#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8MTW

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	GENCY		Facility ID: 00294
1. MEDICARE/MEDICAID PROVIDER 1 (L1) 245432 2.STATE VENDOR OR MEDICAID NO.	NO.	3. NAME AND ADDRESS OF FACILITY (L3) GRACEPOINTE CROSSING GABLES V (L4) 135 FERN STREET NORTH					4. TYPE OF ACTION 1. Initial 3. Termination	N: 7 (L8)  2. Recertification 4. CHOW
(L2) 893042200  5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	(L5) CAMBRIDGE, MN  7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		(L6) 55008  02 (L7)  13 PTIP 22 CLIA		Validation     On-Site Visit     Full Survey After 0	Complaint     Other  Complaint	
6. DATE OF SURVEY 05/0- 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	140 (L18) 140 (L17)	B. Not in Com	equirements		2. Tec 3. 24 4. 7-1	chnical Personnel	e Following Requirements:	vices Limit ector
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  140  (L37) (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILITY N 1861 (e) (1) o		(L15)	
16. STATE SURVEY AGENCY REMAR								
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	RVEY AGENCY AP	PROVAL	Date:
Brenda Fischer,	*	SOT BE COMPLETE	05/04/2015 D RV HCFA RE	(L19)			Forcement Spec	cialist 05/04/2015 (L20)
DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to Pa 2. Facility is not Eligible	Y	20. COM	IPLIANCE WITH C		21. 1. 2.	Statement of Financi	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE  OF PARTICIPATION  03/01/1987	23. LTC AGREEMI BEGINNING		24. LTC AGREEME ENDING DATI		VOLUNTARY 01-Merger, Clos	ATION ACTION:  00  sure on W/ Reimbursemen	05-Fail to	(L30)  NTARY  Meet Health/Safety  Meet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATIVI  A. Suspension of B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Invol 04-Other Reason	luntary Termination n for Withdrawal	<u>OTHER</u>	er Status Change
	D. resema sus	pension Date.	(L45)					
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS	3		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION ( 04/27/2015	OF APPROVAL DAT	ΤΕ (L33)		5/07/2015 Co.		



#### 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



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

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245432	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/4/2015
Name	of Facility		Street Address, City, State, Zip Code	
GRACEPOINTE CROSSING GABLES WEST		Т	135 FERN STREET NORTH CAMBRIDGE. MN 55008	

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

(Y4) Item	(Y:	5) Date	(Y4) Item	()	(5) Date	(Y4)	ltem	(	Y5)	Date
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0282	04/17/2015	ID Prefix	F0314	04/17/2015		ID Prefix	F0315		04/17/2015
-	483.20(k)(3)(ii)	_		483.25(c)				483.25(d)		_
LSC		_	LSC				LSC			_
		Compation			Composition					Competion
		Correction Completed			Correction Completed					Correction Completed
ID Prefix	F0327	04/17/2015	ID Prefix	F0441	04/17/2015		ID Prefix	F0465		04/17/2015
Reg. #	483.25(j)		Reg. #	483.65			Reg. #	483.70(h)		
LSC		_	LSC							_ _
		Correction			Correction					Correction
		Correction Completed			Correction					Correction Completed
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. #			_
		_	_							_
		Correction			Correction					Correction
ID Profiv		Completed	ID Profix		Completed		ID Profix			Completed
ID Prefix		_								_
Reg. #		<u> </u>	Reg. #				Reg. #			_
		_	LSC			-	LSC			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			_
Reg. #			Reg. #				Reg. #			_
LSC		_	LSC				LSC			_
Reviewed By	Reviewed	і Ву	Date:	Signature of Su	rveyor:				Date:	
State Agency	,	BF/KJ	5/4/201	5		1056	52			5/4/2015
Reviewed By	Reviewed	і Ву	Date:	Signature of Su	rveyor:				Date:	
CMS RO										
Followup to	Survey Completed on:				ny Uncorrected			-		
	3/12/2015			Uncorre	cted Deficiencie	s (CMS	3-2567) Sent	to the Facility?	YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 8MTW

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AG	ENCY	F	acility ID: 00294
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245432 2.STATE VENDOR OR MEDICAID NO. (L2) 893042200	Э.	3. NAME AND ADDRESS OF FACILITY (L3) GRACEPOINTE CROSSING GABLES V (L4) 135 FERN STREET NORTH (L5) CAMBRIDGE, MN			WEST (L6) 55008		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	TERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other mplaint
6. DATE OF SURVEY <b>03/12/</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds	140 (L18) 140 (L17)	X B. Not in Com	equirements	n	2. Techn 3. 24 He 4. 7-Day 5. Life the	nical Personnel our RN y RN (Rural SNF)	Following Requirements:	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 140	19 SNF	ICF	IID		15. FACILITY ME		(L15)	
(L37) (L38)  16. STATE SURVEY AGENCY REMARK	(L39) S (IF APPLICABLE S	(L42) SHOW LTC CANCELI	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY API	PROVAL	Date:
Tim Rhonemus,			04/22/2015	(L19)			orcement Special	list 04/23/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR S	INGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Part	icipate		IPLIANCE WITH C HTS ACT:	CIVIL	2. O		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 03/01/1987 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction	00		eet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV  A. Suspension  B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involun 04-Other Reason fo	•	OTHER 07-Provider S 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION (	OF APPROVAL DA		Posted 04	/27/2015 Co		
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	



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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Gracepointe Crossing Gables West March 27, 2015 Page 2

#### 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

Gracepointe Crossing Gables West March 27, 2015 Page 4

in your plan of correction.

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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

Gracepointe Crossing Gables West March 27, 2015 Page 5

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

PRINTED: 04/22/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	FIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245432	B. WING _		03/	12/2015
	PROVIDER OR SUPPLIER OINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282 SS=D	as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electror be used as verificated.  Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  483.20(k)(3)(ii) SEFPERSONS/PER CATTHE SERVICES provided by accordance with ear care.  This REQUIREMENT by:  Based on observation review, the facility fand toileting assistate by the care plan for planned to require some repositioning and in Findings include:  R60's care plan for pl	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 are submission of the POC will ion of compliance.  Cacceptable electronic POC, an air facility may be conducted to notial compliance with the en attained in accordance with a RVICES BY QUALIFIED ARE PLAN  Ided or arranged by the facility you qualified persons in charesident's written plan of the resident's written plan of a resident (R60) care staff assistance for continence checks.	F 0	A bowel and bladder evaluation a risk and Braden assessment were completed on R60. The toileting repositioning plan on R60 reasses the care plan was reviewed and under the toileting and repositioning on residents in house were reviewed revised as necessary. The repose and toileting care plans on all residents of the care plans on all residents.	e and ssed and pdated. all and itioning dents in	4/17/15
	alteration in skin int	[R60] have the potential for egrity related to Decreased ce. I have a history of fragile		house were reviewed and revised necessary.	as	

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of support whether or not a plan of correction is provided. For pursing homes, the above findings and plans of correction are disclosable 14.

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.

