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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8MTW

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 **05/04/2015** (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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/04/2015 (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
Posted 05/07/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245432
May 4, 2015

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 April 17, 2015 the above facility is certified for or recommended 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.

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
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 4, 2015

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

RE: Project Number S5432024

Dear Ms. Sykes:

On March 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2015. 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 May 4, 2015, 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 March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2015, effective April 17, 2015 and therefore remedies outlined in our letter to you dated March 27, 2015, 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
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245432	A. Building B. Wing	5/4/2015

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 **04/17/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/17/2015**
ID Prefix **F0327** Reg. # **483.25(j)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/17/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/17/2015**
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	5/4/2015	10562	5/4/2015
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
3/12/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8MTW

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(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: **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 **03/12/2015** (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)

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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

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

17. SURVEYOR SIGNATURE Date :
Tim Rhonemus, HFE NE II 04/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/23/2015 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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
Posted 04/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 27, 2015

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

RE: Project Number S5432024

Dear Ms. Sykes:

On March 12, 2015, 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 April 21, 2015, 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 June 12, 2015 (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 September 12, 2015 (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
Health Regulation Division
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.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
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 _____	03/12/2015

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 document review, the facility failed to ensure repositioning and toileting assistance was provided as directed by the care plan for 1 of 1 resident (R60) care planned to require staff assistance for repositioning and incontinence checks. Findings include: R60's care plan for skin dated as revised on 7/3/13, identified, "I [R60] have the potential for alteration in skin integrity related to Decreased mobility, Incontinence. I have a history of fragile	F 282	A bowel and bladder evaluation and skin risk and Braden assessment were completed on R60. The toileting and repositioning plan on R60 reassessed and the care plan was reviewed and updated. The toileting and repositioning on all residents in house were reviewed and revised as necessary. The repositioning and toileting care plans on all residents in house were reviewed and revised as necessary.	4/17/15

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

Electronically Signed | 03/30/2015

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 _____	03/12/2015

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 skin and frequent bruising/skin tears." The care plan goal identified, "My skin will remain intact" and the care plan directed, "Please repositioning [sic] me every 3 hours and PRN [as needed] and every 4 hours when asleep." R60's care plan for incontinence dated as revised on 5/12/14, identified, "I [R60] have functional bladder/bowel incontinence r/t [related to] Dementia, Impaired Mobility. My level of incontinence of bowel and bladder can fluctuate. The goal indicated, "I will remain free from skin breakdown due to incontinence and brief use through the review date." The care plan directed, "INCONTINENT: Check me 3 hours and as required for incontinence when awake, and every 4 hours and PRN [as needed] when asleep. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered offloading (repositioning assistance) for three hours and thirty-two minutes. At 7:39 a.m. R60 was laying in bed, a nursing assistant (NA)-A assisted R60 with perineal care and grooming. R60 was then transferred from the bed to the wheelchair at 7:45 a.m. with total assistance provided by NA-A, NA-B and a mechanical lift. R60 remained in her wheelchair, went to breakfast and finished breakfast at 8:01 a.m. She was then brought to the television/common room where she remained until 11:05 a.m. At 11:22 a.m. three hours and thirty-two minutes since she was last toileted or repositioned. NA-C and NA-A assisted R60 to offload, and verified R60 was incontinent and her skin was intact. Both NA-C and NA-A verified R60's care plan directed to reposition and check R60 for incontinence every	F 282	The policy and procedure was reviewed and is current. Education on following residents' plan of care will be completed with staff responsible for direct resident care by 4-10-15. The facility will monitor and sustain correction by completing care plan and observation audits on 5% of residents weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 4-17-15	

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 _____	03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES WEST	135 FERN STREET NORTH CAMBRIDGE, MN 55008

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F 282	Continued From page 2 three hours while up in the wheelchair. During interview at 11:31 a.m. registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been checked for incontinence and offered repositioning assistance every three hours while in the wheelchair. RN-C stated staff should have notified her of falling behind and did not. On 3/11/15, at 1:30 p.m. when asked about the incontinence and repositioning plans for R60, RN-B stated R60 should have been offered incontinence checks and repositioning as directed by the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be offered incontinence checks and repositioned as determined by assessment and directed by the care plan. The Presbyterian Homes And Services Repositioning of Resident policy and procedure dated as modified last on 6/2003, identified the purpose of the policy was to ensure timely repositioning as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning needs should be identified on the care plan and the nursing assistant care guide (Assignment Group sheet). The policy further directed, "Nursing will reposition resident per their plan of care and as needed or requested."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		4/17/15

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F 314	Continued From page 3 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 randomly observed residents (R60) was provided timely repositioning assistance to prevent the development of potential pressure ulcers; R60 was not offered or provided repositioning for three hours and thirty-two minutes. Findings include: R60's care plan for skin dated as revised on 7/3/13, identified, "I [R60] have the potential for alteration in skin integrity related to Decreased mobility, Incontinence. I have a history of fragile skin and frequent bruising/skin tears." The care plan goal identified, "My skin will remain intact" and the care plan directed to use a pressure reducing cushion in the wheelchair and directed, "Please repositioning me every 3 hours and PRN [as needed] and every 4 hours when asleep. R60's quarterly Minimum Data Set (MDS) dated 1/23/15, identified R60 had severe cognitive impairment, physical behaviors occurred four to six days (but no less than daily), verbal behavior and other behaviors (such as but not limited to hit, scratched self, or disruptive sounds) occurred	F 314	R60's skin continues to be free of breakdown. A skin risk and Braden assessment was completed on R60. The repositioning plan on R60 was reassessed and the care plan reviewed and updated. The skin risk and repositioning 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 with staff responsible for assisting residents with repositioning needs by 4-10-15 The facility will monitor and sustain correction by completing repositioning audits on 5% of residents weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance.	

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F 314	Continued From page 4 one to three days. The MDS identified R60 required extensive assistance with bed mobility, transferring, dressing, personal hygiene, eating and toilet use; R60 did not walk and required total assistance for locomotion on and off the unit. R60 was always incontinent of urine and frequently incontinent of bowel. R60 had no pressure ulcers. The Care Area Assessment (CAA) for pressure ulcers dated 5/12/14, indicated, "Resident is at risk for skin breakdown. Does need assistance for bed mobility. Resident is incontinent of bowel and bladder. Staff repositions resident per schedule along with toileting. No current areas of concern." A copy of the CAA summary was requested, but not provided. The quarterly Skin Risk and Braden Assessment dated 1/19/15, identified R60 was at "high risk for skin alteration," was totally incontinent of bladder, frequently incontinent of bowel and wore an incontinence brief. The assessment identified R60 was "toileted and repositioned every 3 hours when up and every 4 hours when in bed as tissue tolerates." The Admission Record dated 3/11/15, identified R60's diagnoses to include senile dementia, muscle wasting and congestive heart failure. On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered offloading (repositioning assistance) for three hours and thirty-two minutes. Observations were as follows: - At 7:39 a.m. R60 was observed to be laying in bed, a nursing assistant (NA)-A was observed to assist R60 with perineal care and grooming. R60 was then transferred from the bed to the	F 314	Correction date for certification: 4-17-15	

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F 314	Continued From page 5	F 314		

wheelchair at 7:45 a.m. with total assistance provided by NA-A and NA-B and a mechanical lift.
- From 7:45 a.m. until 8:01 a.m. NA-A assisted R60 with grooming in the wheelchair.
- At 8:01 a.m. NA-A transported R60 to the television (TV)/common sitting area directly in front of the nursing station desk. Music was playing from a radio in the area.
- From 8:01 a.m. until 8:24 a.m. R60 remained seated in the wheelchair in the TV area.
- At 8:24 a.m. the health unit coordinator (HUC)-A was observed to transport R60 into the dining area and to a table. HUC-A offered R60 a clothing protector and assisted her to apply it. The supply manager (SM) sat directly to the left of R60 and another table mate.
- From 8:24 a.m. to 9:08 a.m. R60 remained in the dining area at the dining table and was provided total assistance to eat and drink.
- At 9:08 a.m. R60 was transported out of the dining room by SM and to the TV area. SM left the unit and R60 remained in the TV area.
- At 9:16 a.m. NA-B verified she was recording the dietary and fluid intakes for the breakfast meal. NA-B stated R60 consumed 0-25% of the meal and verified R60 only ate "bites" of the foods. NA-B stated R60 consumed 20 cc (cubic centimeters) of fluids.
- At 9:20 a.m. the clinical manager/registered nurse (RN)-B moved R60 a few feet closer to the radio and window in the TV/common area. RN-B changed the music to Christian rock then left the area.
- From 9:20 a.m. until 9:45 a.m. R60 remained in the TV area with no position change or offloading offered (two hours since offloaded and transferred from the bed to the wheelchair).
Various facility staff, including NA-A, NA-B and RN-B were observed to be in and out of the

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F 314	Continued From page 6	F 314		

TV/common area, assisting other residents.
- From 9:45 a.m. to 10:29 a.m. R60 remained unmoved. At 10:05 a.m. RN-B turned off the music and started an "I Love Lucy" movie on the television. R60 faced out the window and not the TV.
- At 10:29 a.m. NA-B moved R60 away from the window and faced her towards the I Love Lucy program. R60's eyes were open and looking at the TV.
- From 10:29 a.m. until 11:00 a.m. R60 remained in the TV area. R60's eyes had closed during the program.
- At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV area, placed it under the TV and stated to the residents there would be an exercise activity and then cookie baking.
- At 11:05 a.m. R60 remained unchanged in wheelchair positioning (three hours and 20 minutes since last offload during transfer from bed to wheelchair at 7:45 a.m.).
- At 11:09 a.m. NA-A was asked when R60 was supposed to be offloaded. NA-A removed an undated Assignment Group sheet (a form used to reference resident care needs) and stated R60's repositioning and times were "every three hours" while up in the chair and every "four hours" while in bed. When asked regarding the last time R60 was repositioned, NA-A stated she was unclear when last repositioned, but then stated, "She's next on my list." When asked how repositioning times were tracked, NA-A stated the times of repositioning were documented in the "Tub room." NA-A stated she would get assistance and reposition R60. Repositioning times were noted to be written on an unnamed form in the unit tub room. The form directed, "Please write time toileted, if dry or wet, incontinent or requested,

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and BM's [bowel movements] incontinent or requested *Bold times are for when resident is in bed, unbolded is for when resident is in chair." The form had the times of "610 [6:10 a.m.] and 800 [8:00 a.m.].
- At 11:15 NA-C and NA-A verified they had both recorded times down on the tub room form. NA-C stated she "only checked on" R60 at 6:10 a.m. and no offloading was provided. NA-A verified the 8:00 a.m. time did not match the surveyor observed time of the 7:45 a.m. offload. NA-A stated she had to directly assist another resident at the time of the offload and "guesstimated" the time of R60's offload was 8:00 a.m. R60 was transported to her room.
- At 11:22 a.m. NA-C and NA-A offloaded pressure and stood R60 in the stand lift (three hours and thirty-two minutes). R60 was observed to be incontinent of a small amount of urine. NA-C removed the soiled pad and performed perineal care. R60's skin was observed to be intact. Both NA staff verified they did not report running late with repositioning.
- At 11:31 a.m. when asked regarding the repositioning for R60, the registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been repositioned every three hours while in the wheelchair. RN-C stated she "checks the sheets" and will "intervene" if she noticed a resident was going over the assessed time for repositioning. RN-C stated staff should be writing down the actual times of the off load and verified a fifteen minute time difference was "too much" of a difference. RN-C stated staff should have notified her of falling behind and did not.

