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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C9OP

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245432**
2.STATE VENDOR OR MEDICAID NO.
(L2) **893042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES WEST**
(L4) **135 FERN STREET NORTH**
(L5) **CAMBRIDGE, MN** (L6) **55008**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **108** (L18)
13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE-NE II — 10/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 10/16/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/16/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/20/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245432 October 6, 2017

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables West
135 Fern Street North
Cambridge, MN 55008

Dear Ms. Barthel:

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

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

Effective September 15, 2017 the above facility is certified for or recommended for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 6, 2017

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables West
135 Fern Street North
Cambridge, MN 55008

RE: Project Number S5432026

Dear Ms. Barthel:

On August 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 18, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2017, effective September 15, 2017 and therefore remedies outlined in our letter to you dated August 17, 2017, 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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Electronically delivered

October 6, 2017

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables West
135 Fern Street North
Cambridge, MN 55008

Re: Reinspection Results - Project Number S5432026

Dear Ms. Barthel:

On September 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 3, 2017, with orders received by you on August 18, 2017. At this time these correction orders were found corrected.

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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C9OP

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

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(L1) **245432**
2.STATE VENDOR OR MEDICAID NO.
(L2) **893042200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES WEST**
(L4) **135 FERN STREET NORTH**
(L5) **CAMBRIDGE, MN** (L6) **55008**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/03/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **108** (L18)
13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mardelle Trettel, HFE NE II — 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/20/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/20/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2017

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables West
135 Fern Street North
Cambridge, MN 55008

RE: Project Number S5432026, H5432044 & H5432045
Dear Ms. Barthel:

On August 3, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the August 3, 2017 standard survey the Minnesota Department of Health completed investigations of complaint number H5432044 & H5432045 that were found to be unsubstantiated.

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

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

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

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

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

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

months after the survey date; and

Informal Dispute Resolution - 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 Fisher, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fisher@state.mn.us
Phone: (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 September 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 12, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 3, 2017 (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 February 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/31/17 to 8/3/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Gracepointe Crossing Gables - West was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. In addition, two complaint investigations were reviewed while on-site for the survey. H5432044 and H5432045 were reviewed and both found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's	F 309		9/6/17

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

Electronically Signed | 08/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive pain assessment, and coordinated hospice management plan was completed for 1 of 1 residents (R82) on hospice who had pain during movement. Findings include: R82's admission Minimum Data Set (MDS) dated 6/22/17, indicated she had severe cognitive	F 309	R82□s pain was reassessed and the care plan reviewed and updated by Inter Disciplinary Team including the primary provider on 8-4-17. All residents with identified pain were reviewed for effective pain management and their plan of care was revised as necessary. All residents are assessed for pain minimally on admission quarterly, and annually, or with a change of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 impairment, needed extensive assist of two with bed mobility and transfers and walking did not occur. The MDS identified she had a fracture related to a fall six months prior to admission and a chronic condition/disease that may result in a life expectancy of less than six months. The MDS further indicated R82 had pain with non-verbal sounds (crying, whining, gasping, moaning, or groaning), vocalized complaints of pain (that hurts, ouch, stop), facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), and protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). R82's Care Area Assessment (CAA) dated 6/22/17, indicated she was "Admitted following a hospitalization for a fx [fracture] of the distal R [right] femur. Client had a couple of falls over a couple of days prior to hospital admission and was c/o [complaints of] pain in the right leg. Client is not a surgical candidate and on the day of admission the client signed onto hospice for care for heart failure. Pain assessment was done by the staff due to the client inability to answer the questions. Pain is being controlled with PRN [as needed] morphine at this time and is effective. pain is located on the R knee distal femur where the fracture is located. Other risks for pain are dx [diagnosis] of depression. Proceed to care plan to provide palliative care for pain." R82's Care Plan dated 6/28/17, indicated she had acute pain related to a right femur fracture and potential for chronic pain related to decreased mobility. Staff were directed to administer pain medications per orders and monitor the effectiveness of the pain medication. In addition,	F 309	condition in conjunction with the RIA process. All residents are observed daily for signs/symptoms of pain and are reported through alerts in the EMR to trigger further assessment as needed. The policy and procedure was reviewed and is current. Education will be completed for staff on signs of pain and pain management modalities. All nursing staff are educated on pain upon hire, annually, and as needed. The facility will monitor and sustain correction by completing pain audits on 5% of residents weekly for 2 months. Results of audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible for ensuring ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 3	F 309		

the care plan directed staff to monitor for grunting, moans, yelling out, and silence, and notify a nurse if complains of pain. The Care Plan also directed staff to utilize the wedge pillow for stabilization (of the femur fracture) when repositioning R82, which was implemented on 7/25/17.