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
		245432	B. WING	· · · · · · · · · · · · · · · · · · ·	03/-	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST	1	STREET ADDRESS, CITY, STATE, ZIP COD 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	skin and frequent by plan goal identified and the care plan of [sic] me every 3 ho every 4 hours where R60's care plan for on 5/12/14, identified bladder/bowel incontinence of box The goal indicated, breakdown due to it through the review "INCONTINENT: Or required for incontine 4 hours and PRN [a Wash, rinse and dr PRN after incontine On 3/11/15, during 7:45 a.m. until 11:2 offloading (reposition hours and thirty-two was laying in bed, a assisted R60 with preakfast and finish was then brought to where she remained a.m. three hours ar was last toileted or assisted R60 to off incontinent and her and NA-A verified F	pruising/skin tears." The care , "My skin will remain intact" lirected, "Please repositioning urs and PRN [as needed] and n asleep."  incontinence dated as revised ed, "I [R60] have functional ntinence r/t [related to] d Mobility. My level of wel and bladder can fluctuate. "I will remain free from skin ncontinence and brief use date." The care plan directed, wheck me 3 hours and as nence when awake, and every as needed] when asleep. y perineum. Change clothing	F 282	The policy and procedure was and is current. Education on fresidents' plan of care will be owith staff responsible for direct care by 4-10-15.  The facility will monitor and sure correction by completing care observation audits on 5% of reweekly for 2 months. The resi will be reviewed in QAA and dowill be made for continued auditional Administrator or design responsible for ensuring ongoin compliance.  Correction date for certification	ollowing completed t resident stain plan and esidents ults of audits etermination lits.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	B) DATE SURVEY COMPLETED	
		245432	B. WING _		03/	12/2015	
	PROVIDER OR SUPPLIER  OINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282	three hours while up During interview at (RN)-C checked and sheet and verified F checked for inconting assist in the wheelchair. Finotified her of falling On 3/11/15, at 1:30 incontinence and re RN-B stated R60 sl incontinence check by the care plan.  On 3/11/15, at 2:35 (DON) stated reside incontinence check determined by assecting as a modified lapurpose of the policy repositioning as ide plan. The policy indicated as modified lapurpose of the policy repositioning as ide plan. The policy indicated should be idented the nursing assistant Group sheet). The "Nursing will repositioare and as needed."	11:31 a.m. registered nurse undated Assignment Group R60 should have been nence and offered ance every three hours while RN-C stated staff should have g behind and did not.  p.m. when asked about the epositioning plans for R60, nould have been offered and repositioning as directed and repositioned as essment and directed by the expositioned as essment and directed by the expositioning was to ensure timely ntified in the resident's care icated repositioning was essment, the repositioning entified on the care plan and and care guide (Assignment policy further directed, tion resident per their plan of d or requested."	F 28				
F 314 SS=D	PREVÈNT/HEAL P	ENT/SVCS TO RESSURE SORES rehensive assessment of a	F 3 <sup>-</sup>	14		4/17/15	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245432	B. WING	·····	03/-	12/2015
	PROVIDER OR SUPPLIER OINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZI 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	who enters the facility does not develop provided in they were unavoided pressure sores reconservices to promote prevent new sores.  This REQUIREMED by: Based on observed treview, the facility for the facility	must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.  NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 residents (R60) was provided assistance to prevent the cential pressure ulcers; R60 provided repositioning for three	F3	R60's skin continues to be breakdown. A skin risk a assessment was completed repositioning plan on R60 reassessed and the care and updated.  The skin risk and repositional residents in house were revised as necessary.  The policy and procedure and is current. Education completed with staff respassisting residents with respassisting residents with respassisting residents with respection by completing audits on 5% of residents months. The results of a reviewed in QAA and determade for continued audit Clinical Administrator or continued audits.	and Braden ted on R60. The owas plan reviewed oning plans on the reviewed and was reviewed and will be onsible for epositioning and sustain repositioning weekly for 2 udits will be ermination will be second on R60.	
	and other behaviors	s (such as but not limited to or disruptive sounds) occurred		responsible for ensuring compliance.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST	1	STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	one to three days. required extensive transferring, dressis and toilet use; R60 assistance for locol was always incontinincontinent of bowe. The Care Area Assulcers dated 5/12/1 risk for skin breakd for bed mobility. Rand bladder. Staff reschedule along with concern." A copy of requested, but not the quarterly Skin dated 1/19/15, iden skin alteration," was frequently incontine incontinence brief. R60 was "toileted a when up and every tolerates."  The Admission Rec R60's diagnoses to muscle wasting and On 3/11/15, during 7:45 a.m. until 11:2 offloading (reposition hours and thirty-two as follows:  At 7:39 a.m. R60 bed, a nursing assist R60 with per size of lower and size of lower assist R60 with per size of lower and size of lower assist R60 with per size of lower and size of lower assist R60 with per size of lower and size of lo	The MDS identified R60 assistance with bed mobility, ng, personal hygiene, eating did not walk and required total motion on and off the unit. R60 nent of urine and frequently el. R60 had no pressure ulcers.  essment (CAA) for pressure 4, indicated, "Resident is at own. Does need assistance esident is incontinent of bowel repositions resident per n toileting. No current areas of the CAA summary was	F 314	Correction date for certification: 4	-17-15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3) DATE SUR' COMPLETE			
		245432	B. WING		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP COD 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	provided by NA-A a - From 7:45 a.m. u R60 with grooming - At 8:01 a.m. NA-A television (TV)/comfront of the nursing playing from a radic - From 8:01 a.m. u seated in the whee - At 8:24 a.m. the h was observed to tra area and to a table protector and assis manager (SM) sat another table mate - From 8:24 a.m. to the dining area at t provided total assis - At 9:08 a.m. R60 dining room by SM the unit and R60 re - At 9:16 a.m. NA-E the dietary and fluid meal. NA-B stated meal and verified F foods. NA-B stated centimeters) of fluid - At 9:20 a.m. the conurse (RN)-B mover radio and window in changed the music area From 9:20 a.m. uthe TV area with no offered (two hours transferred from th Various facility staff	a.m. with total assistance and NA-B and a mechanical lift. Intil 8:01 a.m. NA-A assisted in the wheelchair. A transported R60 to the amon sitting area directly in station desk. Music was in the area. Intil 8:24 a.m. R60 remained lichair in the TV area. Itelath unit coordinator (HUC)-A ansport R60 into the dining. HUC-A offered R60 a clothing ated her to apply it. The supply directly to the left of R60 and and and and to the TV area. SM left and to the TV area.	F 31	4		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245432	B. WING		03/	/12/2015
_	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	TV/common area, a - From 9:45 a.m. to unmoved. At 10:05 music and started at television. R60 face TV At 10:29 a.m. NA-window and faced hyrogram. R60's eye the TV From 10:29 a.m. uin the TV area. R60 program At 11:03 a.m. active backed regular chaunder the TV and swould be an exercise baking At 11:05 a.m. R60 wheelchair position minutes since last of bed to wheelchair at a last of the two the two the two the two the common the chair in bed. When asked was repositioning and time while up in the chair in bed. When asked was repositioned, Nowhen last reposition ext on my list." What times were tracked reposition R60. Repos	assisting other residents. 10:29 a.m. R60 remained a.m. RN-B turned off the an "I Love Lucy" movie on the ed out the window and not the B moved R60 away from the ner towards the I Love Lucy es were open and looking at until 11:00 a.m. R60 remained by eyes had closed during the wity staff (AS) carried a straight ir into the TV area, placed it tated to the residents there se activity and then cookie  remained unchanged in ing (three hours and 20 offload during transfer from		314		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		245432	B. WING		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	and BM's [bowel m requested *Bold tin bed, unbolded is for The form had the til 800 [8:00 a.m.].  - At 11:15 NA-C an recorded times down stated she "only chand no offloading w 8:00 a.m. time did observed time of the stated she had to cat the time of the otime of R60's offloatransported to her in the time of the otime of R60's offloatransported to her in the time of the otime of R60's offloatransported to her in the time of the otime of R60's offloatransported to her in the time of the otime of R60's offloatransported to her in the time of the perineal care. R60' intact. Both NA state running late with repositioning for R60's offloatransported to her in the time difference and verified in the time of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference.	ovements] incontinent or nes are for when resident is in chair." Imes of "610 [6:10 a.m.] and d NA-A verified they had both on the tub room form. NA-C ecked on" R60 at 6:10 a.m. was provided. NA-A verified the not match the surveyor ne 7:45 a.m. offload. NA-A lirectly assist another resident ffload and "guesstimated" the ad was 8:00 a.m. R60 was room.  •C and NA-A offloaded at R60 in the stand lift (three or minutes). R60 was observed a small amount of urine. soiled pad and performed as skin was observed to be ff verified they did not report apositioning. In asked regarding the so, the registered nurse in undated Assignment Group R60 should have been three hours while in the stated she "checks the sheets" if she noticed a resident was essed time for repositioning. Should be writing down the off load and verified a fifteen nice was "too much" of a tated staff should have notified	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	in the wheelchair are explained R60's tist staff during the associated at three hour hour time frame was taff should record repositioning "as clethe nurse" if repositioning "as clethe nurse" if repositioning the nurse of the policy of the nurse of the policy of the nurse of the policy of the nurse of the nurse of the nurse of the policy of the nursing as ideal plan. The policy indicated as modified I purpose of the policy of the nursing assistant of the nursing assistant of the nursing assistant of the nursing will reposited as needed 483.25(d) NO CATI	paded every three hours while and four hours in bed. RN-B sue perfusion was checked by essment, no redness was and that was how the three as determined. RN-B stated accurate times of the ose as possible" and "notify tioning was "falling behind." The nurse should then help." should have been repositioned eare plan.  p.m. the director of nursing ents should be repositioned as essment and directed by the ted staff should document the estitioning to ensure the care and verified the staff should urse when falling behind with the long and procedure ast on 6/2003, identified the ey was to ensure timely entified in the resident's care dicated repositioning was resident policy and procedure ast on 6/2003, identified the ey was to ensure timely entified on the care plan and and care guide (Assignment policy further directed, tion resident per their plan of dor requested."  HETER, PREVENT UTI,	F3			4/17/15
SS=D	RESTORE BLADD  Based on the reside	ER ent's comprehensive				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245432	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 315	resident who enters indwelling catheter resident's clinical c catheterization was who is incontinent of treatment and serv infections and to re function as possible	cility must ensure that a sthe facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F3	15		
	Based on observa review, the facility f incontinence check resident (R60) rand and dependent upo and assistance; R6	tion, interview and document ailed to ensure an was provided to 1 of 1 domly observed in the sample on staff for incontinence cares 0 was not checked for see hours and thirty-two		A bowel and bladder evalued completed on R60. The to R60 was reassessed and reviewed and updated.  The toileting plans on all rehouse were reviewed and necessary.	oileting plan on the care plan esidents in	
	1/23/15, identified I impairment, physic six days (but no les and other behavior hit, scratched self, one to three days. required extensive transferring, dressi and toilet use; R60 assistance for loco was always incontinincontinent of bower.			The policy and procedure and is current. Education completed with staff respotoileting residents by 4-10-  The facility will monitor and correction by completing to on 5% of residents weekly. The results of audits will be QAA and determination with continued audits.  Clinical Administrator or determination of compliance.	will be ensible for 15 d sustain colleting audits of r 2 months. The reviewed in the made for esignee will be ngoing	
		dder Quarterly Review dated		Correction date for certification	ation: 4-17-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING _		03	/12/2015	
	PROVIDER OR SUPPLIER	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP COD 135 FERN STREET NORTH CAMBRIDGE, MN 55008		, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 315	incontinent of bowed x. [diagnosis] of does fluctuate. Resubladder, frequently incontinent brief. Is sabina [a type of mand PRN [as need and PRN when in but transfers to toilet. A regimen." The assiplan.  R60's care plan daidentified, "I have fincontinence r/t [re Mobility. My level obladder can fluctuaremain free from sincontinence and but date." The care plate Check me 3 hours incontinence when PRN [as needed] we said the same said to the said the	"Resident remains functionally el and bladder r/t [related to] lementia. Level of continence sident was totally incontinent of incontinent of bowel. Wears a toileted by staff utilizing nechanical lift] every 3 hours ed] when up and every 4 hours bed. Utilized sabina for Will continue with current essment contradicted the care ted as revised on 5/12/14, unctional bladder/bowel lated to] Dementia, Impaired of incontinence of bowel and ate. The goal indicated, "I will kin breakdown due to be in the care through the review and directed, "INCONTINENT: and as required for awake, and every 4 hours and when asleep. Wash, rinse and	F 31	5			
	incontinence episo On 3/11/15, during 7:45 a.m. until 11:2 incontinence check minutes. Observati - At 7:39 a.m. R60 bed, a nursing ass assist R60 with per verified R60 was in the time. After com application of clear then transferred from	continuous observations from 22 a.m. R60 was not offered an a for three hours and thirty-two ions were as follows: was observed to be laying in istant (NA)-A was observed to rineal care and grooming. NA-A acontinent of urine and bowel at a pletion of perineal cares and in incontinence brief, R60 was om the bed to the wheelchair at assistance provided by two					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP C 135 FERN STREET NORTH CAMBRIDGE, MN 55008		.=/=0.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 315	staff (NA-A and NA - From 7:45 a.m. ur R60 with grooming - At 8:01 a.m. NA-A television (TV)/comfront of the nursing playing from a radio - From 8:01 a.m. ur seated in the whee - At 8:24 a.m. the htransported R60 int table. HUC-A offered assisted her to app sat directly to the lemate From 8:24 a.m. to the dining area at the provided total assisted - At 9:08 a.m. R60 dining room by SM the unit and R60 renot offer or provide - At 9:20 a.m. the conurse (RN)-B mover radio and window in changed the music area From 9:20 a.m. ur the TV area and was checks (two hours and transfer to whe facility staff, including were observed to be TV/common area, and the TV area and transfer to whe facility staff, including were observed to be TV/common area, and the TV area and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including were observed to be TV/common area, and transfer to whe facility staff, including th	and a mechanical lift. Intil 8:01 a.m. NA-A assisted in the wheelchair. Intransported R60 to the mon sitting area directly in station desk. Music was in the area. Intil 8:24 a.m. R60 remained Ichair in the TV area. Itil 8:24 a.m. R60 remained Ichair in the TV area. Itil 8:60 a clothing protector and Ity it. The supply manager (SM) Ift of R60 and another table  9:08 a.m. R60 remained in the dining table and was transported out of the and to the TV area. SM left mained in the TV area. SM left mained in the TV area. SM did assistance with toileting. Ilinical manager/registered and R60 a few feet closer to the in the TV/common area. RN-B to Christian rock then left the Intil 9:45 a.m. R60 remained in the TV area in the TV/common area. RN-B to Christian rock then left the Intil 9:45 a.m. R60 remained in the Ity area in the Ity area. SM Intil 9:45 a.m. R60 remained in the Ity area in the Ity area. In Ity area in the Ity area in the Ity area. In Ity area in Ity area. Ity area in Ity	F3	.15		

AND DIAN OF CODDECTION INDESTRUCTION NUMBER.		TIPLE CONSTRUCTION UNG		(X3) DATE SURVEY COMPLETED		
		245432	B. WING _		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP COL 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	Lucy" movie on the window and not the At 10:29 a.m. NA window and faced program. R60's eye the TV.  - From 10:29 a.m. in the TV area. R60 program.  - At 11:03 a.m. acti backed regular chaunder the TV and swould be an exerci baking.  - At 11:05 a.m. rem wheelchair position assistance with toil minutes since last transfer to the whe At 11:09 a.m. NAbe checked for incundated Assignme reference resident incontinence check hours" while up in twhile in bed. Althouse," NA-A verified a check only. When R60 was checked she was unclear, bmy list." When ask were tracked, NA-A incontinence check "Tub room." NA-A sassistance and check times were resident check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incontinence check "Tub room." NA-A sassistance and check times were resident incon	e music and started an "I Love e television. R60 faced out the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/1	2/2015	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		2,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 315	wet, incontinent or movements] incontare for when resided when resident is in of "610 [6:10 a.m.] documented for R6 - At 11:15 NA-C an recorded times down stated she "only chand verified the 8:0 surveyor observed care/offload. NA-A assist another reside care/offload and "gincontinence check transported to her and the stand lift (three hown between incontinent of a sm smelling urine. NA-performed perineal they did not report checks. Both NA stand lift (three hown between incontinent of a sm smelling urine. NA-performed perineal they did not report checks. Both NA stand lift (three hown between incontinent of a sm smelling urine. NA-performed perineal they did not report checks. Both NA stand lift (three hown between incontinent of a sm smelling urine. NA-performed perineal they did not report checked for incontinent of a uniform the wheeled the sheets" and will resident was going incontinence check writing down the active will be a fifteen middle a fifteen middl	ase write time toileted, if dry or requested, and BM's [bowel tinent or requested *Bold times ent is in bed, unbolded is for chair." The form had the times and 800 [8:00 a.m.] 60.  d NA-A verified they had both wn on the tub room form. NA-C ecked on" R60 at 6:10 a.m. 00 a.m. time did not match the time of the 7:45 a.m. perineal stated she had to directly dent at the time of the perineal uesstimated" the time of R60's a was 8:00 a.m. R60 was	F 315				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245432	B. WING _	<del> </del>	03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 327 SS=D	toileting plan for R6 checked every threand four hours in be stated staff should incontinence check "notify the nurse" if checks were "falling "The nurse should have been pas directed by the owny the assessment of the stated staff should incontinence check assessment and directed staff should incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check followed and verified notified the nurse wholleting or incontinence check	p.m. when asked about the 0, RN-B stated R60 was to be e hours while in the wheelchair ed for incontinence. RN-B record accurate times of the s "as close as possible" and toileting or incontinence g behind." RN-B then stated, then help." RN-B verified R60 provided incontinence checks are plan. RN-B was unclear at differed from the care plan.  p.m. the director of nursing ents should be provided as a determined by rected by the care plan. DON document the correct time of s to ensure the care plan was d the staff should have when falling behind with ence checks. DON verified the atch the assessment.  Ty Presbyterian Homes and f Residents policy and a last modified on 6/2003, se of the policy was to "insure lentified in the resident's care rected, "6. Residents will be oileting needs and at intervals sident care plan."  ENT FLUID TO MAINTAIN	F 31			4/17/15
	sufficient fluid intak	e to maintain proper hydration				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING _		03/	12/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 327	by: Based on observareview, the facility potential dehydration reassessed for 1 of sample reviewed for Findings include: R60's Physician Of Treatment (POLST 10/21/08, with hand identified R60 requirements (POLST 10/21/08, with hand identified R60 regularization, no to be drawn. The Finding difference of feasible." and directed, "Always of feasible." and directed for Nutrition dated (Polston Valley) (Polston Vall	NT is not met as evidenced tion, interview, and document failed to ensure symptoms of on were identified and f 1 resident (R60) in the or hydration.  The ders for Life Sustaining of form dated as signed on divitten update dated 2/22/12, rested comfort care only, no antibiotics and directed no labse POLST form for hydration offer food and liquids by mouth ected "No artificial nutrition of "No IV [intravenous] fluids."  The MDS identified R60 of the MDS iden	F 32	A hydration assessment was coon R60. The hydration care plan was reviewed and updated.  The hydration plans on all reside house were reviewed and revise necessary.  The policy and procedure was reand is current. Education will be completed with staff responsible assisting residents with hydratio by 4-10-15.  The facility will monitor and sust correction by completing hydration 5% of residents weekly for 2. The results of audits will be revie QAA and determination will be no continued audits.  Clinical Administrator or designer responsible for ensuring ongoing compliance.  Correction date for certification:	ents in ed as eviewed e for n needs ain on audits months. ewed in nade for		
	Maintenance did n	ot trigger. Although a copy of a summary was requested, it					