On 3/11/15, at 1:30 p.m. when asked about the repositioning plan for R60, RN-B stated R60 was

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F 314	Continued From page 8 assessed to be offloaded every three hours while in the wheelchair and four hours in bed. RN-B explained R60's tissue perfusion was checked by staff during the assessment, no redness was noted at three hours and that was how the three hour time frame was determined. RN-B stated staff should record accurate times of the repositioning "as close as possible" and "notify the nurse" if repositioning was "falling behind." RN-B then stated, "The nurse should then help." RN-B verified R60 should have been repositioned as directed by the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be repositioned as determined by assessment and directed by the care plan. DON stated staff should document the correct time of repositioning to ensure the care plan was followed and verified the staff should have notified the nurse when falling behind with repositioning. The Presbyterian Homes And Services Repositioning of Resident policy and procedure dated as modified last on 6/2003, identified the purpose of the policy was to ensure timely repositioning as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning needs should be identified on the care plan and the nursing assistant care guide (Assignment Group sheet). The policy further directed, "Nursing will reposition resident per their plan of care and as needed or requested."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		4/17/15

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F 315	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an incontinence check was provided to 1 of 1 resident (R60) randomly observed in the sample and dependent upon staff for incontinence cares and assistance; R60 was not checked for incontinence for three hours and thirty-two minutes. Findings include: R60's quarterly Minimum Data Set (MDS) dated 1/23/15, identified R60 had severe cognitive impairment, physical behaviors occurred four to six days (but no less than daily), verbal behavior and other behaviors (such as but not limited to hit, scratched self, or disruptive sounds) occurred one to three days. The MDS identified R60 required extensive assistance with bed mobility, transferring, dressing, personal hygiene, eating and toilet use; R60 did not walk and required total assistance for locomotion on and off the unit. R60 was always incontinent of urine and frequently incontinent of bowel. The Bowel and Bladder Quarterly Review dated	F 315	A bowel and bladder evaluation was completed on R60. The toileting plan on R60 was reassessed and the care plan reviewed and updated. The toileting 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 with staff responsible for toileting residents by 4-10-15 The facility will monitor and sustain correction by completing toileting audits on 5% of residents weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 4-17-15	

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F 315	Continued From page 10	F 315		

1/19/15, indicated, "Resident remains functionally incontinent of bowel and bladder r/t [related to] dx. [diagnosis] of dementia. Level of continence does fluctuate. Resident was totally incontinent of bladder, frequently incontinent of bowel. Wears incontinent brief. Is toileted by staff utilizing sabina [a type of mechanical lift] every 3 hours and PRN [as needed] when up and every 4 hours and PRN when in bed. Utilized sabina for transfers to toilet. Will continue with current regimen." The assessment contradicted the care plan.

R60's care plan dated as revised on 5/12/14, identified, "I have functional bladder/bowel incontinence r/t [related to] Dementia, Impaired Mobility. My level of incontinence of bowel and bladder can fluctuate. The goal indicated, "I will remain free from skin breakdown due to incontinence and brief use through the review date." The care plan directed, "INCONTINENT: Check me 3 hours and as required for incontinence when awake, and every 4 hours and PRN [as needed] when asleep. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.

On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered an incontinence check for three hours and thirty-two minutes. Observations were as follows:
- At 7:39 a.m. R60 was observed to be laying in bed, a nursing assistant (NA)-A was observed to assist R60 with perineal care and grooming. NA-A verified R60 was incontinent of urine and bowel at the time. After completion of perineal cares and application of clean incontinence brief, R60 was then transferred from the bed to the wheelchair at 7:45 a.m. with total assistance provided by two

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F 315	Continued From page 11	F 315		

staff (NA-A and NA-B) and a mechanical lift.
- From 7:45 a.m. until 8:01 a.m. NA-A assisted R60 with grooming in the wheelchair.
- At 8:01 a.m. NA-A transported R60 to the television (TV)/common sitting area directly in front of the nursing station desk. Music was playing from a radio in the area.
- From 8:01 a.m. until 8:24 a.m. R60 remained seated in the wheelchair in the TV area.
- At 8:24 a.m. the health unit coordinator (HUC)-A transported R60 into the dining area and to a table. HUC-A offered R60 a clothing protector and assisted her to apply it. The supply manager (SM) sat directly to the left of R60 and another table mate.
- From 8:24 a.m. to 9:08 a.m. R60 remained in the dining area at the dining table and was provided total assistance to eat and drink.
- At 9:08 a.m. R60 was transported out of the dining room by SM and to the TV area. SM left the unit and R60 remained in the TV area. SM did not offer or provide assistance with toileting.
- At 9:20 a.m. the clinical manager/registered nurse (RN)-B moved R60 a few feet closer to the radio and window in the TV/common area. RN-B changed the music to Christian rock then left the area.
- From 9:20 a.m. until 9:45 a.m. R60 remained in the TV area and was not offered any incontinence checks (two hours since last incontinence check and transfer to wheelchair at 7:45 a.m.). Various facility staff, including NA-A, NA-B and RN-B were observed to be in and out of the TV/common area, assisting other residents. There was no one that offered or assisted R60 with incontinence checks or toileting during this time.
- From 9:45 a.m. to 10:29 a.m. R60 remained unmoved or approached by staff. At 10:05 a.m.

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

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F 315	Continued From page 12 RN-B turned off the music and started an "I Love Lucy" movie on the television. R60 faced out the window and not the TV. - At 10:29 a.m. NA-B moved R60 away from the window and faced her towards the I Love Lucy program. R60's eyes were open and looking at the TV. - From 10:29 a.m. until 11:00 a.m. R60 remained in the TV area. R60's eyes had closed during the program. - At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV area, placed it under the TV and stated to the residents there would be an exercise activity and then cookie baking. - At 11:05 a.m. remained unchanged in wheelchair positioning and was not offered assistance with toileting (Three- hours and 20 minutes since last incontinence check and transfer to the wheelchair at 7:45 a.m.). - At 11:09 a.m. NA-A was asked when R60 was to be checked for incontinence. NA-A removed an undated Assignment Group sheet (a form used to reference resident care needs) and stated R60's incontinence check times were "every three hours" while up in the chair and every "four hours" while in bed. Although the form indicated "Toilet use," NA-A verified R60 should have been offered a check only. When asked regarding the last time R60 was checked for incontinence, NA-A stated she was unclear, but then stated, "She's next on my list." When asked how incontinence checks were tracked, NA-A stated the times of incontinence checks were documented in the "Tub room." NA-A stated she would get assistance and check R60 for incontinence. Review of the facility repositioning/incontinence check times were noted to be written on an unnamed form in the unit tub room for R60. The	F 315		

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form directed, "Please write time toileted, if dry or wet, incontinent or requested, and BM's [bowel movements] incontinent or requested *Bold times are for when resident is in bed, unbolded is for when resident is in chair." The form had the times of "610 [6:10 a.m.] and 800 [8:00 a.m.] documented for R60.
- At 11:15 NA-C and NA-A verified they had both recorded times down on the tub room form. NA-C stated she "only checked on" R60 at 6:10 a.m. and verified the 8:00 a.m. time did not match the surveyor observed time of the 7:45 a.m. perineal care/offload. NA-A stated she had to directly assist another resident at the time of the perineal care/offload and "guesstimated" the time of R60's incontinence check was 8:00 a.m. R60 was transported to her room.
- At 11:22 a.m. NA-C and NA-A stood R60 in the stand lift (three hours and thirty-two minutes between incontinence checks). R60 was incontinent of a small amount of dark, strong smelling urine. NA-C removed the soiled pad and performed perineal care. Both NA staff verified they did not report running late with incontinence checks. Both NA staff verified R60 was only checked for incontinence and not toileted.
- At 11:31 a.m. when asked regarding the incontinence checks for R60, the registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been "checked" for incontinence every three hours while in the wheelchair. RN-C stated she "checks the sheets" and will "intervene" if she noticed a resident was going over the assessed time for incontinence checks. RN-C stated staff should be writing down the actual times of the check and verified a fifteen minute time difference was "too much" of a difference. RN-C stated staff should have notified her of falling behind and did not.

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F 315	Continued From page 14 On 3/11/15, at 1:30 p.m. when asked about the toileting plan for R60, RN-B stated R60 was to be checked every three hours while in the wheelchair and four hours in bed for incontinence. RN-B stated staff should record accurate times of the incontinence checks "as close as possible" and "notify the nurse" if toileting or incontinence checks were "falling behind." RN-B then stated, "The nurse should then help." RN-B verified R60 should have been provided incontinence checks as directed by the care plan. RN-B was unclear why the assessment differed from the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be provided incontinence checks as determined by assessment and directed by the care plan. DON stated staff should document the correct time of incontinence checks to ensure the care plan was followed and verified the staff should have notified the nurse when falling behind with toileting or incontinence checks. DON verified the care plan should match the assessment. Review of the facility Presbyterian Homes and Services Toileting of Residents policy and procedure dated as last modified on 6/2003, identified the purpose of the policy was to "insure timely toileting as identified in the resident's care plan." The policy directed, "6. Residents will be assisted with their toileting needs and at intervals specified on the resident care plan."	F 315		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	F 327		4/17/15

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F 327	Continued From page 15 and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure symptoms of potential dehydration were identified and reassessed for 1 of 1 resident (R60) in the sample reviewed for hydration. Findings include: R60's Physician Orders for Life Sustaining Treatment (POLST) form dated as signed on 10/21/08, with hand written update dated 2/22/12, identified R60 requested comfort care only, no hospitalization, no antibiotics and directed no labs to be drawn. The POLST form for hydration directed, "Always offer food and liquids by mouth if feasible." and directed "No artificial nutrition [tube feeding]" and "No IV [intravenous] fluids." The annual Minimum Data Set (MDS) dated 5/9/14, identified R60's weight was 143, height 61 inches, identified no eating concerns, and no weight loss or gain; the MDS identified R60 received a mechanically altered diet/liquid consistency. The Care Area Assessment (CAA) for Nutrition dated 5/12/14, indicated, "Res [resident] requires use of soft diet with thickened liquids d/t [due to] chewing and swallowing difficulty. Res has had general weight gain in past 180 days (not sig [significant]). Res meeting estimated needs from meals, supplements and snacks." The CAA for Dehydration/Fluid Maintenance did not trigger. Although a copy of the Nutritional CAA summary was requested, it was not provided.	F 327	A hydration assessment was completed on R60. The hydration care plan on R60 was reviewed and updated. The hydration 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 with staff responsible for assisting residents with hydration needs by 4-10-15. The facility will monitor and sustain correction by completing hydration audits on 5% of residents weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 4-17-15	

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F 327	Continued From page 16 R60's care plan dated as revised on 8/8/12, identified, "I have dehydration or potential fluid deficit r/t [related to] Dementia with behavioral disturbances" with the goal, "I will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor." The care plan directed, "Encourage me to drink fluids of choice and offer fluids throughout the day and at mealtimes/snacks;" and further directed, "Observe for and report to MD [medical doctor] as needed s/sx [signs and symptoms] of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes." Although the POLST form identified no laboratory work would be completed on R60, the care plan directed, "Obtain and monitor lab/diagnostic work as ordered. Report results to MD [medical doctor] and follow up as indicated." The Nutritional Assessment dated 1/18/15, identified current supplement/snack orders of "Water Pass, 80 cc [cubic centimeters] 2+ [a high protein dietary supplement] tid [three times daily]" and identified R60 accepted the supplement. The Comments- Food/Fluid Intake section indicated, "There has been a decline in food and fluid intake in past 90 days d/t illness. Res provided with spout cups and coated spoons at meals." The "Reviewed nursing hydration risk assessment" was not checked either yes or no. The Comments-Hydration indicated, "Fluids provided with med [mediation] pass as ordered, supplements and at the bedside." The	F 327		

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assessment identified R60 required total to partial assistance to eat/drink and identified the fluid intake to be between "30-400 cc." The Assessment Summary identified R60 did not understand the diet order, "Current diet remains warranted d/t difficulty chewing/swallowing regular consistency foods and fluids." The Summary further identified, "Current weight 139.8# [pounds] which shows a loss of 5.5% in 30 days (sig) [significant] and 7.5% in 180 days. Res has had recent illness and appetite has not improved....Res is also provided with water pass for additional fluids. Spoke with NP [nurse practitioner] and agrees with POC [plan of care]. Message left with NP re: [regarding] weight changes and update interventions. NP questions if intake will improve d/t illness. Will follow high risk d/t weight changes. CP [care plan] reviewed." R60's estimated fluid needs were identified as "25-28 cc/kg" which was approximately 1590-1781 cc of fluid. The assessment did not clearly identify how much R60's fluid needs were in 24 hours.

