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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8G4P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00294

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245432**

2.STATE VENDOR OR MEDICAID NO.
(L2) **893042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES WEST**
(L4) **135 FERN STREET NORTH**
(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)

6. DATE OF SURVEY **06/02/2014** (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 **140** (L18)

13.Total Certified Beds **140** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	140			
(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 :
Brenda Fischer, Unit Supervisor — 06/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/04/2014 (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
03/01/1987
(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
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245432	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES WEST	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/03/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/03/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/03/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/03/2014**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **05/03/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	06/04/2014	10652	06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/10/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8G4P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00294

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245432**

2.STATE VENDOR OR MEDICAID NO.
(L2) **893042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES**
(L4) **WEST 135 FERN STREET NORTH**
(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)

6. DATE OF SURVEY **04/10/2014** (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 **140** (L18)

13.Total Certified Beds **140** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: **B** * Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	140			
(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 :
Michelle Thompson, HFE NE II — 05/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/04/2014 (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
03/01/1987
(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
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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:

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

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

Remedies - 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;

Potential Consequences - 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

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

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/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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES WEST	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 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		
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 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	F 282	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 4-25-2014. 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 by 5-3-2014.	5/3/14

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

Electronically Signed | 05/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES WEST	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 walking. The care plan further indicated increased urinary incontinence and staff to toilet every 1.5 to 2 hours and as needed. The undated Nursing Assistant care sheet indicated to toilet every 1.5 to 2 hours and as needed. The sheet also identified R200 wore incontinent pull up briefs. During continuous observation 4/9/14, from 8:18 a.m. to 10:45 a.m., nursing assistant (NA)-A was observed at 8:18 a.m. to assist R200 to the bathroom. At 8:35 a.m. NA-A brought R200 to the dining room for breakfast and at 8:45 a.m. NA-D returned R200 to her room without toileting her and placed R200 back into bed. At 10:45 a.m. NA-A was observed to assist R200 to the bathroom, 2hrs and 22 minutes later. R200 was continent and her skin was intact. During interview 4/9/14, at 10:50 a.m. NA-A stated she thought NA-D had toileted her when she placed R200 into bed and thought she had toileted her according to her schedule. During interview 4/9/14, at 12:30 p.m. RN-A stated R200 should had been toileted according to her toileting schedule.	F 282	The facility will monitor and sustain correction by completing bowel and bladder audits on 5% of residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014.	
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.	F 309		5/3/14

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F 309	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 was observed in the day room watching television in his chair tilted back, he had no shoes on and his feet were dangling approximately two inches from the floor, not being supported. During interview 4/10/14, at 9:20 a.m. registered nurse (RN)-A stated R132 should have shoes on when he in his wheelchair and verified his feet	F 309	R123 wheel chair positioning was reassessed on 4-25-2014 by Inter Disciplinary Team (R123 responsible party declined therapy evaluation). A calf panel was added to Rock-N-Go wheel chair for positioning of lower extremities. Wheel chair positioning for all residents in house was reviewed and revised as necessary. The policy and procedure was reviewed and 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 residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 309	Continued From page 3 were not touching the floor. RN-A stated she would have occupational therapy (OT) look at R132 to see if his chair could be adjusted to support R132 feet. During interview 4/11/14, at 11:49 a.m. RN-A stated the director of nursing (DON) and nurse consultant observed R132 to have his feet fully on the floor and felt if his shoes were on his feet would touch the floor. RN-A stated the DON and nurse consultant did not feel a need to have OT look at R132 in his Rock N Go chair. During review of R132's medical record did not identify any therapy records or notes in the chart about R132's wheelchair positioning. These notes were requested from the DON 4/11/4, at 1:00 p.m. and none were provided. Although R132's feet would dangle in his Rock N Go chair when tilted or not tilted or if R132 shoes were on or off, they did not properly assess R132 for proper wheelchair positioning.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		5/3/14