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		245432	B. WING		03/12/	2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) OMPLETION DATE
F 327	identified, "I have of deficit r/t [related to deficit r/t [related to disturbances" with symptoms of dehydrations membrane plan directed, "End choice and offer flumealtimes/snacks; "Observe for and relations dehydration: decre concentrated urine cracked lips, furrow confusion, dizzines increased pulse, he dizziness, fever, the dry/sunken eyes." identified no laboration R60, the care promotion lab/diagnoresults to MD [mediated."  The Nutritional Assidentified current some water Pass, 80 composed protein dietary supland identified R60 Comments-Food/"There has been a in past 90 days d/t spout cups and comments-Hydration with med [mediation]	ted as revised on 8/8/12, dehydration or potential fluid of Dementia with behavioral the goal, "I will be free of dration and maintain moist es, good skin turgor." The care courage me to drink fluids of slids throughout the day and at " and further directed, eport to MD [medical doctor] as and symptoms] of ased or no urine output, strong odor, tenting skin, wed tongue, new onset on sitting/standing, eadache, fatigue/weakness, irst, recent/sudden weight loss, Although the POLST form atory work would be completed lan directed, "Obtain and stic work as ordered. Report dical doctor] and follow up as sessment dated 1/18/15, supplement/snack orders of c [cubic centimeters] 2+ [a high plement] tid [three times daily]" accepted the supplement. The Fluid Intake section indicated, decline in food and fluid intake illness. Res provided with ated spoons at meals." The hydration risk assessment" ither yes or no. The ion indicated, "Fluids provided on pass as ordered, at the hedside." The	F 327			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		E SURVEY MPLETED	
		245432	B. WING	·····	03/	/12/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 327	assistance to eat/of intake to be betwee Assessment Summunderstand the die warranted d/t difficonsistency foods further identified, "which shows a loss [significant] and 7. recent illness and improvedRes is for additional fluids practitioner] and as Message left with I changes and updatif intake will improvins d/t weight changes and the R60's estimated fluids 1590-1781 cc of fluids 1	fied R60 required total to partial drink and identified the fluid en "30-400 cc." The mary identified R60 did not of order, "Current diet remains ulty chewing/swallowing regular and fluids." The Summary Current weight 139.8# [pounds] s of 5.5% in 30 days (sig) 5% in 180 days. Res has had	F 327	7			
	identified R60 had Alzheimer's diseas problems. "No curr dehydration, no few assessment did not dehydration. The adaily intake of fluids (Amount in ml's [mintake of fluids betwassessment identifier dehydration."  - The Comments A section indicated, '	essment dated 1/19/15, diagnoses of dementia, se, and had swallowing rent dx [diagnosis] of ver/vomiting/diarrhea." The of identify physical symptoms of assessment identified Average s with meals was "700 illililiters]" and average daily ween meals was 500 ml. The fied R60 was "At potential risk assessment/Plan/Referrals 'Resident is potentially at risk frelated tol dx. [diagnosis] of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING			03/12/2015	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STAT 135 FERN STREET NORTH CAMBRIDGE, MN 55008	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD B TO THE APPROPRI		
F 327	Is currently on nection [history] of constipar management. Resignass and supplement meals. Is encourag and med passes. No Focus is on comfor plan of care."  The GracePointe Course of the GracePointe Cours of the ginning 1/13/15; high protein, high cours a day, which consumed 100% of times a day, which consumed 100% of the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consistency is the unit in that times a day, which consis	lity to recognize thirst needs. ar thick fluids. Does have hx. tion and is on laxative for dent is on additional water ent throughout day between ed to drink fluids with meals o current signs of dehydration. t. Will continue with current rossing Gables West Order ated as signed by the directed to offer nectar thick and "encourage fluids" offer 120 cc Med Plus 2.0 (a alorie dietary supplement) four was 480cc per day if she the supplement.  It is a signed by the dietary supplement of the supplement.  It is a signed by the dietary supplement of the supplement.  It is a signed by the dietary supplement of the supplement.  It is a signed by the dietary supplement of the supplement.  It is a signed by the dietary supplement of the supplement of the residents of the residents of the residents of the residents of the supplement of the s	F3	27			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING _		03	/12/2015	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP C 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 327	the nursing station observed to be open with her eyes close and dry; R60's tong dry; her tongue ap very bumpy, leathed cracked with deep slightly red and dry to voice at the time the approximately the area were all of assistance to drink nor was any assistance to drink nor was any assistance.  On 3/11/15, during 7:39 a.m. until the dam. R60 was not of fluids to prevent posses was only offered fluscheduled fluid/supmedication passes was only offered fluscheduled fluid/supmedication pass arobserved to assist while in bed. Two ewith a spout for dring on the bedside table soiled.  - At 7:41 a.m. NA-Emechanical lift and wheelchair at 7:45 NA-B left the room "usually work" in "the she "usually worke" - At 7:52 a.m. NA-Emechanically worked as "In the "usually worked" in "the "usually worked"	desk. R60's mouth was en during the church activity, ed. R60's lips were chapped gue was dark red colored and peared very rough textured, ry in appearance, and heavily furrows. R60's gums appeared. R60 did not rouse or respond of the observation. Although 17-20 observed residents in fered fluids and provided the fluids, R60 had no fluids ance to drink was offered to continuous observations from end of observations at 11:22 offered the opportunity to drink otential dehydration between and scheduled meals. R60 uids by the nurse during a oplement pass, during the end during an observed meal. as follows: rsing assistant (NA)-A was R60 with incontinence cares empty clear plastic glasses, one nking, were observed stacked le. The glasses appeared to be a entered the room with a R60 was transferred to the a.m. by both NA-A and NA-B. NA-A stated she did not his building" and when she did	F 32	7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03.	/12/2015	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP COI 135 FERN STREET NORTH CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 327	NA-A stated R60's green toothette wh water. NA-A stated and can't spit" and consistency liquids out the access war asked regarding the room, NA-A stated by her and were bethe room at approverified no nectar of available to offer F-At 8:01 a.m. NA-common area. At was R60 offered the At 8:16 a.m. NA-offered to R60 by I stated she did not while doing cares water was empty" occurred "now." Not distributing water the common area, R60's eyes were owindow.  At 8:24 a.m. R60 area by the health wheeled to a table protector and assis were observed at the management (SM) next to another restaff wheeled a cardiscussed with SM poured nectar con a carton. Staff immand held the glass	mouth was swabbed with a sich was moistened with tap of R60 "does not follow direction stated R60 received nectar is. NA-A stated she squeezed ter from the sponge. When the empty plastic glasses in the the glasses were not provided both empty when she entered kimately 7:00 a.m. NA-A consistency fluids were	F3	327			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		0	3/12/2015	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, ST 135 FERN STREET NORTI CAMBRIDGE, MN 5500	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 327	water was poured nectar consistency offered to R60 From 8:24 a.m. uthe dining area for remained with R60 offering various fluto R60. R60 was contresist the offer coughing or swalld - At 9:08 a.m. R60 to TV/common are the unit. R60's mowhile seated in the after drinking sips lips appeared pink tongue remained scolored; R60's ton appearance, heav - At 9:16 a.m. NA-process of recordifor the observed in plate and glasses stated R60 consur of fluids and 0-25% the fluid amount constitution. From 9:16 a.m. uin the TV/common watching "I Love L Although various sthe clinical manage the registered nurs the area to change was only moved in towards and away were fluids offered - At 11:03 a.m. activities.	'A nectar consistency glass of and offered, R60 drank sips. A milk was also poured but not antil 9:08 a.m. R60 remained in the breakfast meal. SM and alternated between ids and bites of pureed foods observed to take small sips, did ed fluids and had no observed owing concerns.  Was wheeled out of the room as by SM. SM immediately left with was observed to be open a common area. Immediately of fluids from the meal, R60's, less dry and supple; R60's slightly dry, appeared dark pink gue remained leathery in ally cracked, and furrowed.  B stated she was in the meal. NA-B reviewed R60's of remaining fluids. NA-B med 20 cc (cubic centimeters) (bites) of solids. NA-B verified onsumed by R60 was "low." antil 11:00 a.m. R60 remained area listening to the radio, ucy" in the wheelchair. Staff, including NA-A, NA-B and per/registered nurse (RN)-B and se (RN)-C were in and out of a music, turn on the TV, R60 at the wheelchair a few feet from the window. At no time	F3	327			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED	
		245432	B. WING		03	/12/2015	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	•		
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F 327	PROVIDER OR SUPPLIER  POINTE CROSSING GABLES WEST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F3	227			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		TIPLE CONSTRUCTION	(1	(X3) DATE SURVEY COMPLETED	
		245432	B. WING			03/1	12/2015
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CO 135 FERN STREET NORTH CAMBRIDGE, MN 55008	)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE
F 327	after offloading/inco On 3/11/15, at 11:3 R60 120 cc of wate twice on her shift. F offered the water at the morning." Whet consumed this mor Medication Adminis Electronic Medical drank "everything" a total of "240 cc." were offered, RN-C medications betwee verified she offered a.m. (on 3/11/15). V of R60's potential s RN-C stated she we not assessed R60 f what symptoms of offer and expected to "looks for tenting [a turgor, a sign used potential dehydration "focuses on what [F of potential dehydration"]	ed by the NA staff before or ontinence check was provided.  1 a.m. RN-C stated she gave or, plus 120 cc of supplement RN-C stated she usually and supplement "Right away in a sked if offered and oning, RN-C referred to the stration Record (MAR) in the Record. RN-C stated R60 offered that morning and it was when asked when the fluids a stated she gave both with en 6:30 a.m 7:00 a.m. RN-C R60 no other fluids after 7:00 When asked if she was notified ymptoms of dehydration, as not. RN-C stated she had for dehydration. When asked dehydration she would assess a be reported, RN-C stated she at test used to determine skin to assess fluid loss or on]." RN-C then stated she at test used to determine skin to assess fluid loss or only." RN-C then stated she at the time of the interview, RN-C the surveyor present. RN-C the survey	F3	27			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		<del> </del>	03/	12/2015
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 327	look into R60's mocomment.  - At 1:28 p.m. RN-offered fluids to R6 Review of the MAR through March 201 R60 120 cc of water three times daily. If and January 2015 water or supplement 1/13/15. Beginning amounts of water and urse where documented the MAR indicated 120 cc amount, R6 with a noted decreconsumed beginnition 3/9/15, the MAZ 240 cc of fluids on 3/10/15 (where MAR indicated R6 and 480 cc of supplement 1/10/15 (where MAR indicated R6 and 480 cc of fluids on 3/11/14, the MZ 240 cc of fluids and 510 cc of fluids and 510 cc of fluids frow and before supperfrom murse);  - Review of the Grad West Follow Up Q through 3/11/15, in with Meals in ml [eidentified R60's fluids on 3/9/15, R60 reserved.	C stated staff should have 60 throughout the day.  Rs from December 2014 15, indicated the nurse offered er and 120 cc of supplement The MARs for December 2014 did not include the amount of ent consumed by R60 until yon 1/13/15, the consumed and supplement offered by the mented on the MAR. Although R60 usually consumed the full 60's fluid intakes were variable ase in amount of fluid ng on 3/9/15: AR indicated R60 consumed d 480 cc of supplement (total from nurse); a R60 was first observed), the 0 consumed 270 cc of water olement (total of 750 cc of fluids IAR indicated R60 consumed d 270 cc of supplement (total of m nurse between breakfast).  CePointe Crossing Gables uestion Report from 12/1/14, icluded a report of "Fluid Taken equal to cc]." The report id intakes were variable. Efused fluids at breakfast and umed 25 ml of fluids at lunch	F3	327			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		245432	B. WING		03	3/12/2015	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		, , _ , _ ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE	
F 327	R60 consumed 50 50 ml from meals); on 3/11/15, R60 c and 120 ml at lunch R60's intake record 24-hour fluid intake on 3/9/15, total of on 3/10/15, total of on 3/11/15, R60 c fluids up to lunch. Freflect adequate fluid dehydration.  On 3/11/15, at 1:30 fluid intake, RN-B s scheduled in the Mobserved for "anxiebeing thirsty; RN-B her mouth" it was a thirst. RN-B stated cares and verified signing the observations when "knew" the stafthem "daily." RN-B get to drink, explair fluids if she "was the for "anxiety" as a mpain, hunger or thirm "end stages of Alzh "expected" to be "s dying process. Who dying, RN-B stated but stated the famil "comfort." Although an indicator for R60 resident specific incomplete in the stage of the stated the famil "comfort." Although an indicator for R60 resident specific incomplete.	fluids at breakfast and lunch, ml of fluids at supper (total of onsumed 20 ml at breakfast in (total of 140 ml from meals).  Is indicated the following totals:	F3	27			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 327	- At 1:57 p.m. RN-E in her room at the I verified R60's tongottime of the observation consistency water a verified she should furrowed tongue arbeen offered to R60.  On 3/11/15, at 2:25 (RD) stated R60's chydration were 125 asked if she believe fluids to meet this contakes in the Elect verified R60's fluid 3/9/15. RD stated sidietary intakes on a RD stated she was with R60's fluid intafluids to be offered R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required a new needs; RD verified dehydration due to fluids and use of new needs; RD verified R60 required R	tified by facility staff.  B and surveyor observed R60 ight of the room window. RN-B ue appeared furrowed. At the tion, the glass of nectar at bedside remained full. RN-B have been notified of the not stated fluids should have throughout the day.  p.m. the registered dietician estimated needs for fluids and 0 - 1350 cc/24 hours. When ed R60 was offered enough goal, RD checked R60's fluid ronic Medical Record. RD intakes were "low" since the "looked at" the fluid and a quarterly or as needed basis. Not alerted to any concerns thes. RD stated she expected throughout the day. RD stated or assessment for hydration R60 was at higher risk for dependence on staff to obtain ectar consistency liquids.  p.m. the director of nursing should have offered fluids at the day. DON stated the staff raged fluids when other	F 32'	7		

