CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8G4P

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COM	PLETED BY TH	HE STAT	E SURVEY AGEN	NCY	Fac	eility ID: 00294	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245432 2.STATE VENDOR OR MEDICAID NO. (L2) 893042200	(L3) GRACEI	N STREET N	OSSIN	G GABLES W I	EST 55008	 TYPE OF ACTION: Initial Termination Validation 		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUF	PPLIER CATEGORY	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Comp	9. Other plaint	
6. DATE OF SURVEY 06/02/2014 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L34) 02 SNF/NF/Dual (L10) 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING D	ATE: (L35)	
2 AOA 3 Other								
11. LTC PERIOD OF CERTIFICATION	10.THE FACILITY							
From (a): To (b):	X A. In Complian Program Re Compliance	equirements		And/Or Approved 2. Technica 2. 3. 24 Hour	al Personnel	Following Requirements:		
2. Total Facility Beds 140 (L18)1. Acceptable POC				4. 7-Day R 5. Life Safe	N (Rural SNF)	7. Medical Director8. Patient Room Siz9. Beds/Room		
13. Total Certified Beds 140	(L1/)	pliance with Program ents and/or Applied W	aivers:	* Code: A *		(L12)		
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEET	`S			
18 SNF 18/19 SNF 140	19 SNF ICF	IID		1861 (e) (1) or 186	1 (j) (1):	(L15)		
(L37) (L38)	(L39) (L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS (IF APPI	LICABLE SHOW LTC CANCELL	LATION DATE):						
See Attached Remarks								
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY	AGENCY APP	ROVAL	Date:	
Brenda Fischer, Unit Sup	<u>pervisor</u>	06/02/2014	(L19)	<u>Kate JohnsTon, Enforcement Specialist</u> 06/04/2014				
PART	II - TO BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SIN	GLE STATE	E AGENCY		
 DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate 		IPLIANCE WITH CI HTS ACT:	VIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE 23. LTC	AGREEMENT 2	24. LTC AGREEMEN	NT	26. TERMINATION	NACTION:	(L3	60)	
OF PARTICIPATION BE 03/01/1987	GINNING DATE	ENDING DATE		VOLUNTARY 01-Merger, Closure	00	INVOLUNTAL 05-Fail to Meet		
(L24) (L4	11)	(L25)		02-Dissatisfaction W/		t 06-Fail to Meet	t Agreement	
	TERNATIVE SANCTIONS Suspension of Admissions:			03-Risk of Involuntary 04-Other Reason for V		<u>OTHER</u> 07-Provider St	atus Change	
(L27) B. I	Rescind Suspension Date:	(L44) (L45)				00-Active		
28. TERMINATION DATE:	29. INTERMEDIARY/C			30. REMARKS				
20. TERMINATION DATE.		ARRIER NO.		50. KEWAKKS				
(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32. DETERMINATION (OF APPROVAL DATI	E					
(L32)			(L33)	DETERMINATION	ON APPROV	/AL		

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00294

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: 24-5432

Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facilitys plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 5/3/2014, the facility is certified for 140 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245432

June 4, 2014

Ms. Laurie Sykes, Administrator Gracepointe Crossing Gables West 135 Fern Street North Cambridge, Minnesota 55008

Dear Ms. Sykes:

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 May 3, 2014, the above facility is certified for:

140 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 140 skilled nursing facility beds.

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

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

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.

Gracepointe Crossing Gables West June 4, 2014 Page 2

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 4, 2014

Ms. Laurie Sykes, Administrator Gracepointe Crossing Gables West 135 Fern Street North Cambridge, Minnesota 55008

RE: Project Number S5432023 and Complaints Numbered H5432038 & H5432039

Dear Ms. Sykes:

On April 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2014, that included an investigation of complaints numbered H5432038 & H5432039. This survey found the most serious deficiencies 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 June 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 3, 2014 and therefore remedies outlined in our letter to you dated April 23, 2014, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Gracepointe Crossing Gables West June 4, 2014 Page 2

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 245432	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/2/2014
Name	of Facility		Street Address, City, State, Zip Code	
GRACEPOINTE CROSSING GABLES WEST		Т	135 FERN STREET NORTH 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	()	/ 5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		С	Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0282	0	5/03/2014		ID Prefix	F0309		05/03/2014		ID Prefix	F0315		05/03/2014
	483.20(k)(3)(ii)				Reg. #						483.25(d)		_
LSC		_			LSC					LSC			
			Correction					Correction					Correction
ID Prefix	F0371		5/03/2014		ID Prefix	F0463		Completed 05/03/2014		ID Prefix			Completed
	483.35(i)					483.70(f)		-		Reg. #			_
•	465.55(1)	_			LSC	403.70(1)				•			_
		_		-					+				
		С	Correction					Correction					Correction
		C	Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#					Reg.#					Reg. #			_
LSC													_
									+-				
		С	Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			_
Reg. #					Reg. #					Reg. #	-		_
LSC					LSC					LSC			_
Reviewed By	Reviewe	d By	,	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	,	_ <u>B</u>	F/KJ	0	5/04/20	14		106	<u>52</u>			06/	02/2014
Reviewed By	Reviewe	d By		Da		Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:					Check f	or any	Uncorrected I	Defic	iencies. Was	a Summary of	-	
	4/10/2014					Unco	orrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8G4P

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	F	acility ID: 00294
1. MEDICARE/MEDICAID PROVIDI (L1) 245432 2.STATE VENDOR OR MEDICAID N (L2) 893042200	TATE VENDOR OR MEDICAID NO. (L4) WEST 135 FI			ROSSIN			2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP			Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY () 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 S 140 (L37) (L38)	140 (L18) 140 (L17) DWN NF 19 SNF (L39)	B. Not in Comp Requirement ICF (L42)	place With equirements Passed On: Acceptable POC pliance with Program ents and/or Applied V IID (L43)	n Waivers:	And/Or Approved Waivers Of2. Technical Personne3. 24 Hour RN4. 7-Day RN (Rural S5. Life Safety Code B * Code: 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	7. Medical Direct	or
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Michelle Thomps	on, HFE NE II		05/06/2014	(L19)	Kate JohnsTon, En	nforcement Specialist	06/04/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR SINGLE ST	TATE AGENCY	()
DETERMINATION OF ELIGIBIT 1. Facility is Eligible to 2. Facility is not Eligible	o Participate		IPLIANCE WITH C	CIVIL		nancial Solvency (HCFA-2572) http://discoursestate/linearies/solve in the control of the control	-1513)
22. ORIGINAL DATE OF PARTICIPATION 03/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEME ENDING DATI (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	00 INVOLUNT 05-Fail to Me sement 06-Fail to Me	ARY tet Health/Safety tet Agreement
25. LTC EXTENSION DATE: (L27)	ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ГЕ			
	(L32)			(L33)	DETERMINATION APP	PROVAL	
					1		