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F 315	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and/or provide timely assistance with toileting for 2 of 2 residents (R200 and R206) reviewed who had a change with urinary incontinence. Findings include: R200's admission Minimum Data Det (MDS) dated 10/21/13, indicated R200 was always continent of urine. R200's quarterly MDS dated 1/10/14, indicated R200 to be moderately cognitively intact the MDS further indicated she was always incontinent with no episodes of continent voiding needed limited assist and had been on a trial voiding program. R200's care area assessment (CAA) dated 11/18/13, indicated she was continent of bladder and staff to assist with toileting. R200's care plan dated 1/10/14, indicated she had diagnoses of hypertension and difficulty walking. The care plan further indicated increased urinary incontinence and staff to toilet every 1.5 to 2 hours and as needed. The Nursing Assistant care sheet indicated to toilet every 1.5 to 2 hours and as needed and she wears pull ups. During continuous observation 4/9/14, at 8:18 a.m. nursing assistant (NA)-A was observed to assist R200 to the bathroom. At 8:35 a.m. NA-A	F 315	A new bowel and bladder assessment was completed on R200 and R206 on 4-25-2014. Toileting plans on R200 and R206 were reassessed and care plans were updated on 4-25-2014. Toileting plans for all residents in house were reviewed and updated as necessary. The policy and procedure was reviewed and is current. Education will be completed for staff responsible for assisting residents with toileting needs by 5-3-2014. The facility will monitor and sustain correction by completing bowel and bladder audits on 5% of residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 315	Continued From page 5 brought R200 to the dining room for breakfast and at 8:45 a.m. NA-D returned R200 to her room without toileting and placed R200 back into bed. At 10:45 a.m. NA-A was observed to assist R200 to the bathroom 2hrs and 22 minutes later. R200 was continent and her skin was intact. During interview 4/9/14, at 10:50 a.m. NA-A stated she thought NA-D had toileted her when she placed R200 into bed and thought she had toileted her according to her schedule. Review of R200's Bowel and Bladder Evaluation dated 10/18/13, indicated she frequently asked to use the bathroom and was continent of bladder. R200's Bowel and Bladder quarterly review dated 11/19/13, indicated "Resident is occasionally incontinent of urine and continent of bowel. Prompt toileting q2hr (every hours) and prn (as needed) unless resident is sleeping." Resident frequently asks to go to the bathroom and does not always void and needs frequent cues once on the toilet to void. "Prompt q [every] 1.5 hr [hour] toileting." The assessment did not address mobility, medications or environmental causes. R200's Bowel and Bladder quarterly review dated 1/10/14, indicated she had a change with an increase in urinary incontinence from occasionally incontinent on 11/19/13 to always being incontinent on 1/10/14. The staff were directed to toilet R200 every 1.5 to 2 hours, even though R200 does not always urinate while on toilet but	F 315		

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F 315	Continued From page 6 frequently requests the need for toileting. The assessment also indicated R200 was wearing pull ups. The quarterly assessment did not address the reason for the increase with urinary incontinence or the possible cause. During interview 4/9/14, at 12:25 p.m. RN-A verified R200 was incontinent of urine and she had not been reassessed for her change in continence. Although R200 went from continent of urine to always incontinent of urine the facility failed to assess the cause for the change and type of incontinence. In addition the facility failed to follow R200's current toileting plan. R206's admission MDS dated 11/11/13, indicated she was continent of urine. R206's quarterly MDS dated 2/01/14, indicated she was moderately cognitively intact, needed extensive assistance with toileting and was frequently incontinent of urine. R206 CAA indicated she had restricted mobility, urinary urgency, and received diuretics. R206's Bowel and Bladder evaluation dated 11/9/13, indicated she was continent of urine. A Quarterly Review dated 1/30/14, indicated staff are to assist to toilet every four hours and as needed while awake as resident can communicate her needs for toileting. Resident prefers to sleep without interruptions at night and will use her call light for help. Resident is frequently incontinent of bowel and bladder and	F 315		

