduce distractions; take your time, slow rate of intake, allow resident to eat slowly, check for oral residue, smaller, frequent meals; small amounts, 1 teaspoon bites/sips; verify a swallow with each bit or sip eating; if patient is holding food/liquid in mouth try tactile cue with spoon/ spouted cup tip to trigger swallow; use spouted cups; give verbal cues (ex. ready) prior to presentation of food; pay attention to patient warning signs such as pulling head away, holding food/liquid in mouth with no swallow; trouble breathing, coughing/chocking=discontinue feeding."

During dining observation on 7/15/13 at 5:11p.m. R19 was being assisted with her meal by household coordinator (HC)-C (who was a nursing assistant). R19 was sitting in a geri chair with multiple pillows propped around her. R19 was leaning towards the left and not sitting up at a 90 degree angle per the specific feeding instructions. Her neck was hyperextend back with a neck pillow and was not supported per the speech recommendations. At 5:11 p.m. HC-C gave R19 a drink of thickened water out of a spouted cup without warning the resident and making sure she was prepared for a drink. R19 did not place her lips around the cup and her eyes were closed. R19 began to cough and gag on the thickened water for approximately 10 seconds. HC-C asked another (unknown) staff member to assist in repositioning R19 in her geri chair. The staff assisted R19 to sit more upright in the geri chair, however, the neck pillow was still directly behind her neck and her neck was

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hyperextend back and not being supported. At 5:13p.m. HC-C gave R19 another drink of thickened water, again, R19 began to cough and choke on the water. At 5:17p.m. R19 was given a drink of thickened apple juice, the resident began to choke and cough again. Throughout the meal observation through 5:28p.m., R19's neck remained hyperextend and the resident not repositioned. The specific feeding instructions also instructed if the resident began to choke feeding should be discontinued; which it was not.

During meal observation on 7/16/13 at 12:55 p.m R19 was being fed by nursing assistant (NA)-B. R19 was sitting in her geri chair with the neck support pillow behind her neck, her neck was hyperextend back, she was leaning to the left and her mouth was hanging open. NA-B gave R19 a drink of thickened water. The resident began to choke and gasp for air. Her eyes got wide and began to water and her face turned red. NA-B asked another (unknown) NAto assist in sitting the resident up in her geri chair. The NA's held the resident straight up in her wheelchair by placing their arms around the residents back and the resident was drooling and continuing to choke and gasp for air. This continued until1:00 p.m. when NA-B told the other NA to get the nurse who was out of sight around the corner from the dining room. Registered nurse (RN)-A assisted sitting R19 upright in her geri chair. At 1:01 p.m. RN-A gave R19 a drink of thickened water from the spouted cup and proceeded to feed the resident until1:11 p.m., the resident had no further chocking episodes and was positioned correctly in the wheelchair while being fed by RN-A. At 1:12 p.m. household unit coordinator (HUC)-1 sat by R19 and continued to feed her. The resident did not have anymore choking

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episodes after 1:11 p.m., however, R19 did cough several times while eating.

During interview on 7/16/13 at 1:25 p.m. RN-A stated R19 choking is "about an every other day occurrence." RN-A stated sometimes it seems like staff "just pours the food in her mouth without her being aware." RN-A stated staff should all be aware of R19's specific feeding instructions and if they need assistance they can come and ask the nurse.

During interview on 7/17113 at 7:55a.m., LPN-A stated R19 chokes quite a bit and it can be "scary" to feed her because she is always choking.

During interview on 7/17113 at 11:30 a.m, hospice case manager stated R19 is at high risk for choking, however, the family wants no aggressive treatment (ex. feeding tube). She stated hospice obtained the speech evaluation to ensure R19 was fed in a way to make her as comfortable as possible. She stated R19 had very specific feeding instructions and all staff should be aware of them and be following them. She stated if the resident does choke when she is eating, staff should stop feeding her and try at a later time. She verified she was not aware of the five minute choking episode R19 had on 7/16/13, but staff should have discontinued feeding the resident per her specific feeding instructions.

