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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CXPP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 25613

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245615**

2.STATE VENDOR OR MEDICAID NO.
(L2) **378150100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GABLES OF BOUTWELLS LANDING**
(L4) **13575 58TH STREET**
(L5) **OAK PARK HEIGHTS, MN** (L6) **55082**

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 **01/21/2016** (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 :
Susanne Reuss, Unit Supervisor 01/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 02/03/2016 (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
03/04/2009
(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.
00320
(L31)

30. REMARKS
Posted 02/17/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/31/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245615
February 3, 2016

Ms. Julie Thompson, Administrator
Gables of Boutwells Landing
13575 58th Street
Oak Park Heights, Minnesota 55082

Dear Ms. Thompson:

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 December 30, 2015 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245615 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	12/30/2015	LSC	12/30/2015	LSC	12/30/2015
ID Prefix F0329	Correction	ID Prefix F0441	Correction	ID Prefix F0492	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(b)	Completed
LSC	12/30/2015	LSC	12/30/2015	LSC	12/30/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	SR/KJ	02/03/2016	16022	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

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(L5) **OAK PARK HEIGHTS, MN** (L6) **55082**

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7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/03/2015** (L34)

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0 Unaccredited 1 TJC
2 AOA 3 Other

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

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
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___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 12/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/31/2015 (L20)

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

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_____ 2. Facility is not Eligible
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03/04/2009
(L24)

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

26. TERMINATION ACTION: (L30)

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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.
00320
(L31)

30. REMARKS
Posted 12/31/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 11, 2015

Ms. Julie Thompson, Administrator
Gables Of Boutwells Landing
13575 58th Street
Oak Park Heights, MN 55082

RE: Project Number S5615008

Dear Ms. Thompson:

On December 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 215-9697

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 January 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 3, 2016 (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 June 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

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
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in accordance with the resident's written plan of care for 2 of 3 residents (R113, R155) in the sample who required assistance with activities of daily living (ADL's) for ambulation and morning cares. Findings include: R113's plan of care for ambulation dated 7/30/15 directed staff, "I require assist of one to ambulate.	F 282	This plan and response to these survey findings is written solely to maintain certification in the Medicare program. These written responses do not constitute and admission of noncompliance with any requirement nor an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for informal dispute resolution for certain findings and determinations.	12/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2015

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
	245615	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 I need a FWW [front wheeled walker] with cues to pick up my feet and stop and restart if shuffling. I am at risk for falls, If I am restless in my chair assist me to ambulate or stand." Document review of the untitled ambulation task read, "Nursing walking program A1 [assist of 1] 100 + feet with FWW, [front wheeled walker] to and from all meals with staff to assist. Cue resident to pick up feet while walking and if shuffling gait stop and restart. Walk as soon as possible following completion of dinner." During observations on 11/30/15, at 4:00 p.m. through 7:15 p.m. R113 attempted to stand multiple times and was told by staff to sit back down in the wheel chair. There were no offers to ambulate R113. After the evening meal R113 was wheeled to the small dining area for an activity and there was no offer or attempt to ambulate. When interviewed on 11/30/15, at 7:15 p.m. family member (F)-B expressed concern that R113 was not walked according to the plan established for frequent ambulation and F-B expressed frustration because R113 was often restless and attempting many times to stand up from the wheel chair without assistance only to be told to sit back down by the staff. F-B expressed if family did not ask, they did not think R113 would be walked. During observation on 12/1/15, at 8:00 am, R113 was seated in the wheel chair at the dining room table. At 9:00 a.m. R113 was observed propelling self about the unit. There were no offers to ambulate before or after the breakfast meal. When interviewed on 12/1/15, at 9:00 a.m.	F 282	Resident #113 and resident #155 care plan and NAR care communication tool was reviewed and updated to reflect current interventions. NAR-A was re-educated on ensuring all residents' plans of care are followed and was required to re-attend NAR skills training. All residents' assessments and care plans were reviewed and updated for those residents needing assist with ADL's and ambulation. The NAR care communication tool was also updated to reflect interventions. Staff are communicated regarding changes in the plan of care at shift change stand up meetings and through daily report and in the NAR care communication tool. All residents are assessed on admission, annually, with significant change in condition and reviewed quarterly for care planning/ADL's and ambulation. Nursing staff was in-serviced on the importance of following the residents plan of care at all times. The policy and procedure related to care planning for each resident has been reviewed and is current. The Clinical Administrator or designee will audit staff providing direct cares to assure compliance. Random audits will be conducted on 10% of the residents weekly. Audit results will be reported to	