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F 315	Continued From page 7 resident wears a medium brief. This continence status was a changed from her 11/9/13 assessment of being continent of urine. There was no indication of why there was a change in R206, urinary continent status, which had not been reassessed. R206's care plan dated 2/3/14, indicated she was incontinent of urine and wears a full brief. The care plan also indicated she needs assistance with toileting. During interview 4/9/14, at 12:25 p.m. RN-A verified R206 is frequently incontinent of urine throughout the day and that she had not been reassessed for her change in continence. During interview 4/9/14, at 12:33 p.m. the director of nursing (DON) stated a Bowel and Bladder Evaluation should be completed when a resident is admitted and also if there is a change of continence and a quarterly summary should be completed if there had been no changes. During interview 4/9/14, at 12:53 p.m. RN-A stated she was not aware that R206 had a change in bladder continence, and a reassessment should be completed and not just a summary. The facility Bowel and Bladder Assessment Policy reviewed 7/10 indicated each resident will be assessed for bowel and bladder incontinence and evaluated for the feasibility in retraining bowel	F 315		

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F 315	Continued From page 8 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.	F 315		
F 371 SS=E	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 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:	F 371	On 4-7-2014 the lettuce and egg salad in the cooler were disposed of and the floor in the cooler along with the ceiling vents were sanitized. On 4-7-2014 DS-A was reeducated on proper serving technique. On 4-7-2014 all floors and ceiling vents in the kitchen were inspected for cleanliness. On 4-7-2014 all coolers were evaluated for outdated and/or unsealed food items. The policy and procedure was reviewed and is current. Education will be completed for staff responsible for serving food and kitchen sanitation by 5-3-2014.	5/3/14

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F 371	Continued From page 9 The walk-in cooler had a small bowl of lettuce loosely covered with plastic wrap (unsealed) that was dated 4/2/14. There was a small plastic container of egg salad dated 4/2/14 and a approximate 4X4 inch area of a black liquid on the floor under the food shelving. In the food prep area the ceiling vents over the food prep area had a visible heavy accumulation of dust and debris. The DM-A stated the lettuce, and egg salad should have been discarded a few days ago. The preventative maintenance of the kitchen had fallen by the way side but now they have hired a new maintenance manager and it will get back on track. DM-A verified the vents and spills on the floor needed to be cleaned more frequently. An undated policy provided by the facility entitled Food Storage indicated under the cooler bullet point number 4, identifies, "Clearly label and date all prepared products and plan to use with in three days." During observation of food service on 4/7/14, at 5:05 p.m. in the CV1 dining room the residents were choosing the food they wanted for the meal on a paper menus. The paper menus, that were just touched by the resident were placed onto a table next to the steam table for the dietary server to fill. The dietary server (DS)-A who was serving food in the CV1 dining room during this time was wearing a glove on her left hand and not the right hand. She picked up the resident's paper menu with her left gloved hand and proceed to serve the food onto the plate which the resident requested. DS-A would touch the menu (that was touched by the residents), then proceed to touch	F 371	The facility will monitor and sustain correction by completing kitchenette, dining, and sanitation audits on each unit weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Culinary Manager or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 371	Continued From page 10 the sandwiches with the soiled left gloved hand. She then touched the touched the handle of the salad cart and proceeded to touch additional sandwiches with the soiled left glove hand. She continued to touch the toaster, processed turkey breast sandwich meat, cupboard handles, resident menus, and sliced raw tomatoes with the same soiled left gloved hand and placed the items onto the residents plate. She then placed her soiled gloved hand into the bread bag for bread, and touch prepared sandwiches and other items without first removing her left soiled glove and washing her hands. She continue with this same process until five resident (R105, R172, R114, R168, R122) were served their meal. At 5:20 p.m. the DM-A talked to DS-A, and DS-A removed her soiled gloves and washed her hands. DS-A, then proceeded to do the same with her new clean gloves. She touched a resident paper menu, sandwiches, toaster handle, and raw sliced tomatoes, with her soiled left glove and placed these items onto the residents plates without first removing her soiled glove or washing her hands. She continued this same process until five residents (R22, R74, R177, R59, and R58) were served their meal. During interview on 4/7/14, at 5:45 p.m. DS-A stated, "I found myself screwing up a couple of times, I was nervous," when serving the residents. On 4/7/14, at 5:50 p.m. the DM-A, stated I know about DS-A touching food with her soiled gloves, she was nervous and froze. An undated policy provided by facility entitled Policy And Procedure Of Glove Use In Food Service, under procedure #5, "When serving,	F 371		