During observation on 8/3/17, at 7:18 a.m. registered nurse (RN)-B was observed to be in R82's room along with nursing assistant (NA)-B and NA-C. Surveyor entered the room and RN-B stated she was giving R82 her scheduled morphine. NA-B who was already in the room, was holding wash cloths and incontinent product in her hands, and stated she was getting ready to turn, reposition and change R82's incontinent product. NA-B turned to the surveyor and stated "she is gonna yell." NA-B lowered the head of her bed while R82 stated "ow, ow." NA-B and NA-C opened the incontinent product while R82 continued to moan and whimper "ow, ow." NA-C asked R82 to roll right on her affected side (right leg) towards the wall where NA-B was standing. While R82 was on her side she continued to cry out loud "ow, ow, ow" whimpered and was squeezing her eyes shut and grimacing while cares were provided. NA-B and NA-C continued to provide peri-care, moving R82 back and forth from right side to left side while providing care not allowing any rest periods for R82, even though she was yelling out. During the entire time R82 continued to whimper, had facial grimacing and cried out "ow, ow." NA-B and NA-C continued to provide cares while R82 was crying and yelling out. R82 told NA-B and NA-C, "that took a lot out of me," sighed and then closed her eyes. NA-B immediately stated to R82 they were almost done and proceeded with cares, again not allowing R82

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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F 309	Continued From page 4	F 309		

any rest periods while providing cares. R82 was then rolled towards NA-C on her unaffected side (left leg) and R82 continued to yell out "oh don't do that" as they were cleaning her buttocks, and rectal area. NA-B stated, "I think she gets scared more than anything, when we provide cares for her." At 7:31 a.m. NA-B and NA-C completed R82's personal cares, fastened her incontinent brief, and raised the head of the bed up while the head of the bed was being raised R82 continued to yell out, "owe, owe." Once NA-B and NA-C stopped providing cares R82 closed her eyes and stopped yelling. Even though RN-B had just administrated R82's scheduled morphine while NA-B and NA-C were both in the room, RN-B did not direct the NAs to wait 15-30 minutes so the medication could be effective prior to providing cares to R82.

During interview 8/3/17, at 7:52 a.m. NA-C stated she does not have a wedge cushion or immobilizer and they only use pillows under her arm, and heels. NA-C added they do not use any immobilizes/wedge cushion for R82, when they turn and reposition R82.

R82's Order Listing Report dated 6/16/17 - 8/31/17, indicated she had hospice care that started 6/16/17, due to diastolic heat failure and received lorazepam 0.25 milliliters (ml) (anti-anxiety medication) every four hours as needed for terminal agitation and utilize interventions of warm blanket, reassurance, 1:1 conversation, offer snacks such as pudding, music, relaxing massage prior to administration and document effectiveness and if ineffective proceed to medication. In addition, the Order Listing Report identified R82 received morphine sulfate concentrate solution 20 mg/ml

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 5	F 309		

(milligrams/milliliter) give 0.25 ml by mouth every three hours as needed on 6/16/17 and discontinued on 7/10/17. The morphine 20 mg/ml (milligrams/milliliter) give 0.25 ml was changed to scheduled every 6 hours from 7/10 and discontinued on 7/27/17, and then increased on 7/27/17 to every four hours scheduled, and every one hour as needed. The order identified on 7/3/17, "no brace or immobilize per NP [nurse practitioner]," even though this was identified on the care plan to use a wedge cushion.

An Allina Hospice & Palliative Care Facility Visit Record dated 6/28/17, completed by the hospice physical therapist (PT) indicated they recommended a use of a immobilizer or wedge cushion between legs to keep alignment of leg during cares and repositioning.

An Allina Hospice & Palliative Care Hospice and Aide Visit Log dated from 6/23/17 to 8/1/17, indicated the following:
On 6/23/17- received a partial bath and was peaceful.
On 6/29/17- received a bed bath and listed no issues or concerns.
On 7/6/17- received a bed bath with no issues or concerns.
On 7/13/17- received a partial bath and no issues or concerns.
On 7/18/17- received a partial bath with no issues or concerns.
On 7/28/18- received a bed bath with some moaning during repositioning.
On 8/1/17- received a bed bath with moaning during repositiong.