The Hydration Assessment dated 1/19/15, identified R60 had diagnoses of dementia, Alzheimer's disease, and had swallowing problems. "No current dx [diagnosis] of dehydration, no fever/vomiting/diarrhea." The assessment did not identify physical symptoms of dehydration. The assessment identified Average daily intake of fluids with meals was "700 (Amount in ml's [milliliters]" and average daily intake of fluids between meals was 500 ml. The assessment identified R60 was "At potential risk for dehydration."
- The Comments Assessment/Plan/Referrals section indicated, "Resident is potentially at risk for dehydration r/t [related to] dx. [diagnosis] of

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dementia and inability to recognize thirst needs. Is currently on nectar thick fluids. Does have hx. [history] of constipation and is on laxative for management. Resident is on additional water pass and supplement throughout day between meals. Is encouraged to drink fluids with meals and med passes. No current signs of dehydration. Focus is on comfort. Will continue with current plan of care."

The GracePointe Crossing Gables West Order Summary Report dated as signed by the physician on 2/4/15, directed to offer nectar thick consistency liquids and "encourage fluids" beginning 1/13/15; offer 120 cc Med Plus 2.0 (a high protein, high calorie dietary supplement) four times a day, which was 480cc per day if she consumed 100% of the supplement.

On 3/10/15, at approximately 1:00 p.m. the administrator reported there were problems with a "fan" and the City View 2 unit temperature was going to be warmer than usual. The administrator verified fluids were being offered to the residents of the unit in that time.
- At approximately 2:00 p.m. R60 was observed to be seated in a wheelchair in the television (TV)/common area during a scheduled activity, regular consistency fluids were observed to be passed out and offered to the other residents attending the activity and seated in the area. Although R60 was seated directly in front of the activity staff (AS), R60 did not have any fluids offered to her during the activity. R60 skin was pale in color, with dry lips. Her mouth was open, and her eyes were closed. R60's arms were covered with derma savers (a protective sleeve worn to prevent injury to skin).
- At 2:25 p.m. R60 was observed to be in the

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church activity in the same area directly in front of the nursing station desk. R60's mouth was observed to be open during the church activity, with her eyes closed. R60's lips were chapped and dry; R60's tongue was dark red colored and dry; her tongue appeared very rough textured, very bumpy, leathery in appearance, and heavily cracked with deep furrows. R60's gums appeared slightly red and dry. R60 did not rouse or respond to voice at the time of the observation. Although the approximately 17-20 observed residents in the area were all offered fluids and provided assistance to drink the fluids, R60 had no fluids nor was any assistance to drink was offered to her.

On 3/11/15, during continuous observations from 7:39 a.m. until the end of observations at 11:22 a.m. R60 was not offered the opportunity to drink fluids to prevent potential dehydration between medication passes and scheduled meals. R60 was only offered fluids by the nurse during a scheduled fluid/supplement pass, during the medication pass and during an observed meal. Observations were as follows:
- At 7:39 a.m. a nursing assistant (NA)-A was observed to assist R60 with incontinence cares while in bed. Two empty clear plastic glasses, one with a spout for drinking, were observed stacked on the bedside table. The glasses appeared to be soiled.
- At 7:41 a.m. NA-B entered the room with a mechanical lift and R60 was transferred to the wheelchair at 7:45 a.m. by both NA-A and NA-B. NA-B left the room. NA-A stated she did not "usually work" in "this building" and when she did she "usually worked downstairs."
- At 7:52 a.m. NA-A was asked what cares she provided prior to the surveyor entering the room,

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F 327	Continued From page 20 NA-A stated R60's mouth was swabbed with a green toothette which was moistened with tap water. NA-A stated R60 "does not follow direction and can't spit" and stated R60 received nectar consistency liquids. NA-A stated she squeezed out the access water from the sponge. When asked regarding the empty plastic glasses in the room, NA-A stated the glasses were not provided by her and were both empty when she entered the room at approximately 7:00 a.m. NA-A verified no nectar consistency fluids were available to offer R60 in the room. - At 8:01 a.m. NA-A transported R60 to the common area. At no time during the observations was R60 offered the opportunity to drink fluids. - At 8:16 a.m. NA-A was asked if any fluids were offered to R60 by NA-A prior to 7:39 a.m., NA-A stated she did not offer R60 anything to drink while doing cares in the room. NA stated "her water was empty" and the "water pass" had just occurred "now." NA-A pointed to a staff person distributing water to resident rooms on the unit. - At 8:18 a.m. R60 remained in her wheelchair in the common area, Music playing on a radio. R60's eyes were open and looking out the window. - At 8:24 a.m. R60 was transported into the dining area by the health unit coordinator (HUC)-A and wheeled to a table. HUC-A offered a clothing protector and assisted with applying it. No fluids were observed at the table. The supply management (SM) staff sat to the left of R60 and next to another resident at the table. A dietary staff wheeled a cart with various fluids to R60, discussed with SM R60's fluid consistency and poured nectar consistency orange juice (OJ) from a carton. Staff immediately offered the OJ to R60 and held the glass for the resident. R60 drank sips without difficulty. SM stated, "You're thirsty	F 327		

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this morning huh?" A nectar consistency glass of water was poured and offered, R60 drank sips. A nectar consistency milk was also poured but not offered to R60.
- From 8:24 a.m. until 9:08 a.m. R60 remained in the dining area for the breakfast meal. SM remained with R60 and alternated between offering various fluids and bites of pureed foods to R60. R60 was observed to take small sips, did not resist the offered fluids and had no observed coughing or swallowing concerns.
- At 9:08 a.m. R60 was wheeled out of the room to TV/common area by SM. SM immediately left the unit. R60's mouth was observed to be open while seated in the common area. Immediately after drinking sips of fluids from the meal, R60's lips appeared pink, less dry and supple; R60's tongue remained slightly dry, appeared dark pink colored; R60's tongue remained leathery in appearance, heavily cracked, and furrowed.
- At 9:16 a.m. NA-B stated she was in the process of recording the dietary and fluid intakes for the observed meal. NA-B reviewed R60's plate and glasses of remaining fluids. NA-B stated R60 consumed 20 cc (cubic centimeters) of fluids and 0-25% (bites) of solids. NA-B verified the fluid amount consumed by R60 was "low."
- From 9:16 a.m. until 11:00 a.m. R60 remained in the TV/common area listening to the radio, watching "I Love Lucy" in the wheelchair. Although various staff, including NA-A, NA-B and the clinical manager/registered nurse (RN)-B and the registered nurse (RN)-C were in and out of the area to change music, turn on the TV, R60 was only moved in the wheelchair a few feet towards and away from the window. At no time were fluids offered to R60.
- At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV/common area,

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F 327	Continued From page 22 placed the chair under the TV, and turned off the I Love Lucy program. AS spoke to the residents and stated there would be an exercise activity and then cookie baking. - From 11:03 a.m. until 11:20 a.m. R60 remained in the TV/common area, no fluids were observed to be offered during the continuous observations. - At 11:20 a.m. NA-A and NA-C were notified by the surveyor R60 had not been repositioned or offered incontinence checks for three hours and thirty-two minutes. R60 was transported to her room. While preparing to check R60 for incontinence, NA-A and NA-C verified they did not offer fluids to R60 during the day. NA-C stated "the nurse offers" supplements in between meals. NA-C stated fluids were "never" offered. When asked when fluids should be offered to R60, NA-C stated, "If she's thirsty, we offer." When asked how staff know R60 is thirsty, NA-C stated R60 "doesn't verbally talk" and described R60 "will get anxious, grab at people" when thirsty. NA-C verified the same behavior could also be attributed to pain or hunger. Neither NA staff were clear when fluids should have been offered to R60. - At 11:22 a.m. R60 was lifted in the stand lift and her incontinence brief was removed. The brief was observed to be wet with a small amount of dark colored, concentrated urine; the urine was strong smelling. When asked if they noted R60's urine was strong smelling or dark colored, NA-C denied the urine was strong smelling. At the time of the observation, a full glass of thickened water with a spout top was observed to be on the bedside stand. R60 was wheeled back to the TV/common area immediately after perineal care was completed. Although both staff verified the glass of water at the bedside was the correct nectar consistency and intended for R60 to drink,	F 327		

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F 327	Continued From page 23 no fluids were offered by the NA staff before or after offloading/incontinence check was provided. On 3/11/15, at 11:31 a.m. RN-C stated she gave R60 120 cc of water, plus 120 cc of supplement twice on her shift. RN-C stated she usually offered the water and supplement "Right away in the morning." When asked if offered and consumed this morning, RN-C referred to the Medication Administration Record (MAR) in the Electronic Medical Record. RN-C stated R60 drank "everything" offered that morning and it was a total of "240 cc." When asked when the fluids were offered, RN-C stated she gave both with medications between 6:30 a.m. - 7:00 a.m. RN-C verified she offered R60 no other fluids after 7:00 a.m. (on 3/11/15). When asked if she was notified of R60's potential symptoms of dehydration, RN-C stated she was not. RN-C stated she had not assessed R60 for dehydration. When asked what symptoms of dehydration she would assess for and expected to be reported, RN-C stated she "looks for tenting [a test used to determine skin turgor, a sign used to assess fluid loss or potential dehydration]." RN-C then stated she "focuses on what [R60's] drinking as an indicator of potential dehydration." RN-C confirmed she was not aware R60 only consumed 20 cc at the breakfast meal. At the time of the interview, RN-C observed R60 with the surveyor present. RN-C checked R60's skin by lifting it slightly with forefinger and thumb on the back of R60's left arm and stated R60's tenting was "poor," then immediately stated "all residents" had problems with "tenting." RN-C then rubbed R60's left arm (where she had lifted the skin) and stated "see it's fine" (Decreased skin turgor is a late sign in dehydration) When asked if R60's tongue appeared dry and furrowed, RN-C appeared to	F 327		

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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 327	Continued From page 24	F 327		

look into R60's mouth quickly, but did not comment.
- At 1:28 p.m. RN-C stated staff should have offered fluids to R60 throughout the day.

Review of the MARs from December 2014 through March 2015, indicated the nurse offered R60 120 cc of water and 120 cc of supplement three times daily. The MARs for December 2014 and January 2015 did not include the amount of water or supplement consumed by R60 until 1/13/15. Beginning on 1/13/15, the consumed amounts of water and supplement offered by the nurse where documented on the MAR. Although the MAR indicated R60 usually consumed the full 120 cc amount, R60's fluid intakes were variable with a noted decrease in amount of fluid consumed beginning on 3/9/15:
- on 3/9/15, the MAR indicated R60 consumed 240 cc of water and 480 cc of supplement (total of 720 cc of fluids from nurse);
- on 3/10/15 (when R60 was first observed), the MAR indicated R60 consumed 270 cc of water and 480 cc of supplement (total of 750 cc of fluids from nurse);
- on 3/11/14, the MAR indicated R60 consumed 240 cc of fluids and 270 cc of supplement (total of 510 cc of fluids from nurse between breakfast and before supper).