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F 371	Continued From page 11 always use extra caution when handling a non food item, such as microwave door, toaster, outside of bread bags or tray tickets, to change gloves before having direct contact with the food".	F 371		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure and maintain a functioning call system for 7 of 37 residents on the City View unit (R155, R26, R39, R188, R98, R74 and R58) whose bathrooms had mal-functioning call lights, or lacked a useable call light pull cord. Findings include: During observation on 4/8/2014 at 8:03 a.m., in the resident bathroom shared by R155 and R26 on the City View wing, housekeeping services assistant (HSA)-A tried to activate the call system after pulling the call light cord. The call light box, to which the cord was attached, was mounted on the wall next to the toilet in the resident bathroom. After tugging the cord several times, HSA-A was unable to activate the call light. At 8:07 a.m., HSA-A entered the bathroom shared by R39 and R188. HSA-A attempted, but was unable, to activate the call light after pulling the call light cord in the resident bathroom. At 8:09 a.m.	F 463	On 4-8-2014 the call light cords in the bathrooms of R155, R26, R39, R188, R98, R74, and R58 were replaced and/or call lights were repaired. All call lights in house were checked on 4-8-2014 and are in proper working 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	5/3/14

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F 463	Continued From page 12 HSA-A entered the bathroom of R98. HSA-A attempted, but again was unable to activate the call light in R98's bathroom. R155's quarterly Minimum Data Set (MDS) dated 1/3/2014, indicated R155 was cognitively intact, and was independent with toileting. R26's quarterly MDS, dated 3/17/2014, identified R26 was cognitively intact, and was independent with toileting. R39's quarterly MDS, dated 3/7/2014 identified R39 was cognitively intact, and was independent with toileting. R188's quarterly MDS, dated 1/24/2014, identified R188 was moderately, cognitively impaired. The MDS also indicated R188 required limited assistance with toileting. R98's quarterly MDS identified R98 was moderately, cognitively impaired, and required extensive assistance with toileting. During an interview on 4/8/2014 at 8:10 a.m., HSA-A stated, after pulling the cords of the call boxes in each of three resident bathrooms, "If I can't get them, these ladies wouldn't be able to turn the call light on." HSA-A said the residents could "push the button" to turn on the call light, but they should be able "to pull the cord, too." HSA-A said she was "pretty sure" the call lights were not routinely checked to see if they were working. During observation on 4/8/2014 at 9:30 a.m., HSA-B verified the pull cord on the call light box of roommates R74 and R58, was less than three	F 463	designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 463	Continued From page 13 inches in length. HSA-B was able to activate the call light after pressing the button on the call box. R74's quarterly MDS, dated 3/21/2014, identified R74 was cognitively intact, and was independent with toileting. During an interview on 4/8/2014 at 7:16 a.m., R74 stated she could use the call light in her bathroom by "pressing the button." When asked if the cord could be used to turn on the call light, R74 said "Look at it, it's so short. I can't." R58's annual MDS, dated 2/21/2014, identified R58 was mildly, cognitively impaired. The MDS also identified that R58 required extensive assistance with toileting. During an interview on 4/7/2014 at 5:30 p.m., R58 stated that she was "supposed" to call for help when going to the bathroom, but admitted that she "has gone there myself." When asked if she used the call light when in the bathroom, R58 stated "Yes, I have." During an interview on 4/10/2014 at 10:41 a.m., nursing assistant (NA)-B stated that R58 and R98 both required assistance with toileting, and also, that each resident "can and does" use the light to call for help. NA-B also verified that R74, R155, R26, R188 and R39 were independent with toileting. NA-B said that "all of those residents" know when and how to use their call lights. During an interview on 4/10/2014 at 11:00 a.m., the director of environmental services (DES)	F 463		

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	245432	A. BUILDING _____ B. WING _____	04/10/2014

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GRACEPOINTE CROSSING GABLES WEST	**135 FERN STREET NORTH CAMBRIDGE, MN 55008**