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	245615	A. BUILDING _____ B. WING _____	12/03/2015

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F 282	Continued From page 2 nursing assistant (NA)-A verified R113 had not walked. R155 was not thoroughly provided with morning cares on 12/2/15. R155 plan of care dated 7/3/15, read, "I have an ADL [activities of daily living] self care performance deficit r/t [related to] Dementia, limited mobility, confusion, Alzheimers's impaired balance, cognitive impairment, chronic pain, psychosis. I require assistance with bathing, grooming, hygiene, oral care, dressing, eating." During a family (F)-A interview on 11/30/15, at 5:02 p.m. concern was expressed about the cleanliness of R155 following medication administration, meals, and if oral care was being provided consistently. F-A said it was not unusual for them to visit and find R155 did not have dentures in the mouth. F-A expressed frustration regarding lack of basic care which the family has discussed on numerous occasions with the facility staff. During an observation of morning cares on 12/2/15, at 8:30 a.m. nursing assistant (NA)-A proceeded to dress R155 while in bed, sat R155 on the side of the bed, used the mechanical stand to transfer R155 to the toilet and used peri wipes for perineal cleansing after R155 was stood in the mechanical stand. NA-A transferred R155 to the specialty chair and wheeled R155 to the dining room for breakfast. There were no offers for oral care, no hands, face or under arm cleansing offered. R155 has upper and lower denture but they were not offered before breakfast.	F 282	the QA committee and action plans developed as needed. Date certain for the purpose of ongoing compliance is 12/30/15.	

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F 282	Continued From page 3 When interviewed on 12/2/15, at 9:52 a.m., regarding morning cares, licensed practical nurse (LPN)-A revealed morning cares would include staff assisting residents with oral care, perineal cares and washing of the underarms, face and hands. When interviewed on 12/2/15, at 9:55 a.m. NA-A verified morning cares were not completed according to the staff training and facility expectations for morning care. NA-A said she would take care of R155's teeth right away.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation assistance to improve or maintain each resident's ability for 1 of 1 residents (R113) reviewed for ambulation with activities of daily living (ADL's). Findings include: R113 had a diagnosis of Parkinson's disease with a history of falls according to the Admission Record dated 7/10/15. R113 was assessed as cognitively intact according to the most recent Minimum Data Set [MDS], dated 10/16/15. During observation on 11/30/15, at 4:00 p.m. through 7:15 p.m. there were no offers to	F 311	Resident #113 nursing rehab program for ambulation was reassessed and care plan updated as indicated. The NAR care communication tool was also reviewed and is current for resident #113. NAR-B was re-educated on ensuring that proper documentation occurs and that all residents nursing restorative programs are completed. All residents' restorative nursing programs were reviewed and their care plans updated to reflect current needs. The NAR care communication tool for residents was reviewed and is current.	12/30/15

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F 311	Continued From page 4 ambulate R113 and multiple observations of R113 attempting to stand and being told to sit back down in the wheel chair. After the evening meal R113 was wheeled to the small dining area for an activity and there was no offer or attempt to ambulate. When interviewed on 11/30/15, at 7:15 p.m. family member (F)-B expressed concern that R113 was not walked according to the plan established for frequent ambulation and F-B expressed frustration because R113 was often restless and attempting many times to stand up from the wheel chair without assistance only to be told to sit back down by the staff. F-B expressed if family did not ask, they did not think R113 would be walked. During observation on 12/1/15, at 8:00 a.m., R113 was seated in the wheel chair at the dining room table. At 9:00 a.m. R113 was observed propelling self about the unit. There had been no offers to ambulate before or after the breakfast meal. When interviewed on 12/1/15, at 9:00 a.m. nursing assistant (NA)-A verified R113 had not walked. Document review of the untitled ambulation task read, "Nursing walking program A1 [assist of 1] 100 + feet with FWW, [front wheeled walker] to and from all meals with staff to assist. Cue resident to pick up feet while walking and if shuffling gait stop and restart. Walk as soon as possible following completion of dinner." When interviewed on 12/1/15, at 3:50 p.m. NA-B verified documentation indicated R113 refused to	F 311	The policy and procedure related to treatments/maintain ADL's has been reviewed and is current. All residents are assessed on admission, annually, with significant change in condition and reviewed quarterly for treatments/services to improve/maintain ADL's. Nursing staff was in-serviced on the importance of providing assist with restorative nursing programs and following care plan. The Clinical Administrator or designee will audit staff providing direct cares to assure compliance. Random audits will be conducted on 10% of the residents weekly. Audit results will be reported to the QA committee and action plans developed as needed. Date certain for the purpose of ongoing compliance is 12/30/2015.	