Review of the GracePointe Crossing Gables West Follow Up Question Report from 12/1/14, through 3/11/15, included a report of "Fluid Taken with Meals in ml [equal to cc]." The report identified R60's fluid intakes were variable.
- on 3/9/15, R60 refused fluids at breakfast and supper, R60 consumed 25 ml of fluids at lunch (total of 25 ml from meals);
- on 3/10/15 (the day R60 was first observed),

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F 327	Continued From page 25 R60 consumed "0" fluids at breakfast and lunch, R60 consumed 50 ml of fluids at supper (total of 50 ml from meals); - on 3/11/15, R60 consumed 20 ml at breakfast and 120 ml at lunch (total of 140 ml from meals). R60's intake records indicated the following 24-hour fluid intake totals: - on 3/9/15, total of 745 cc/ml of fluids; - on 3/10/15, total of 800 cc/ml of fluids; - on 3/11/15, R60 consumed only 530 cc/ml of fluids up to lunch. R60's clinical record did not reflect adequate fluid intake to prevent potential dehydration. On 3/11/15, at 1:30 p.m. when asked about R60's fluid intake, RN-B stated extra water passes were scheduled in the MAR. RN-B stated R60 was observed for "anxiety issues" as an indicator for being thirsty; RN-B stated if R60 "seems dry in her mouth" it was another potential indicator of thirst. RN-B stated staff should offer fluids with cares and verified staff should have offered fluids during the observations. RN-B further explained she "knew" the staff offered fluids as she saw them "daily." RN-B explained R60 was difficult to get to drink, explained she should be offered fluids if she "was thirsty" and stated staff looked for "anxiety" as a means of communication for pain, hunger or thirst. RN-B stated R60 was in the "end stages of Alzheimer's" and she would be "expected" to be "slightly dehydrated" during the dying process. When asked if R60 was actively dying, RN-B stated R60 was not actively dying, but stated the family and facility's focus was on "comfort." Although RN-B identified "anxiety" as an indicator for R60's thirst, RN-B was unclear on resident specific indicators of thirst for R60. RN-B was unclear how R60's water needs were	F 327		

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F 327	Continued From page 26 assessed and identified by facility staff. - At 1:57 p.m. RN-B and surveyor observed R60 in her room at the light of the room window. RN-B verified R60's tongue appeared furrowed. At the time of the observation, the glass of nectar consistency water at bedside remained full. RN-B verified she should have been notified of the furrowed tongue and stated fluids should have been offered to R60 throughout the day. On 3/11/15, at 2:25 p.m. the registered dietician (RD) stated R60's estimated needs for fluids and hydration were 1250 - 1350 cc/24 hours. When asked if she believed R60 was offered enough fluids to meet this goal, RD checked R60's fluid intakes in the Electronic Medical Record. RD verified R60's fluid intakes were "low" since 3/9/15. RD stated she "looked at" the fluid and dietary intakes on a quarterly or as needed basis. RD stated she was not alerted to any concerns with R60's fluid intakes. RD stated she expected fluids to be offered throughout the day. RD stated R60 required a new assessment for hydration needs; RD verified R60 was at higher risk for dehydration due to dependence on staff to obtain fluids and use of nectar consistency liquids. On 3/11/15, at 2:35 p.m. the director of nursing (DON) verified R60 should have offered fluids at other times during the day. DON stated the staff should have encouraged fluids when other residents were offered fluids. Review of a Geriatric Services of Minnesota Progress Notes dated 3/11/15, indicated R60 was assessed by the nurse practitioner (NP) for "Signs of Dehydration" (after surveyor alerted facility of R60's symptoms). Although the review identified R60's goals were for comfort and no	F 327		

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

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F 327	Continued From page 27	F 327		

heroic measures were identified for R60, the NP note directed "it is appropriate to offer fluids" and identified, "Labs are not indicated."

On 3/12/15, at 10:57 a.m. RD stated she assessed R60 for changes in hydration needs and discussed the findings with the family. RD stated after assessing R60's intakes she increased the fluids offered to R60 to 120 cc six times per day. RD stated R60's fluid needs were greater than the fluids received on 3/9/15, through 3/11/15.
- Review of the Progress Note provided by RD dated 3/11/15, written at 4:02 p.m. indicated R60's estimated fluid needs were 1500-1700 cc/actual body weight. The note indicated, "Staff report res [resident] has had a decline in intakes since breakfast meal 3/9/15, and identified fluid intake prior to be "100-400 cc fluids per meal." The note identified R60 was accepting 75-100% of the 120 cc supplement and 120 cc water pass three times daily which provided "820 cc fluids." The note indicated fluid intake would be requested to be increased to six times per day, "intake from water pass and supplement will provide 1080 cc. Staff will also offer fluids with cares. Will follow high risk d/t [due to] variable fluid intake and monitor need for further nutritional interventions."

Review of the Presbyterian Homes & Services Hydration Risk Policy dated as modified 2/2012, directed, "5) Fluids will be offered to the residents at the following times: During meals, Between meals, At med pass." The policy identified residents at higher risk may require more urgent notification and identified potential symptoms of dehydration to include: skin tenting, low urine output, concentrated urine, dry mucous

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F 327	Continued From page 28 membranes, mouth furrows (absence of moisture under the tongue moisture).	F 327		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		4/17/15

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F 441	Continued From page 29 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gloves were changed during incontinence cares after bowel and bladder incontinence, to prevent the potential spread of infection for 1 of 2 residents (R60) in the sample observed for perineal cares. Findings include: During observation on 3/11/15, at 7:39 a.m. surveyor knocked on R60's door, announced presence and was allowed admittance to R60's room. A nursing assistant (NA)-A was observed to be assisting R60. R60 was observed to be laying in bed, partially dressed with her pants down. NA-A stated she was "in the middle" of perineal cares. A soiled incontinence product remained under R60. NA-A stated R60 was incontinent of urine and "having a BM." NA-A rolled R60 to the right side, obtained an incontinence wipe and wiped from the front to back on R60's buttocks. NA-A then removed the soiled brief. Without changing gloves or performing hand hygiene, NA-A reached to the head of the bed, picked up a clean incontinence pad and placed it under R60. NA-A rolled R60 back onto the pad and applied the incontinence product. After the brief was applied, NA-A removed the gloves, and did not wash her hands. NA-B knocked on the door at 7:41 a.m., brought in a mechanical lift, both applied a lift sling under R60 and transferred her to the wheelchair at 7:45 a.m. No hand hygiene was observed.	F 441	The policy and procedure was reviewed and is current. Education on hand washing and peri-care will be completed with staff by 4-10-15 The facility will monitor and sustain correction by completing hand washing and peri-care audits on 5% of residents weekly for 2 months. The results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 4-17-15	

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F 441	Continued From page 30 On 3/11/15, at 7:52 a.m. NA-A verified she did not change gloves after wiping R60's stool and verified she contaminated the clean incontinence brief with the soiled gloves. NA-A confirmed she did not perform hand hygiene after removing the soiled gloves and should have. At 11:31 a.m. the registered nurse (RN)-C stated the gloves should have been removed and hand hygiene completed before handling the clean incontinence brief. On 3/11/15 at 12:20 p.m. the director of nursing (DON) verified gloves should have been changed and hand hygiene completed after the perineal area was cleaned and the soiled brief was removed; before the clean brief applied. Review of the Presbyterian Homes and Services Perineal Care policy and procedure dated as last modified on 4/2010, directed after placing the soiled brief in bag to "21. Remove gloves, and wash hands or use waterless hand sanitizer."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the building was kept in good repair and maintained for 4 of 5 nursing units, City View 1 (CV1), City View 2 (CV2), River View 1 (RV1), and River View 2	F 465	All water stains, wall paper tears, cracked ceiling tiles, gouged walls, and chipped paint throughout the Gables West building have been repaired and/or replaced. All ceiling lights have been dismantled and	4/17/15

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F 465	Continued From page 31 (RV2), which had the potential to affect approximately 78 residents who resided on these units. Findings include: During the environmental tour with administrator (Adm) and environmental services director (ESD) on 3/11/15, at 11:50 a.m. was completed with the following areas identified: Water Stains on the Ceiling: The River View 2 (RV2) dining room, there was an approximate 12 inch size brown and yellow colored stain on the ceiling tile. There was a large crack in the ceiling above the food service area, and the wallpaper was peeling near dining room windows which was approximately 8 inches in length. City View 2 (CV2) common area had an approximate 12 inch brown stain on the ceiling and yellow colored stain above window. The area had approximately 6 inch brown and yellow color stained ceiling tiles located above nurses' station. City View 1 (CV1) dining room had an approximate 6 inch size brown and yellow colored stain in hallway above tub and shower room. CV1 had two brown and yellow colored stains (approximately 12 inch) in hallway outside the first floor main dining room. RV1 had a cracked ceiling tile (approximately six inches) in the hallway, near the nurses' station. There were large brown and yellow colored stain (approximately 12 inches) outside of room 120	F 465	cleaned of all foreign objects. Faucet washer has been replaced to eliminate leaking and lime buildup. Foot board was replaced. All fans and vents have been cleaned or replaced. Vanity and countertop replaced in room 239. Splintered wood in room 252 has been removed and sanded. The facility Environmental Engineer instituted a weekly resident room audit. The audit is completed weekly by Household Coordinators in each unit on all resident rooms and reviewed with Environmental Engineer weekly. A weekly environmental audit will be completed by maintenance, housekeeping, and laundry to ensure all other common areas are maintained. The facility will monitor and sustain correction by completing the above audits weekly for two months. The results of the audits will be reviewed in QAA and determination will be made for continued audits. Environmental Engineer or designee will be responsible for ensuring ongoing compliance. Correction date for certification: 4-17-15	

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and there were small ceiling brown and yellow colored stain (approximately three inches) opposite to it.

RV1 ceiling near the nurses' station had two brown and yellow colored stains (one was approximately 12 inches and a smaller one that measured approximately three inches).

RV2 there were two brown and yellow colored stains (approximately 6 inches) above the nurses station.

Peeling wallpaper and wall condition:

CV2 east hallway had wallpaper which had a tear approximately 6 inches long near room 252.

CV2 had an approximately three inch size peeling wallpaper noted above linen room.

CV2 in the common area near the nursing station, had an approximately six inch size area of peeling wallpaper behind the recliner chairs on both walls.

CV2 room 251 there were two long gouges in the wall over the bed's headboard. One gouge was approximately eight inches long by one inch wide and second gouge was approximately six inches long by one inch wide with the dry wall exposed.

Dead insect in the lights:

CV2 had several dead bugs in the hallway light near nurses' station, also there were multiple insect bodies/debris in bathroom light of room 251.