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F 463	Continued From page 14 stated he has been at the facility only since "the end of March", and was unaware of any routine audits of the call light system. The DES stated the affected call boxes "were adjusted", new pull cords were installed, and the lights were now functioning properly. The DES also said call lights should be able to be activated by both "pressing the button and pulling the cords." The DES stated there "should be a check" in place, and said he took it upon himself to make sure "maintenance" would be in charge of testing call lights in the future. During an interview on 4/10/2104 at 11:44 a.m., registered nurse (RN)-B stated that the call lights needed to be accessible and work properly. RN-B said functioning call lights were "a matter of safety" for the residents. The facility policy for "Call Light," dated 10/04, indicated under "Purpose": "To assure call system is in proper working order."	F 463		

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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		
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 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	F 282	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 4-25-2014. 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 by 5-3-2014.	5/3/14

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

Electronically Signed | 05/01/2014

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F 282	Continued From page 1 walking. The care plan further indicated increased urinary incontinence and staff to toilet every 1.5 to 2 hours and as needed. The undated Nursing Assistant care sheet indicated to toilet every 1.5 to 2 hours and as needed. The sheet also identified R200 wore incontinent pull up briefs. During continuous observation 4/9/14, from 8:18 a.m. to 10:45 a.m., nursing assistant (NA)-A was observed at 8:18 a.m. to assist R200 to the bathroom. At 8:35 a.m. NA-A brought R200 to the dining room for breakfast and at 8:45 a.m. NA-D returned R200 to her room without toileting her and placed R200 back into bed. At 10:45 a.m. NA-A was observed to assist R200 to the bathroom, 2hrs and 22 minutes later. R200 was continent and her skin was intact. During interview 4/9/14, at 10:50 a.m. NA-A stated she thought NA-D had toileted her when she placed R200 into bed and thought she had toileted her according to her schedule. During interview 4/9/14, at 12:30 p.m. RN-A stated R200 should had been toileted according to her toileting schedule.	F 282	The facility will monitor and sustain correction by completing bowel and bladder audits on 5% of residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014.	
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.	F 309		5/3/14

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F 309	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 was observed in the day room watching television in his chair tilted back, he had no shoes on and his feet were dangling approximately two inches from the floor, not being supported. During interview 4/10/14, at 9:20 a.m. registered nurse (RN)-A stated R132 should have shoes on when he in his wheelchair and verified his feet	F 309	R123 wheel chair positioning was reassessed on 4-25-2014 by Inter Disciplinary Team (R123 responsible party declined therapy evaluation). A calf panel was added to Rock-N-Go wheel chair for positioning of lower extremities. Wheel chair positioning for all residents in house was reviewed and revised as necessary. The policy and procedure was reviewed and 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 residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 309	Continued From page 3 were not touching the floor. RN-A stated she would have occupational therapy (OT) look at R132 to see if his chair could be adjusted to support R132 feet. During interview 4/11/14, at 11:49 a.m. RN-A stated the director of nursing (DON) and nurse consultant observed R132 to have his feet fully on the floor and felt if his shoes were on his feet would touch the floor. RN-A stated the DON and nurse consultant did not feel a need to have OT look at R132 in his Rock N Go chair. During review of R132's medical record did not identify any therapy records or notes in the chart about R132's wheelchair positioning. These notes were requested from the DON 4/11/4, at 1:00 p.m. and none were provided. Although R132's feet would dangle in his Rock N Go chair when tilted or not tilted or if R132 shoes were on or off, they did not properly assess R132 for proper wheelchair positioning.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		5/3/14