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  ING		ATE SURVEY DMPLETED
		245432	B. WING		0:	3/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP O 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 327	note directed "it is a identified, "Labs and identified, "Labs and On 3/12/15, at 10:5 assessed R60 for cand discussed the stated after assess increased the fluids times per day. RD greater than the fluthrough 3/11/15.  Review of the Produced 3/11/15, writt R60's estimated flucc/actual body weig report res [resident since breakfast meintake prior to be "1 The note identified of the 120 cc suppl three times daily will the note indicated requested to be inc "intake from water provide 1080 cc. Sicares. Will follow h fluid intake and monutritional intervent Review of the Pres Hydration Risk Polidirected, "5) Fluids at the following time meals, At med pas residents at higher notification and ide dehydration to incl	ere identified for R60, the NP appropriate to offer fluids" and a not indicated."  77 a.m. RD stated she changes in hydration needs findings with the family. RD ing R60's intakes she offered to R60 to 120 cc six stated R60's fluid needs were ids received on 3/9/15,  18 gress Note provided by RD en at 4:02 p.m. indicated id needs were 1500-1700 ght. The note indicated, "Staff has had a decline in intakes al 3/9/15, and identified fluid 100-400 cc fluids per meal."  18 R60 was accepting 75-100% ement and 120 cc water pass hich provided "820 cc fluids." fluid intake would be reased to six times per day, pass and supplement will taff will also offer fluids with igh risk d/t [due to] variable nitor need for further	F3	27		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245432	B. WING _		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 327 F 441 SS=D	under the tongue m 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infection (a) Infection Control The facility must es Program under whit (1) Investigates, co- in the facility;	a furrows (absence of moisture noisture). I CONTROL, PREVENT  Itablish and maintain an accomfortable environment and development and transmission action.  I Program tablish an Infection Control	F 32			4/17/15
	should be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each din hand washing is incomprofessional practic (c) Linens Personnel must hand	o an individual resident; and ord of incidents and corrective ifections.  ead of Infection ion Control Program esident needs isolation to of infection, the facility must in the prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245432	B. WING _		03/-	12/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		. 2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	infection.  This REQUIREME by: Based on observareview, the facility changed during incand bladder incont spread of infection the sample observ  Findings include:  During observation surveyor knocked presence and was room. A nursing as be assisting R60. Fin bed, partially drew NA-A stated she we cares. A soiled incounder R60. NA-A surine and "having a right side, obtained."	NT is not met as evidenced tion, interview and document failed to ensure gloves were continence cares after bowel inence, to prevent the potential for 1 of 2 residents (R60) in ed for perineal cares.  I on 3/11/15, at 7:39 a.m. on R60's door, announced allowed admittance to R60's sistant (NA)-A was observed to R60 was observed to be laying essed with her pants down. as "in the middle" of perineal ontinence product remained tated R60 was incontinent of a BM." NA-A rolled R60 to the I an incontinence wipe and at to back on R60's buttocks.	F 44	, , , , , , , , , , , , , , , , , , ,	ain ashing sidents of audits ermination s. e will be	
	changing gloves or NA-A reached to the clean incontinence NA-A rolled R60 be the incontinence properties, NA-A removes applied, NA-A removes her hands. Notes 17:41 a.m., brought	d the soiled brief. Without performing hand hygiene, he head of the bed, picked up a pad and placed it under R60. ack onto the pad and applied roduct. After the brief was oved the gloves, and did not A-B knocked on the door at in a mechanical lift, both under R60 and transferred her				
	wash her hands. N 7:41 a.m., brought applied a lift sling u	A-B knocked on the door at				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DATE SURVEY COMPLETED
		245432	B. WING		03/12/2015
	PROVIDER OR SUPPLIER OINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 465 SS=E	change gloves afte verified she contambrief with the soiled did not perform har soiled gloves and s registered nurse (Rhave been removed before handling the On 3/11/15 at 12:20 (DON) verified glovand hand hygiene of area was cleaned a removed; before the Review of the Pres Perineal Care polic modified on 4/2010 soiled brief in bag to wash hands or use 483.70(h) SAFE/FUNCTIONAE ENVIRON	a.m. NA-A verified she did not r wiping R60's stool and hinated the clean incontinence gloves. NA-A confirmed she had hygiene after removing the hould have. At 11:31 a.m. the lN)-C stated the gloves should d and hand hygiene completed e clean incontinence brief.  D.p.m. the director of nursing res should have been changed completed after the perineal and the soiled brief was e clean brief applied.  Byterian Homes and Services y and procedure dated as last y, directed after placing the o "21. Remove gloves, and waterless hand sanitizer."  AL/SANITARY/COMFORTABL	F 465		4/17/15
	This REQUIREMENT by: Based on observative review, facility failed kept in good repair nursing units, City N			All water stains, wall paper tears, crack ceiling tiles, gouged walls, and chipped paint throughout the Gables West build have been repaired and/or replaced. A ceiling lights have been dismantled and	ng I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER	ABLES WEST	-	STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	approximately 78 reunits.  Findings include:  During the environr (Adm) and environr on 3/11/15, at 11:50 following areas idea water Stains on the The River View 2 (I an approximate 12 colored stain on the crack in the ceiling and the wallpaper windows which was length.  City View 2 (CV2) of approximate 12 income and yellow colored had approximately stained ceiling tiles.  City View 1 (CV1) of approximate 6 inchestain in hallway about CV1 had two brown (approximately 12 if floor main dining room RV1 had a cracked	mental tour with administrator mental services director (ESD) a.m. was completed with the ntified:  e Ceiling:  RV2) dining room, there was inch size brown and yellow e ceiling tile. There was a large above the food service area, was peeling near dining room approximately 8 inches in common area had an h brown stain on the ceiling stain above window. The area 6 inch brown and yellow color located above nurses' station.  dining room had an size brown and yellow colored ove tub and shower room.	F 465	cleaned of all foreign objects. Fau washer has been replaced to elimi leaking and lime buildup. Foot boreplaced. All fans and vents have cleaned or replaced. Vanity and countertop replaced in room 239. Splintered wood in room 252 has bremoved and sanded.  The facility Environmental Engineer instituted a weekly resident room at The audit is completed weekly by Household Coordinators in each urall resident rooms and reviewed with Environmental Engineer weekly. An environmental audit will be complemaintenance, housekeeping, and it to ensure all other common areas maintained.  The facility will monitor and sustain correction by completing the above weekly for two months. The result audits will be reviewed in QAA and determination will be made for conaudits.  Environmental Engineer or designed be responsible for ensuring ongoin compliance.  Correction date for certification: 4-	nate ard was been  been  oeen  or audit.  nit on th a weekly ted by aundry are  oe audits s of the tinued  oee will og	
	There were large b	ay, near the nurses' station. rown and yellow colored stain nches) outside of room 120				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING _		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465	and there were smacolored stain (approposite to it.  RV1 ceiling near the brown and yellow capproximately 12 in measured approximately 12 in measured approximates tation.  RV2 there were two stains (approximates station.  Peeling wallpaper at CV2 east hallway happroximately 6 incomposite to	all ceiling brown and yellow oximately three inches)  e nurses' station had two colored stains (one was niches and a smaller one that mately three inches).  b brown and yellow colored ely 6 inches) above the nurses and wall condition:  and wall paper which had a tear ches long near room 252.  It with the inch size peeling ove linen room.  In area near the nursing proximately six inch size area are behind the recliner chairs on the were two long gouges in the headboard. One gouge was to inches long by one inch wide was approximately six inches de with the dry wall exposed.	F 4	55		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245432	B. WING _		03	/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP COD 135 FERN STREET NORTH CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	Continued From pa	ge 33	F 46	5		
	Other room concer	ns:				
	of bathroom. The b	chipped paint directly to right athroom sink had a leaking ripping from faucet, build-up of				
RV2 room 224, R126's footboard of bed had plastic edge peeling and hanging from wood.						
	fan with a heavy bu material hanging or	creation room 249, had a black ildup of gray fuzzy dust-like n front grate. The fan was lents who were having coffee vity in this room.				
	black pedestal fan	near the nurses' station had a to be turned on and running. I a heavy buildup of grayish ee fan blades.				
	1-1/2 inches in diar bathroom door fron vanity had a white of 3-4 inch size half ci	d a circular hole approximately neter punched through that in the door stop. The built in colored veneer approximately rcle that was peeling away sharp, uncleanable surface.				
	RV2 - room 234 roowith a heavy build u	om had a vent in the ceiling up of visible dust.				
	at the bottom of the inches up from floo sticking out two inc veneer at the bottom	m door had a splintered wood e door approximately four r bottom which then was hes from edge of door. The m of the door was pulled away n left a sharp edge on the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED			
		245432	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER	ABLES WEST	,	13	TREET ADDRESS, CITY, STATE, ZIP CODE 85 FERN STREET NORTH AMBRIDGE, MN 55008	, 30,	. = / = 0 . 10
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	environmental servimaintenance has a program. When play scheduled, the work program in the morare in the Excel procompleted, maintenance to the sender.  On 3/11/15, at 12:5 work order system maintenance staff not aware of these.  On 3/12/15, at 2:20 (HD) indicated staff room monthly. What they have deep cleroutine list, housek daily tasks to do.  Review of the undachecklist identified bathroom, resident list. Dayroom, nursiand household coordoom, wash handra accessories within View 1 North (CV 11E), strip, wash an room. Once a wee bathrooms, empty CV1N. Note: house units and fill out validischarged/decease.	9 p.m. when interviewed, vices director (ESD) stated in Excel work order computer anned maintenance is the k order appears in the Excel rining. All daily work requests orgam. When work has been nance sends a progress note of the endirector of the	F 4	465			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245432	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 135 FERN STREET NORTH CAMBRIDGE, MN 55008	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 465	Policy/Procedure T Billable for Services date: 9/2014, indica order was requeste	age 35 ask/Work Order Requests and soriginal date: 2009, revision ated purpose was when a worked the Environmental Services provide the service within one	F 4	65		