R82's Pain Assessment dated 7/31/17, indicated she had a history of pain and had a diagnoses

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 6	F 309		

which indicated potential for discomfort or pain, and had no behaviors with cares. The pain assessment summary and analysis indicated R82 received scheduled morphine sulfate 0.25 ml by mouth for pain and shortness of breath (narcotic to treat moderate to severe pain) every four hours and non-pharmacological interventions which include rest, relaxation, changing position and use of pillows. The assessment further identified to provide comfort with movement and there were no changes to the pain management plan at this time. The assessment did not mention using an immobilizer or wedge cushion, even though R82's care plan identified this was to be used when repositioning R82.

Review of R82's Medication Administration Record (MAR) from 7/10/17 to 8/3/17, at 9:17 a.m. indicated R82 had an order for lorazepam 0.25 ml by mouth every four hours for pain which was started 6/18/17, and morphine sulfate solution 0.25 ml by mouth every three hour as needed (PRN) for pain and shortness of breath with a start date of 6/16/17. Review of the July 2017 MAR indicated R82 received morphine every three hours as needed, 18 times from July 1-10, 2017. The order was changed to scheduled morphine every six hours on 7/10/17 and then changed to every four hours on 7/27/17, and every hours as needed. R82 only received an PRN dose of lorazepam once on 7/7/17, and no PRN every hour morphine. The August 2017 MAR indicated R82 had not received any as needed lorazepam or any as needed morphine, until 8/3/17.

Review of the facility progress note dated 8/3/17, at 3:25 a.m. indicated "Resident was moaning of pain during T&R [turning and repositioning]

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 7	F 309		

scheduled morphine was given. Resident has been sleeping. Will continue to monitor and address concerns."

During interview on 8/3/17, at 8:17 a.m. RN-C stated she was the clinical coordinator and (R82) does not have a specific order for scheduled pain medications prior to cares, but if she was showing pain they need to stop and reproached later with cares. RN-C further indicated (R82) was seen 1-2 times a week by the hospice RN and had been seen by the hospice PT who recommended an immobilizer or wedge cushion but the facility did not have this equipment. She was unsure when the immobilizer/wedge cushion was ordered, and thought hospice took care of it but the family was supposed to get the immobilize/wedge cushion. RN-C stated she received the immobilizer on Monday 7/31/17, but was waiting for staff to get training on this device prior to implementing the device. R82 waited 32 days for the immobilizer to be implemented even though PT recommended to use this device for comfort while turning and repositioning on 6/28/17.

During interview 8/3/17, at 9:31 a.m. the surveyor shared observation on 8/3/17, at 7:18 a.m. to 7:31 a.m. to hospice nurse RN-A. RN-A stated if the nurse had just given the morphine and the NAs started cares right away "it was too soon to do cares" and they should have waited. If she was still having that much pain they should have stopped providing cares. Hospice RN-A stated (R82) might be getting tolerant of her pain medication and they may need to increase her scheduled dose. Hospice RN-A further stated PT made the recommendation for the immobilizer but hospice does not provide this and family would need to have purchased the device, which they

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 8	F 309		

just received Monday evening. RN-A stated she had worked with family in getting the correct wedge cushion with a washable cover. RN-A further stated the family had it at home for awhile before finally brining it in her room. Although hospice had ordered the immobilizer for R82 there was no coordination of services between nursing home, PT, nurse practitioner and hospice agency so R82 could receive the immobilizer/wedge cushion timely. Also, there was no indication why the nurse practitioner did not recommend the immobilizer for use.

During interview 8/3/17, at 11:49 a.m. the facility RN-B stated R82 had scheduled morphine and they try to give it before cares. She was aware when the aides turn her she yells and thinks it pain but sometimes (R82) is scared that she might fall out of bed. RN-B further stated the only time she noticed (R82) had pain was when she was repositioned or moved while cares were provided. In addition, RN-B stated if the aides are doing cares and she is having pain they should stop, and let the nurse know so they could see her and maybe give her something more (pain medication). RN-B stated she did not know R82 was having that much pain during cares this morning until RN-C informed her but knew (R82) had pain with turning and repositioning.