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00294

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: 24-5432

Item 16 Continuation for CMS-1539

At the time of the standard survey completed 04/10/2014, the facility was not in substantial compliance and the most serious deficiencies 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 as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 23, 2014

Ms. Laurie Sykes, Administrator Gracepointe Crossing Gables West 135 Fern Street North Cambridge, Minnesota 55008

RE: Project Number S5432023

Dear Ms. Sykes:

On April 10, 2014, 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 programs. This survey found the most serious deficiencies in your facility 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.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 14, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC 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 ePoC 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

Gracepointe Crossing Gables West April 23, 2014 Page 4

in your 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by July 10, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 October 10, 2014 (six months after the

Gracepointe Crossing Gables West April 23, 2014 Page 5

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 an ePoC 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_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 pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Gracepointe Crossing Gables West April 23, 2014 Page 6

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		· ·		SURVEY PLETED
		245432	B. WING			04/1	10/2014
	PROVIDER OR SUPPLIER	ABLES WEST		13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F0	000			
	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will sion of compliance.					
F 282	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with	F 2	282			5/3/14
SS=D	PERSONS/PER CA The services provided by must be provided by						
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview, and record iiled to follow the plan of care or 1 of 2 residents (R200) who with toileting.			A new bowel and bladder assessmen was completed on R200 on 4-25-201-Toileting plan on R200 was reassessed and care plan was updated on 4-25-2	4. ed	
	1/10/14, indicated F cognitively intact, al episodes of contine assistance with toile R200's care plan da	nimum Data Set (MDS) dated R200 was moderately ways incontinent with no ent voiding, and needed limited eting. ated 1/10/14, indicated she ypertension and difficulty			Bowel and bladder assessments and toileting care plans on all residents in house were reviewed and revised as necessary. The policy and procedure was review and is current. Education will be completed for staff responsible for assisting residents with toileting need: 5-3-2014.	ved	
L ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed**

(X6) DATE

05/01/2014

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		245432	B. WING _		04/	10/2014	
	PROVIDER OR SUPPLIER	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309 SS=D	walking. The care pincreased urinary in every 1.5 to 2 hours undated Nursing Astoilet every 1.5 to 2 sheet also identified up briefs. During continuous of a.m. to 10:45 a.m., observed at 8:18 a. bathroom. At 8:35 the dining room for NA-D returned R20 her and placed R20 a.m. NA-A was obs bathroom, 2hrs and continent and her s During interview 4/S stated she thought she placed R200 in toileted her according to her toileting sche 483.25 PROVIDE CHIGHEST WELL BIE Each resident must provide the necessor maintain the high mental, and psychological states and psychological states are provided the necessor maintain the high mental, and psychological states are provided to her toileting sche 483.25 PROVIDE CHIGHEST WELL BIE Each resident must provide the necessor maintain the high mental, and psychological states are provided to her toileting sche 483.25 PROVIDE CHIGHEST WELL BIE Each resident must provide the necessor maintain the high mental, and psychological states are provided to her toileting sche 483.25 PROVIDE CHIGHEST WELL BIE Each resident must provide the necessor maintain the high mental, and psychological states are provided to her toileting scheduling the provided the necessor maintain the high mental, and psychological states are provided to her toileting scheduling the provided the necessor maintain the high mental, and psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor maintain the high mental psychological states are provided the necessor	colan further indicated acontinence and staff to toilet and as needed. The sistant care sheet indicated to hours and as needed. The display a special resistant care sheet indicated to hours and as needed. The display a special resistant care sheet indicated to hours and as needed. The display a special resistant care sheet indicated to hours and as needed. The display a special resistant care sheet indicated to hours and as needed. The display a special resistant care sheet indicated to her as needed. At 10:45 and to her room without toileting to back into bed. At 10:45 and to her sheet indicated her when to bed and thought she had and thought she had had been toileted according dule. CARE/SERVICES FOR	F 28	The facility will monitor and sust correction by completing bowel a bladder audits on 5% of resident for 2 months. Results of audits reviewed in QAA and determinate made for continued audits. Clinical Administrator or designer responsible for ensuring ongoing compliance. Correction date for certification:	and ts weekly will be tion will be ee will be		