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F 465	Continued From page 33 Other room concerns: CV2 room 261 had chipped paint directly to right of bathroom. The bathroom sink had a leaking water from base, dripping from faucet, build-up of scale lime. RV2 room 224, R126's footboard of bed had plastic edge peeling and hanging from wood. The therapeutic recreation room 249, had a black fan with a heavy buildup of gray fuzzy dust-like material hanging on front grate. The fan was blowing on 10 residents who were having coffee during a social activity in this room. CV2 common area near the nurses' station had a black pedestal fan to be turned on and running. The fan blades had a heavy buildup of grayish fuzz on ends of three fan blades. CV2 - room 239 had a circular hole approximately 1-1/2 inches in diameter punched through that bathroom door from the door stop. The built in vanity had a white colored veneer approximately 3-4 inch size half circle that was peeling away from wood creating sharp, uncleanable surface. RV2 - room 234 room had a vent in the ceiling with a heavy build up of visible dust. Room 252 bathroom door had a splintered wood at the bottom of the door approximately four inches up from floor bottom which then was sticking out two inches from edge of door. The veneer at the bottom of the door was pulled away from the door which left a sharp edge on the corner.	F 465		

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F 465	Continued From page 34 On 3/11/15, at 12:19 p.m. when interviewed, environmental services director (ESD) stated maintenance has an Excel work order computer program. When planned maintenance is scheduled, the work order appears in the Excel program in the morning. All daily work requests are in the Excel program. When work has been completed, maintenance sends a progress note back to the sender. On 3/11/15, at 12:55 p.m. the Excel computer work order system was reviewed with maintenance staff (MS-A) who stated they were not aware of these issues. On 3/12/15, at 2:20 p.m. housekeeping director (HD) indicated staff does deep cleaning of each room monthly. When they have a vacant room, they have deep cleaning checklist. On daily job routine list, housekeeping has identified specific daily tasks to do. Review of the undated City View 1 (CV1) checklist identified the following: "Resident bathroom, resident room, and common areas on list. Dayroom, nurse station, kitchenette, clinical and household coord. Office, tub room, utility room, wash handrails, door knobs, walls, wall accessories within reach, vacuum hallways, City View 1 North (CV 1N) & City View 1 East (CV 1E), strip, wash and make beds/deep cleaning room. Once a week on Wednesday clean bathrooms, empty rooms and utility room on CV1N. Note: housekeeping will wash complete units and fill out vacant room checklist on discharged/deceased residents." Review of Presbyterian Homes and Services	F 465		

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F 465	Continued From page 35 Policy/Procedure Task/Work Order Requests and Billable for Services original date: 2009, revision date: 9/2014, indicated purpose was when a work order was requested the Environmental Services department was to provide the service within one to two days.	F 465		

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	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grace Pointe Crossing Gables West was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Graceponit Crossing Gables West is a 2-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1974, 86, & 99 an addition(s) were constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 140 beds and had a census of 104 at the time of the survey.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 27, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5432024

Dear Ms. Sykes:

The above facility was surveyed on March 9, 2015 through March 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
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
	00294	A. BUILDING: _____ B. WING _____	03/12/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 9-12, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure repositioning and toileting assistance was provided as directed by the care plan for 1 of 1 resident (R60) care planned to require staff assistance for repositioning and incontinence checks. Findings include: R60's care plan for skin dated as revised on 7/3/13, identified, "I [R60] have the potential for alteration in skin integrity related to Decreased mobility, Incontinence. I have a history of fragile skin and frequent bruising/skin tears." The care plan goal identified, "My skin will remain intact" and the care plan directed, "Please repositioning [sic] me every 3 hours and PRN [as needed] and every 4 hours when asleep." R60's care plan for incontinence dated as revised on 5/12/14, identified, "I [R60] have functional bladder/bowel incontinence r/t [related to]	2 565	N/A	4/17/15

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2 565	Continued From page 3 Dementia, Impaired Mobility. My level of incontinence of bowel and bladder can fluctuate. The goal indicated, "I will remain free from skin breakdown due to incontinence and brief use through the review date." The care plan directed, "INCONTINENT: Check me 3 hours and as required for incontinence when awake, and every 4 hours and PRN [as needed] when asleep. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered offloading (repositioning assistance) for three hours and thirty-two minutes. At 7:39 a.m. R60 was laying in bed, a nursing assistant (NA)-A assisted R60 with perineal care and grooming. R60 was then transferred from the bed to the wheelchair at 7:45 a.m. with total assistance provided by NA-A, NA-B and a mechanical lift. R60 remained in her wheelchair, went to breakfast and finished breakfast at 8:01 a.m. She was then brought to the television/common room where she remained until 11:05 a.m. At 11:22 a.m. three hours and thirty-two minutes since she was last toileted or repositioned. NA-C and NA-A assisted R60 to offload, and verified R60 was incontinent and her skin was intact. Both NA-C and NA-A verified R60's care plan directed to reposition and check R60 for incontinence every three hours while up in the wheelchair. During interview at 11:31 a.m. registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been checked for incontinence and offered repositioning assistance every three hours while in the wheelchair. RN-C stated staff should have notified her of falling behind and did not.	2 565		

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2 565	Continued From page 4 On 3/11/15, at 1:30 p.m. when asked about the incontinence and repositioning plans for R60, RN-B stated R60 should have been offered incontinence checks and repositioning as directed by the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be offered incontinence checks and repositioned as determined by assessment and directed by the care plan. The Presbyterian Homes And Services Repositioning of Resident policy and procedure dated as modified last on 6/2003, identified the purpose of the policy was to ensure timely repositioning as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning needs should be identified on the care plan and the nursing assistant care guide (Assignment Group sheet). The policy further directed, "Nursing will reposition resident per their plan of care and as needed or requested." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 905	Continued From page 5	2 905		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 randomly observed residents (R60) was provided timely repositioning assistance to prevent the development of potential pressure ulcers; R60 was not offered or provided repositioning for three hours and thirty-two minutes. Findings include: R60's care plan for skin dated as revised on 7/3/13, identified, "I [R60] have the potential for alteration in skin integrity related to Decreased mobility, Incontinence. I have a history of fragile skin and frequent bruising/skin tears." The care plan goal identified, "My skin will remain intact" and the care plan directed to use a pressure reducing cushion in the wheelchair and directed, "Please repositioning me every 3 hours and PRN [as needed] and every 4 hours when asleep. R60's quarterly Minimum Data Set (MDS) dated 1/23/15, identified R60 had severe cognitive impairment, physical behaviors occurred four to six days (but no less than daily), verbal behavior	2 905	N/A	4/17/15

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2 905	Continued From page 6	2 905		

and other behaviors (such as but not limited to hit, scratched self, or disruptive sounds) occurred one to three days. The MDS identified R60 required extensive assistance with bed mobility, transferring, dressing, personal hygiene, eating and toilet use; R60 did not walk and required total assistance for locomotion on and off the unit. R60 was always incontinent of urine and frequently incontinent of bowel. R60 had no pressure ulcers.

The Care Area Assessment (CAA) for pressure ulcers dated 5/12/14, indicated, "Resident is at risk for skin breakdown. Does need assistance for bed mobility. Resident is incontinent of bowel and bladder. Staff repositions resident per schedule along with toileting. No current areas of concern." A copy of the CAA summary was requested, but not provided.

The quarterly Skin Risk and Braden Assessment dated 1/19/15, identified R60 was at "high risk for skin alteration," was totally incontinent of bladder, frequently incontinent of bowel and wore an incontinence brief. The assessment identified R60 was "toileted and repositioned every 3 hours when up and every 4 hours when in bed as tissue tolerates."

The Admission Record dated 3/11/15, identified R60's diagnoses to include senile dementia, muscle wasting and congestive heart failure.

On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered offloading (repositioning assistance) for three hours and thirty-two minutes. Observations were as follows:
- At 7:39 a.m. R60 was observed to be laying in bed, a nursing assistant (NA)-A was observed to assist R60 with perineal care and grooming. R60

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2 905	Continued From page 7 was then transferred from the bed to the wheelchair at 7:45 a.m. with total assistance provided by NA-A and NA-B and a mechanical lift. - From 7:45 a.m. until 8:01 a.m. NA-A assisted R60 with grooming in the wheelchair. - At 8:01 a.m. NA-A transported R60 to the television (TV)/common sitting area directly in front of the nursing station desk. Music was playing from a radio in the area. - From 8:01 a.m. until 8:24 a.m. R60 remained seated in the wheelchair in the TV area. - At 8:24 a.m. the health unit coordinator (HUC)-A was observed to transport R60 into the dining area and to a table. HUC-A offered R60 a clothing protector and assisted her to apply it. The supply manager (SM) sat directly to the left of R60 and another table mate. - From 8:24 a.m. to 9:08 a.m. R60 remained in the dining area at the dining table and was provided total assistance to eat and drink. - At 9:08 a.m. R60 was transported out of the dining room by SM and to the TV area. SM left the unit and R60 remained in the TV area. - At 9:16 a.m. NA-B verified she was recording the dietary and fluid intakes for the breakfast meal. NA-B stated R60 consumed 0-25% of the meal and verified R60 only ate "bites" of the foods. NA-B stated R60 consumed 20 cc (cubic centimeters) of fluids. - At 9:20 a.m. the clinical manager/registered nurse (RN)-B moved R60 a few feet closer to the radio and window in the TV/common area. RN-B changed the music to Christian rock then left the area. - From 9:20 a.m. until 9:45 a.m. R60 remained in the TV area with no position change or offloading offered (two hours since offloaded and transferred from the bed to the wheelchair). Various facility staff, including NA-A, NA-B and RN-B were observed to be in and out of the	2 905		

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2 905	Continued From page 8 TV/common area, assisting other residents. - From 9:45 a.m. to 10:29 a.m. R60 remained unmoved. At 10:05 a.m. RN-B turned off the music and started an "I Love Lucy" movie on the television. R60 faced out the window and not the TV. - At 10:29 a.m. NA-B moved R60 away from the window and faced her towards the I Love Lucy program. R60's eyes were open and looking at the TV. - From 10:29 a.m. until 11:00 a.m. R60 remained in the TV area. R60's eyes had closed during the program. - At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV area, placed it under the TV and stated to the residents there would be an exercise activity and then cookie baking. - At 11:05 a.m. R60 remained unchanged in wheelchair positioning (three hours and 20 minutes since last offload during transfer from bed to wheelchair at 7:45 a.m.). - At 11:09 a.m. NA-A was asked when R60 was supposed to be offloaded. NA-A removed an undated Assignment Group sheet (a form used to reference resident care needs) and stated R60's repositioning and times were "every three hours" while up in the chair and every "four hours" while in bed. When asked regarding the last time R60 was repositioned, NA-A stated she was unclear when last repositioned, but then stated, "She's next on my list." When asked how repositioning times were tracked, NA-A stated the times of repositioning were documented in the "Tub room." NA-A stated she would get assistance and reposition R60. Repositioning times were noted to be written on an unnamed form in the unit tub room. The form directed, "Please write time toileted, if dry or wet, incontinent or requested, and BM's [bowel movements] incontinent or	2 905		

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2 905	Continued From page 9 requested *Bold times are for when resident is in bed, unbolded is for when resident is in chair." The form had the times of "610 [6:10 a.m.] and 800 [8:00 a.m.]. - At 11:15 NA-C and NA-A verified they had both recorded times down on the tub room form. NA-C stated she "only checked on" R60 at 6:10 a.m. and no offloading was provided. NA-A verified the 8:00 a.m. time did not match the surveyor observed time of the 7:45 a.m. offload. NA-A stated she had to directly assist another resident at the time of the offload and "guesstimated" the time of R60's offload was 8:00 a.m. R60 was transported to her room. - At 11:22 a.m. NA-C and NA-A offloaded pressure and stood R60 in the stand lift (three hours and thirty-two minutes). R60 was observed to be incontinent of a small amount of urine. NA-C removed the soiled pad and performed perineal care. R60's skin was observed to be intact. Both NA staff verified they did not report running late with repositioning. - At 11:31 a.m. when asked regarding the repositioning for R60, the registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been repositioned every three hours while in the wheelchair. RN-C stated she "checks the sheets" and will "intervene" if she noticed a resident was going over the assessed time for repositioning. RN-C stated staff should be writing down the actual times of the off load and verified a fifteen minute time difference was "too much" of a difference. RN-C stated staff should have notified her of falling behind and did not. On 3/11/15, at 1:30 p.m. when asked about the repositioning plan for R60, RN-B stated R60 was assessed to be offloaded every three hours while in the wheelchair and four hours in bed. RN-B	2 905		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 10 explained R60's tissue perfusion was checked by staff during the assessment, no redness was noted at three hours and that was how the three hour time frame was determined. RN-B stated staff should record accurate times of the repositioning "as close as possible" and "notify the nurse" if repositioning was "falling behind." RN-B then stated, "The nurse should then help." RN-B verified R60 should have been repositioned as directed by the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be repositioned as determined by assessment and directed by the care plan. DON stated staff should document the correct time of repositioning to ensure the care plan was followed and verified the staff should have notified the nurse when falling behind with repositioning. The Presbyterian Homes And Services Repositioning of Resident policy and procedure dated as modified last on 6/2003, identified the purpose of the policy was to ensure timely repositioning as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning needs should be identified on the care plan and the nursing assistant care guide (Assignment Group sheet). The policy further directed, "Nursing will reposition resident per their plan of care and as needed or requested." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of	2 905		