During interview on 7/17/13 at 12:35 p.m., [MDS coordinator] registered nurse(RN)-F stated she goes through all resident notes every morning to see if there were any issues that need to be followed up on. She verified R19's choking episode was not documented in her medical

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record, nor was she aware it occurred. RN-F stated after the choking episode occurred staff should have stopped all feeding per speech recommendations. RN-F stated the facility had no specific training program on how to feed R19, however, the nursing assistant care sheets (all NA's use these to know specific residents needs) would tell the RA's how to feed R19 according to the specific feeding instructions per the speech evaluation.

Review of the nursing assistant care sheets for R19 updated on 7/15/13 indicated the resident needs meal assist, sippy cup, to sit upright, and the nurse to monitor position for eating. The care sheet did not list any1hing further regarding R19's specific feeding instructions.

During interview on 7/17/13 at 1:15 p.m., NA-C stated if a resident had special feeding instructions the nurse would educate staff on them. She stated R19 needed a neck pillow, sippy cups, and if the resident chokes she will go get the nurse and give the resident a break for a while. NA-C stated R19 had choked before while she was feeding her and she just gives the resident a "break" before continuing to feed her. NA-C also stated "a lot of staff' aren't comfortable feeding R19 because she "chokes so much."

During interview on 7/18/13 at 9:30a.m. NA-B stated she feeds R19 one or two times a week. She staled if lhe resident coughs she will lean the resident forward, make sure she is breathing, and get the nurse if she needs. NA-B stated if R19 chokes she will make sure the resident is comfortable, and then continue to feed her.

During interview on 7/18/13 at 9:35a.m. director

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F 309	Continued From page 18 of nursing (DON) stated she was unaware of any training that was done for staff regarding R19's specific feeding techniques.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this S(Jction. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing services were consistently provided for 3 of 3 residents (R81,R54 &R53) reviewed in the sample for restorative services. Findings include: R81 did not receive her standing program as ordered. R81's diagnoses included pain in thoracic spine, lumbago and pathologic fracture of vertebrae. The quarterly Minimum Data Set (MDS) dated 4/25/13, identified R81 was cognitively intact and needed extensive assist of two with transfers. The MDS also indicated she received physical therapy (PT) two times a week. R81's care plan dated 6/22/13, indicated R81 was on a restorative program to stand from wheelchair at handrail in private restroom. Minimal assist of one two times daily, five times from sitting to standing, stand 1-2 minutes each time.	F 311	Resident R81, R53, R54have been reassessed for restorative programs. Restorative nursing programs have been re-evaluated by therapy. Education with staff on restorative nursing is in process and will be ongoing. Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated. Restorative Nursing Task audits will be completed on 10% of residents weekly for four weeks. The facility QA&A committee will review audits to determine the need for ongoing monitoring. The Clinical Administrator and/or designee are responsible for ongoing compliance. Date certain for purposes of ongoing compliance is August 26, 2013	

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R81's Physical Therapy (PT) Evaluation and Plan of Care dated 7/4/12, indicated R81 was seen for a standing program and use of stand lift to increase and maintain arm and leg strength. The PT eval also indicated R81 is very agreeable to therapy to walk and ease of transfer. The rehabilitation Daily flow sheet dated 7/17112, indicated PT spoke to R81's son to discontinue therapy and he still wished for patient to be seen private pay for PT for ambulation and exercise. The Physical Therapy progress note dated 7/19/12, indicated R81 was discontinued from PT and placed on a functional maintenance program for standing with nursing staff. The program included, "nursing transfer program: stand from w/c {wheelchair} in the hallway at the rail 2x per day, 5x to sit to stand and for 1-2 minutes each time."

Review of the nursing transfer program data from 5/1/13 to 7/16/13 indicated the following:
May 2013- activity did not occur 26 out of 62 opportunites.
June 2013- activity did not occur 24 out of 60 opportunities.
July 2013- activity did not occur 11 out of 32 opportunities.