				(X3) DATE SURVEY COMPLETED	
245432		B. WING			0/2014
ROVIDER OR SUPPLIER OINTE CROSSING G	SABLES WEST	1			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
This REQUIREME by: Based on observareview, the facility funded wheelchair position reviewed for wheel Findings include: R132 significant cheelchair position reviewed for wheel Findings include: R132 significant cheelchair day (MDS) dated 3/03/1003/1003/1003/1003/1003/1003/1003	NT is not met as evidenced tion, interview and document railed to provide optimal hing for 1 of 3 residents (R132) chair positioning. The ange Minimum Data Set 14, indicated he was severely d and needed extensive insfers and used a wheelchair. ated 3/25/14 indicates he used rocking wheelchair). 14/08/14, at 11:19 a.m. R132 in edayroom. He was sitting in elelchair tilted back. He had my shoes. His feet were lately one inch from the floor d. 14/09/14, at 7:26 a.m. R132 in eday room in his Rock N Go ack, the tips of his shoes were but the rest of the foot was not 14/10/14, at 9:11 a.m., R132	F 309	R123 wheel chair positioning was reassessed on 4-25-2014 by Inter Disciplinary Team (R123 responsit declined therapy evaluation). A ca was added to Rock-N-Go wheel chair positioning for all residences was reviewed and revised an ecessary. The policy and procedure was reviand is current. Education will be completed for staff on wheel chair positioning by 5-3-2014. The facility will monitor and sustair correction by completing wheel chair positioning audits on 5% of resider weekly for 2 months. Results of an will be reviewed in QAA and determined the made for continued audits. Clinical Administrator or designed responsible for ensuring ongoing compliance.	If panel hair for dents in s ewed air hts udits nination will be	
	SUMMARY STA (EACH DEFICIENC REGULATORY OR LE Continued From pa This REQUIREME by: Based on observa review, the facility of wheelchair position reviewed for wheel Findings include: R132 significant ch (MDS) dated 3/03/1000 cognitively impaired assistance with tra R132's care planda a Rock N Go w/c (Industry) During observation was observed in the his Rock N Go who socks on without a dangling, approximant being supported During observation was observed in the wheelchair tilted bat touching the floor be being supported.	Based on observation, interview and document review, the facility failed to provide optimal wheelchair positioning for 1 of 3 residents (R132) reviewed for wheelchair positioning. Findings include: R132 significant change Minimum Data Set (MDS) dated 3/03/14, indicated he was severely cognitively impaired and needed extensive assistance with transfers and used a wheelchair. R132's care plan dated 3/25/14 indicates he used a Rock N Go w/c (rocking wheelchair). During observation 4/08/14, at 11:19 a.m. R132 was observed in the dayroom. He was sitting in his Rock N Go wheelchair tilted back. He had socks on without any shoes. His feet were dangling, approximately one inch from the floor not being supported. During observation 4/09/14, at 7:26 a.m. R132 was observed in the day room in his Rock N Go wheelchair tilted back, the tips of his shoes were touching the floor but the rest of the foot was not	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide optimal wheelchair positioning for 1 of 3 residents (R132) reviewed for wheelchair positioning. Findings include: R132 significant change Minimum Data Set (MDS) dated 3/03/14, indicated he was severely cognitively impaired and needed extensive assistance with transfers and used a wheelchair. R132's care plan dated 3/25/14 indicates he used a Rock N Go w/c (rocking wheelchair). During observation 4/08/14, at 11:19 a.m. R132 was observed in the dayroom. He was sitting in his Rock N Go wheelchair tilted back. He had socks on without any shoes. His feet were dangling, approximately one inch from the floor not being supported. During observation 4/09/14, at 7:26 a.m. R132 was observed in the day room in his Rock N Go wheelchair tilted back, the tips of his shoes were touching the floor but the rest of the foot was not being supported. During observation 4/10/14, at 9:11 a.m., R132	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide optimal wheelchair positioning for 1 of 3 residents (R132) reviewed for wheelchair positioning. Findings include: R132 significant change Minimum Data Set (MDS) dated 3/03/14, indicated he was severely cognitively impaired and needed extensive assistance with transfers and used a wheelchair. R132's care plan dated 3/25/14 indicates he used a Rock N Go w/c (rocking wheelchair). During observation 4/08/14, at 11:19 a.m. R132 was observed in the dayroom. He was sitting in his Rock N Go wheelchair tilted back. He had socks on without any shoes. His feet were dangling, approximately one inch from the floor not being supported. During observation 4/09/14, at 7:26 a.m. R132 was observed in the day room in his Rock N Go wheelchair tilted back, the tips of his shoes were touching the floor but the rest of the foot was not being supported. During observation 4/10/14, at 9:11 a.m., R132 Correction date for certification: 5-	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MY SEPENCE DED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide optimal wheelchair positioning for 1 of 3 residents (R132) reviewed for wheelchair positioning. Findings include: R132 significant change Minimum Data Set (MDS) dated 3/03/14, indicated he was severely cognitively impaired and needed extensive assistance with transfers and used a wheelchair. R132's care plan dated 3/25/14 indicates he used a Rock N Go w/c (rocking wheelchair). During observation 4/08/14, at 11:19 a.m. R132 was observed in the dayroom. He was sitting in his Rock N Go wheelchair tilted back. He had socks on without any shoes. His feet were dangling, approximately one inch from the floor not being supported. During observation 4/09/14, at 7:26 a.m. R132 was observed in the day room in his Rock N Go wheelchair tilted back, the tips of his shoes were touching the floor but the rest of the foot was not being supported. CAMBRIDGE, MN 55008 PREPIX TAG PREPIX