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2 905	Continued From page 11 pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an incontinence check was provided to 1 of 1 resident (R60) randomly observed in the sample and dependent upon staff for incontinence cares and assistance; R60 was not checked for incontinence for three hours and thirty-two	2 910	N/A	4/17/15

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2 910	Continued From page 12 minutes. Findings include: R60's quarterly Minimum Data Set (MDS) dated 1/23/15, identified R60 had severe cognitive impairment, physical behaviors occurred four to six days (but no less than daily), verbal behavior and other behaviors (such as but not limited to hit, scratched self, or disruptive sounds) occurred one to three days. The MDS identified R60 required extensive assistance with bed mobility, transferring, dressing, personal hygiene, eating and toilet use; R60 did not walk and required total assistance for locomotion on and off the unit. R60 was always incontinent of urine and frequently incontinent of bowel. The Bowel and Bladder Quarterly Review dated 1/19/15, indicated, "Resident remains functionally incontinent of bowel and bladder r/t [related to] dx. [diagnosis] of dementia. Level of continence does fluctuate. Resident was totally incontinent of bladder, frequently incontinent of bowel. Wears incontinent brief. Is toileted by staff utilizing sabina [a type of mechanical lift] every 3 hours and PRN [as needed] when up and every 4 hours and PRN when in bed. Utilized sabina for transfers to toilet. Will continue with current regimen." The assessment contradicted the care plan. R60's care plan dated as revised on 5/12/14, identified, "I have functional bladder/bowel incontinence r/t [related to] Dementia, Impaired Mobility. My level of incontinence of bowel and bladder can fluctuate. The goal indicated, "I will remain free from skin breakdown due to incontinence and brief use through the review date." The care plan directed, "INCONTINENT:	2 910		

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2 910	Continued From page 13 Check me 3 hours and as required for incontinence when awake, and every 4 hours and PRN [as needed] when asleep. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 3/11/15, during continuous observations from 7:45 a.m. until 11:22 a.m. R60 was not offered an incontinence check for three hours and thirty-two minutes. Observations were as follows: - At 7:39 a.m. R60 was observed to be laying in bed, a nursing assistant (NA)-A was observed to assist R60 with perineal care and grooming. NA-A verified R60 was incontinent of urine and bowel at the time. After completion of perineal cares and application of clean incontinence brief, R60 was then transferred from the bed to the wheelchair at 7:45 a.m. with total assistance provided by two staff (NA-A and NA-B) and a mechanical lift. - From 7:45 a.m. until 8:01 a.m. NA-A assisted R60 with grooming in the wheelchair. - At 8:01 a.m. NA-A transported R60 to the television (TV)/common sitting area directly in front of the nursing station desk. Music was playing from a radio in the area. - From 8:01 a.m. until 8:24 a.m. R60 remained seated in the wheelchair in the TV area. - At 8:24 a.m. the health unit coordinator (HUC)-A transported R60 into the dining area and to a table. HUC-A offered R60 a clothing protector and assisted her to apply it. The supply manager (SM) sat directly to the left of R60 and another table mate. - From 8:24 a.m. to 9:08 a.m. R60 remained in the dining area at the dining table and was provided total assistance to eat and drink. - At 9:08 a.m. R60 was transported out of the dining room by SM and to the TV area. SM left the unit and R60 remained in the TV area. SM did not offer or provide assistance with toileting.	2 910		

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2 910	Continued From page 14 - At 9:20 a.m. the clinical manager/registered nurse (RN)-B moved R60 a few feet closer to the radio and window in the TV/common area. RN-B changed the music to Christian rock then left the area. - From 9:20 a.m. until 9:45 a.m. R60 remained in the TV area and was not offered any incontinence checks (two hours since last incontinence check and transfer to wheelchair at 7:45 a.m.). Various facility staff, including NA-A, NA-B and RN-B were observed to be in and out of the TV/common area, assisting other residents. There was no one that offered or assisted R60 with incontinence checks or toileting during this time. - From 9:45 a.m. to 10:29 a.m. R60 remained unmoved or approached by staff. At 10:05 a.m. RN-B turned off the music and started an "I Love Lucy" movie on the television. R60 faced out the window and not the TV. - At 10:29 a.m. NA-B moved R60 away from the window and faced her towards the I Love Lucy program. R60's eyes were open and looking at the TV. - From 10:29 a.m. until 11:00 a.m. R60 remained in the TV area. R60's eyes had closed during the program. - At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV area, placed it under the TV and stated to the residents there would be an exercise activity and then cookie baking. - At 11:05 a.m. remained unchanged in wheelchair positioning and was not offered assistance with toileting (Three- hours and 20 minutes since last incontinence check and transfer to the wheelchair at 7:45 a.m.). - At 11:09 a.m. NA-A was asked when R60 was to be checked for incontinence. NA-A removed an undated Assignment Group sheet (a form used to	2 910		

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2 910	Continued From page 15 reference resident care needs) and stated R60's incontinence check times were "every three hours" while up in the chair and every "four hours" while in bed. Although the form indicated "Toilet use," NA-A verified R60 should have been offered a check only. When asked regarding the last time R60 was checked for incontinence, NA-A stated she was unclear, but then stated, "She's next on my list." When asked how incontinence checks were tracked, NA-A stated the times of incontinence checks were documented in the "Tub room." NA-A stated she would get assistance and check R60 for incontinence. Review of the facility repositioning/incontinence check times were noted to be written on an unnamed form in the unit tub room for R60. The form directed, "Please write time toileted, if dry or wet, incontinent or requested, and BM's [bowel movements] incontinent or requested *Bold times are for when resident is in bed, unbolded is for when resident is in chair." The form had the times of "610 [6:10 a.m.] and 800 [8:00 a.m.] documented for R60. - At 11:15 NA-C and NA-A verified they had both recorded times down on the tub room form. NA-C stated she "only checked on" R60 at 6:10 a.m. and verified the 8:00 a.m. time did not match the surveyor observed time of the 7:45 a.m. perineal care/offload. NA-A stated she had to directly assist another resident at the time of the perineal care/offload and "guesstimated" the time of R60's incontinence check was 8:00 a.m. R60 was transported to her room. - At 11:22 a.m. NA-C and NA-A stood R60 in the stand lift (three hours and thirty-two minutes between incontinence checks). R60 was incontinent of a small amount of dark, strong smelling urine. NA-C removed the soiled pad and performed perineal care. Both NA staff verified they did not report running late with incontinence	2 910		

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2 910	Continued From page 16 checks. Both NA staff verified R60 was only checked for incontinence and not toileted. - At 11:31 a.m. when asked regarding the incontinence checks for R60, the registered nurse (RN)-C checked an undated Assignment Group sheet and verified R60 should have been "checked" for incontinence every three hours while in the wheelchair. RN-C stated she "checks the sheets" and will "intervene" if she noticed a resident was going over the assessed time for incontinence checks. RN-C stated staff should be writing down the actual times of the check and verified a fifteen minute time difference was "too much" of a difference. RN-C stated staff should have notified her of falling behind and did not. On 3/11/15, at 1:30 p.m. when asked about the toileting plan for R60, RN-B stated R60 was to be checked every three hours while in the wheelchair and four hours in bed for incontinence. RN-B stated staff should record accurate times of the incontinence checks "as close as possible" and "notify the nurse" if toileting or incontinence checks were "falling behind." RN-B then stated, "The nurse should then help." RN-B verified R60 should have been provided incontinence checks as directed by the care plan. RN-B was unclear why the assessment differed from the care plan. On 3/11/15, at 2:35 p.m. the director of nursing (DON) stated residents should be provided incontinence checks as determined by assessment and directed by the care plan. DON stated staff should document the correct time of incontinence checks to ensure the care plan was followed and verified the staff should have notified the nurse when falling behind with toileting or incontinence checks. DON verified the care plan should match the assessment.	2 910		

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2 910	Continued From page 17 Review of the facility Presbyterian Homes and Services Toileting of Residents policy and procedure dated as last modified on 6/2003, identified the purpose of the policy was to "insure timely toileting as identified in the resident's care plan." The policy directed, "6. Residents will be assisted with their toileting needs and at intervals specified on the resident care plan." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who needed assistnace with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure symptoms of potential dehydration were identified and reassessed for 1 of 1 resident (R60) in the sample reviewed for hydration. Findings include:	2 940	N/A	4/17/15

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2 940	Continued From page 18 R60's Physician Orders for Life Sustaining Treatment (POLST) form dated as signed on 10/21/08, with hand written update dated 2/22/12, identified R60 requested comfort care only, no hospitalization, no antibiotics and directed no labs to be drawn. The POLST form for hydration directed, "Always offer food and liquids by mouth if feasible." and directed "No artificial nutrition [tube feeding]" and "No IV [intravenous] fluids." The annual Minimum Data Set (MDS) dated 5/9/14, identified R60's weight was 143, height 61 inches, identified no eating concerns, and no weight loss or gain; the MDS identified R60 received a mechanically altered diet/liquid consistency. The Care Area Assessment (CAA) for Nutrition dated 5/12/14, indicated, "Res [resident] requires use of soft diet with thickened liquids d/t [due to] chewing and swallowing difficulty. Res has had general weight gain in past 180 days (not sig [significant]). Res meeting estimated needs from meals, supplements and snacks." The CAA for Dehydration/Fluid Maintenance did not trigger. Although a copy of the Nutritional CAA summary was requested, it was not provided. R60's care plan dated as revised on 8/8/12, identified, "I have dehydration or potential fluid deficit r/t [related to] Dementia with behavioral disturbances" with the goal, "I will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor." The care plan directed, "Encourage me to drink fluids of choice and offer fluids throughout the day and at mealtimes/snacks;" and further directed, "Observe for and report to MD [medical doctor] as needed s/sx [signs and symptoms] of dehydration: decreased or no urine output,	2 940		

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2 940	Continued From page 19 concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes." Although the POLST form identified no laboratory work would be completed on R60, the care plan directed, "Obtain and monitor lab/diagnostic work as ordered. Report results to MD [medical doctor] and follow up as indicated." The Nutritional Assessment dated 1/18/15, identified current supplement/snack orders of "Water Pass, 80 cc [cubic centimeters] 2+ [a high protein dietary supplement] tid [three times daily]" and identified R60 accepted the supplement. The Comments- Food/Fluid Intake section indicated, "There has been a decline in food and fluid intake in past 90 days d/t illness. Res provided with spout cups and coated spoons at meals." The "Reviewed nursing hydration risk assessment" was not checked either yes or no. The Comments-Hydration indicated, "Fluids provided with med [mediation] pass as ordered, supplements and at the bedside." The assessment identified R60 required total to partial assistance to eat/drink and identified the fluid intake to be between "30-400 cc." The Assessment Summary identified R60 did not understand the diet order, "Current diet remains warranted d/t difficulty chewing/swallowing regular consistency foods and fluids." The Summary further identified, "Current weight 139.8# [pounds] which shows a loss of 5.5% in 30 days (sig) [significant] and 7.5% in 180 days. Res has had recent illness and appetite has not improved....Res is also provided with water pass for additional fluids. Spoke with NP [nurse practitioner] and agrees with POC [plan of care].	2 940		