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F 311	Continued From page 5	F 311		

walk 11/30/15, but explained that was a mistake because there was so much commotion after the evening meal. NA-B just wheeled R113 to the activity room and did not offer to ambulate R113 at all that evening.

Document review of the ambulation task for 11/30/15, indicated R113 walked 100 feet on the day shift and refused the evening shift. Documentation 11/29/15, reflected walking 110 feet on the day shift and refused on the evening shift. Documentation 11/28/15, indicated refused walking on the day shift and walked 75 feet on the evening shift. Document review 11/27/15, indicated R113 walked 50 feet on the day shift and 10 feet on the evening shift.

Document review of the plan of care dated 7/30/15 read, "I am at risk for falls, If I am restless in my chair, assist me to ambulate or stand."

Document review of the Physical Therapy Progress and Discharge Summary dated 10/2/15, directed staff, "The patient requires front wheeled walker and contact guard assist (contact with patient due to unsteadiness) for ambulation for 300 feet with verbal instruction/cues 90% of the time. Pt requires SBA (stand by assistance) for transfers and gait due to balance, but no longer requires physical assistance and has exceeded gait distances."

When interviewed on 12/2/15, at 4:00 p.m. occupational therapy verified R113 was capable of ambulating more than 300 feet at any given time because of exceeding the therapy goal to walk 300 feet at a time.

When interviewed on 12/3/15, at 8:30 a.m. the

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F 311	Continued From page 6 director of nursing (DON) indicated the facility did not have a specific policy if a resident refused services but the industry standard would be to expect the staff to re-approach the resident and if that continued in a refusal to involve the nurse for further direction.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 3 residents (R155) reviewed for activities of daily living (ADL's). Finding include: R155 had a diagnosis of Alzheimer's disease and unspecified dementia with behavioral disturbances according to the admission record dated 6/12/15. The Care Area Assessment dated 8/5/15 indicated R155 had moderate cognitive impairment. The Minimum Data Set [MDS, dated 10/29/15, indicated R155 required extensive assistance with bathing, grooming, hygiene, oral care, dressing, eating. During a family (F)-A interview on 11/30/15, at	F 312	Resident #155 assessments and care plan for ADL's was reviewed and are current. The NAR communication tool was reviewed and is current. NAR-A was re-educated on ensuring all residents' plans of care are followed and was required to re-attend NAR skills training. All residents' assessments and care plans were reviewed and updated for those residents needing assist with ADL's. The NAR care communication tool was also updated to reflect interventions. Staff are communicated regarding changes in the plan of care at shift standup meetings and through daily report and in the NAR are communication tool.	12/30/15

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F 312	Continued From page 7 5:02 p.m. concern was expressed about the cleanliness of R155 following medication administration, meals, and if oral care was being provided consistently. F-A said it was not unusual to visit and find R155 did not have dentures in the mouth. F-A expressed frustration regarding lack of basic care which the family has discussed on numerous occasions with the facility staff. During an observation of morning cares on 12/2/15, at 8:30 a.m. nursing assistant (NA)-A proceeded to dress R155 while in bed, sat R155 on the side of the bed, used the mechanical stand to transfer R155 to the toilet and used peri wipes for perineal cleansing after R155 was stood in the mechanical stand. NA-A transferred R155 to the specialty chair and wheeled R155 to the dining room for breakfast. There were no offers for oral care, no hands, face or underarm cleansing offered. R155 had upper and lower dentures which were not offered before breakfast. When interviewed on 12/2/15, at 9:52 a.m., regarding morning cares, licensed practical nurse (LPN)-A revealed morning cares would include staff assisting residents with oral care, perineal cares and washing of the underarms, face and hands. When interviewed on 12/2/15, at 9:55 a.m. NA-A verified morning cares were not completed according to the staff training and facility expectations for morning care and said she would take care of R155's teeth right away. A review of the facility policy dated, December 2014 and titled, Cares AM and HS read, "Wash resident's face and hands and dry. Wash resident's back, under arms and under breasts,	F 312	All residents are assessed on admission, annually, with significant change in condition and reviewed quarterly for care planning/ADL's. Nursing staff was in-serviced on the importance of following the residents plan of care at all times and regarding AM and PM cares. The policy and procedure related to care planning/ADL's for each resident has been reviewed and is current. The Clinical Administrator or designee will audit staff providing direct cares to assure compliance. Random audits will be conducted on 10% of residents weekly. Audits results will be reported to the QA committee and actions plans developed as needed. Date certain for the purposes of ongoing compliance is 12/30/2015.	