During observation of cares for R82 on 8/3/17, at 11:59 a.m. with the hospice nurse RN-A, R82 was in her room along with NA-B and NA-D. RN-A stated she had received an "as needed morphine after her morning cares" at 10:19 a.m. and received her scheduled morphine at 11:35 a.m.. RN-A further stated (R82) has pain and anxiety but was unable to express this. They prefer not to use her lorazepam (medication used

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 9	F 309		

for anxiety) unless she really needs it. RN-A stated (R82) "looks more comfortable now." During the observation, hospice RN-A provided education for the use of the immobilizer/wedge with NA-B and NA-D. Hospice RN-A placed the immobilizer/wedge between R82 legs to stabilize the fracture before NA-B and NA-D turned and repositioning R82 while the immobilizer/wedge cushion was in place. RN-A stated she "did well". N-B stated "she was nothing like she was this morning." R82 quietly said, "ow" but did not yell out or show any facial grimacing while being repositioned.

During interview 8/3/17, at 12:32 p.m. the facility administrator and director of nursing (DON), stated if hospice recommended the immobilizer/wedge cushion and were unable to provide this, the facility could have purchased one, for (R82). The DON stated she thought the hospice nurse was in contact with the family in purchasing it. The DON further indicated she did not know why R82 went so long without it and the hospice nurse should have followed up with the family as to why this took so long to get.

During interview on 8/3/17, at 1:01 p.m. PT-A from Allina Hospice stated she was consulted to assess R82 if she could get out of bed. PT-A stated during her evaluation on 6/28/17, she saw (R82) was obviously in a lot of pain with turning and movement and the immobilizer/wedge would have made her more comfortable. The PT-A stated she recommended this for comfort to keep her right fractured femur in alignment while turning or repositioning. PT-A further stated after she recommended the immobilizer/wedge it should have been ordered within a day or two and received the immobilizer/wedge in a week or so

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	245432	A. BUILDING _____ B. WING _____	C 08/03/2017

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

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F 309	Continued From page 10 and exclaimed, "Why did it take so long!" PT-A stated she had sent and received a few e-mails from RN-A with in a week after the recommendation was made for the immobilizer/wedge about sizes. I never heard from her since then, and was out of the loop. Hospice RN-A never told me she had not received it sooner. Although R82 had pain with movement and cares the facility failed to coordinate care with Allina hospice to ensure R82's pain was adequately assessed with movement, administer pain medications for adequate control and timely implementation of the immobilizer/wedge cushion to stabilize and align R82's right femur fracture to decrease pain when staff assisted R82 with turning and repositioning. A facility Pain Assessment and Management Policy modified November 2016, indicated "It is the policy that pain management is provided to residents that require such services, consistent with professional standards of practice, the comprehensive person centered care plan and the residents goal and preferences. All residents have the right for appropriate pain assessment and pain management. All residents will be assessed for presence, absence or a history of pain on admission, quarterly, with a significant change in status, and with new onset of potential pain or discomfort."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Gracepointe Crossing Gables West was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as one building: Gracepointe Crossing Gables West is a 2-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1974, 86, & 99 additions were constructed to the building that was determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 108 beds	K 000		

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	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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

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K 000	Continued From page 2 and had a census of 92 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by:	K 321		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 20 of 92 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, observations revealed that the Riverview soiled utility room did not positively latch into the frame at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 321	The door to the Riverview soiled utility room that did not close and latch properly will be repaired to meet the requirements of NFPA 101 (2012) section 19.3.2.1. This facility's fire doors are scheduled to be inspected monthly. The Environmental Services Director will be responsible for ongoing compliance.	
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		9/15/17

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	245432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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

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K 341	Continued From page 4 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect 10 of 92 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, observation revealed, that the smoke detector located in the corridor outside of resident room 148 was found to be installed within 36 inches of a HVAC vent diffuser. This deficient condition was verified by the Maintenance Supervisor.	K 341	An air vent was installed to divert air away from the smoke detector to meet the requirements. The Environmental Services Director will be responsible for ensuring ongoing compliance.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction	K 372		9/15/17

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K 372	Continued From page 5 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of multiple smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 92 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, observations revealed that the smoke barrier doors by resident room 249 has a 1/2 inch gap between on the mating edge of the double smoke barrier doors. This deficient condition was verified by a Maintenance Supervisor.	K 372	The double smoke barrier doors by resident room 249 that has a 1/2 inch gap on the mating edge will be made to conform to the requirements. The doors will be adjusted or an astragal will be installed. The smoke barrier doors are scheduled to be inspected monthly. All smoke barrier doors will be inspected to ensure they meet the code requirements. The Environmental Services Director will be responsible to ensure compliance.	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories	K 901		9/15/17

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K 901	Continued From page 6 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 92 of 92 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, during the documentation review and an interview with the maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	All required documentation will be completed as required by NFPA 99 (2012) section 4.1. The PHS Regional Engineering Department and the site Environmental Services Director will be responsible for the completion of the Building Utility Risk Assessment. The Environmental Services Director is responsible for ongoing compliance.	
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		9/15/17

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K 914	Continued From page 7 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 10.3. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 92 of 92 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet	K 914	Electrical Testing and maintenance of this facility's electrical system will be done as required by NFPA 99 (2012) section 10.3. The annual receptacle inspection and testing will be completed. Ongoing inspection and testing will be done as required. The Environmental Services Director will be responsible for ensuring the inspection and testing is completed annually as required and for ongoing compliance.	