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245432	B. WING		04	/10/2014	
	PROVIDER OR SUPPLIER	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
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F 309	would have occupa	ge 3 he floor. RN-A stated she tional therapy (OT) look at hair could be adjusted to	F 3	09			
F 315 SS=D	stated the director of consultant observed the floor and felt if would touch the floor nurse consultant did look at R132 in his. During review of R1 identify any therapy about R132's whee notes were request 1:00 p.m. and none. Although R132's fee Go chair when tilted were on or off, they for proper wheelcha 483.25(d) NO CATH RESTORE BLADDID Based on the reside assessment, the face resident who enters indwelling catheter resident's clinical consultant and seed on the resident who enters indwelling catheter resident's clinical consultant and seed on the resident's clinical consultant and seed on the resident who enters indwelling catheter resident's clinical consultant and seed on the resident's clinical consultant and seed on the resident who enters indwelling catheter resident's clinical consultant and seed on the resident and seed	32's medical record did not records or notes in the chart lichair positioning. These ed from the DON 4/11/4, at were provided. et would dangle in his Rock N d or not tilted or if R132 shoes did not properly assess R132 air positioning. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a sign the facility without an is not catheterized unless the pondition demonstrates that	F 3	15		5/3/14	
	who is incontinent of treatment and servi	necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder e.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		04/10/2	2014
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE CC	(X5) DMPLETION DATE
F 315	by: Based on observareview the facility fatimely assistance w (R200 and R206) rewith urinary inconting. Findings include: R200's admission of dated 10/21/13, indicated facontinent of urine. 1/10/14, indicated facognitively intact the was always inconting not been on a trial void area assessment (assessment of the was continent with toileting. R200's care plan dated diagnoses of head diagnoses of head diagnoses of head diagnoses of head diagnoses.	NT is not met as evidenced tion, interview, and record ailed to assess and/or provide with toileting for 2 of 2 residents eviewed who had a change	F 319	,	6 on 00 and plans nouse cessary. riewed reeds by n nd weekly ill be on will be will be	
	every 1.5 to 2 hours Assistant care shee	s and as needed. The Nursing et indicated to toilet every 1.5 needed and she wears pull			2 - 2	
	a.m. nursing assist	observation 4/9/14, at 8:18 ant (NA)-A was observed to bathroom. At 8:35 a.m. NA-A				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245432	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER			13	REET ADDRESS, CITY, STATE, ZIP CODE 5 FERN STREET NORTH AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	brought R200 to the and at 8:45 a.m. Nowithout toileting an At 10:45 a.m. NA-7 to the bathroom 2h	age 5 he dining room for breakfast A-D returned R200 to her room he placed R200 back into bed. A was observed to assist R200 hrs and 22 minutes later. R200 her skin was intact.	F 3	15			
	stated she thought she placed R200 in	/9/14, at 10:50 a.m. NA-A t NA-D had toileted her when nto bed and thought she had ling to her schedule.					
	dated 10/18/13, inc	Bowel and Bladder Evaluation dicated she frequently asked to and was continent of bladder.					
	11/19/13, indicated incontinent of urine Prompt toileting q2 needed) unless refrequently asks to not always void an on the toilet to voic [hour] toileting."	Bladder quarterly review dated d "Resident is occasionally e and continent of bowel. 2hr (every hours) and prn (as sident is sleeping." Resident go to the bathroom and does d needs frequent cues once d. "Prompt q [every] 1.5 hr lid not address mobility, vironmental causes.					
	1/10/14, indicated increase in urinary incontinent on 11/1 incontinent on 1/10 toilet R200 every 1	Bladder quarterly review dated she had a change with an incontinence from occasionally 19/13 to always being 0/14. The staff were directed to .5 to 2 hours, even though vays urinate while on toilet but					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245432	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH EAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	frequently requests assessment also in ups. The quarterly	the need for toileting. The dicated R200 was wearing pull assessment did not address ncrease with urinary	F 3	15			
	verified R200 was i	9/14, at 12:25 p.m. RN-A ncontinent of urine and she essed for her change in					
	always incontinent assess the cause for	nt from continent of urine to of urine the facility failed to or the change and type of dition the facility failed to nt toileting plan.					
	she was continent of MDS dated 2/01/14 moderately cognitive assistance with toil incontinent of urine	MDS dated 11/11/13, indicated of urine. R206's quarterly indicated she was rely intact, needed extensive eting and was frequently . R206 CAA indicated she had urinary urgency, and received					
	11/9/13, indicated s Quarterly Review d are to assist to toile needed while awak communicate her n prefers to sleep wit will use her call ligh	Bladder evaluation dated the was continent of urine. A ated 1/30/14, indicated staff of every four hours and as e as resident can eeds for toileting. Resident thout interruptions at night and at for help. Resident is ent of bowel and bladder and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

_	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		1	TREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH CAMBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	resident wears a m status was a chang assessment of beir was no indication o	edium brief. This continence led from her 11/9/13 ng continent of urine. There if why there was a change in nent status, which had not	F3	315			
	incontinent of urine	ated 2/3/14, indicated she was and wears a full brief. The cated she needs assistance					
	verified R206 is free throughout the day	9/14, at 12:25 p.m. RN-A quently incontinent of urine and that she had not been change in continence.					
	of nursing (DON) si Evaluation should be is admitted and also continence and a q	9/14, at 12:33 p.m. the director tated a Bowel and Bladder be completed when a resident o if there is a change of uarterly summary should be had been no changes.					
	stated she was not change in bladder of	9/14, at 12:53 p.m. RN-A aware that R206 had a continence, and a uld be completed and not just a	t				
	reviewed 7/10 indicassessed for bowe	and Bladder Assessment Policy ated each resident will be I and bladder incontinence and easibility in retraining bowel					

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245432	B. WING	B. WING		04/	10/2014
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		13	REET ADDRESS, CITY, STATE, ZIP CODE S FERN STREET NORTH AMBRIDGE, 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315 F 371 SS=E	and bladder control upon admission, readmission, upon annual reviews and with significant changes. Quarterly, the bowel and bladder assessment will be reviewed to ensure the plan is appropriate for the resident. 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local		F3				5/3/14
	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure outdated food items were disposed of in accordance with food service standards to prevent potential food borne illness. In addition the facility failed to ensure staff serving residents food used sanitary practice while having contact with food during food service for 10 of 15 residents (R105, R172, R114, R168, R122, R22, R74, R177, R59, and R58) being served in the City View 1 (CV1) dining room. Findings include: During observation of the kitchen on 4/7/14, at 12:40 p.m. with the dietary manager (DM)-A the following were identified:				On 4-7-2014 the lettuce and egg sal the cooler were disposed of and the in the cooler along with the ceiling vewere sanitized. On 4-7-2014 DS-A reeducated on proper serving technic On 4-7-2014 all floors and ceiling verthe kitchen were inspected for cleanliness. On 4-7-2014 all coolers evaluated for outdated and/or unseafood items. The policy and procedure was review and is current. Education will be completed for staff responsible for sefood and kitchen sanitation by 5-3-20	floor ents was que. nts in s were led wed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245432	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		1	STREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH CAMBRIDGE, MN 55008		
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F 371	loosely covered with was dated 4/2/14. The container of egg sate approximate 4X4 in the floor under the preparea the ceilin area had a visible hand debris. The DM-A stated the should have been of preventative maintefallen by the way sin new maintenance of track. DM-A verifief floor needed to be of the contained of the containe	had a small bowl of lettuce h plastic wrap (unsealed) that There was a small plastic lad dated 4/2/14 and a ach area of a black liquid on food shelving. In the food g vents over the food prepheavy accumulation of dust he lettuce, and egg salad discarded a few days ago. The enance of the kitchen had de but now they have hired a manager and it will get back on d the vents and spills on the cleaned more frequently. Provided by the facility entitled ated under the cooler bullet entifies, "Clearly label and date ents and plan to use with in of food service on 4/7/14, at 1/1 dining room the residents food they wanted for the meal The paper menus, that were resident were placed onto a seam table for the dietary server server (DS)-A who was serving ing room during this time was her left hand and not the right p the resident's paper menu hand and proceed to serve late which the resident rould touch the menu (that was dents), then proceed to touch	F3	371	The facility will monitor and sustair correction by completing kitchenet dining, and sanitation audits on ea weekly for 2 months. Results of a will be reviewed in QAA and deterr will be made for continued audits. Culinary Manager or designee will responsible for ensuring ongoing compliance. Correction date for certification: 5-	te, ch unit udits nination be	