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2 940	Continued From page 20 Message left with NP re: [regarding] weight changes and update interventions. NP questions if intake will improve d/t illness. Will follow high risk d/t weight changes. CP [care plan] reviewed." R60's estimated fluid needs were identified as "25-28 cc/kg" which was approximately 1590-1781 cc of fluid. The assessment did not clearly identify how much R60's fluid needs were in 24 hours. The Hydration Assessment dated 1/19/15, identified R60 had diagnoses of dementia, Alzheimer's disease, and had swallowing problems. "No current dx [diagnosis] of dehydration, no fever/vomiting/diarrhea." The assessment did not identify physical symptoms of dehydration. The assessment identified Average daily intake of fluids with meals was "700 (Amount in ml's [milliliters]" and average daily intake of fluids between meals was 500 ml. The assessment identified R60 was "At potential risk for dehydration." - The Comments Assessment/Plan/Referrals section indicated, "Resident is potentially at risk for dehydration r/t [related to] dx. [diagnosis] of dementia and inability to recognize thirst needs. Is currently on nectar thick fluids. Does have hx. [history] of constipation and is on laxative for management. Resident is on additional water pass and supplement throughout day between meals. Is encouraged to drink fluids with meals and med passes. No current signs of dehydration. Focus is on comfort. Will continue with current plan of care." The GracePointe Crossing Gables West Order Summary Report dated as signed by the physician on 2/4/15, directed to offer nectar thick consistency liquids and "encourage fluids" beginning 1/13/15; offer 120 cc Med Plus 2.0 (a	2 940		

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2 940	Continued From page 21 high protein, high calorie dietary supplement) four times a day, which was 480cc per day if she consumed 100% of the supplement. On 3/10/15, at approximately 1:00 p.m. the administrator reported there were problems with a "fan" and the City View 2 unit temperature was going to be warmer than usual. The administrator verified fluids were being offered to the residents of the unit in that time. - At approximately 2:00 p.m. R60 was observed to be seated in a wheelchair in the television (TV)/common area during a scheduled activity, regular consistency fluids were observed to be passed out and offered to the other residents attending the activity and seated in the area. Although R60 was seated directly in front of the activity staff (AS), R60 did not have any fluids offered to her during the activity. R60 skin was pale in color, with dry lips. Her mouth was open, and her eyes were closed. R60's arms were covered with derma savers (a protective sleeve worn to prevent injury to skin). - At 2:25 p.m. R60 was observed to be in the church activity in the same area directly in front of the nursing station desk. R60's mouth was observed to be open during the church activity, with her eyes closed. R60's lips were chapped and dry; R60's tongue was dark red colored and dry; her tongue appeared very rough textured, very bumpy, leathery in appearance, and heavily cracked with deep furrows. R60's gums appeared slightly red and dry. R60 did not rouse or respond to voice at the time of the observation. Although the approximately 17-20 observed residents in the area were all offered fluids and provided assistance to drink the fluids, R60 had no fluids nor was any assistance to drink was offered to her.	2 940		

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2 940	Continued From page 22 On 3/11/15, during continuous observations from 7:39 a.m. until the end of observations at 11:22 a.m. R60 was not offered the opportunity to drink fluids to prevent potential dehydration between medication passes and scheduled meals. R60 was only offered fluids by the nurse during a scheduled fluid/supplement pass, during the medication pass and during an observed meal. Observations were as follows: - At 7:39 a.m. a nursing assistant (NA)-A was observed to assist R60 with incontinence cares while in bed. Two empty clear plastic glasses, one with a spout for drinking, were observed stacked on the bedside table. The glasses appeared to be soiled. - At 7:41 a.m. NA-B entered the room with a mechanical lift and R60 was transferred to the wheelchair at 7:45 a.m. by both NA-A and NA-B. NA-B left the room. NA-A stated she did not "usually work" in "this building" and when she did she "usually worked downstairs." - At 7:52 a.m. NA-A was asked what cares she provided prior to the surveyor entering the room, NA-A stated R60's mouth was swabbed with a green toothette which was moistened with tap water. NA-A stated R60 "does not follow direction and can't spit" and stated R60 received nectar consistency liquids. NA-A stated she squeezed out the access water from the sponge. When asked regarding the empty plastic glasses in the room, NA-A stated the glasses were not provided by her and were both empty when she entered the room at approximately 7:00 a.m. NA-A verified no nectar consistency fluids were available to offer R60 in the room. - At 8:01 a.m. NA-A transported R60 to the common area. At no time during the observations was R60 offered the opportunity to drink fluids. - At 8:16 a.m. NA-A was asked if any fluids were offered to R60 by NA-A prior to 7:39 a.m., NA-A	2 940		

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	00294	A. BUILDING: _____ B. WING _____	03/12/2015

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2 940	Continued From page 23 stated she did not offer R60 anything to drink while doing cares in the room. NA stated "her water was empty" and the "water pass" had just occurred "now." NA-A pointed to a staff person distributing water to resident rooms on the unit. - At 8:18 a.m. R60 remained in her wheelchair in the common area, Music playing on a radio. R60's eyes were open and looking out the window. - At 8:24 a.m. R60 was transported into the dining area by the health unit coordinator (HUC)-A and wheeled to a table. HUC-A offered a clothing protector and assisted with applying it. No fluids were observed at the table. The supply management (SM) staff sat to the left of R60 and next to another resident at the table. A dietary staff wheeled a cart with various fluids to R60, discussed with SM R60's fluid consistency and poured nectar consistency orange juice (OJ) from a carton. Staff immediately offered the OJ to R60 and held the glass for the resident. R60 drank sips without difficulty. SM stated, "You're thirsty this morning huh?" A nectar consistency glass of water was poured and offered, R60 drank sips. A nectar consistency milk was also poured but not offered to R60. - From 8:24 a.m. until 9:08 a.m. R60 remained in the dining area for the breakfast meal. SM remained with R60 and alternated between offering various fluids and bites of pureed foods to R60. R60 was observed to take small sips, did not resist the offered fluids and had no observed coughing or swallowing concerns. - At 9:08 a.m. R60 was wheeled out of the room to TV/common area by SM. SM immediately left the unit. R60's mouth was observed to be open while seated in the common area. Immediately after drinking sips of fluids from the meal, R60's lips appeared pink, less dry and supple; R60's tongue remained slightly dry, appeared dark pink	2 940		

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2 940	Continued From page 24	2 940		

colored; R60's tongue remained leathery in appearance, heavily cracked, and furrowed.
- At 9:16 a.m. NA-B stated she was in the process of recording the dietary and fluid intakes for the observed meal. NA-B reviewed R60's plate and glasses of remaining fluids. NA-B stated R60 consumed 20 cc (cubic centimeters) of fluids and 0-25% (bites) of solids. NA-B verified the fluid amount consumed by R60 was "low."
- From 9:16 a.m. until 11:00 a.m. R60 remained in the TV/common area listening to the radio, watching "I Love Lucy" in the wheelchair. Although various staff, including NA-A, NA-B and the clinical manager/registered nurse (RN)-B and the registered nurse (RN)-C were in and out of the area to change music, turn on the TV, R60 was only moved in the wheelchair a few feet towards and away from the window. At no time were fluids offered to R60.
- At 11:03 a.m. activity staff (AS) carried a straight backed regular chair into the TV/common area, placed the chair under the TV, and turned off the I Love Lucy program. AS spoke to the residents and stated there would be an exercise activity and then cookie baking.
- From 11:03 a.m. until 11:20 a.m. R60 remained in the TV/common area, no fluids were observed to be offered during the continuous observations.
- At 11:20 a.m. NA-A and NA-C were notified by the surveyor R60 had not been repositioned or offered incontinence checks for three hours and thirty-two minutes. R60 was transported to her room. While preparing to check R60 for incontinence, NA-A and NA-C verified they did not offer fluids to R60 during the day. NA-C stated "the nurse offers" supplements in between meals. NA-C stated fluids were "never" offered. When asked when fluids should be offered to R60, NA-C stated, "If she's thirsty, we offer." When asked how staff know R60 is thirsty, NA-C stated

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2 940	Continued From page 25 R60 "doesn't verbally talk" and described R60 "will get anxious, grab at people" when thirsty. NA-C verified the same behavior could also be attributed to pain or hunger. Neither NA staff were clear when fluids should have been offered to R60. - At 11:22 a.m. R60 was lifted in the stand lift and her incontinence brief was removed. The brief was observed to be wet with a small amount of dark colored, concentrated urine; the urine was strong smelling. When asked if they noted R60's urine was strong smelling or dark colored, NA-C denied the urine was strong smelling. At the time of the observation, a full glass of thickened water with a spout top was observed to be on the bedside stand. R60 was wheeled back to the TV/common area immediately after perineal care was completed. Although both staff verified the glass of water at the bedside was the correct nectar consistency and intended for R60 to drink, no fluids were offered by the NA staff before or after offloading/incontinence check was provided. On 3/11/15, at 11:31 a.m. RN-C stated she gave R60 120 cc of water, plus 120 cc of supplement twice on her shift. RN-C stated she usually offered the water and supplement "Right away in the morning." When asked if offered and consumed this morning, RN-C referred to the Medication Administration Record (MAR) in the Electronic Medical Record. RN-C stated R60 drank "everything" offered that morning and it was a total of "240 cc." When asked when the fluids were offered, RN-C stated she gave both with medications between 6:30 a.m. - 7:00 a.m. RN-C verified she offered R60 no other fluids after 7:00 a.m. (on 3/11/15). When asked if she was notified of R60's potential symptoms of dehydration, RN-C stated she was not. RN-C stated she had not assessed R60 for dehydration. When asked	2 940		

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2 940	Continued From page 26 what symptoms of dehydration she would assess for and expected to be reported, RN-C stated she "looks for tenting [a test used to determine skin turgor, a sign used to assess fluid loss or potential dehydration]." RN-C then stated she "focuses on what [R60's] drinking as an indicator of potential dehydration." RN-C confirmed she was not aware R60 only consumed 20 cc at the breakfast meal. At the time of the interview, RN-C observed R60 with the surveyor present. RN-C checked R60's skin by lifting it slightly with forefinger and thumb on the back of R60's left arm and stated R60's tenting was "poor," then immediately stated "all residents" had problems with "tenting." RN-C then rubbed R60's left arm (where she had lifted the skin) and stated "see it's fine" (Decreased skin turgor is a late sign in dehydration) When asked if R60's tongue appeared dry and furrowed, RN-C appeared to look into R60's mouth quickly, but did not comment. - At 1:28 p.m. RN-C stated staff should have offered fluids to R60 throughout the day. Review of the MARs from December 2014 through March 2015, indicated the nurse offered R60 120 cc of water and 120 cc of supplement three times daily. The MARs for December 2014 and January 2015 did not include the amount of water or supplement consumed by R60 until 1/13/15. Beginning on 1/13/15, the consumed amounts of water and supplement offered by the nurse where documented on the MAR. Although the MAR indicated R60 usually consumed the full 120 cc amount, R60's fluid intakes were variable with a noted decrease in amount of fluid consumed beginning on 3/9/15: - on 3/9/15, the MAR indicated R60 consumed 240 cc of water and 480 cc of supplement (total of 720 cc of fluids from nurse);	2 940		

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2 940	Continued From page 27 - on 3/10/15 (when R60 was first observed), the MAR indicated R60 consumed 270 cc of water and 480 cc of supplement (total of 750 cc of fluids from nurse); - on 3/11/14, the MAR indicated R60 consumed 240 cc of fluids and 270 cc of supplement (total of 510 cc of fluids from nurse between breakfast and before supper). Review of the GracePointe Crossing Gables West Follow Up Question Report from 12/1/14, through 3/11/15, included a report of "Fluid Taken with Meals in ml [equal to cc]." The report identified R60's fluid intakes were variable. - on 3/9/15, R60 refused fluids at breakfast and supper, R60 consumed 25 ml of fluids at lunch (total of 25 ml from meals); - on 3/10/15 (the day R60 was first observed), R60 consumed "0" fluids at breakfast and lunch, R60 consumed 50 ml of fluids at supper (total of 50 ml from meals); - on 3/11/15, R60 consumed 20 ml at breakfast and 120 ml at lunch (total of 140 ml from meals). R60's intake records indicated the following 24-hour fluid intake totals: - on 3/9/15, total of 745 cc/ml of fluids; - on 3/10/15, total of 800 cc/ml of fluids; - on 3/11/15, R60 consumed only 530 cc/ml of fluids up to lunch. R60's clinical record did not reflect adequate fluid intake to prevent potential dehydration. On 3/11/15, at 1:30 p.m. when asked about R60's fluid intake, RN-B stated extra water passes were scheduled in the MAR. RN-B stated R60 was observed for "anxiety issues" as an indicator for being thirsty; RN-B stated if R60 "seems dry in her mouth" it was another potential indicator of thirst. RN-B stated staff should offer fluids with	2 940		