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F 315	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and/or provide timely assistance with toileting for 2 of 2 residents (R200 and R206) reviewed who had a change with urinary incontinence. Findings include: R200's admission Minimum Data Det (MDS) dated 10/21/13, indicated R200 was always continent of urine. R200's quarterly MDS dated 1/10/14, indicated R200 to be moderately cognitively intact the MDS further indicated she was always incontinent with no episodes of continent voiding needed limited assist and had been on a trial voiding program. R200's care area assessment (CAA) dated 11/18/13, indicated she was continent of bladder and staff to assist with toileting. R200's care plan dated 1/10/14, indicated she had diagnoses of hypertension and difficulty walking. The care plan further indicated increased urinary incontinence and staff to toilet every 1.5 to 2 hours and as needed. The Nursing Assistant care sheet indicated to toilet every 1.5 to 2 hours and as needed and she wears pull ups. During continuous observation 4/9/14, at 8:18 a.m. nursing assistant (NA)-A was observed to assist R200 to the bathroom. At 8:35 a.m. NA-A	F 315	A new bowel and bladder assessment was completed on R200 and R206 on 4-25-2014. Toileting plans on R200 and R206 were reassessed and care plans were updated on 4-25-2014. Toileting plans for all residents in house were reviewed and updated as necessary. The policy and procedure was reviewed and is current. Education will be completed for staff responsible for assisting residents with toileting needs by 5-3-2014. The facility will monitor and sustain correction by completing bowel and bladder audits on 5% of residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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F 315	Continued From page 5	F 315		

brought R200 to the dining room for breakfast and at 8:45 a.m. NA-D returned R200 to her room without toileting and placed R200 back into bed. At 10:45 a.m. NA-A was observed to assist R200 to the bathroom 2hrs and 22 minutes later. R200 was continent and her skin was intact.

During interview 4/9/14, at 10:50 a.m. NA-A stated she thought NA-D had toileted her when she placed R200 into bed and thought she had toileted her according to her schedule.

Review of R200's Bowel and Bladder Evaluation dated 10/18/13, indicated she frequently asked to use the bathroom and was continent of bladder.

R200's Bowel and Bladder quarterly review dated 11/19/13, indicated "Resident is occasionally incontinent of urine and continent of bowel. Prompt toileting q2hr (every hours) and prn (as needed) unless resident is sleeping." Resident frequently asks to go to the bathroom and does not always void and needs frequent cues once on the toilet to void. "Prompt q [every] 1.5 hr [hour] toileting."
The assessment did not address mobility, medications or environmental causes.

R200's Bowel and Bladder quarterly review dated 1/10/14, indicated she had a change with an increase in urinary incontinence from occasionally incontinent on 11/19/13 to always being incontinent on 1/10/14. The staff were directed to toilet R200 every 1.5 to 2 hours, even though R200 does not always urinate while on toilet but

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F 315	Continued From page 6	F 315		

frequently requests the need for toileting. The assessment also indicated R200 was wearing pull ups. The quarterly assessment did not address the reason for the increase with urinary incontinence or the possible cause.

During interview 4/9/14, at 12:25 p.m. RN-A verified R200 was incontinent of urine and she had not been reassessed for her change in continence.

Although R200 went from continent of urine to always incontinent of urine the facility failed to assess the cause for the change and type of incontinence. In addition the facility failed to follow R200's current toileting plan.

R206's admission MDS dated 11/11/13, indicated she was continent of urine. R206's quarterly MDS dated 2/01/14, indicated she was moderately cognitively intact, needed extensive assistance with toileting and was frequently incontinent of urine. R206 CAA indicated she had restricted mobility, urinary urgency, and received diuretics.

R206's Bowel and Bladder evaluation dated 11/9/13, indicated she was continent of urine. A Quarterly Review dated 1/30/14, indicated staff are to assist to toilet every four hours and as needed while awake as resident can communicate her needs for toileting. Resident prefers to sleep without interruptions at night and will use her call light for help. Resident is frequently incontinent of bowel and bladder and

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resident wears a medium brief. This continence status was a changed from her 11/9/13 assessment of being continent of urine. There was no indication of why there was a change in R206, urinary continent status, which had not been reassessed.

R206's care plan dated 2/3/14, indicated she was incontinent of urine and wears a full brief. The care plan also indicated she needs assistance with toileting.

During interview 4/9/14, at 12:25 p.m. RN-A verified R206 is frequently incontinent of urine throughout the day and that she had not been reassessed for her change in continence.

During interview 4/9/14, at 12:33 p.m. the director of nursing (DON) stated a Bowel and Bladder Evaluation should be completed when a resident is admitted and also if there is a change of continence and a quarterly summary should be completed if there had been no changes.

During interview 4/9/14, at 12:53 p.m. RN-A stated she was not aware that R206 had a change in bladder continence, and a reassessment should be completed and not just a summary.