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F 312	Continued From page 8 and under abdominal folds and dry, Wash resident's perineal area and dry. Apply deodorant and lotion dry skin areas as needed. Assist with oral care according to care plan."	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to adequately monitor and assess clinical indicators for the use of a whenever	F 329	Resident #113 was reviewed for current interventions related to behavioral symptoms and medications. Staff were	12/30/15

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F 329	Continued From page 9 necessary (PRN) antipsychotic medication for 1 of 1 residents (R113) reviewed in the sample for PRN use of an antipsychotic. Findings include: R113 had a diagnosis of Parkinson's dementia with behavioral disturbances listed on the Admission record dated 7/10/15. Document review of R113's assessment for mental status, dated 10/16/15, indicated R113 was cognitively intact. The undated nursing assistant care plan had R113 on a walking program and R113 was to walk 100+ feet with front wheeled walker to and from all meals with staff to assist. Furthermore, the nursing assistant communication sheet dated 12/1/15 read, "If restless in chair assist to stand or ambulate if combative with cares." Document review of R113's interdisciplinary team (IDT) notes indicated R113 had a physician order for Seroquel 25 mg (milligrams) give 2 tablets every 6 hours as needed for Dementia R/T (related to) Psychosis uncontrolled agitation/delusions/hallucinations. On 11/30/15 at 9:21 p.m. the IDT notes read "The pt [patient] has not received PRN medication yet tonight only his scheduled. The pt is being aggressive towards staff." A review of the medication sheet verified R113 was given 50 mg of Seroquel at 9:21 p.m. There was no documentation to indicate what R113 was doing prior to being given the antipsychotic medication. Documentation on 11/30/15, at 11:20 p.m. read, "PRN Administration was: Effective." R113 was signed off as walked 100 feet on the day shift. zero walking on	F 329	re-educated on the importance of non pharmacological interventions and the importance of documentation. Resident #113 care plan was updated to reflect current interventions. The policy and procedure related to procedures for proper monitoring of medication usage has been reviewed and is current. All residents receiving antipsychotic medications were reviewed for appropriate interventions. All nursing staff was educated on the importance of non pharmacological interventions and behavioral strategies. All residents are assessed on admission, annually, with significant change in condition and reviewed quarterly for unnecessary drugs. The facility pharmacist consultant also reviews all residents' medications monthly. All residents on psychotropic medications have a review of psychotropic medications by IDT to review use of medication and appropriate interventions. The Clinical Administrator or designee will audit medication use to assure compliance. Random audits will be conducted weekly on 10% of residents weekly. Audit results will be reported to QA committee and action plans developed as needed. Date certain for the purposes of ongoing	

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F 329	Continued From page 10 evenings and nights. There was no documented reapproach if combative with cares and no individualized clarification of "aggressive" in the IDT note. IDT notes for R113 on 11/29/15, at 10:57 a.m. read, "Resident has been very agitated, and restless. He kept saying, Are you ready? lets go. I need to be there." wheeling around himself, pushing his wheelchair against other residents. Redirected, and reassured but resident kept moving round with his wheelchair. PRN Seroquel given. Resident calm down and slept until lunch time." There was no documentation to indicate what non-pharmaceutical interventions were attempted and in reviewing the ambulation for R113 who is to be walked 400 + feet a day on the day shift, R113 was signed off as walked 110 feet on 11/29/15 for the day shift and zero walk for evenings and nights. IDT notes on 11/21/15 at 4:06 p.m. read, "Resident shaking head back and forth, repeatedly saying "Peter" Resident would not answer if in pain or how staff could help him. Residents hands clenched to chair. In activity, Redirection, took to room with resident's wife, prn Seroquel given assisted with toileting. repositioning . PRN administration was effective." There was no documentation to indicate if non-pharmacological interventions had been attempted. There was no documented ambulation for R113 on 11/21/15. IDT notes on 11/15/15 at 7:41 p.m. read, "Seroquel Tablet 25 mg Give 2 tablets by mouth every 6 hours as needed for Dementia R/T Psychosis uncontrolled agitation/delusions/hallucinations." There was no	F 329	compliance is 12/30/15.	