Printed: 03/13/2015 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1, ,	PLE CONSTRUCTION B 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
245432			B. WING	B. WING 03/1			
	PROVIDER OR SUPPLIER POINTE CROSSING	GABLES WEST	135 FEI	RESS, CITY, S RN STREE RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Minnesota Departmentime of this survey, Gables West was for with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing Graceponit Crossin building with a particular constructed at 4 difficulty building was constructed at 4 difficulty was constructed to be of 1974, 86, & 99 an at the building that was II(111)construction.	Survey was conductorent of Public Safety. Grace Pointe Crossic bund in substantial cours for participation in at 42 CFR, Subpartery from Fire, and the Fire Protection Associate Life Safety Code	At the ing ompliance in 2000 ciation (LSC), 2-story ilding was ginal as action. In structed to of Type I building	K 000			
LABORATOR	allowed for existing surveyed as one bu  The building is fully facility has a comple smoke detection in open to the corridor automatic fire depart	buildings, the facility ilding.  sprinkler protected. ete fire alarm system the corridors and sprint that is monitored fortment notification. Tacity of 140 beds and etime of the survey.	was The with aces or he facility I had a	<b>NATURE</b>	TITLE		(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

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 <u>only a suggestion</u> 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

Gracepointe Crossing Gables West March 27, 2015 Page 2

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00294	B. WING	<del></del>	03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	N STREET NO DGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficition herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of I lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/30/15

STATE FORM 6899 8MTW11 If continuation sheet 1 of 38

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES WEST	I STREET NO OGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department evideral software. To statute/rule out of commany Statement evidence the "To correction order. The findings which are in after the statement evidence by." Followare the Suggested Time period for Country Provider's PLASE DISREGATOURTH COLUMNING PROVIDER'S PLAAPPLIES TO FEDE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  It is surveyors of this visited the above provider and ation orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting correction Orders using ag numbers have been not a state statutes/rules for the interest of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 8MTW11 If continuation sheet 2 of 38

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00294	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			4/17/15
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observati review, the facility fand toileting assista by the care plan for planned to require s	ent is not met as evidenced ion, interview and document ailed to ensure repositioning ance was provided as directed 1 of 1 resident (R60) care staff assistance for acontinence checks.		N/A		
	Findings include:					
	7/3/13, identified, "I alteration in skin int mobility, Incontinen skin and frequent b plan goal identified, and the care plan d	skin dated as revised on [R60] have the potential for regrity related to Decreased ce. I have a history of fragile ruising/skin tears." The care "My skin will remain intact" lirected, "Please repositioning urs and PRN [as needed] and a asleep."				
	on 5/12/14, identified	incontinence dated as revised ed, "I [R60] have functional ntinence r/t [related to]				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
-	PROVIDER OR SUPPLIER POINTE CROSSING G	ARI ES WEST 135 FERN	DRESS, CITY, S I STREET NO OGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Dementia, Impaired incontinence of bow The goal indicated, breakdown due to ithrough the review "INCONTINENT: Crequired for incontine 4 hours and PRN [a Wash, rinse and dr. PRN after incontine On 3/11/15, during 7:45 a.m. until 11:2: offloading (reposition hours and thirty-two was laying in bed, a assisted R60 with pR60 was then trans wheelchair at 7:45 a provided by NA-A, IR60 remained in he breakfast and finish was then brought to where she remaine a.m. three hours ar was last toileted or assisted R60 to offl incontinent and her and NA-A verified Freposition and checked for incontinent and checked for incontinent incontinent and checked for incontinent incontinent and checked for incontinent incontinent and seed and verified Frepositioning assist in the wheelchair. Finally a service of the checked for incontinent incontinent incontinent and checked for incontinent incontinent and checked for incontinent	I Mobility. My level of wel and bladder can fluctuate. "I will remain free from skin noontinence and brief use date." The care plan directed, heck me 3 hours and as nence when awake, and every as needed] when asleep. I perineum. Change clothing ence episodes.  Continuous observations from 2 a.m. R60 was not offered oning assistance) for three of minutes. At 7:39 a.m. R60 a nursing assistant (NA)-A perineal care and grooming. I ferred from the bed to the fa.m. with total assistance NA-B and a mechanical lift. For wheelchair, went to perine ded breakfast at 8:01 a.m. She of the television/common room do until 11:05 a.m. At 11:22 and thirty-two minutes since she repositioned. NA-C and NA-A load, and verified R60 was skin was intact. Both NA-C R60's care plan directed to like R60 for incontinence every on in the wheelchair.  11:31 a.m. registered nurse undated Assignment Group R60 should have been	2 565			

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550	******		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
2 565	On 3/11/15, at 1:30 incontinence and re RN-B stated R60 sl incontinence check by the care plan.  On 3/11/15, at 2:35 (DON) stated reside incontinence check determined by assecare plan.  The Presbyterian H Repositioning of Redated as modified lapurpose of the polic repositioning as ide plan. The policy ind determined by asseneds should be ide the nursing assistant Group sheet). The l'Nursing will repositioner and as needed SUGGESTED MET The director of nurs (s)could review and procedures related	p.m. when asked about the epositioning plans for R60, nould have been offered is and repositioning as directed in p.m. the director of nursing ents should be offered is and repositioned as essment and directed by the session of the entry and procedure ast on 6/2003, identified the east on 6/2003, identified the entry was to ensure timely intified in the resident's care icated repositioning was essment, the repositioning entified on the care plan and into care guide (Assignment policy further directed, ition resident per their plan of directed."  THOD OF CORRECTION: sing (DON) or designee	2 565			
	to educate staff and to ensure staff are p the written plan of o	nee (s)could develop a system develop a monitoring system providing care as directed by eare.  R CORRECTION: Twenty-one				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARLES WEST	I STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 5	2 905			
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			4/17/15
	positioned in good of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir the physician has of this MN Requirements. Based on observation review, the facility for randomly observed timely repositioning development of potential positions.	ig. Residents must be body alignment. The position to change their own position to change their own position to least every two hours, if time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or redered a different interval.  The provided a different interval on, interview and document ailed to ensure 1 of 1 residents (R60) was provided assistance to prevent the ential pressure ulcers; R60 provided repositioning for three or minutes.		N/A		
	Findings include:					
	R60's care plan for 7/3/13, identified, "I alteration in skin int mobility, Incontinen skin and frequent b plan goal identified, and the care plan d reducing cushion in "Please repositionir	skin dated as revised on [R60] have the potential for regrity related to Decreased ce. I have a history of fragile ruising/skin tears." The care "My skin will remain intact" irected to use a pressure the wheelchair and directed, ag me every 3 hours and PRN ery 4 hours when asleep.				
	1/23/15, identified Find impairment, physical	imum Data Set (MDS) dated R60 had severe cognitive al behaviors occurred four to s than daily), verbal behavior				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
		00294	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	,		
GRACE	POINTE CROSSING G	ARI ES WEST	RN STREET NO IDGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 905	and other behaviors hit, scratched self, one to three days. required extensive transferring, dressir and toilet use; R60 assistance for locor was always incontinincontinent of bowe.  The Care Area Assulcers dated 5/12/1 risk for skin breakd for bed mobility. Reand bladder. Staff r schedule along with concern." A copy of requested, but not pushed the skin alteration," was frequently incontine incontinence brief. R60 was "toileted a when up and every tolerates."  The Admission Rec R60's diagnoses to muscle wasting and 7:45 a.m. until 11:20 offloading (reposition hours and thirty-two as follows:  At 7:39 a.m. R60 bed, a nursing assistance for locor was recommended.	s (such as but not limited to or disruptive sounds) occurred The MDS identified R60 assistance with bed mobility, ng, personal hygiene, eating did not walk and required tota notion on and off the unit. R6 nent of urine and frequently el. R60 had no pressure ulcers essment (CAA) for pressure 4, indicated, "Resident is at own. Does need assistance esident is incontinent of bowe epositions resident per a toileting. No current areas of the CAA summary was	al O			

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STATE FORM 8MTW11 If continuation sheet 7 of 38

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SI COMPLE	
		D WING			
	00294	B. WING		03/12	/2015
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING	SARLES WEST 135 FER	DDRESS, CITY, S' N STREET NO DGE, MN 550	RTH		
OUR MAR DV O		-		-1011	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 905 Continued From p	age 7	2 905			
was then transferr wheelchair at 7:45 provided by NA-A - From 7:45 a.m. u R60 with grooming - At 8:01 a.m. NA-television (TV)/con front of the nursing playing from a rad - From 8:01 a.m. u seated in the whee - At 8:24 a.m. the was observed to tarea and to a table protector and assi manager (SM) sat another table mate - From 8:24 a.m. the dining area at provided total assi - At 9:08 a.m. R60 dining room by SN the unit and R60 r - At 9:16 a.m. NA-the dietary and flu meal. NA-B stated meal and verified foods. NA-B stated centimeters) of flurate - At 9:20 a.m. the nurse (RN)-B mov radio and window changed the musi area From 9:20 a.m. u the TV area with roffered (two hours transferred from the Various facility states)	ed from the bed to the a.m. with total assistance and NA-B and a mechanical lift until 8:01 a.m. NA-A assisted in the wheelchair.  A transported R60 to the mon sitting area directly in g station desk. Music was io in the area.  until 8:24 a.m. R60 remained elchair in the TV area.  health unit coordinator (HUC)-A ransport R60 into the dining e. HUC-A offered R60 a clothing sted her to apply it. The supply directly to the left of R60 and e.  o 9:08 a.m. R60 remained in the dining table and was stance to eat and drink.  was transported out of the M and to the TV area. SM left emained in the TV area.  B verified she was recording id intakes for the breakfast I R60 consumed 0-25% of the R60 only ate "bites" of the				