On 7/17113 at 11:06 a.m., R81 was observed to be sitting in her room in her wheelchair. R81 stated she is on a restorative program to sit and stand, which is to be done twice a day. R81 provided an activity calendar on her night stand and then stated "I write down each time my program is done." R81 stated it is not done twice a day and stated, "they just have too much work to do and they just cant get it done". R81 also stated she receives PT two times a week per her

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F 311	Continued From page 20 son's request. During interview on 7/16/13 at 1:25 p.m., with resident assistant (RA)-A who stated "there is days where I am just too busy and sometimes we just cant do it" RA-A further stated there is several days a week that I cant complete the restorative nursing. R54 had a ambulation program that was not completed as ordered. R55 was admitted 6/6/13 and had diagnoses which included abnormality of gait, difficulty in walking and muscle weakness. The admission MDS dated 6/19/13, indicated R57 was cognitively intact, needed extensive assistance with transfers, and did not walk in his room or corridor. R.54's care plan dated 6/19/13, included, "nursing walking program: Ambulate with CGA {contact guard assist} of 1 with 4 wheeled walker 100 plus feet 1-2 times/day. Try to ambulate towards the dining room". R54's Functional Maintenance Program (FMP) dated 6/18/13, indicated R57 to be on "Nursing walking program ambulate with CGA [contact guard assist] of 1 with 4 wheeled walker 100 plus feet 1-2 times/day. Try to ambulate towards the dining room". Review of the FMP data indicated the following from 5/1/13 to 7/16/13: May 2013- June 2013-	F 311		

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(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
F 311	Continued From page 21	F 311		

July 2013- Reused to ambulate 3 times, did not ambulate 4 times out of 32 opportunities.

On 7/18/13 at 10:33 a.m., R54 was observed in the hallway to be ambulating with the staff in hallway. R54 returned to his room and stated, "I just got done walking and my ankle hurts, the staff come and get me when it is time to walk. R54 also stated he never refuses to walk but they don't do it all time them." R54 further stated, "I think it doesn't get done all the time because they are just to busy here to get it done". R54 further stated that this happens weekly that he is not ambulated.

During interview on 7/18/13 at 12:18 p.m., with the Rehab Supervisor, who stated "I was not aware that R54 was not ambulating on a daily basis, nursing staff should inform me if he is not" The Rehab Supervisor also stated that R54 does not refuse his therapy and did not think he would refuse his FMP.

R53 did not receive his ambulation program as ordered.

R53 diagnoses included difficulty walking, abnormality of gait and acquired deformity of ankle and foot R53's quarterly MDS dated 6/28/13 indicated he was severely cognitively impaired and needed extensive assistance of one with ambulation.

R53's current care plan dated 7/11/13, included, "I have a restorative ambulation program. I use a , walker with my program. I often refuse to walk and say that I am unable to anymore."

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	245120	A BUILDING ________ B. WING	07/18/2013

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F 311	Continued From page 22 R53 therapy recommendations/FMP dated 1/07/13 included, "nursing walking program: 25-50 feet with minimum assist of 1 with 2 WW {wheeled walker}. Assist of 1 with w/c to follow 2 times per day. Cue resident to pick up feet while walking especially right fooL" Review of the FMP data from May1st 20013 to July 16th 2013 indicated the following: May- Refused 13 times and documented ambulation at zero feet 42 out of 62 opportunities. June- Refused 13 times and documented ambulation at zero feet 34 out of 60 opportunities. July- Refused 8 times and documented ambulation at zero feet 15 out of 32 opportunities. During interview on 7/16/13 at 1:25 p.m. with NA-B, who stated they are so busy on the floor they just cant get everything done NA-B further stated the resident walking programs and restorative programs are not being completed due to staffing. NA-B further stated this has been going on for several months. During interview 7/18/13 at 11:00 a.m., with NA-A, who stated there is days he is just too busy and can't get his work done. NA-A then stated sometimes he is unable to complete his restorative nursing. During interview on 7/18/13 at 12:18 p.m., with the rehab supervisor, she stated R81 is on a sit to stand restorative program and she was not aware that R81 had not been receiving her program as ordered, the rehab supervisor also stated that R53 does refuse to walk at times and then stated if the stallare not able to ambulate R53 they need to document why and if he refuses they	F 311		