The facility Bowel and Bladder Assessment Policy reviewed 7/10 indicated each resident will be assessed for bowel and bladder incontinence and evaluated for the feasibility in retraining bowel

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F 315	Continued From page 8 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.	F 315		
F 371 SS=E	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 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:	F 371	On 4-7-2014 the lettuce and egg salad in the cooler were disposed of and the floor in the cooler along with the ceiling vents were sanitized. On 4-7-2014 DS-A was reeducated on proper serving technique. On 4-7-2014 all floors and ceiling vents in the kitchen were inspected for cleanliness. On 4-7-2014 all coolers were evaluated for outdated and/or unsealed food items. The policy and procedure was reviewed and is current. Education will be completed for staff responsible for serving food and kitchen sanitation by 5-3-2014.	5/3/14

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F 371	Continued From page 9 The walk-in cooler had a small bowl of lettuce loosely covered with plastic wrap (unsealed) that was dated 4/2/14. There was a small plastic container of egg salad dated 4/2/14 and a approximate 4X4 inch area of a black liquid on the floor under the food shelving. In the food prep area the ceiling vents over the food prep area had a visible heavy accumulation of dust and debris. The DM-A stated the lettuce, and egg salad should have been discarded a few days ago. The preventative maintenance of the kitchen had fallen by the way side but now they have hired a new maintenance manager and it will get back on track. DM-A verified the vents and spills on the floor needed to be cleaned more frequently. An undated policy provided by the facility entitled Food Storage indicated under the cooler bullet point number 4, identifies, "Clearly label and date all prepared products and plan to use with in three days." During observation of food service on 4/7/14, at 5:05 p.m. in the CV1 dining room the residents were choosing the food they wanted for the meal on a paper menus. The paper menus, that were just touched by the resident were placed onto a table next to the steam table for the dietary server to fill. The dietary server (DS)-A who was serving food in the CV1 dining room during this time was wearing a glove on her left hand and not the right hand. She picked up the resident's paper menu with her left gloved hand and proceed to serve the food onto the plate which the resident requested. DS-A would touch the menu (that was touched by the residents), then proceed to touch	F 371	The facility will monitor and sustain correction by completing kitchenette, dining, and sanitation audits on each unit weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Culinary Manager or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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the sandwiches with the soiled left gloved hand. She then touched the touched the handle of the salad cart and proceeded to touch additional sandwiches with the soiled left glove hand. She continued to touch the toaster, processed turkey breast sandwich meat, cupboard handles, resident menus, and sliced raw tomatoes with the same soiled left gloved hand and placed the items onto the residents plate. She then placed her soiled gloved hand into the bread bag for bread, and touch prepared sandwiches and other items without first removing her left soiled glove and washing her hands. She continue with this same process until five resident (R105, R172, R114, R168, R122) were served their meal. At 5:20 p.m. the DM-A talked to DS-A, and DS-A removed her soiled gloves and washed her hands. DS-A, then proceeded to do the same with her new clean gloves. She touched a resident paper menu, sandwiches, toaster handle, and raw sliced tomatoes, with her soiled left glove and placed these items onto the residents plates without first removing her soiled glove or washing her hands. She continued this same process until five residents (R22, R74, R177, R59, and R58) were served their meal.

During interview on 4/7/14, at 5:45 p.m. DS-A stated, "I found myself screwing up a couple of times, I was nervous," when serving the residents.

On 4/7/14, at 5:50 p.m. the DM-A, stated I know about DS-A touching food with her soiled gloves, she was nervous and froze.