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		04/	10/2014	
	NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	She then touched salad cart and proc sandwiches with the continued to touch breast sandwich mesident menus, ar same soiled left gloitems onto the resiher soiled gloved horead, and touch pitems without first rand washing her hasame process until R114, R168, R122 5:20 p.m. the DM-removed her soiled hands. DS-A, then with her new clean resident paper men handle, and raw slileft glove and place residents plates winglove or washing hasame process until R177, R59, and R50. During interview or stated, "I found my times, I was nervor residents. On 4/7/14, at 5:50 about DS-A touching she was nervous and an undated policy Policy And Proceded.	th the soiled left gloved hand. The touched the handle of the ceeded to touch additional the soiled left glove hand. She the toaster, processed turkey teat, cupboard handles, and sliced raw tomatoes with the oved hand and placed the dents plate. She then placed the dents plate. She continue with this of the removing her left soiled glove the thing and the sandwiches and other the sands. She continue with this of the five resident (R105, R172, and DS-A did gloves and washed her proceeded to do the same gloves. She touched a nut, sandwiches, toaster the sandwiches, toaster the determination of the thout first removing her soiled the serving up a couple of us," when serving the	F 371				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
		245432	B. WING		4/10/2014
	PROVIDER OR SUPPLIER	ABLES WEST	1	STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	
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F 371 F 463 SS=E	food item, such as outside of bread ba gloves before havir 483.70(f) RESIDEN ROOMS/TOILET/B The nurses' station resident calls throu from resident room facilities. This REQUIREMED by: Based on observareview, the facility functioning call systhe City View unit (IR74 and R58) who	aution when handling a non microwave door, toaster, gs or tray tickets, to change ag direct contact with the food". IT CALL SYSTEM - ATH must be equipped to receive gh a communication system s; and toilet and bathing NT is not met as evidenced tion, interview and document ailed to ensure and maintain a tem for 7 of 37 residents on R155, R26, R39, R188, R98,	F 371	On 4-8-2014 the call light cords in the bathrooms of R155, R26, R39, R188, R98, R74, and R58 were replaced and/o call lights were repaired. All call lights in house were checked on 4-8-2014 and are in proper working	5/3/14
	the resident bathroon the City View wi assistant (HSA)-A t after pulling the cal to which the cord w the wall next to the After tugging the co unable to activate t HSA-A entered the R188. HSA-A atter activate the call ligh	on 4/8/2014 at 8:03 a.m., in om shared by R155 and R26 ng, housekeeping services ried to activate the call system I light cord. The call light box, as attached, was mounted on toilet in the resident bathroom. ord several times, HSA-A was he call light. At 8:07 a.m., bathroom shared by R39 and inpted, but was unable, to at after pulling the call light bathroom. At 8:09 a.m.		condition. The policy and procedure was reviewed and is current. Education will be completed for staff on call lights and what to do in the event a call light is not functioning properly by 5-3-2014. The facility will monitor and sustain correction by completing call light audits on 100% of resident rooms weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for frequency of continued audits. Environmental Services Manager or	

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		245432	B. WING			04/10/2014	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH AMBRIDGE, MN 55008		, = 0
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 463	F 463 Continued From page 12		F4	163			
	HSA-A entered the bathroom of R98. HSA-A attempted, but again was unable to activate the call light in R98's bathroom.				designee will be responsible for encongoing compliance. Correction date for certification: 5-		
		inimum Data Set (MDS) dated R155 was cognitively intact, ent with toileting.			Correction date for certification. 5-	3-2014	
		S, dated 3/17/2014, identified y intact, and was independent					
	R39's quarterly MDS, dated 3/7/2014 identified R39 was cognitively intact, and was independent with toileting.						
	R188 was moderat	DS, dated 1/24/2014, identified ely, cognitively impaired. The I R188 required limited eting.					
		S identified R98 was vely impaired, and required ce with toileting.					
	HSA-A stated, after boxes in each of th can't get them, thes turn the call light or could "push the but but they should be HSA-A said she wa	r on 4/8/2014 at 8:10 a.m., r pulling the cords of the call ree resident bathrooms, "If I se ladies wouldn't be able to n." HSA-A said the residents ton" to turn on the call light, able "to pull the cord, too." s "pretty sure" the call lights checked to see if they were					
	HSA-B verified the	on 4/8/2014 at 9:30 a.m., pull cord on the call light box and R58, was less than three					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245432	B. WING			04/	10/2014	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		135	EET ADDRESS, CITY, STATE, ZIP CODE FERN STREET NORTH MBRIDGE, MN 55008			
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 463	R74's quarterly MD R74 was cognitively with toileting. During an interview stated she could us by "pressing the bu could be used to tu "Look at it, it's so sl R58's annual MDS, R58 was mildly, cog also identified that I assistance with toile During an interview stated that she was when going to the bashe "has gone there used the call light was tated "Yes, I have. During an interview nursing assistant (Noth required assist that each resident "	SA-B was able to activate the sing the button on the call box. S, dated 3/21/2014, identified y intact, and was independent on 4/8/2014 at 7:16 a.m., R74 at the call light in her bathroom tton." When asked if the cord on the call light, R74 said thort. I can't." Adated 2/21/2014, identified gnitively impaired. The MDS R58 required extensive eting. Ton 4/7/2014 at 5:30 p.m., R58 as "supposed" to call for help beathroom, but admitted that the myself." When asked if she when in the bathroom, R58. Ton 4/10/2014 at 10:41 a.m., NA)-B stated that R58 and R98 tance with toileting, and also, I'can and does" use the light to	F 4	63				
	R26, R188 and R39 toileting. NA-B said know when and how During an interview	also verified that R74, R155, were independent with that "all of those residents" to use their call lights. on 4/10/2014 at 11:00 a.m., conmental services (DES)						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245432	B. WING		04/	/10/2014	
	PROVIDER OR SUPPLIER	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP 135 FERN STREET NORTH 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 463	stated he has been end of March", and audits of the call lig the affected call box cords were installed functioning properly should be able to be the button and pullis stated there "should said he took it upon "maintenance" wou lights in the future. During an interview registered nurse (R needed to be access RN-B said functioni safety" for the resid	at the facility only since "the was unaware of any routine ht system. The DES stated xes "were adjusted", new pull d, and the lights were now of the DES also said call lights e activated by both "pressinging the cords." The DES d be a check" in place, and a himself to make sure ld be in charge of testing call on 4/10/2104 at 11:44 a.m., N)-B stated that the call lights esible and work properly. In a matter of ents. or "Call Light," dated 10/04, prose": "To assure call system	F 4	63			