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K 914	Continued From page 8 inspection and testing for the electrical outlets located in the resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914		
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable.	K 918		9/15/17

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K 918	Continued From page 9 Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice could affect the safety of 92 of 92 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 10:30 a.m. to 3:30 p.m. on 08/03/2017, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor it was revealed that the facility did not have a letter of reliable service for their natural gas fuel supply from the fuel company. This deficient condition was verified by a Maintenance Supervisor.	K 918	This facility's generator documentation will be made to conform to the requirements of NFPA 101 (2012) section 9.1.3 and NFPA 110 sections 6.4, 6.4.1, and 6.4.2.2. The documentation will include a letter of reliable service for the natural gas fuel supply from the natural gas fuel company. The Environmental Services Director will be responsible for ensuring ongoing compliance.	

Electronically delivered
August 16, 2017

Ms. Brandi Barthel, Administrator
Gracepointe Crossing Gables West
135 Fern Street North
Cambridge, MN 55008

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5432026, H5432044 & H5432045

Dear Ms. Barthel:

The above facility was surveyed on July 31, 2017 through August 3, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaints numbered H5432044 & H5432045 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 Brenda Fisher, Unit Supervisor at (320) 223-7338 or brenda.fisher@state.mn.us.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00294	A. BUILDING: _____ B. WING _____	C 08/03/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/31/17 to 8/3/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A	2 000		

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2 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive pain assessment, and coordinated hospice management plan was completed for 1 of 1 residents (R82) on hospice who had pain during movement. Findings include: R82's admission Minimum Data Set (MDS) dated 6/22/17, indicated she had severe cognitive impairment, needed extensive assist of two with bed mobility and transfers and walking did not occur. The MDS identified she had a fracture related to a fall six months prior to admission and a chronic condition/disease that may result in a	2 830	Corrected	9/6/17

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2 830	Continued From page 3 life expectancy of less than six months. The MDS further indicated R82 had pain with non-verbal sounds (crying, whining, gasping, moaning, or groaning), vocalized complaints of pain (that hurts, ouch, stop), facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), and protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). R82's Care Area Assessment (CAA) dated 6/22/17, indicated she was "Admitted following a hospitalization for a fx [fracture] of the distal R [right] femur. Client had a couple of falls over a couple of days prior to hospital admission and was c/o [complaints of] pain in the right leg. Client is not a surgical candidate and on the day of admission the client signed onto hospice for care for heart failure. Pain assessment was done by the staff due to the client inability to answer the questions. Pain is being controlled with PRN [as needed] morphine at this time and is effective. pain is located on the R knee distal femur where the fracture is located. Other risks for pain are dx [diagnosis] of depression. Proceed to care plan to provide palliative care for pain." R82's Care Plan dated 6/28/17, indicated she had acute pain related to a right femur fracture and potential for chronic pain related to decreased mobility. Staff were directed to administer pain medications per orders and monitor the effectiveness of the pain medication. In addition, the care plan directed staff to monitor for grunting, moans, yelling out, and silence, and notify a nurse if complains of pain. The Care Plan also directed staff to utilize the wedge pillow for stabilization (of the femur fracture) when repositioning R82, which was implemented on	2 830		