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NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  B. WING  O3/12/2015  STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008  (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		E CONSTRUCTION	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  (X4) ID  SUMMARY STATEMENT OF DEFICIENCES TAG  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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						
CAMBRIDGE, MN 55008   CAMBRIDGE, MN 55008		00294	B. WING		03/1	2/2015
(x4) ID PREFIX TAG  (x4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCY MISS BE PRECEDED BY FULL REQUIRED FEICIENCY MISS BE PRECEDED BY FULL REQUIRED FEICIENCY MISS BE PRECEDED BY FULL REQUIRED FEICIENCY MISS BE PRECEDED BY FULL REQUIRED FOR THE APPROPRIATE DEFICIENCY)  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	NAME OF PROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMBRIDGE, MN 55008  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 905  Continued From page 8  TV/common area, assisting other residents From 9:45 a.m. to 10:29 a.m. R80 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. until 11:00 a.m. R60 remained in the TV area. 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	GRACEPOINTE CROSSING (	DINTE CROSSING GARLES WEST				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 110:29 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	dilAGEI GIIVIE GIIGGGIIVA (	CAMBRID	GE, MN 550	008		
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	PREFIX (EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
- 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	2 905 Continued From page 2	Continued From page 8	2 905			
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,	TV/common area, - From 9:45 a.m. to unmoved. At 10:05 music and started television. R60 fac TV At 10:29 a.m. NA window and faced program. R60's ey the TV From 10:29 a.m. in the TV area. R6 program At 11:03 a.m. act backed regular cha under the TV and a would be an exerc baking At 11:05 a.m. R6 wheelchair position minutes since last bed to wheelchair - At 11:09 a.m. NA supposed to be off undated Assignme reference resident repositioning and t while up in the cha in bed. When aske was repositioned, when last reposition next on my list." W times were tracked repositioning were room." NA-A stated reposition R60. Re be written on an ur room. The form dii	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				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
00294			B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
L GRACEPOINTE CROSSING GARLES WEST		STREET NO GE, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	requested *Bold timbed, unbolded is for The form had the time of [8:00 a.m.].  - At 11:15 NA-C and recorded times down stated she "only chand no offloading with 8:00 a.m. time did no observed time of the offload transported to her result of the foliation of the offload transported to her result of the incontinent of the incontinent of NA-C removed the perineal care. R60's intact. Both NA staff running late with reepositioning for R6 (RN)-C checked and sheet and verified Frepositioned every wheelchair. RN-C stand will "intervene" going over the asses RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference. RN-C stated staff sactual times of the minute time difference.	nes are for when resident is in r when resident is in chair." mes of "610 [6:10 a.m.] and d NA-A verified they had both on on the tub room form. NA-C ecked on" R60 at 6:10 a.m. ras provided. NA-A verified the not match the surveyor e 7:45 a.m. offload. NA-A irectly assist another resident fload and "guesstimated" the d was 8:00 a.m. R60 was soom. C and NA-A offloaded R60 in the stand lift (three or minutes). R60 was observed a small amount of urine. soiled pad and performed as skin was observed to be f verified they did not report positioning. In asked regarding the so, the registered nurse a undated Assignment Group R60 should have been three hours while in the stated she "checks the sheets" if she noticed a resident was essed time for repositioning. hould be writing down the off load and verified a fifteen noce was "too much" of a ated staff should have notified	2 905			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCE) MUST BE PRECEDED BY FULL PREFIX TAG  (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  (EACH DEPICIENCY)  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 determined by assessment and 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 was followed and verified the staff should have notified the nurse when falling behind with 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 as determined by assessment.	STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CAT ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX TAG		00294		B. WING		03/1	2/2015
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES RECARCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. RNB 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 determined by assessment and 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 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 as determined by assessment.	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
### CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 905  Continued From page 10  explained R60's tissue perfusion was checked by staff during the assessment, no redness was noted at three hour 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 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 bon stated staff should hour entified 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 as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning as identified in the resident's care plan. The policy indicated repositioning was determined by assessment, the repositioning	GRACE	POINTE CROSSING G	ARI ES WEST				
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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	2 905	explained R60's tiss staff during the ass noted at three hour hour time frame was staff should record repositioning "as clithe nurse" if reposit RN-B then stated, "RN-B verified R60 sas directed by the company of the	sue perfusion was checked by essment, no redness was and that was how the three is determined. RN-B stated accurate times of the ose as possible" and "notify tioning was "falling behind." The nurse should then help." should have been repositioned that sare plan.  p.m. the director of nursing tents should be repositioned as the sament and directed by the ted staff should document the ositioning to ensure the care and verified the staff should urse when falling behind with the long and procedure ast on 6/2003, identified the cay was to ensure timely entified in the resident's care dicated repositioning was resident policy and procedure ast on 6/2003, identified the cay was to ensure timely entified on the care plan and that care guide (Assignment policy further directed, tion resident per their plan of directed."  THOD OF CORRECTION: Sing or designee, could review	2 905			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00294	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRACEP	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 11	2 905			
	designee, could coudelivery of care; to services are impler pressure ulcer devel	he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for elopment.				
	(21) days.	·				
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			4/17/15
	have a continuous management to recunnecessary use of comprehensive reshome must ensure  A. a resident without an indwelling unless the resident that catheterization  B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to infections and to restore as the function as possible.				
	by: Based on observation review, the facility for incontinence check resident (R60) rand and dependent upon and assistance; R6	ent is not met as evidenced ion, interview and document ailed to ensure an was provided to 1 of 1 domly observed in the sample on staff for incontinence cares 0 was not checked for see hours and thirty-two		N/A		

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  COMPLE	JRVEY ETED
00294 B. WING 03/12/3	/2015
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  STREET ADDRESS, CITY, STATE, ZIP CODE  135 FERN STREET NORTH  CAMBRIDGE, MN 55008	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 rif (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	

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER					) DATE SURVEY COMPLETED	
	7. BOILBING:					
	00294	B. WING		03/1	2/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRACEPOINTE CROSSING GA	ARI ES WEST	STREET NO GE, MN 550				
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
PRN [as needed] when dry perineum. Changin incontinence episod.  On 3/11/15, during of 7:45 a.m. until 11:22 incontinence check minutes. Observation - At 7:39 a.m. R60 who bed, a nursing assist assist R60 with perinverified R60 was incompared the time. After compared application of clean of the time. After compared application of clean of the transferred from 7:45 a.m. with total assist (NA-A and NA-From 7:45 a.m. until R60 with grooming in - At 8:01 a.m. NA-A television (TV)/common front of the nursing splaying from a radion - From 8:01 a.m. until seated in the wheeled - At 8:24 a.m. the heat transported R60 into table. HUC-A offered assisted her to apply sat directly to the left mate.  - From 8:24 a.m. to the dining area at the provided total assist.  - At 9:08 a.m. R60 with groom by SM at the unit and R60 rem	and as required for awake, and every 4 hours and nen asleep. Wash, rinse and ge clothing PRN after es.  continuous observations from a.m. R60 was not offered an for three hours and thirty-two was observed to be laying in that (NA)-A was observed to neal care and grooming. NA-A continent of urine and bowel at obletion of perineal cares and incontinence brief, R60 was in the bed to the wheelchair at assistance provided by two B) and a mechanical lift. til 8:01 a.m. NA-A assisted in the wheelchair. transported R60 to the mon sitting area directly in station desk. Music was in the area.  til 8:24 a.m. R60 remained	2 910				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D W/N/O			
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES WEST	STREET NO			
	T		GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	.D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 14	2 910			
2 910	- At 9:20 a.m. the conurse (RN)-B moveradio and window in changed the music area From 9:20 a.m. unthe TV area and was checks (two hours and transfer to whe facility staff, including were observed to be TV/common area, and There was no one to with incontinence of time From 9:45 a.m. to unmoved or approact RN-B turned off the Lucy" movie on the window and not the At 10:29 a.m. NA-window and faced to program. R60's eyes the TV From 10:29 a.m. unin the TV area. R60 program At 11:03 a.m. active backed regular changular chan	linical manager/registered at R60 a few feet closer to the at the TV/common area. RN-B to Christian rock then left the atil 9:45 a.m. R60 remained in as not offered any incontinence since last incontinence check elchair at 7:45 a.m.). Various ag NA-A, NA-B and RN-B e in and out of the assisting other residents. That offered or assisted R60 hecks or toileting during this at 10:29 a.m. R60 remained ached by staff. At 10:05 a.m. In music and started an "I Love television. R60 faced out the	2 910			
		ontinence. NA-A removed an nt Group sheet (a form used to				

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STATE FORM 8MTW11 If continuation sheet 15 of 38

NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST as PRECEDED BY FULL PREDULATORY OR LSC IDENTIFYING INFORMATION)  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 the times of incontinence check 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 "Bold times are 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	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
MAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  135 FERN STREET NORTH CAMBRIDGE, MN 55008  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCY MILES DEATH INFORMATION)  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 "Bold times are for when resident is in chair." The form had the times of "610 [6:10 a.m.] and 500 [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							
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 [lowel movements] incontinent or requested, and BM's [lowel movements] incontinent or requested and 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	GRACE	POINTE CROSSING G	ARI ES WEST				
PRIÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 check 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 "Bold times are for when resident is in bed, unbolded is 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	GIIAGEI	Ontile Ontogonita G	CAMBRID	GE, MN 550	008		
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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	2 910	reference resident incontinence check hours" while up in t while in bed. Althou use," NA-A verified a check only. When R60 was checked f she was unclear, brown list." When asked were tracked, NA-A incontinence check "Tub room." NA-A sassistance and che Review of the facilit check times were runnamed form in the form directed, "Plea wet, incontinent or movements] incontare for when resident is in of "610 [6:10 a.m.] documented for R6-At 11:15 NA-C and recorded times down stated she "only chand verified the 8:0 surveyor observed care/offload. NA-A assist another reside care/offload and "grincontinence check transported to her resident in the stand lift (three hou between incontinent of a smillight incontinent of a s	care needs) and stated R60's times were "every three he chair and every "four hours" agh the form indicated "Toilet R60 should have been offered a asked regarding the last time or incontinence, NA-A stated at then stated, "She's next on ed how incontinence checks a stated the times of s were documented in the stated she would get eck R60 for incontinence. By repositioning/incontinence are unit tub room for R60. The ase write time toileted, if dry or requested, and BM's [bowel inent or requested *Bold times ent is in bed, unbolded is for chair." The form had the times and 800 [8:00 a.m.] 10.  Id NA-A verified they had both on the tub room form. NA-C ecked on" R60 at 6:10 a.m.  In a.m. time did not match the time of the 7:45 a.m. perineal stated she had to directly dent at the time of the perineal usesstimated" the time of R60's was 8:00 a.m. R60 was soom.  C and NA-A stood R60 in the are and thirty-two minutes are checks). R60 was all amount of dark, strong	2 910			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	checks. Both NA st checked for incontinence check (RN)-C checked and sheet and verified F "checked" for incontinence check of the sheets" and will resident was going incontinence check writing down the activiting plan for R6 checked every thre and four hours in bestated staff should incontinence check "notify the nurse" if checks were "falling "The nurse should should have been pastificated by the compassion of the continence check assessment and distated staff should incontinence check assessment and distated staff should incontinence check followed and verified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified notified the nurse with the continence check followed and verified notified the nurse with the checked and verified notified notified notif	aff verified R60 was only nence and not toileted. In asked regarding the start of R60, the registered nurse a undated Assignment Group R60 should have been tinence every three hours hair. RN-C stated she "checks "intervene" if she noticed a over the assessed time for s. RN-C stated staff should be tual times of the check and nute time difference was "too ce. RN-C stated staff should falling behind and did not.  p.m. when asked about the coo, RN-B stated R60 was to be the hours while in the wheelchair and for incontinence. RN-B record accurate times of the s "as close as possible" and toileting or incontinence to behind." RN-B then stated, then help." RN-B verified R60 provided incontinence checks that are plan. RN-B was unclear at differed from the care plan.  p.m. the director of nursing the stated of the provided incontinence of the plan.	2 910			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 17	2 910			
	Review of the facility Services Toileting of procedure dated as identified the purpotimely toileting as identified the purpotimely toileting as identified on the results of the policy disassisted with their the specified on the results of the services of the process of the pr	ty Presbyterian Homes and of Residents policy and slast modified on 6/2003, se of the policy was to "insure dentified in the resident's care rected, "6. Residents will be oileting needs and at intervals				
2 940	Subp. 9. Hydration and receive adequa	5 Subp. 9 Rehab - Hydration  . Residents must be offered ate water and other fluids to dration and health, unless	2 940			4/17/15
	This MN Requirements by: Based on observation review, the facility footential dehydration	ent is not met as evidenced ion, interview, and document ailed to ensure symptoms of on were identified and if 1 resident (R60) in the		N/A		