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F 311	Continued From page 23 need to re-approach him and re-attempt. The rehab supervisor also stated the clinical coordinators or the house hold coordinators complete weekly audits and are to be informing her of programs not completed or resident refusals. The Rehab supervisor then stated that R81,R54 &R53 have not had a decline in there mobility. During interview on 7/18/13 at 1:20 p.m., with the Director of Nursing (DON) and the clinical coordinator verified the findings of the FMP's. The DON stated the programs are reviewed weekly at the medicare meetings and that is when we assess the program. The DON further indicated the staff should be documenting why the programs are not being completed.	F 311	Resident R81, R53, R54have been reassessed for restorative programs. Restorative nursing programs have been re-evaluated by therapy. Resident R34's treatments were re-assessed and updated.	
F 353 SS;E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353	Resident R16's treatments were reviewed and current and a pain assessment is in the process of being completed. Resident R45's need for wanderguard checks were reviewed and is current. Resident R57's treatment s were reviewed and updated. Resident R56, R34, R16, & R73 were interviewed and concerns addressed. Plan was initiated and residents were educated/informed of plan in place. Follow up interviews with residents will be conducted to ensure residents' needs are being met.	

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F 353	Continued From page 24 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living for 11 of 70 (R81,R57, R53, R34, R16, R45, R81, R83, R56,R73 & R16) residents who resided in the facility. In addition 2 of 4 family members (FM-A. and FM-8) interviewed had concerns that call lights were not being answered timely due to lack of staff. Additionally, 6 staff members interviewed stated resident cares were not being consistently completed due to not having enough staff. Findings include. The facility failed to ensure restorative nursing services were consistently provided for 3 of 3 resident (R81,R54 &R53) who received restorative nursing, due to insufficient staffing. Refer to F311 for additional information. Treatments were not completed as ordered for R34, R16, R45, & R57. R34 significant change Minimum Data Set (MDS) dated 6/11113, indicated she was severely cognitively impaired and had no behavior problems.	F 353	Resident R83 was interviewed and concerns addressed. Preferred bed times were reviewed with resident and care plan updated. Plan was initiated and resident was educated/informed of plan in place. Follow up interviews with resident will be conducted to ensure residents' needs are being met. Residents' treatments, medication passes, and restorative nursing programs have been reviewed and assessed as appropriate to ensure direct care staff has been allocated in a manner to ensure resident needs are being met. The call light nurse application computer is placed at each nursing station to assist with timely response to resident call lights. Utilize present technology to improve communication and efficiencies through SIP phones technology enabling staff to communicate through out the building. Pertinent phone numbers have been added to the RA group sheets. Education with staff to compliment areas of skill sets with emphasis on restorative nursing, medication passes, and nursing treatments is in process and will be ongoing. The above education is being completed to enhance efficiencies in work knowledge, competencies, and team work.	

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R34's treatment sheet for July indicated on 6/29/13 she had received an order to have a dressing changed to her right foot, wash with soap and water. Normal saline wet to dry gauze with kerlix and ace wrap twice a day. Review of the treatment sheet indicated from 7/1/13 to 7/17/13 R34 did not receive her treatment twelve times that it had been ordered. The treatment sheet did not indicate why the treatment was not completed.

R16 had diagnosis of arthritis. R16's quarterly MDS dated 6/27113 indicated she was alert and oriented.

Review of R16 treatment sheets indicated on 5/7/13 she received an order for Aspercreame twice a day and as needed. The treatment sheets revealed the following data:

May 2013- the treatment was not documented as being completed 16 times
June 2013- the treatment was not documented as being completed 11 times
July 2013- the treatment was not documented as being completed 10 times

R45 quarterly MDS dated 5/21113, indicated she was severely cognitively impaired. R45's care plan dated 5/22/13, indicated she was at risk for elopement and has had a history of attempts to leave the facility unattended.