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2 830	Continued From page 4 7/25/17. During observation on 8/3/17, at 7:18 a.m. registered nurse (RN)-B was observed to be in R82's room along with nursing assistant (NA)-B and NA-C. Surveyor entered the room and RN-B stated she was giving R82 her scheduled morphine. NA-B who was already in the room, was holding wash cloths and incontinent product in her hands, and stated she was getting ready to turn, reposition and change R82's incontinent product. NA-B turned to the surveyor and stated "she is gonna yell." NA-B lowered the head of her bed while R82 stated "ow, ow." NA-B and NA-C opened the incontinent product while R82 continued to moan and whimper "ow, ow." NA-C asked R82 to roll right on her affected side (right leg) towards the wall where NA-B was standing. While R82 was on her side she continued to cry out loud "ow, ow, ow" whimpered and was squeezing her eyes shut and grimacing while cares were provided. NA-B and NA-C continued to provide peri-care, moving R82 back and forth from right side to left side while providing care not allowing any rest periods for R82, even though she was yelling out. During the entire time R82 continued to whimper, had facial grimacing and cried out "ow, ow." NA-B and NA-C continued to provide cares while R82 was crying and yelling out. R82 told NA-B and NA-C, "that took a lot out of me," sighed and then closed her eyes. NA-B immediately stated to R82 they were almost done and proceeded with cares, again not allowing R82 any rest periods while providing cares. R82 was then rolled towards NA-C on her unaffected side (left leg) and R82 continued to yell out "oh don't do that" as they were cleaning her buttocks, and rectal area. NA-B stated, "I think she gets scared more than anything, when we provide cares for her." At 7:31 a.m. NA-B and NA-C completed	2 830		

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	00294	A. BUILDING: _____ B. WING _____	C 08/03/2017

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2 830	Continued From page 5 R82's personal cares, fastened her incontinent brief, and raised the head of the bed up while the head of the bed was being raised R82 continued to yell out, "owe, owe." Once NA-B and NA-C stopped providing cares R82 closed her eyes and stopped yelling. Even though RN-B had just administrated R82's scheduled morphine while NA-B and NA-C were both in the room, RN-B did not direct the NAs to wait 15-30 minutes so the medication could be effective prior to providing cares to R82. During interview 8/3/17, at 7:52 a.m. NA-C stated she does not have a wedge cushion or immobilizer and they only use pillows under her arm, and heels. NA-C added they do not use any immobilizes/wedge cushion for R82, when they turn and reposition R82. R82's Order Listing Report dated 6/16/17 - 8/31/17, indicated she had hospice care that started 6/16/17, due to diastolic heat failure and received lorazepam 0.25 milliliters (ml) (anti-anxiety medication) every four hours as needed for terminal agitation and utilize interventions of warm blanket, reassurance, 1:1 conversation, offer snacks such as pudding, music, relaxing massage prior to administration and document effectiveness and if ineffective proceed to medication. In addition, the Order Listing Report identified R82 received morphine sulfate concentrate solution 20 mg/ml (milligrams/milliliter) give 0.25 ml by mouth every three hours as needed on 6/16/17 and discontinued on 7/10/17. The morphine 20 mg/ml (milligrams/milliliter) give 0.25 ml was changed to scheduled every 6 hours from 7/10 and discontinued on 7/27/17, and then increased on 7/27/17 to every four hours scheduled, and every one hour as needed. The order identified on	2 830		

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2 830	Continued From page 6 7/3/17, "no brace or immobilize per NP [nurse practitioner]," even though this was identified on the care plan to use a wedge cushion. An Allina Hospice & Palliative Care Facility Visit Record dated 6/28/17, completed by the hospice physical therapist (PT) indicated they recommended a use of a immobilizer or wedge cushion between legs to keep alignment of leg during cares and repositioning. An Allina Hospice & Palliative Care Hospice and Aide Visit Log dated from 6/23/17 to 8/1/17, indicated the following: On 6/23/17- received a partial bath and was peaceful. On 6/29/17- received a bed bath and listed no issues or concerns. On 7/6/17- received a bed bath with no issues or concerns. On 7/13/17- received a partial bath and no issues or concerns. On 7/18/17- received a partial bath with no issues or concerns. On 7/28/18- received a bed bath with some moaning during repositioning. On 8/1/17- received a bed bath with moaning during repositiong. R82's Pain Assessment dated 7/31/17, indicated she had a history of pain and had a diagnoses which indicated potential for discomfort or pain, and had no behaviors with cares. The pain assessment summary and analysis indicated R82 received scheduled morphine sulfate 0.25 ml by mouth for pain and shortness of breath (narcotic to treat moderate to severe pain) every four hours and non-pharmacological interventions which include rest, relaxation, changing position and use of pillows. The assessment further identified	2 830		