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F 329	Continued From page 11	F 329		

documentation to indicate what was happening with R113 and what non-pharmacological interventions were attempted prior to the use of the antipsychotic medication. R113 was documented as walked 5 feet on the day shift and 50 feet on the evening shift.

IDT notes on 11/13/15, at 7:21 p.m. read, "Seroquel Tablet 25 mg Give 2 tablets by mouth every 6 hours as needed for Dementia R/T Psychosis uncontrolled agitation/delusions/hallucinations." There was no documentation to indicate what was happening with R113 and what non-pharmacological interventions were attempted prior to the use of the antipsychotic medication given. R113 was documented as walked 100 feet on the day shift and zero on the evening and night shift.

IDT notes on 11/8/15, at 12:04 a.m. read, "Seroquel Tablet 25 mg Give 2 tablets by mouth every 6 hours as needed for Dementia R/T Psychosis uncontrolled agitation/delusions/hallucinations." There was no documentation to indicate what was happening with R113 and what non-pharmacological interventions were attempted prior to the use of the antipsychotic medication. R113 was documented as walked 200 feet on the day shift, and zero for evenings and nights.

IDT notes on 11/4/15, at 7:30 p.m. read, "Seroquel Tablet 25 mg Give 2 tablets by mouth every 6 hours as needed for Dementia R/T Psychosis uncontrolled agitation/delusions/hallucinations." There was no documentation to indicate what was happening with R113 and what non-pharmacological interventions were attempted prior to the use of

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F 329	Continued From page 12	F 329		

the antipsychotic medication. R113 was documented as walked 75 feet on the day shift and zero for evenings and nights.

Document review of the form titled, Consultant Pharmacist Communication to Physician, addressed the use of Seroquel along with taking Levodopa-carbidopa "is well known for its potential to cause a wide variety of psychiatric/behavioral side effects."

When interviewed on 12/2/15, at 10:57 a.m., the consultant pharmacist verified discussions with the nursing staff and the nurse practitioner "numerous times", cautioning the use of PRN anti-psychotic medications without specific interventions prior to use.

When interviewed on 12/2/15, at 11:30 a.m. the nurse practitioner verified the expectation prior to giving the PRN Seroquel would be to evaluate staff approach,to evaluate the incident leading up to the agitation and to clearly document the non-pharmalogical interventions and re-approaches prior to giving the Seroquel.

Document review of the facility policy dated 7/2015, titled Psychotropic Medication and Unnecessary Medication Use Policy read, "Facility staff (such as licensed nurses, certified nursing assistants, activity therapists, social workers, and other staff members) will monitor the resident's medical symptoms, condition, circumstances and environment in order to evaluate the appropriateness of the psychoactive medication being used. Furthermore the policy read, "Anti-psychotics should not be used if one or more of the following is/are the only indication: a. Wandering b. Poor self care c. Restlessness d.

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	245615	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

(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 329	Continued From page 13 Impaired memory e. Anxiety f. Depression (without psychotic features) g. insomnia h. Unsociability i. Indifference to surroundings. j. Fidgeting k. Nervousness l. Uncooperativeness or m. Agitated behaviors, which do not represent danger to the resident or others." During an interview with the director of nursing (DON) on 12/2/15, at 1:44 p.m., verified there should be better documentation to explain what led up to the anxiety for R113 and what non-pharmacological interventions were attempted prior to the use of an anti-psychotic medication being given.	F 329		
F 441 SS=C	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		12/30/15

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F 441	Continued From page 14 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that laundry room staff protective garments, (worn when processing soiled linens), covered staffs arms in a manner to prevent potential cross-contamination between dirty and clean linens. This had the potential to affect 97 of 97 residents residing in the facility. Findings include: At 10:00 a.m. on 12/3/15, a tour of the laundry room was conducted. According to laundry aide (LA)-A there were no linens to process at this time, and linens were observed processing in both the washers and the dryers. At 10:03 a.m. approximately three 3/4 sleeved gowns and 4 aprons were observed hanging on a hook located next to the door that separated the soiled linen and washer rooms. There were no	F 441	Laundry staff were re-educated regarding infection control practices. The policy and procedure related to prevention of cross contamination between dirty and clean linens were reviewed and changes made as needed. Laundry staff was in-serviced on the new changes to the policy and procedure that disposable long sleeved gowns would be provided to laundry staff when any potential for cross contamination may occur. The Housekeeping/Laundry supervisor or designee will audit for infection control compliance. Random audits to be conducted 4 times weekly regarding infection control practices. Audit results will be reported to the QA committee and	

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	245615	A. BUILDING _____ B. WING _____	12/03/2015