PRINTED: 06/04/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		04/10/2014	
	ROVIDER OR SUPPLIER	ES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 000	00 INITIAL COMMENTS		F 00	0		
F 282 SS=D	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. 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.		F 28.	2	5/3/14	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow the plan of care for toileting needs for 1 of 2 residents (R200) who needed assistance with toileting. Findings include: R200's quarterly Minimum Data Set (MDS) dated 1/10/14, indicated R200 was moderately cognitively intact, always incontinent with no episodes of continent voiding, and needed limited assistance with toileting. R200's care plan dated 1/10/14, indicated she had diagnoses of hypertension and difficulty			A new bowel and bladder assessment was completed on R200 on 4-25-2014 Toileting plan on R200 was reassessed and care plan was updated on 4-25-20 Bowel and bladder assessments and toileting care plans on all residents in house were reviewed and revised as necessary. The policy and procedure was reviewed and is current. Education will be completed for staff responsible for assisting residents with toileting needs 5-3-2014.	d 114.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 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.

05/01/2014

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245432	B. WING	B. WING		04/10/2014	
	ROVIDER OR SUPPLIER DINTE CROSSING GABL	ES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 282 F 309 SS=D	walking. The care plaincreased urinary incovery 1.5 to 2 hours a undated Nursing Assistoilet every 1.5 to 2 his sheet also identified Fup briefs. During continuous ob a.m. to 10:45 a.m., nobserved at 8:18 a.m. bathroom. At 8:35 a. the dining room for br NA-D returned R200 her and placed R200 a.m. NA-A was obserbathroom, 2hrs and 2 continent and her skill During interview 4/9/3 stated she thought Nashe placed R200 into toileted her according During interview 4/9/3 stated R200 should her to ileting schedul 483.25 PROVIDE CAHIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosol	an further indicated ontinence and staff to toilet and as needed. The stant care sheet indicated to ours and as needed. The R200 wore incontinent pull servation 4/9/14, from 8:18 ursing assistant (NA)-A was to assist R200 to the m. NA-A brought R200 to reakfast and at 8:45 a.m. to her room without toileting back into bed. At 10:45 wed to assist R200 to the 2 minutes later. R200 was in was intact. 14, at 10:50 a.m. NA-A A-D had toileted her when bed and thought she had to her schedule. 14, at 12:30 p.m. RN-A ad been toileted according alle. RE/SERVICES FOR NG	F 282	The facility will monitor and sustain correction by completing bowel and bladder audits on 5% of residents wee for 2 months. Results of audits will be reviewed in QAA and determination wi made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-20	ll be	5/3/14	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245432 B. WING			04/10/2014	
	ROVIDER OR SUPPLIER	ES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	, 0.0.200	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 309	Continued From page	e 2	F 309	9		
	by: Based on observation review, the facility fail wheelchair positionin reviewed for wheelch Findings include: R132 significant chart (MDS) dated 3/03/14 cognitively impaired a assistance with trans R132's care plan date a Rock N Go w/c (rock) During observation 4 was observed in the his Rock N Go wheel socks on without any dangling, approximate not being supported. During observation 4 was observed in the wheelchair tilted back touching the floor but being supported. During observation 4 was observed in the wheelchair tilted back touching the floor but being supported. During observation 4 was observed in the in his chair tilted back his feet were dangling from the floor, not be defined to the puring interview 4/10.	on, interview and document led to provide optimal g for 1 of 3 residents (R132) hair positioning. Inge Minimum Data Set indicated he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicated he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicated he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicated he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicated he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicates he was severely and needed extensive fers and used a wheelchair. led 3/25/14 indicates he used oking wheelchair). Inge Minimum Data Set indicates he was severely and needed extensive fers and used indicates he used oking wheelchair). Inge Minimum Data Set indicates he was severely and needed extensive fers and used indicates he used oking wheelchair). Inge Minimum Data Set indicates he was severely and needed extensive fers and used oxidity. Inge Minimum Data Set indicates he used oxidity indica		R123 wheel chair positioning was reassessed on 4-25-2014 by Inter Disciplinary Team (R123 responsible declined therapy evaluation). A cal was added to Rock-N-Go wheel chair positioning of lower extremities. Wheel chair positioning for all reside house was reviewed and revised as necessary. The policy and procedure was reviewed is current. Education will be completed for staff on wheel chair positioning by 5-3-2014. The facility will monitor and sustain correction by completing wheel chair positioning audits on 5% of resident weekly for 2 months. Results of au will be reviewed in QAA and determing the made for continued audits. Clinical Administrator or designee we responsible for ensuring ongoing compliance. Correction date for certification: 5-3	f panel air for ents in s ewed ir ts dits hination	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	l \ /	(X3) DATE SURVEY COMPLETED	
		245432	B. WING _			04/10/2014	
	ROVIDER OR SUPPLIER	ES WEST	•	STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	F 309 Continued From page 3		F3	809			
	would have occupation	e floor. RN-A stated she onal therapy (OT) look at air could be adjusted to					
	stated the director of consultant observed the floor and felt if hi would touch the floor nurse consultant did look at R132 in his R During review of R13 identify any therapy rabout R132's wheelc	e2's medical record did not records or notes in the chart rhair positioning. These d from the DON 4/11/4, at					
	Go chair when tilted of were on or off, they of for proper wheelchair	ETER, PREVENT UTI,	F3	115		5/3/14	
	resident who enters to indwelling catheter is resident's clinical concatheterization was now ho is incontinent of treatment and services.	lity must ensure that a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245432 B. WING			04/10/2014
	NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	, 0
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 315	Continued From page 4 This REQUIREMENT is not met as evidenced		F 31	5	
	review the facility faile timely assistance with	on, interview, and record ed to assess and/or provide in toileting for 2 of 2 residents iewed who had a change ince.		A new bowel and bladder assessment was completed on R200 and R200 4-25-2014. Toileting plans on R200 R206 were reassessed and care part were updated on 4-25-2014.	on 00 and
	Findings include:			Toileting plans for all residents in h were reviewed and updated as neo	
	dated 10/21/13, indic continent of urine. R: 1/10/14, indicated R2 cognitively intact the was always incontine continent voiding nee	MDS further indicated she int with no episodes of ided limited assist and had		The policy and procedure was revi and is current. Education will be completed for staff responsible for assisting residents with toileting no 5-3-2014. The facility will monitor and sustain correction by completing bowel and	eeds by
	area assessment (CA	g program. R200's care AA) dated 11/18/13, indicated bladder and staff to assist		bladder audits on 5% of residents for 2 months. Results of audits will reviewed in QAA and determinatio made for continued audits.	I be
	had diagnoses of hyp walking. The care pla increased urinary increased urinary increased urinary increased every 1.5 to 2 hours a Assistant care sheet	ed 1/10/14, indicated she pertension and difficulty an further indicated continence and staff to toilet and as needed. The Nursing indicated to toilet every 1.5 eded and she wears pull		Clinical Administrator or designee responsible for ensuring ongoing compliance. Correction date for certification: 5-	
	a.m. nursing assistan	servation 4/9/14, at 8:18 It (NA)-A was observed to throom. At 8:35 a.m. NA-A			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	245432		B. WING			04/10/2014	
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP COL 135 FERN STREET NORTH CAMBRIDGE, MN 55008	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 315	and at 8:45 a.m. NA- without toileting and At 10:45 a.m. NA-A	dining room for breakfast D returned R200 to her room placed R200 back into bed. vas observed to assist R200 and 22 minutes later. R200	F 3	15			
	stated she thought N	14, at 10:50 a.m. NA-A A-D had toileted her when bed and thought she had g to her schedule.					
	dated 10/18/13, indic	wel and Bladder Evaluation atted she frequently asked to d was continent of bladder.					
	11/19/13, indicated "I incontinent of urine a Prompt toileting q2hr needed) unless resid frequently asks to go not always void and it						
	1/10/14, indicated sh increase in urinary in incontinent on 11/19/ incontinent on 1/10/1 toilet R200 every 1.5	adder quarterly review dated e had a change with an continence from occasionally 13 to always being 4. The staff were directed to to 2 hours, even though as urinate while on toilet but					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	245432		B. WING			04/10/2014	
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CO 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 315	assessment also indi	he need for toileting. The icated R200 was wearing pull ssessment did not address crease with urinary	F 3	15			