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2 830	Continued From page 7 to provide comfort with movement and there were no changes to the pain management plan at this time. The assessment did not mention using an immobilizer or wedge cushion, even though R82's care plan identified this was to be used when repositioning R82. Review of R82's Medication Administration Record (MAR) from 7/10/17 to 8/3/17, at 9:17 a.m. indicated R82 had an order for lorazepam 0.25 ml by mouth every four hours for pain which was started 6/18/17, and morphine sulfate solution 0.25 ml by mouth every three hour as needed (PRN) for pain and shortness of breath with a start date of 6/16/17. Review of the July 2017 MAR indicated R82 received morphine every three hours as needed, 18 times from July 1-10, 2017. The order was changed to scheduled morphine every six hours on 7/10/17 and then changed to every four hours on 7/27/17, and every hours as needed. R82 only received an PRN dose of lorazepam once on 7/7/17, and no PRN every hour morphine. The August 2017 MAR indicated R82 had not received any as needed lorazepam or any as needed morphine, until 8/3/17. Review of the facility progress note dated 8/3/17, at 3:25 a.m. indicated "Resident was moaning of pain during T&R [turning and repositioning] scheduled morphine was given. Resident has been sleeping. Will continue to monitor and address concerns." During interview on 8/3/17, at 8:17 a.m. RN-C stated she was the clinical coordinator and (R82) does not have a specific order for scheduled pain medications prior to cares, but if she was showing pain they need to stop and reproached later with cares. RN-C further indicated (R82) was seen 1-2	2 830		

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2 830	Continued From page 8 times a week by the hospice RN and had been seen by the hospice PT who recommended an immobilizer or wedge cushion but the facility did not have this equipment. She was unsure when the immobilizer/wedge cushion was ordered, and thought hospice took care of it but the family was supposed to get the immobilize/wedge cushion. RN-C stated she received the immobilizer on Monday 7/31/17, but was waiting for staff to get training on this device prior to implementing the device. R82 waited 32 days for the immobilizer to be implemented even though PT recommended to use this device for comfort while turning and repositioning on 6/28/17. During interview 8/3/17, at 9:31 a.m. the surveyor shared observation on 8/3/17, at 7:18 a.m. to 7:31 a.m. to hospice nurse RN-A. RN-A stated if the nurse had just given the morphine and the NAs started cares right away "it was too soon to do cares" and they should have waited. If she was still having that much pain they should have stopped providing cares. Hospice RN-A stated (R82) might be getting tolerant of her pain medication and they may need to increase her scheduled dose. Hospice RN-A further stated PT made the recommendation for the immobilizer but hospice does not provide this and family would need to have purchased the device, which they just received Monday evening. RN-A stated she had worked with family in getting the correct wedge cushion with a washable cover. RN-A further stated the family had it at home for awhile before finally brining it in her room. Although hospice had ordered the immobilizer for R82 there was no coordination of services between nursing home, PT, nurse practitioner and hospice agency so R82 could receive the immobilizer/wedge cushion timely. Also, there was no indication why the nurse practitioner did	2 830		

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2 830	Continued From page 9 not recommend the immobilizer for use. During interview 8/3/17, at 11:49 a.m. the facility RN-B stated R82 had scheduled morphine and they try to give it before cares. She was aware when the aides turn her she yells and thinks it pain but sometimes (R82) is scared that she might fall out of bed. RN-B further stated the only time she noticed (R82) had pain was when she was repositioned or moved while cares were provided. In addition, RN-B stated if the aides are doing cares and she is having pain they should stop, and let the nurse know so they could see her and maybe give her something more (pain medication). RN-B stated she did not know R82 was having that much pain during cares this morning until RN-C informed her but knew (R82) had pain with turning and repositioning. During observation of cares for R82 on 8/3/17, at 11:59 a.m. with the hospice nurse RN-A, R82 was in her room along with NA-B and NA-D. RN-A stated she had received an "as needed morphine after her morning cares" at 10:19 a.m. and received her scheduled morphine at 11:35 a.m.. RN-A further stated (R82) has pain and anxiety but was unable to express this. They prefer not to use her lorazepam (medication used for anxiety) unless she really needs it. RN-A stated (R82) "looks more comfortable now." During the observation, hospice RN-A provided education for the use of the immobilizer/wedge with NA-B and NA-D. Hospice RN-A placed the immobilizer/wedge between R82 legs to stabilize the fracture before NA-B and NA-D turned and repositioning R82 while the immobilizer/wedge cushion was in place. RN-A stated she "did well". N-B stated "she was nothing like she was this morning." R82 quietly said, "ow" but did not yell out or show any facial grimacing while being	2 830		