Review of her treatment sheets indicated R45 had a wanderguard on her wrist and staff were to check every shift in the month of July. There

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Deficiencies were reviewed at the Campus All Staff Meeting on 8/13/13 to ensure staff across campus is aware and educated.

As a Campus wide initiative the following practices were put into place to ensure resident needs were being met.

- Facility hired bath aids, an additional 10 hours Monday thru Friday (Formerly completed by resident assistants) to complete all but 5 residents baths (due to specific times when bath aids are not available).
- GracePointe Crossing partnered with Anoka Ramsey Community College to hire 16-18 year old high school and home schooled students to complete the nursing assistant course. GracePointe Crossing gave up front scholarships to 25 students who completed the NAR class May 21st at which time Gables East raised it's PPD from 2.70 to 3.0+.
- An additional $3.50/hour is offered to nursing staff to pick up shifts when facility is compromised.
- Other PHS facilities partner with GracePointe to offer additional hours to staff, interested in working shifts a to keep at a 3.0+ PPD

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was four times the wanderguard was not checked, two of the times a staff member had circled his initials. No explanation was provided why the wanderguard was not checked.

R57 quarterly MDS dated 5/15/13, indicated she was severely cognitively impaired and she did not reject evaluation or care.

Review of R57 treatment sheets indicated she had an order dated 5/6/13 to clean her lids/lashes each day a.m. and p.m., twice a day. The treatment sheets revealed the following:

May 2013- there was 12 circled initials or not signed out on the treatment sheet
June 2013- there was 17 circled initials or not signed out on the treatment sheet
July 1st thru July 17th, 2013-there was 6 circled initials or not signed out on the treatment sheet.

During interview on 7/16/13 at 1:24 p.m. registered nurse (RN)-A stated that treatments are not being completed and staff are just circling them if they cant get completed. RN-A and surveyor reviewed the treatment sheets and RN-A stated that R34 would not refuse her treatment to her left foot and that it was important for that treatment to be completed. RN-A further stated that none of the residents listed above would refuse or resist there treatments the staff just don't have enough time to complete them.

R56 complained the facility was short staffed.

R56 quarterly (MDS) dated 5/14/13 indicated he was alert and oriented and needs assist of two staff for transfers and toileting and assist of one

F 353

- Reassessed and completed resident room changes to better group acuity levels allowing Gables East to reallocate the 9-5 nurse hours with two (2) TMA/RA positions who would complete resident cares and medication passes. (Currently interviewing/hiring students from the 9/16/13 TMA class being held)
- Recently PHS had a policy change regarding the 2 person mechanical transfer lift, this change allowed the facility to decrease the number of residents needing a 2 person lift from 28 to 17 residents after assessment.
- Supplies were moved to a staff requested central location to be more accessible and allowing staff to be more efficient in their duties along with taking fewer steps.
- Mechanical beds (pump/crank) were replaced by electric beds.
- The Chapel was moved from the lower level to main floor for the convenience of residents and time management for staff that assisted with transporting residents to/ from spiritual care activities.

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F 353	Continued From page 27 with eating. During interview on 7/16/13 at 9:40a.m. R56 stated "there is not enough staff here sometimes I wait 40 minutes to an hour for help". R56 also indicated that he has to wait a long time in the dining room to be fed for lunch and supper. R56 further stated he has addressed this concern at his last care conference in May and it had not changed. R56 further stated this was not an issue on 7/15/13 and felt there was enough staff since the state was there monitoring. R56 also indicated he is frustrated that they take staff from the other building to help when they need staff and he feels they just don't know the residents routines in this building. R56 also stated "I put my call light on, they shut if off right away and say they will be back as soon as they can get help, many times its over 40 minutes and I have an accident and then need my clothes to be changed". R56 further stated staffing has been a concern for along time here and that he goes to resident council and it has been brought up there too. R83 complained that call lights were not answered timely. R83 quarterly MDS dated 5/21/13 indicated he is alert and oriented and needs extensive assist with transfers and toileting. During interview on 7/16/13 at 9:18a.m., R83 stated " I don't think they have enough staff, when I push the button they don't come quick enough, sometimes I have to wait 15-20 minutes. It takes a long time to get back into bed." R83 further stated this has been happening for at least the last three months.	F 353	Call light audits will be completed on 10% of residents weekly for four weeks. Restorative Nursing Audit will be completed on 10% of residents weekly for four weeks. MAR/TAR Audits will be completed on 10% of residents weekly for four weeks. Random resident interviews will be completed on 5% of residents weekly for four weeks. The facility QA&A committee will review audits to determine the need for ongoing monitoring. The Care Center Administrator and Clinical Administrator and/or designee are responsible for ongoing compliance. Date certain for purposes of ongoing compliance is August 26, 2013	