An undated policy provided by facility entitled Policy And Procedure Of Glove Use In Food Service, under procedure #5, "When serving,

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	245432	A. BUILDING _____ B. WING _____	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES WEST	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 always use extra caution when handling a non food item, such as microwave door, toaster, outside of bread bags or tray tickets, to change gloves before having direct contact with the food".	F 371		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure and maintain a functioning call system for 7 of 37 residents on the City View unit (R155, R26, R39, R188, R98, R74 and R58) whose bathrooms had mal-functioning call lights, or lacked a useable call light pull cord. Findings include: During observation on 4/8/2014 at 8:03 a.m., in the resident bathroom shared by R155 and R26 on the City View wing, housekeeping services assistant (HSA)-A tried to activate the call system after pulling the call light cord. The call light box, to which the cord was attached, was mounted on the wall next to the toilet in the resident bathroom. After tugging the cord several times, HSA-A was unable to activate the call light. At 8:07 a.m., HSA-A entered the bathroom shared by R39 and R188. HSA-A attempted, but was unable, to activate the call light after pulling the call light cord in the resident bathroom. At 8:09 a.m.	F 463	On 4-8-2014 the call light cords in the bathrooms of R155, R26, R39, R188, R98, R74, and R58 were replaced and/or call lights were repaired. All call lights in house were checked on 4-8-2014 and are in proper working 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	5/3/14

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F 463	Continued From page 12 HSA-A entered the bathroom of R98. HSA-A attempted, but again was unable to activate the call light in R98's bathroom. R155's quarterly Minimum Data Set (MDS) dated 1/3/2014, indicated R155 was cognitively intact, and was independent with toileting. R26's quarterly MDS, dated 3/17/2014, identified R26 was cognitively intact, and was independent with toileting. R39's quarterly MDS, dated 3/7/2014 identified R39 was cognitively intact, and was independent with toileting. R188's quarterly MDS, dated 1/24/2014, identified R188 was moderately, cognitively impaired. The MDS also indicated R188 required limited assistance with toileting. R98's quarterly MDS identified R98 was moderately, cognitively impaired, and required extensive assistance with toileting. During an interview on 4/8/2014 at 8:10 a.m., HSA-A stated, after pulling the cords of the call boxes in each of three resident bathrooms, "If I can't get them, these ladies wouldn't be able to turn the call light on." HSA-A said the residents could "push the button" to turn on the call light, but they should be able "to pull the cord, too." HSA-A said she was "pretty sure" the call lights were not routinely checked to see if they were working. During observation on 4/8/2014 at 9:30 a.m., HSA-B verified the pull cord on the call light box of roommates R74 and R58, was less than three	F 463	designee will be responsible for ensuring ongoing compliance. Correction date for certification: 5-3-2014	

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inches in length. HSA-B was able to activate the call light after pressing the button on the call box.

R74's quarterly MDS, dated 3/21/2014, identified R74 was cognitively intact, and was independent with toileting.

During an interview on 4/8/2014 at 7:16 a.m., R74 stated she could use the call light in her bathroom by "pressing the button." When asked if the cord could be used to turn on the call light, R74 said "Look at it, it's so short. I can't."

R58's annual MDS, dated 2/21/2014, identified R58 was mildly, cognitively impaired. The MDS also identified that R58 required extensive assistance with toileting.

During an interview on 4/7/2014 at 5:30 p.m., R58 stated that she was "supposed" to call for help when going to the bathroom, but admitted that she "has gone there myself." When asked if she used the call light when in the bathroom, R58 stated "Yes, I have."

During an interview on 4/10/2014 at 10:41 a.m., nursing assistant (NA)-B stated that R58 and R98 both required assistance with toileting, and also, that each resident "can and does" use the light to call for help. NA-B also verified that R74, R155, R26, R188 and R39 were independent with toileting. NA-B said that "all of those residents" know when and how to use their call lights.

During an interview on 4/10/2014 at 11:00 a.m., the director of environmental services (DES)

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stated he has been at the facility only since "the end of March", and was unaware of any routine audits of the call light system. The DES stated the affected call boxes "were adjusted", new pull cords were installed, and the lights were now functioning properly. The DES also said call lights should be able to be activated by both "pressing the button and pulling the cords." The DES stated there "should be a check" in place, and said he took it upon himself to make sure "maintenance" would be in charge of testing call lights in the future.

During an interview on 4/10/2104 at 11:44 a.m., registered nurse (RN)-B stated that the call lights needed to be accessible and work properly. RN-B said functioning call lights were "a matter of safety" for the residents.

The facility policy for "Call Light," dated 10/04, indicated under "Purpose": "To assure call system is in proper working order."