	verified R200 was inc	14, at 12:25 p.m. RN-A continent of urine and she ssed for her change in					
	always incontinent of assess the cause for	from continent of urine to furine the facility failed to the change and type of ition the facility failed to tolleting plan.					
	she was continent of MDS dated 2/01/14, moderately cognitive assistance with toilet incontinent of urine.	DS dated 11/11/13, indicated urine. R206's quarterly indicated she was ly intact, needed extensive ing and was frequently R206 CAA indicated she had inary urgency, and received					
	11/9/13, indicated sh Quarterly Review datare to assist to toilet needed while awake communicate her nee prefers to sleep without will use her call light	eds for toileting. Resident out interruptions at night and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245432	B. WING _			04/10/2014	
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP COD 135 FERN STREET NORTH CAMBRIDGE, MN 55008	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 315	status was a change assessment of being was no indication of	dium brief. This continence	F 3	15			
	incontinent of urine a	ed 2/3/14, indicated she was ind wears a full brief. The ted she needs assistance					
	verified R206 is frequ	14, at 12:25 p.m. RN-A lently incontinent of urine nd that she had not been hange in continence.					
	of nursing (DON) sta Evaluation should be is admitted and also	14, at 12:33 p.m. the director ted a Bowel and Bladder completed when a resident if there is a change of arterly summary should be ad been no changes.					
	stated she was not a change in bladder co	14, at 12:53 p.m. RN-A ware that R206 had a ntinence, and a d be completed and not just a					
	reviewed 7/10 indica assessed for bowel a	d Bladder Assessment Policy ted each resident will be and bladder incontinence and sibility in retraining bowel					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245432	B. WING		04/10/2014
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 315 F 371 SS=E	significant changes. bladder assessment the plan is appropriate 483.35(i) FOOD PRO	pon admission, inual reviews and with Quarterly, the bowel and will be reviewed to ensure e for the resident. ICURE,	F 31		5/3/14
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ons			
	by: Based on observation review, the facility fail items were disposed service standards to pillness. In addition the staff serving residents while having contact for 10 of 15 residents R122, R22, R74, R17 served in the City View Findings include: During observation of	is not met as evidenced n, interview, and document ed to ensure outdated food of in accordance with food prevent potential food borne e facility failed to ensure s food used sanitary practice with food during food service (R105, R172, R114, R168, '7, R59, and R58) being w 1 (CV1) dining room. The kitchen on 4/7/14, at etary manager (DM)-A the ed:		On 4-7-2014 the lettuce and egg sathe cooler were disposed of and the in the cooler along with the ceiling volume were sanitized. On 4-7-2014 DS-A reeducated on proper serving techn. On 4-7-2014 all floors and ceiling volume the kitchen were inspected for cleanliness. On 4-7-2014 all coolers evaluated for outdated and/or unseafood items. The policy and procedure was revie and is current. Education will be completed for staff responsible for staff on and kitchen sanitation by 5-3-2	efloor ents a was ique. ents in s were aled wed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245432	B. WING _		04/10/2014
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIF 135 FERN STREET NORTH CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION DATE
F 371	loosely covered with was dated 4/2/14. The container of egg salar approximate 4X4 incomposition the floor under the form of the floor under the floor of	e 9 ad a small bowl of lettuce plastic wrap (unsealed) that here was a small plastic ad dated 4/2/14 and a h area of a black liquid on ood shelving. In the food vents over the food prep eavy accumulation of dust elettuce, and egg salad scarded a few days ago. The hance of the kitchen had but now they have hired a lanager and it will get back on the vents and spills on the leaned more frequently. In ovided by the facility entitled the ded under the cooler bullet tifies, "Clearly label and date and plan to use with in In food service on 4/7/14, at dining room the residents and they wanted for the meal The paper menus, that were lesident were placed onto a	F3		nd sustain kitchenette, dits on each unit sults of audits and determination d audits. ignee will be ongoing
	to fill. The dietary see food in the CV1 dinir wearing a glove on hand. She picked up with her left gloved hand the food onto the pla requested. DS-A wo	am table for the dietary server erver (DS)-A who was serving and groom during this time was her left hand and not the right the resident's paper menula and and proceed to serve the which the resident build touch the menu (that was ents), then proceed to touch			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245432	B. WING			04/	10/2014
	ROVIDER OR SUPPLIER	BLES WEST	•	135	EET ADDRESS, CITY, STATE, ZIP CODE FERN STREET NORTH MBRIDGE, MN 55008	<u>, </u>	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	She then touched the salad cart and process andwiches with the continued to touch the breast sandwich meresident menus, and same soiled left glovitems onto the resident menus, and same soiled gloved had bread, and touch pritems without first reand washing her has same process until the R114, R168, R122) 5:20 p.m. the DM-A removed her soiled hands. DS-A, then pwith her new clean gresident paper menusident paper menusident paper menusident plates with glove or washing he same process until the R177, R59, and R56 During interview on stated, "I found mystimes, I was nervous residents. On 4/7/14, at 5:50 pabout DS-A touching she was nervous and An undated policy peolicy And Procedures.	in the soiled left gloved hand. The touched the handle of the seeded to touch additional as soiled left glove hand. She the toaster, processed turkey that, cupboard handles, disliced raw tomatoes with the wed hand and placed the ents plate. She then placed and into the bread bag for epared sandwiches and other amoving her left soiled glove ands. She continue with this five resident (R105, R172, were served their meal. At talked to DS-A, and DS-A gloves and washed her proceeded to do the same gloves. She touched a su, sandwiches, toaster and these items onto the mout first removing her soiled at these items onto the mout first removing her soiled are hands. She continued this five residents (R22, R74, B) were served their meal. 4/7/14, at 5:45 p.m. DS-A self screwing up a couple of s," when serving the	F	371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		04/10/2014		
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
	food item, such as moutside of bread bags gloves before having 483.70(f) RESIDENT ROOMS/TOILET/BATThe nurses' station maresident calls through from resident rooms; facilities. This REQUIREMENT by: Based on observation review, the facility fail functioning call systems the City View unit (RAT4 and R58) whose	tion when handling a non icrowave door, toaster, is or tray tickets, to change direct contact with the food". CALL SYSTEM - TH	F 37	1	l/or	
	the resident bathroom on the City View wing assistant (HSA)-A trie after pulling the call lito which the cord was the wall next to the to After tugging the cord unable to activate the HSA-A entered the back R188. HSA-A attempactivate the call light	n 4/8/2014 at 8:03 a.m., in a shared by R155 and R26 g, housekeeping services ed to activate the call system ght cord. The call light box, is attached, was mounted on eilet in the resident bathroom. If several times, HSA-A was e call light. At 8:07 a.m., athroom shared by R39 and oted, but was unable, to after pulling the call light athroom. At 8:09 a.m.		The policy and procedure was reviewed and is current. Education will be completed for staff on call lights and we to do in the event a call light is not functioning properly by 5-3-2014. The facility will monitor and sustain correction by completing call light audit on 100% of resident rooms weekly for months. Results of audits will be reviewed in QAA and determination with made for frequency of continued audit Environmental Services Manager or	ts 2	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245432	B. WING		04/10/2014
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	, 0.1.0.2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 463	attempted, but agai call light in R98's bat R155's quarterly Mi 1/3/2014, indicated and was independed R26's quarterly MD R26 was cognitively with toileting. R39's quarterly MD R39 was cognitively with toileting. R188's quarterly MI R188 was moderated MDS also indicated assistance with toileting. R98's quarterly MD moderately, cognitively with toileting an interview HSA-A stated, after boxes in each of the can't get them, thes turn the call light on could "push the but	bathroom of R98. HSA-A n was unable to activate the athroom. nimum Data Set (MDS) dated R155 was cognitively intact, nt with toileting. S, dated 3/17/2014, identified of intact, and was independent S, dated 3/7/2014 identified of intact, and was independent DS, dated 1/24/2014, identified ely, cognitively impaired. The R188 required limited etting. S identified R98 was ovely impaired, and required	F 46	designee will be responsible for ensongoing compliance. Correction date for certification: 5-3	
	were not routinely of working. During observation HSA-B verified the	s "pretty sure" the call lights hecked to see if they were on 4/8/2014 at 9:30 a.m., pull cord on the call light box and R58, was less than three			