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R34 voiced a concern that the facility does not have enough staff.

R34 significant change MDS dated 6/29/13, indicated that she required assist of two with transfers, and had no behavior problems. R34's care plan dated 6/11113, indicated she is able to communicate her needs and wants, and makes daily decisions with some help or reminders. R34 care plan also indicated she required assist of two with transfers.

During interview 7/17113 at 7:55a.m., R34 stated " I put my call light on and they say they will be right back to get someone else and I wait 45 minutes for them to come back". R34 also stated she has had "accidents" waiting to get help to the bathroom. R34 further stated this has been going on for at least a year.

R16 voiced a concern that the facility does not have enough staff.

R16 quarterly MDS dated 6/27/13, indicated she was alert and oriented and needed assist of two with transfers and toileting. R16's care plan dated 3/12/13, indicated she has potential for alteration in skin integrity related to incontinence and decreased impendence in mobility. R16's progress note dated 7/17/13, included, "resident continues to c/o [complaint of] a tender area in the crease of buttock cheek, resident has orders for butt paste."

During interview on 7/15/13 at 7:04p.m., R16 stated she has to wait along time for help

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especially with toileting. R16 stated sometimes she is left sitting on her bed pan for 45 minutes waiting for help and has received sores on her bottom from waiting for help. R16 further stated this has been going on for several months.

R73's call light was observed on and turned *off* without his care request completed.

R73's diagnosis included a cerebrvasular accident (CVA). His quarterly minimum data set (MDS) dated 06/13/13 indicated he has moderately impaired cognition, and with bed mobility and transfers is a two person physical assist.

During an observation on 07/17/13 at 7:23a.m. R73's call light was turned on from the hallway. At 728 a.m. registered nurse (RN)-B, went into R73's room to take his blood sugar; the call light remained on and RN-B left room. When R73 was asked why his call light was on, R73 replied, "I want to get up for the day." At 7:35a.m. nursing assistant (NA)-E entered R73's room and turned *off* the call light and walked back out of the room; while R73 remained awake in bed.

When interviewed at 7:50 a.m. the NA-E stated he entered R73's room and shut *off* his call light and walked out of the room since the resident is a two person assist and no other staff member can help at this time. NA-E stated he would return when he had help; but uncertain of how long R73 would be waiting. R73's call light remained *off*.

At 8:10a.m. it was observed NA-E and household coordinator (HC)-J entered R73's room and helped him out of bed.

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F 353	Continued From page 30 There were 2 of 4 family members (FM)-A & FM-B interviewed that identified concerns about the facility's lack of staff. During interview 7/15/13 at 7:00p.m., FM-A stated she is here almost every evening and when she puts on her mothers call light the staff will shut off her light and tell her they will be right back. Her mother has had incontinent episodes related to this. FM-A had addressed her complaints at care conference's and is told they staff according to state requirements. FM-A further stated the facility also has staff come over from the other building, and they don't know how to do the care for the residents. FM-A stated this has been a problem for a long time. FMA-A further stated even though she has brought this concern to the Director of Nursing (DON) and had discussed her concerns at her care conferences and it has not changed and staffing has continued to be a concern and a problem. During interview 7/17/13 at 1:15p.m., FM-B stated he felt there is not adequate staff at the facility. It can take a long time for call lights to be answered and the staff are so busy. FM-B further stated it seem like it is worse in the morning and his wife sometimes has to wait 30 minutes for help. Resident Council indicated staffing as a concern. Review of the resident council minutes dated 1/28/13 indicated that staff as an industry they are struggling for applicants. They did indicate they have hired four new NA's and now have TMA's (trained medical assistance) in the building. Review of the resident council minutes dated 6/24/13, included, "some residents complained that the NAR's come into the rooms to answer a	F 353		