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F 441	Continued From page 15 gowns with long sleeves on the hook and the aprons had no sleeves, which would cause exposure of the laundry staff arms or sleeves to soiled linens. LA-A was asked to explain how soiled linens were processed. LA-A stated the laundry staff use either a gown or apron to cover their clothes and wore gloves when sortiing through the soiled linen. The gowns and aprons were hung on hooks in the soiled linen room after the sorted laundry was put into the washing machine, gloves were removed at this time and hands washed. When asked how the clean linens were handled LA-A explained the clean wet linens were put into the dryer and when dry were placed in a cart and taken to a folding table and folded. LA-A stated staff did not wear gowns or protective garments when transferring the linens from the washer to the dryer or from the dryer to the folding table. Any clothing/sleeves that were not covered of the staffs arms when sorting soiled linens, had the potential to come into contact with the clean linens. When asked how frequently the gowns/aprons were washed, LA-A stated it was "weekly." At 10:11 a.m. on 12/3/15, the housekeeping services manager stated gowns and aprons were washed every couple of days and there were enough gowns and aprons so staff were able to rotate between the two garments. The housekeeping services manager stated at the end of each day the gowns and aprons were left hanging on the hook in the soiled linen room. The housekeeping services manager also stated that in addition to the laundry aide working on this	F 441	action plans developed as needed. Date certain for the purposes of ongoing compliance is 12/30/2015. The Housekeeping/Laundry supervisor is responsible for ongoing compliance.	

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F 441	Continued From page 16 date, there was another laundry aide. According to the housekeeping services manager, the second laundry aide wore a smock and placed the apron over the smock, which had 3/4 length sleeves. A review of an undated policy titled Soiled Laundry Procedures indicated sorting gowns were to be used when sorting laundry. There was no indication an apron was appropriate for sorting laundry. Nor did the policy indicate the frequency for washing the sorting gowns/aprons, used by laundry staff to sort soiled linens.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R221) who had requested their bill be submitted to the fiscal intermediary (FI) for a Medicare decision was not charged while the determination decision was pending; and failed to submit the bill for 1 of 3 residents (R221) to the FI. Findings include: A review of randomly selected denial notices revealed R221's power of attorney (POA) was	F 492	All demand bills have been reviewed to make sure no other residents were affected. All staff that provides information to residents and family were educated on demand bill process. The policy and procedure related to demand bills has been reviewed and changes made as needed.	12/30/15

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F 492	Continued From page 17 notified on 3/26/15, that room and board with custodial care or skilled services did not meet the skilled coverage criteria for Medicare Part A. This information was provided on CMS form 10055 and the POA indicated they wanted to file a claim. On 3/26/15, the POA signed the form acknowledging an understanding that if the claim was denied they would be responsible for the facility charges. At 1:10 p.m. on 12/2/15, documentation regarding the FI determination of the claim for R221 was requested. At 2:13 p.m. the accounts receivable specialist (ARS)-A stated the claim had not been submitted to the FI and the daughter had paid the bill. ARS-A stated they had not checked with the corporate billing department to ensure the claim had been submitted and had just found out on this date that the claim had not been submitted to the FI. At 10:40 a.m. R221's POA was interviewed. The POA stated the family was "immediately" billed for R221's stay and had "never" received anything from Medicare or the facility regarding the final determination on the reconsideration. The facility's Demand Bill Policy and Procedure, dated 3/09 revealed that after the billing office received the Medicare Demand bill request the information was to be entered into a log. The business office was to then calculate 30 days from the last covered date and the business office was to send the claim to the FI. The business office was to follow through until a determination was made by the FI and to forward all information to the Medicare Coordinator. The policy also indicated the resident was not to be	F 492	Facility is setting up a new demand bill payer in the facility's electronic medical record system (Point Click Care), which will prevent a bill going out to a resident prior to the Medicare review. The Administrator or designee will audit all current demand bills to assure ongoing compliance. Audit results will be reported to the QA committee and action plans developed as needed. Date certain for the purpose of ongoing compliance is 12/30/2015. The Administrator is responsible for ongoing compliance.	

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F 492	Continued From page 18 billed until the pending decision was made.	F 492		

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	245615	A. BUILDING **01 - THE GABLES OF BOUTWELLS LANDING** B. WING _____	**12/03/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Gables of Boutwells Landing was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care. Gables of Boutwells Landing is a 3-story building with a full basement. The building was constructed in 2008, and was determined to be of Type II(111) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 108 beds and had a census of 98 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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