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	N STREET NO DGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 18	2 940			
	Treatment (POLST 10/21/08, with hand identified R60 requences to be drawn. The Police of the directed, "Always of if feasible." and directed, "Always of if feasible." and directed feasible." and directed feasible." and directed feasible. It is a feasible of the directed feasible. It is a feasible of the directed feasible. It is a feasible of the directed feasible of th	ders for Life Sustaining ) form dated as signed on I written update dated 2/22/12 ested comfort care only, no antibiotics and directed no labs OLST form for hydration ffer food and liquids by mouth ected "No artificial nutrition "No IV [intravenous] fluids."  m Data Set (MDS) dated 60's weight was 143, height 61 o eating concerns, and no the MDS identified R60 ically altered diet/liquid are Area Assessment (CAA) 6/12/14, indicated, "Res use of soft diet with thickened thewing and swallowing lad general weight gain in pasi- significant]). Res meeting om meals, supplements and for Dehydration/Fluid of trigger. Although a copy of summary was requested, it				
	identified, "I have deficit r/t [related to disturbances" with the symptoms of dehydromucous membranes plan directed, "Encochoice and offer flus mealtimes/snacks;"	red as revised on 8/8/12, ehydration or potential fluid ] Dementia with behavioral the goal, "I will be free of Iration and maintain moist as, good skin turgor." The care ourage me to drink fluids of ids throughout the day and at and further directed, eport to MD [medical doctor] as and symptoms] of				
	"Observe for and re needed s/sx [signs	port to MD [medical doctor] as	8			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
GRACEI	POINTE CROSSING G	ARI ES WEST	N STREET NO DGE, MN 550	*****		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 940	concentrated urine, cracked lips, furrow confusion, dizzines increased pulse, he dizziness, fever, thi dry/sunken eyes." A identified no labora on R60, the care pl monitor lab/diagnos results to MD [med indicated."  The Nutritional Ass identified current su "Water Pass, 80 co protein dietary suppand identified R60 a Comments- Food/F "There has been a in past 90 days d/t spout cups and coa "Reviewed nursing was not checked ei Comments-Hydratiwith med [mediation supplements and a assessment identificassistance to eat/dintake to be between Assessment Summunderstand the diet warranted d/t difficut consistency foods a further identified, "Compression of the warranted d/t difficut consistency foods a further identified, "Compression of the consistency foods a further identified	strong odor, tenting skin, yed tongue, new onset is on sitting/standing, eadache, fatigue/weakness, rst, recent/sudden weight loss, although the POLST form tory work would be completed an directed, "Obtain and stic work as ordered. Report ical doctor] and follow up as essment dated 1/18/15, upplement/snack orders of [cubic centimeters] 2+ [a high blement] tid [three times daily]" accepted the supplement. The fluid Intake section indicated, decline in food and fluid intake illness. Res provided with ated spoons at meals." The hydration risk assessment" ther yes or no. The on indicated, "Fluids provided in pass as ordered, the bedside." The ed R60 required total to partial rink and identified the fluid en "30-400 cc." The earry identified R60 did not order, "Current diet remains alty chewing/swallowing regular and fluids." The Summary Current weight 139.8# [pounds] of 5.5% in 30 days (sig) 19% in 180 days. Res has had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00294	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ARI ES WEST 135 FERN	DRESS, CITY, S N STREET NO DGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 940	Message left with N changes and updat if intake will improve risk d/t weight chan R60's estimated flu "25-28 cc/kg" which 1590-1781 cc of flu clearly identify how in 24 hours.  The Hydration Assessidentified R60 had a Alzheimer's disease problems. "No curred dehydration, no fev assessment did not dehydration. The addily intake of fluids (Amount in ml's [mi intake of fluids betwassessment identified for dehydration."  - The Comments Assection indicated, "I for dehydration r/t [indementia and inabils currently on nect [history] of constipar management. Resipass and supplementals. Is encouraged and med passes. No Focus is on comfor plan of care."	ge 20  IP re: [regarding] weight e interventions. NP questions e d/t illness. Will follow high ges. CP [care plan] reviewed." id needs were identified as a was approximately id. The assessment did not much R60's fluid needs were essment dated 1/19/15, diagnoses of dementia, e, and had swallowing ent dx [diagnosis] of er/vomiting/diarrhea." The atidentify physical symptoms of seessment identified Average with meals was "700 llililiters]" and average daily ween meals was 500 ml. The ed R60 was "At potential risk related to] dx. [diagnosis] of lity to recognize thirst needs. For art thick fluids. Does have hx. Ition and is on laxative for dent is on additional water ent throughout day between ed to drink fluids with meals to current signs of dehydration. It. Will continue with current rossing Gables West Order				
	Summary Report d physician on 2/4/15 consistency liquids	ated as signed by the , directed to offer nectar thick and "encourage fluids" offer 120 cc Med Plus 2.0 (a				

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AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 940	times a day, which consumed 100% of On 3/10/15, at appr administrator report "fan" and the City V going to be warmer verified fluids were of the unit in that tir - At approximately 2 to be seated in a wl (TV)/common area regular consistency passed out and offe attending the activit Although R60 was activity staff (AS), F offered to her during pale in color, with d and her eyes were covered with derma worn to prevent injury. At 2:25 p.m. R60 ochurch activity in the nursing station observed to be ope with her eyes close and dry; R60's tong dry; her tongue approvery bumpy, leather cracked with deep is slightly red and dry to voice at the time the approximately 1 the area were all of assistance to drink	alorie dietary supplement) four was 480cc per day if she the supplement.  Toximately 1:00 p.m. the ted there were problems with a iew 2 unit temperature was than usual. The administrator being offered to the residents ne.  2:00 p.m. R60 was observed neelchair in the television during a scheduled activity, fluids were observed to be ered to the other residents y and seated in the area. Seated directly in front of the 160 did not have any fluids g the activity. R60 skin was ry lips. Her mouth was open, closed. R60's arms were a savers (a protective sleeve	2 940			

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AND DI AN OF CORRECTION IN INDENTIFICATION NUMBER:					E SURVEY PLETED	
		00294	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CDACE	CONTE COCCINO C	ARLES WEST 135 FER	N STREET NO	ORTH		
GRACE	POINTE CROSSING G	CAMBRI CAMBRI	DGE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 940	participation pa	ge 22 continuous observations from	2 940			
	7:39 a.m. until the ea.m. R60 was not of fluids to prevent pormedication passes was only offered fluscheduled fluid/supmedication pass and Observations were - At 7:39 a.m. a nurobserved to assist I while in bed. Two ewith a spout for driron the bedside tablisoiled At 7:41 a.m. NA-Emechanical lift and wheelchair at 7:45 a NA-B left the room. "usually work" in "the she "usually worked - At 7:52 a.m. NA-A provided prior to the NA-A stated R60's green toothette whi	end of observations at 11:22 ffered the opportunity to drink tential dehydration between and scheduled meals. R60 ids by the nurse during a plement pass, during the d during an observed meal. as follows: sing assistant (NA)-A was R60 with incontinence cares mpty clear plastic glasses, one iking, were observed stacked e. The glasses appeared to be entered the room with a R60 was transferred to the a.m. by both NA-A and NA-B. NA-A stated she did not its building" and when she did				
	and can't spit" and a consistency liquids. out the access wate asked regarding the	stated R60 received nectar NA-A stated she squeezed er from the sponge. When e empty plastic glasses in the				
	by her and were bo the room at approxiverified no nectar cavailable to offer Re- - At 8:01 a.m. NA-Acommon area. At n	the glasses were not provided th empty when she entered mately 7:00 a.m. NA-A onsistency fluids were 60 in the room. Transported R60 to the o time during the observations e opportunity to drink fluids.				
	- At 8:16 a.m. NA-A	was asked if any fluids were A-A prior to 7:39 a.m., NA-A				

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MAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  TAG  SIMMARY STATEMENT OF DEFICIENCIES.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION)  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 hur?" 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 blies for the preventions of the province of the	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES WEST  (X4) ID PREFIX TAG  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 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 organge 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 glass of water was poured and offered, R60 drank sips. A nectar consistency glass of water was poured and offered, R60 drank sips. A nectar consistency glass and nectar consistency glass of water was poured and offered, R60 drank sips. A nectar consistency meal. SM remained in the dining area for the breakfast meal. SM remained with R60 and literated between							
GRACEPOINTE CROSSING GABLES WEST  (A4) ID PRIETIX TAG  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PRIETIX TAG  CROSS-REFERENCE TO THE APPROPRIATE DATE  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 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			00294	B. WING		03/1	2/2015
(X4) ID PREFIX TAG    XMMARY STATEMENT OF DEFICIENCIES   EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   OMPLETED DATE DEFICIENCY)    2 940   Continued From page 23   2 940   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 hun?" 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	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	GRACE	POINTE CROSSING G	ARI ES WEST				
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  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 hut?" 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	GIIAGEI	OMTE OTTOOGHTA G	CAMBRID	GE, MN 550	008		
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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	2 940	stated she did not of while doing cares in water was empty" a occurred "now." Not distributing water to - At 8:18 a.m. R60 the common area, R60's eyes were on window At 8:24 a.m. R60 area by the health of wheeled to a table. protector and assis were observed at the management (SM) next to another resistaff wheeled a car discussed with SM poured nectar consa carton. Staff imm and held the glass sips without difficult this morning huh?" water was poured a nectar consistency offered to R60 From 8:24 a.m. unthe dining area for remained with R60 offering various fluit to R60. R60 was of not resist the offere coughing or swallow - At 9:08 a.m. R60 to TV/common area the unit. R60's mou while seated in the	offer R60 anything to drink in the room. NA stated "her and the "water pass" had just A-A pointed to a staff person or resident rooms on the unit. It remained in her wheelchair in Music playing on a radio. It is and looking out the was transported into the dining unit coordinator (HUC)-A and HUC-A offered a clothing ted with applying it. No fluids the table. The supply staff sat to the left of R60 and ident at the table. A dietary it with various fluids to R60, R60's fluid consistency and distency orange juice (OJ) from the resident. R60 drank the resident. R60 drank the resident. R60 drank the stated, "You're thirsty A nectar consistency glass of and offered, R60 drank sips. A milk was also poured but not the breakfast meal. SM and alternated between ds and bites of pureed foods observed to take small sips, did and fluids and had no observed wing concerns. Was wheeled out of the room a by SM. SM immediately left the was observed to be open common area. Immediately	2 940			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING	· · · · · · · · · · · · · · · · · · ·	03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES WEST	STREET NO			
	OLUMBA DV OTA		GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 24	2 940			
2 940	colored; R60's tong appearance, heavil - At 9:16 a.m. NA-E process of recording for the observed may plate and glasses of stated R60 consum of fluids and 0-25% the fluid amount corporate in the TV/common watching "I Love Lual Although various state clinical manage the registered nurse the area to change was only moved in towards and away the were fluids offered - At 11:03 a.m. activated the chair un Love Lucy program and stated there we and then cookie baren to be offered during - At 11:20 a.m. NA-the surveyor R60 hoffered incontinence thirty-two minutes. Toom. While preparincontinence, NA-A offer fluids to R60 control the survey of the nurse offers" s NA-C stated fluids to R60 control to the stated fluids to R60 control the nurse offers to the survey of R60 hoffer fluids to R60 control the nurse offers to the nurse offers to the survey of R60 hoffer fluids to R60 control the nurse offers to the nurse of the nurse offers to the nurse of the nurse of th	Jue remained leathery in y cracked, and furrowed. B stated she was in the g the dietary and fluid intakes eal. NA-B reviewed R60's of remaining fluids. NA-B ned 20 cc (cubic centimeters) of (bites) of solids. NA-B verified nsumed by R60 was "low." Intil 11:00 a.m. R60 remained area listening to the radio, acy" in the wheelchair. aff, including NA-A, NA-B and or/registered nurse (RN)-B and or/register				
	NA-C stated, "If she	should be offered to R60, e's thirsty, we offer." When ow R60 is thirsty, NA-C stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	N STREET NO DGE, MN 550	*****		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 940	R60 "doesn't verbal "will get anxious, gr NA-C verified the sa attributed to pain or clear when fluids sh R60.  - At 11:22 a.m. R60 her incontinence br was observed to be dark colored, concestrong smelling. Whurine was strong smelling. Whurine was strong smelling was of the observation, with a spout top was bedside stand. R60 TV/common area ir was completed. Altiglass of water at the nectar consistency no fluids were offer.	Ily talk" and described R60 ab at people" when thirsty. ame behavior could also be hunger. Neither NA staff were nould have been offered to was lifted in the stand lift and ief was removed. The brief wet with a small amount of entrated urine; the urine was nen asked if they noted R60's nelling or dark colored, NA-C as strong smelling. At the time a full glass of thickened water s observed to be on the was wheeled back to the nmediately after perineal care hough both staff verified the e bedside was the correct and intended for R60 to drink, ed by the NA staff before or ontinence check was provided.				
	R60 120 cc of water twice on her shift. Foffered the water and the morning." When consumed this morn Medication Administ Electronic Medical Idrank "everything" (a total of "240 cc.") were offered, RN-C medications between verified she offered a.m. (on 3/11/15). Vof R60's potential structured she was a shift of the water of the w	1 a.m. RN-C stated she gave r, plus 120 cc of supplement RN-C stated she usually and supplement "Right away in a sked if offered and ning, RN-C referred to the stration Record (MAR) in the Record. RN-C stated R60 offered that morning and it was When asked when the fluids a stated she gave both with en 6:30 a.m 7:00 a.m. RN-C R60 no other fluids after 7:00 When asked if she was notified symptoms of dehydration, as not. RN-C stated she had for dehydration. When asked				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00294	B. WING	····	03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES WEST	I STREET NO OGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	what symptoms of for and expected to "looks for tenting [a turgor, a sign used potential dehydratic "focuses on what [I of potential dehydra was not aware R60 breakfast meal. At observed R60 with checked R60's skir forefinger and thur arm and stated R60 immediately stated with "tenting." RN-0 (where she had lifte fine" (Decreased sking dehydration) When appeared dry and flook into R60's more comment.  - At 1:28 p.m. RN-0 offered fluids to R6  Review of the MAR through March 201 R60 120 cc of water three times daily. The and January 2015 of water or supplement 1/13/15. Beginning amounts of water an urse where document whe MAR indicated 120 cc amount, R6 with a noted decreated consumed beginning on 3/9/15, the MAR with a noted decreated sign of the MAR with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount, R6 with a noted decreated sign of the MAR indicated 120 cc amount in the MAR indicated 120 cc amount i	dehydration she would assess be reported, RN-C stated she test used to determine skin to assess fluid loss or on]." RN-C then stated she R60's] drinking as an indicator ation." RN-C confirmed she only consumed 20 cc at the the time of the interview, RN-C the surveyor present. RN-C by lifting it slightly with ab on the back of R60's left D's tenting was "poor," then "all residents" had problems then rubbed R60's left arm ed the skin) and stated "see it's kin turgor is a late sign in asked if R60's tongue urrowed, RN-C appeared to oth quickly, but did not C stated staff should have 0 throughout the day.  Is from December 2014  5, indicated the nurse offered or and 120 cc of supplement he MARs for December 2014 did not include the amount of at consumed by R60 until on 1/13/15, the consumed and supplement offered by the mented on the MAR. Although R60 usually consumed the full 0's fluid intakes were variable ase in amount of fluid ng on 3/9/15:  R indicated R60 consumed to 480 cc of supplement (total at 480 cc o	2 940			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	<u> </u>	_,
GRACEP	POINTE CROSSING G	ARI ES WEST	STREET NO			
		CAMBRID	GE, MN 550		ONL	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 27	2 940			
	MAR indicated R60 and 480 cc of supp from nurse); - on 3/11/14, the M/240 cc of fluids and 510 cc of fluids from and before supper)	R60 was first observed), the consumed 270 cc of water lement (total of 750 cc of fluids AR indicated R60 consumed 270 cc of supplement (total of n nurse between breakfast .  ePointe Crossing Gables				
	West Follow Up Qu through 3/11/15, inc with Meals in ml [ec identified R60's fluid - on 3/9/15, R60 ref supper, R60 consul (total of 25 ml from - on 3/10/15 (the da R60 consumed "0" R60 consumed 50 ml 50 ml from meals); - on 3/11/15, R60 co	restion Report from 12/1/14, cluded a report of "Fluid Taken qual to cc]." The report d intakes were variable. fused fluids at breakfast and med 25 ml of fluids at lunch				
	24-hour fluid intake - on 3/9/15, total of - on 3/10/15, total o - on 3/11/15, R60 of fluids up to lunch. F					
	fluid intake, RN-B s scheduled in the Ma observed for "anxie being thirsty; RN-B her mouth" it was a	p.m. when asked about R60's tated extra water passes were AR. RN-B stated R60 was ty issues" as an indicator for stated if R60 "seems dry in nother potential indicator of staff should offer fluids with				