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F 353	Continued From page 31 call light and they will tell you 'I will be right back' but they don't come back." The minutes indicated they will have the household coordinators educate the NAR's. There were 6 staff members interviewed; expressed concerns that cares were not completed due to lack of staff. During interview on 7/16/13 at 1:24 p.m. registered nurse (RN)-A stated, "most days there is not enough staff." RN-A stated treatments are not getting done, call lights are being shut off, the resident's are complaining about this. During interview 7/16/13 at 1:30 p.m., with Nursing Assistant (NA)-8 who stated there is "not enough staff it is nonstop, my weekend is short all the time" NA-B further stated walking programs and restorative nursing are not getting done , we just cant get it done". NA-B also stated that baths are not getting done and the staff have to shut residents call lights off and wait for another staff to be available to assist those residents who need assist of two with transfers. During interview 7/17113 at 6:32a.m., with Licensed Practical nurse (LPN)-C who stated during the night there is only one aide for the North unit and one nurse. If the residents need assistance with transfers we are both helping them so there is no one else on the floor to help with answering call lights. They only staff here according to census they do not staff according to acuity of cares. During interview 7/17113 at 7:16a.m. with LPN-8 who stated they had removed the 9 am-5pm nurse who helped with orders and treatments.	F 353		

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F 353	Continued From page 32 LPN-B further stated they just cant get everything done and if they cant they circle the treatments that they cant get too on the treatment book.. During interview 7/17/13 at 8:00p.m., with RN-C who stated there is never enough staff on my shift and the unit is very hard do with the residents having a lot of behavior problems. RN-C then stated he does the best he can to keep the residents safe. RN-C further stated there is several treatments that he cant get done on his shift so he circles and initials them and notifies the next shift. RN-C then stated it was really nice when they had the 9a.m. to 5 p.m. nurse to help finish up on the orders and help with the treatments. During interview 7/18/13 at 11:00 a.m., with NA-A, who stated there is days he is just to busy and cant get his work done. NA-A then stated sometimes he is unable to complete his restorative nursing. During interview7/18/13 at 1:20 p.m. with the Director of Nursing (DON) who stated they have increased the staff ratio and have added bath aides to the facility. The DON further stated several months ago they removed the 9-5p.m nurse a few months ago and hired some trained medical assistance's (TMA) to do some of the cares. The DON also stated they have revised there transfer policy and are changing some of the residents who needed assist of two a assist of one now to free up the staff. The DON stated the policy was revised in May 2013. The DON further stated when a treatment is not completed the staff should be documenting why it was not completed and verified all the missed treatments did not explain why they were missed.	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING ______ B. WING	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 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
F 353	Continued From page 33 During interview 7/18/13 at 1:45 p.m. with the campus administrator who stated she felt they have done a lot of changes to improve the staffing. She indicated they had revised there policy on resident transfers which decreased the number of residents needing a two person lift.	F 353		

F5120021

Printed: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**548 FIRST AVENUE** **CAMBRIDGE, MN 55008**

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K 000	INITIAL COMMENTS Surveyor: 03005 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grace Point Crossing Gables East was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Graceponit Crossing Gables East is a 1-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1956 and was determined to be of Type II(111) construction. In 1982, an addition wwas constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 112 beds and had a census of 70 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) met.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5483

August 2, 2013

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5120023

Dear Ms. Barthel:

The above facility was surveyed on July 15, 2013 through July 18, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division, #212, St. Cloud, Minnesota 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**548 FIRST AVENUE** **CAMBRIDGE, MN 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
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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