		IDENTIFICATION NUMBER.		PLE CONSTRUCTION B	1' '	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		04/10/20	014	
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	1 04/10/2014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	(X5) MPLETION DATE	
F 463	_	ge 13 SA-B was able to activate the ing the button on the call box.	F 46	33			
		S, dated 3/21/2014, identified y intact, and was independent					
	stated she could us by "pressing the bu	on 4/8/2014 at 7:16 a.m., R74 be the call light in her bathroom tton." When asked if the cord on the call light, R74 said nort. I can't."					
	R58 was mildly, coo	dated 2/21/2014, identified gnitively impaired. The MDS R58 required extensive eting.					
	stated that she was when going to the b she "has gone there	on 4/7/2014 at 5:30 p.m., R58 supposed" to call for help bathroom, but admitted that e myself." When asked if she when in the bathroom, R58					
	nursing assistant (N both required assist that each resident " call for help. NA-B R26, R188 and R39 toileting. NA-B said	on 4/10/2014 at 10:41 a.m., NA)-B stated that R58 and R98 tance with toileting, and also, can and does" use the light to also verified that R74, R155, were independent with that "all of those residents" w to use their call lights.					
		on 4/10/2014 at 11:00 a.m., onmental services (DES)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245432	B. WING			04/10/2014
	ROVIDER OR SUPPLIER	ES WEST	•	STREET ADDRESS, CITY, STATE, ZIP CO 135 FERN STREET NORTH CAMBRIDGE, MN 55008	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 463	stated he has been at end of March", and w audits of the call light the affected call boxe cords were installed, functioning properly. should be able to be at the button and pulling stated there "should be said he took it upon h "maintenance" would lights in the future. During an interview or registered nurse (RN) needed to be accessi RN-B said functioning safety" for the resider	the facility only since "the as unaware of any routine system. The DES stated is "were adjusted", new pull and the lights were now The DES also said call lights activated by both "pressing the cords." The DES of a check" in place, and imself to make sure be in charge of testing call in 4/10/2104 at 11:44 a.m., and and work properly. It call lights were "a matter of ats. Call Light," dated 10/04, ose": "To assure call system	F	463		