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2 830	Continued From page 10 repositioned. During interview 8/3/17, at 12:32 p.m. the facility administrator and director of nursing (DON), stated if hospice recommended the immobilizer/wedge cushion and were unable to provide this, the facility could have purchased one, for (R82). The DON stated she thought the hospice nurse was in contact with the family in purchasing it. The DON further indicated she did not know why R82 went so long without it and the hospice nurse should have followed up with the family as to why this took so long to get. During interview on 8/3/17, at 1:01 p.m. PT-A from Allina Hospice stated she was consulted to assess R82 if she could get out of bed. PT-A stated during her evaluation on 6/28/17, she saw (R82) was obviously in a lot of pain with turning and movement and the immobilizer/wedge would have made her more comfortable. The PT-A stated she recommended this for comfort to keep her right fractured femur in alignment while turning or repositioning. PT-A further stated after she recommended the immobilizer/wedge it should have been ordered within a day or two and received the immobilizer/wedge in a week or so and exclaimed, "Why did it take so long!" PT-A stated she had sent and received a few e-mails from RN-A with in a week after the recommendation was made for the immobilizer/wedge about sizes. I never heard from her since then, and was out of the loop. Hospice RN-A never told me she had not received it sooner. Although R82 had pain with movement and cares the facility failed to coordinate care with Allina hospice to ensure R82's pain was adequately assessed with movement, administer pain	2 830		

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2 830	Continued From page 11 medications for adequate control and timely implementation of the immobilizer/wedge cushion to stabilize and align R82's right femur fracture to decrease pain when staff assisted R82 with turning and repositioning. A facility Pain Assessment and Management Policy modified November 2016, indicated "It is the policy that pain management is provided to residents that require such services, consistent with professional standards of practice, the comprehensive person centered care plan and the residents goal and preferences. All residents have the right for appropriate pain assessment and pain management. All residents will be assessed for presence, absence or a history of pain on admission, quarterly, with a significant change in status, and with new onset of potential pain or discomfort." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with identified pain, to assure they are receiving the necessary treatment/services for pain management and control. The director of nursing or designee, could conduct random audits to ensure residents with pain have received appropriate care and services to help reduce pain levels. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		9/6/17

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2 915	Continued From page 12 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff gave provide a resident with loose fitting dentures were not used/worn to promote good oral health for 1 of 3 residents (R35) who needed staff assistance for dental hygiene. Findings include: R35's quarterly Minimum Data Set (MDS) dated 5/11/17, identified R35 had severe cognitive impairment and required limited assistance with personal hygiene and eating. R35's signed physician orders dated 5/9/17, identified R35 consumed a, "NDD3 - Dysphagia Advanced texture," diet (moist foods cut into bite sized pieces). R35's most recent dental Chart Progress Note dated 6/30/17, identified R35 was seen for a missing full upper denture. The note described,	2 915	Corrected	

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2 915	Continued From page 13 "Treatment Details," and listed, "[R35] arrived wearing old upper denture [v. poor fit], newer upper denture has been lost, so Try In couldn't be done today." The note directed a narrative would be created to see if new dentures could be made. During observation on 7/31/17, at 11:13 a.m. R35 was seated in a wheelchair in her room. R35 conversed with the surveyor, however, many sentences of the conversation were non-sensical. At one point, R35 opened her mouth and removed a full upper denture and attempted to hand it to the surveyor stating they, "cut a hole," and "fell out." R35 stated she, "can't take bites" with them as, "they're loose." R35's care plan dated 5/12/17, identified R35 had cognitive impairment along with an activities of daily living (ADL) self care deficit requiring, "up to 1 staff extensive assist with personal hygiene and oral care." Further, the care plan identified R35 had a history of, "poorly fitting dentures." When interviewed on 8/2/17, at 6:26 p.m. nursing assistant (NA)-A stated R35 was, "not very good," with eating and would often fall asleep at meals. NA-A stated R35 currently only wore her old upper denture which, "do not fit her properly," adding they, "fall out occasionally," and "wiggle a lot in her mouth." NA-A stated R35 had been wearing her old, loose fitting denture for a, "couple weeks to a month maybe." Further, NA-A stated R35 had no current oral sores or bleeding to her knowledge, however, added she was unaware why R35 continued wearing dentures known to not fit her as staff, "haven't been told anything." During interview on 8/2/17, at 7:01 p.m. registered nurse (RN)-A stated R35 had, "issues	2 915		

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2 915	Continued From page 14 with her teeth," and was last seen by the dentist on 6/30/17, to see if new upper dentures could be made. RN-A stated R35 should not be given her old, loose fitting dentures to wear by staff as she (R35) could develop mouth sores or potentially choke on them since, "they don't fit properly." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents that need assistance with oral health to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD OF CORRECTION: Twenty-one (21) days	2 915		