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2 940	Continued From page 28 cares and verified staff should have offered fluids during the observations. RN-B further explained she "knew" the staff offered fluids as she saw them "daily." RN-B explained R60 was difficult to get to drink, explained she should be offered fluids if she "was thirsty" and stated staff looked for "anxiety" as a means of communication for pain, hunger or thirst. RN-B stated R60 was in the "end stages of Alzheimer's" and she would be "expected" to be "slightly dehydrated" during the dying process. When asked if R60 was actively dying, RN-B stated R60 was not actively dying, but stated the family and facility's focus was on "comfort." Although RN-B identified "anxiety" as an indicator for R60's thirst, RN-B was unclear on resident specific indicators of thirst for R60. RN-B was unclear how R60's water needs were assessed and identified by facility staff. - At 1:57 p.m. RN-B and surveyor observed R60 in her room at the light of the room window. RN-B verified R60's tongue appeared furrowed. At the time of the observation, the glass of nectar consistency water at bedside remained full. RN-B verified she should have been notified of the furrowed tongue and stated fluids should have been offered to R60 throughout the day. On 3/11/15, at 2:25 p.m. the registered dietician (RD) stated R60's estimated needs for fluids and hydration were 1250 - 1350 cc/24 hours. When asked if she believed R60 was offered enough fluids to meet this goal, RD checked R60's fluid intakes in the Electronic Medical Record. RD verified R60's fluid intakes were "low" since 3/9/15. RD stated she "looked at" the fluid and dietary intakes on a quarterly or as needed basis. RD stated she was not alerted to any concerns with R60's fluid intakes. RD stated she expected fluids to be offered throughout the day. RD stated R60 required a new assessment for hydration	2 940		

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2 940	Continued From page 29 needs; RD verified R60 was at higher risk for dehydration due to dependence on staff to obtain fluids and use of nectar consistency liquids. On 3/11/15, at 2:35 p.m. the director of nursing (DON) verified R60 should have offered fluids at other times during the day. DON stated the staff should have encouraged fluids when other residents were offered fluids. Review of a Geriatric Services of Minnesota Progress Notes dated 3/11/15, indicated R60 was assessed by the nurse practitioner (NP) for "Signs of Dehydration" (after surveyor alerted facility of R60's symptoms). Although the review identified R60's goals were for comfort and no heroic measures were identified for R60, the NP note directed "it is appropriate to offer fluids" and identified, "Labs are not indicated." On 3/12/15, at 10:57 a.m. RD stated she assessed R60 for changes in hydration needs and discussed the findings with the family. RD stated after assessing R60's intakes she increased the fluids offered to R60 to 120 cc six times per day. RD stated R60's fluid needs were greater than the fluids received on 3/9/15, through 3/11/15. - Review of the Progress Note provided by RD dated 3/11/15, written at 4:02 p.m. indicated R60's estimated fluid needs were 1500-1700 cc/actual body weight. The note indicated, "Staff report res [resident] has had a decline in intakes since breakfast meal 3/9/15, and identified fluid intake prior to be "100-400 cc fluids per meal." The note identified R60 was accepting 75-100% of the 120 cc supplement and 120 cc water pass three times daily which provided "820 cc fluids." The note indicated fluid intake would be requested to be increased to six times per day,	2 940		

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2 940	Continued From page 30 "intake from water pass and supplement will provide 1080 cc. Staff will also offer fluids with cares. Will follow high risk d/t [due to] variable fluid intake and monitor need for further nutritional interventions." Review of the Presbyterian Homes & Services Hydration Risk Policy dated as modified 2/2012, directed, "5) Fluids will be offered to the residents at the following times: During meals, Between meals, At med pass." The policy identified residents at higher risk may require more urgent notification and identified potential symptoms of dehydration to include: skin tenting, low urine output, concentrated urine, dry mucous membranes, mouth furrows (absence of moisture under the tongue moisture). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for dehydration to assure they are receiving the necessary treatment/services to prevent dehydration. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for dehydration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		4/17/15

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21375	Continued From page 31 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gloves were changed during incontinence cares after bowel and bladder incontinence, to prevent the potential spread of infection for 1 of 2 residents (R60) in the sample observed for perineal cares. Findings include: During observation on 3/11/15, at 7:39 a.m. surveyor knocked on R60's door, announced presence and was allowed admittance to R60's room. A nursing assistant (NA)-A was observed to be assisting R60. R60 was observed to be laying in bed, partially dressed with her pants down. NA-A stated she was "in the middle" of perineal cares. A soiled incontinence product remained under R60. NA-A stated R60 was incontinent of urine and "having a BM." NA-A rolled R60 to the right side, obtained an incontinence wipe and wiped from the front to back on R60's buttocks. NA-A then removed the soiled brief. Without changing gloves or performing hand hygiene, NA-A reached to the head of the bed, picked up a clean incontinence pad and placed it under R60. NA-A rolled R60 back onto the pad and applied the incontinence product. After the brief was applied, NA-A removed the gloves, and did not wash her hands. NA-B knocked on the door at 7:41 a.m., brought in a mechanical lift, both applied a lift sling under R60 and transferred her to the wheelchair at 7:45 a.m. No hand hygiene was observed. On 3/11/15, at 7:52 a.m. NA-A verified she did not	21375	N/A	

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21375	Continued From page 32 change gloves after wiping R60's stool and verified she contaminated the clean incontinence brief with the soiled gloves. NA-A confirmed she did not perform hand hygiene after removing the soiled gloves and should have. At 11:31 a.m. the registered nurse (RN)-C stated the gloves should have been removed and hand hygiene completed before handling the clean incontinence brief. On 3/11/15 at 12:20 p.m. the director of nursing (DON) verified gloves should have been changed and hand hygiene completed after the perineal area was cleaned and the soiled brief was removed; before the clean brief applied. Review of the Presbyterian Homes and Services Perineal Care policy and procedure dated as last modified on 4/2010, directed after placing the soiled brief in bag to "21. Remove gloves, and wash hands or use waterless hand sanitizer." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could completed staff handwasing training and audits while staff are providing resident care to ensure proper handwashing is being provided. The director of nursing or designee, could conduct random weekly audits to ensure appropriate handwashing is being completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a	21685		4/17/15

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21685	Continued From page 33 continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the building was kept in good repair and maintained for 4 of 5 nursing units, City View 1 (CV1), City View 2 (CV2), River View 1 (RV1), and River View 2 (RV2), which had the potential to affect approximately 60 residents who resided on these units. Findings include: During the environmental tour with administrator (Adm) and environmental services director (ESD) on 3/11/15, at 11:50 a.m. was completed with the following areas identified: Water Stains on the Ceiling: The River View 2 (RV2) dining room, there was an approximate 12 inch size brown and yellow colored stain on the ceiling tile. There was a large crack in the ceiling above the food service area, and the wallpaper was peeling near dining room windows which was approximately 8 inches in length. City View 2 (CV2) common area had an approximate 12 inch brown stain on the ceiling and yellow colored stain above window. The area had approximately 6 inch brown and yellow color stained ceiling tiles located above nurses' station.	21685	N/A	

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21685	Continued From page 34 City View 1 (CV1) dining room had an approximate 6 inch size brown and yellow colored stain in hallway above tub and shower room. CV1 had two brown and yellow colored stains (approximately 12 inch) in hallway outside the first floor main dining room. RV1 had a cracked ceiling tile (approximately six inches) in the hallway, near the nurses' station. There were large brown and yellow colored stain (approximately 12 inches) outside of room 120 and there were small ceiling brown and yellow colored stain (approximately three inches) opposite to it. RV1 ceiling near the nurses' station had two brown and yellow colored stains (one was approximately 12 inches and a smaller one that measured approximately three inches). RV2 there were two brown and yellow colored stains (approximately 6 inches) above the nurses station. Peeling wallpaper and wall condition: CV2 east hallway had wallpaper which had a tear approximately 6 inches long near room 252. CV2 had an approximately three inch size peeling wallpaper noted above linen room. CV2 in the common area near the nursing station, had an approximately six inch size area of peeling wallpaper behind the recliner chairs on both walls. CV2 room 251 there were two long gouges in the wall over the bed's headboard. One gouge was	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00294	A. BUILDING: _____ B. WING _____	03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21685	Continued From page 35 approximately eight inches long by one inch wide and second gouge was approximately six inches long by one inch wide with the dry wall exposed. Dead insect in the lights: CV2 had several dead bugs in the hallway light near nurses' station, also there were multiple insect bodies/debris in bathroom light of room 251. Other room concerns: CV2 room 261 had chipped paint directly to right of bathroom. The bathroom sink had a leaking water from base, dripping from faucet, build-up of scale lime. RV2 room 224, R126's footboard of bed had plastic edge peeling and hanging from wood. The therapeutic recreation room 249, had a black fan with a heavy buildup of gray fuzzy dust-like material hanging on front grate. The fan was blowing on 10 residents who were having coffee during a social activity in this room. CV2 common area near the nurses' station had a black pedestal fan to be turned on and running. The fan blades had a heavy buildup of grayish fuzz on ends of three fan blades. CV2 - room 239 had a circular hole approximately 1-1/2 inches in diameter punched through that bathroom door from the door stop. The built in vanity had a white colored veneer approximately 3-4 inch size half circle that was peeling away from wood creating sharp, uncleanable surface.	21685		

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21685	Continued From page 36 RV2 - room 234 room had a vent in the ceiling with a heavy build up of visible dust. Room 252 bathroom door had a splintered wood at the bottom of the door approximately four inches up from floor bottom which then was sticking out two inches from edge of door. The veneer at the bottom of the door was pulled away from the door which left a sharp edge on the corner. On 3/11/15, at 12:19 p.m. when interviewed, environmental services director (ESD) stated maintenance has an Excel work order computer program. When planned maintenance is scheduled, the work order appears in the Excel program in the morning. All daily work requests are in the Excel program. When work has been completed, maintenance sends a progress note back to the sender. On 3/11/15, at 12:55 p.m. the Excel computer work order system was reviewed with maintenance staff (MS-A) who stated they were not aware of these issues. On 3/12/15, at 2:20 p.m. housekeeping director (HD) indicated staff does deep cleaning of each room monthly. When they have a vacant room, they have deep cleaning checklist. On daily job routine list, housekeeping has identified specific daily tasks to do. Review of the undated City View 1 (CV1) checklist identified the following: "Resident bathroom, resident room, and common areas on list. Dayroom, nurse station, kitchenette, clinical and household coord. Office, tub room, utility room, wash handrails, door knobs, walls, wall accessories within reach, vacuum hallways, City	21685		

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21685	Continued From page 37 View 1 North (CV 1N) & City View 1 East (CV 1E), strip, wash and make beds/deep cleaning room. Once a week on Wednesday clean bathrooms, empty rooms and utility room on CV1N. Note: housekeeping will wash complete units and fill out vacant room checklist on discharged/deceased residents." Review of Presbyterian Homes and Services Policy/Procedure Task/Work Order Requests and Billable for Services original date: 2009, revision date: 9/2014, indicated purpose was when a work order was requested the Environmental Services department was to provide the service within one to two days. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate staff regarding the importance of a clean and safe environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure the areas are keep clean, good repair are being maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		