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PRINTED: 04/22/2015 FORM APPROVED

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	l
00294 B. WING 03/12/2015	5
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACEPOINTE CROSSING GABLES WEST  135 FERN STREET NORTH CAMBRIDGE, MN 55008	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPREST)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OA DEFICIENCY	PLETE
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, BN-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 now 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 co/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 was not alerted to any concerns with R60's fluid intakes and any assessment for hydration	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO			
		CAMBRID	GE, MN 550		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 29	2 940			
	dehydration due to fluids and use of ne On 3/11/15, at 2:35 (DON) verified R60	R60 was at higher risk for dependence on staff to obtain ectar consistency liquids.  p.m. the director of nursing should have offered fluids at the day. DON stated the staff				
		raged fluids when other				
	Progress Notes dat assessed by the nu "Signs of Dehydrati facility of R60's sym identified R60's good heroic measures w	ic Services of Minnesota red 3/11/15, indicated R60 was rese practitioner (NP) for on" (after surveyor alerted aptoms). Although the review als were for comfort and no ere identified for R60, the NP appropriate to offer fluids" and e not indicated."				
	assessed R60 for and discussed the stated after assess increased the fluids times per day. RD s greater than the fluithrough 3/11/15.  Review of the Prodated 3/11/15, writte R60's estimated flucc/actual body weig report res [resident since breakfast me intake prior to be "1 The note identified of the 120 cc supple three times daily when the times daily when the note indicated states as the states of the 120 cc supple three times daily when the note indicated states as the states of the s	7 a.m. RD stated she changes in hydration needs findings with the family. RD ing R60's intakes she coffered to R60 to 120 cc six stated R60's fluid needs were ids received on 3/9/15,  gress Note provided by RD en at 4:02 p.m. indicated id needs were 1500-1700 ght. The note indicated, "Staff has had a decline in intakes al 3/9/15, and identified fluid 00-400 cc fluids per meal." R60 was accepting 75-100% ement and 120 cc water pass nich provided "820 cc fluids." fluid intake would be reased to six times per day.				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00294	B. WING	·····	03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ARI ES WEST	I STREET NO OGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	provide 1080 cc. St cares. Will follow hi fluid intake and mo nutritional intervent Review of the Presi Hydration Risk Poli- directed, "5) Fluids at the following time meals, At med pass residents at higher notification and idea dehydration to inclu- output, concentrate membranes, mouth under the tongue m	pass and supplement will raff will also offer fluids with righ risk d/t [due to] variable nitor need for further ions."  byterian Homes & Services cy dated as modified 2/2012, will be offered to the residents es: During meals, Between s." The policy identified risk may require more urgent nitified potential symptoms of ude: skin tenting, low urine and urine, dry mucous in furrows (absence of moisture noisture).	2 940			
	The director of nurs all residents at risk are receiving the ne prevent dehydration designee, could cou delivery of care; to services are implent dehydration.	THOD OF CORRECTION: sing or designee, could review for dehydration to assure they ecessary treatment/services to n. The director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
21375	(21) days.	0 Subp. 1 Infection Control;	21375			4/17/15
	Program	c caspconon control,				., ,
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI FS WEST	I STREET NO OGE, MN 550	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa		21375			
	by: Based on observati review, the facility fachanged during incoming and bladder inconting spread of infection the sample observer.  Findings include:	ent is not met as evidenced on, interview and document ailed to ensure gloves were ontinence cares after bowel nence, to prevent the potential for 1 of 2 residents (R60) in ed for perineal cares.		N/A		
	surveyor knocked of presence and was a room. A nursing assisting R60. R in bed, partially dress NA-A stated she was cares. A soiled incounder R60. NA-A sturine and "having a right side, obtained wiped from the from NA-A then removed changing gloves or NA-A reached to the clean incontinence NA-A rolled R60 bathe incontinence proposed, NA-A remowash her hands. NA 7:41 a.m., brought in applied a lift sling up to the wheelchair at was observed.	on 3/11/15, at 7:39 a.m. on R60's door, announced allowed admittance to R60's sistant (NA)-A was observed to 60 was observed to be laying seed with her pants down. as "in the middle" of perineal ntinence product remained ated R60 was incontinent of BM." NA-A rolled R60 to the an incontinence wipe and to back on R60's buttocks. If the soiled brief. Without performing hand hygiene, we head of the bed, picked up a pad and placed it under R60. ack onto the pad and applied oduct. After the brief was eved the gloves, and did not A-B knocked on the door at a mechanical lift, both ander R60 and transferred her a.m. NA-A verified she did not a.m.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 5012511143.			
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	verified she contambrief with the soiled did not perform har soiled gloves and s registered nurse (Rhave been removed before handling the On 3/11/15 at 12:20 (DON) verified glovand hand hygiene darea was cleaned a removed; before the Review of the Presiperineal Care polic modified on 4/2010 soiled brief in bag to wash hands or use SUGGESTED MET The director of nurs completed staff har while staff are proviproper handwashind director of nursing or random weekly auchandwashing is bei	r wiping R60's stool and hinated the clean incontinence gloves. NA-A confirmed she had hygiene after removing the hould have. At 11:31 a.m. the line line line line line line line lin	21375			
21685	MN Rule 4658.1418 Housekeeping, Ope	eration, & Maintenance	21685			4/17/15
	including walls, floo	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	continuous state of with regard to the h well-being of the reroutine maintenance.  This MN Requirements:  Based on observation review, facility failed kept in good repair nursing units, City V (CV2), River View 1 (RV2), which had the approximately 60 requires.  Findings include:  During the environm (Adm) and environm (Adm) and environm on 3/11/15, at 11:50 following areas idents.  The River View 2 (Fan approximate 12 colored stain on the crack in the ceiling and the wallpaper windows which was length.  City View 2 (CV2) of	good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.  ent is not met as evidenced on, interview and document do to ensure the building was and maintained for 4 of 5 /iew 1 (CV1), City View 2 (RV1), and River View 2 (RV1), and River View 2 (Repotential to affect esidents who resided on these entitled:  e Ceiling:  RV2) dining room, there was inch size brown and yellow e ceiling tile. There was a large above the food service area, was peeling near dining room is approximately 8 inches in	21685	N/A		
	and yellow colored had approximately	h brown stain on the ceiling stain above window. The area 6 inch brown and yellow color located above nurses' station.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00294	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES WEST	STREET NO GE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 34	21685			
		lining room had an size brown and yellow colored ove tub and shower room.				
		and yellow colored stains nch) in hallway outside the first om.				
	inches) in the hallw There were large be (approximately 12 in and there were small	ceiling tile (approximately six ay, near the nurses' station. rown and yellow colored stain nches) outside of room 120 all ceiling brown and yellow eximately three inches)				
	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).					
		b brown and yellow colored ely 6 inches) above the nurses				
	Peeling wallpaper a	and wall condition:				
		ad wallpaper which had a tear hes long near room 252.				
	CV2 had an approx wallpaper noted ab	imately three inch size peeling ove linen room.				
	station, had an app	n area near the nursing roximately six inch size area r behind the recliner chairs on				
		e were two long gouges in the headboard. One gouge was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
	00294		B. WING		03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEPOINTE CROSSING GABLES WEST  135 FERN STREET NORTH CAMBRIDGE, MN 55008						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	and second gouge long by one inch wing a second by one inch wing by one inch wing by one inch wing a second by one inch wing by one inch win	t inches long by one inch wide was approximately six inches de with the dry wall exposed.  ights:  ead bugs in the hallway light and a leaking ripping from faucet, build-up of gray fuzzy dust-like and front grate. The fan was lents who were having coffee wity in this room.  near the nurses' station had a to be turned on and running. It a heavy buildup of grayish ee fan blades.  d a circular hole approximately neter punched through that	21685	DEFICIENCY)		
	bathroom door fron vanity had a white of 3-4 inch size half ci	n the door stop. The built in colored veneer approximately rcle that was peeling away sharp, uncleanable surface.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00294		B. WING		03/1	03/12/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
GRACEPOINTE CROSSING GABLES WEST  135 FERN STREET NORTH CAMBRIDGE, MN 55008							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPL DAT			
21685	Continued From page 36		21685				
	RV2 - room 234 room had a vent in the ceiling with a heavy build up of visible dust.						
	at the bottom of the inches up from floo sticking out two includes veneer at the bottom	m door had a splintered wood door approximately four r bottom which then was hes from edge of door. The m of the door was pulled away n left a sharp edge on the					
	environmental serv maintenance has a program. When pla scheduled, the worl program in the mor are in the Excel pro	9 p.m. when interviewed, ices director (ESD) stated in Excel work order computer anned maintenance is k order appears in the Excel ining. All daily work requests in the seen mance sends a progress note					
	work order system	MS-A) who stated they were					
	(HD) indicated staff room monthly. Whe they have deep clea	p.m. housekeeping director does deep cleaning of each en they have a vacant room, aning checklist. On daily job deeping has identified specific					
	checklist identified bathroom, resident list. Dayroom, nurse and household cooroom, wash handra	ted City View 1 (CV1) the following: "Resident room, and common areas on e station, kitchenette, clinical rd. Office, tub room, utility ils, door knobs, walls, wall reach, vacuum hallways, City					

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			7 50.15 10					
00294		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								
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X: COMP DAT			
View 1 N 1E), strip room. Or bathroom CV1N. N units and discharg Review of Policy/Pr Billable fr date: 9/2 order was department to two das SUGGEs administ regarding environm coordina staff to of frequent good rep	or, wash and note a week ns, empty to ote: house of the indicate of Presbyte ocedure Tor Services of 14, indicate of the indicate of the imponent. The te with man onduct per to ensure air are beit in the interval of the imponent of the im	N) & City View 1 East (CV d make beds/deep cleaning on Wednesday clean rooms and utility room on ekeeping will wash complete cant room checklist on ed residents."  Prian Homes and Services ask/Work Order Requests and soriginal date: 2009, revision ated purpose was when a worked the Environmental Services provide the service within one  THOD OF CORRECTION: The signee, could educate staff rance of a clean and safe DON or designee, could intenance and housekeeping riodic audits of areas residents the areas are keep clean, ng maintained.  R CORRECTION: Twenty-one						

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