#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: HR9U

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

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	AGENCY	F	Facility ID: 00292
1. MEDICARE/MEDICAID PROVIDER (L1) 245120 2.STATE VENDOR OR MEDICAID NO (L2) 195487000		3. NAME AND ADDRESS OF FACILITY (L3) GRACEPOINTE CROSSING GABLES EA (L4) 548 FIRST AVENUE (L5) CAMBRIDGE, MN		(L6) 55008		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OV (L9) <b>01/02/2007</b>	VNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>8/2017</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 90 (L37) (L38)	19 SNF (L39)	B. Not in Com Requirements : ICF (L42)	nee With quirements Based On: acceptable POC pliance with Program and/or Applied Waiv  IID  (L43)		2345. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code A*	e Following Requirements:  6. Scope of Serv. 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	tor
16. STATE SURVEY AGENCY REMARKANT SURVEYOR SIGNATURE		Date :				SURVEY AGENCY A		Date:
Brenda Fischer, U	•		05/23/2017 D BV HCFA DE	(L19)		JohnsTon, Pi Dr single sta	rogram Specialis	06/07/2017 (L20)
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to P      2. Facility is not Eligible	Y	20. COM	IPLIANCE WITH C			Statement of Finance	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	N-1513)
22. ORIGINAL DATE  OF PARTICIPATION  04/17/1967  (L24)	23. LTC AGREEMI BEGINNING I (L41)		24. LTC AGREEME ENDING DATH (L25)		VOLUNTAL		0 INVOLUNT 05-Fail to Mo	L30)  CARY eeet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI  A. Suspension of B. Rescind Suspension of the sus	of Admissions:	(L44)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	(L45) ARRIER NO.	(L31)	30. REMAR	RKS		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION ( 04/11/2017	OF APPROVAL DAT	ΓΕ (L33)		06/09/2017 Co.	DVAI.	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 23, 2017

Ms. Brandi Barthel, Administrator Gracepointe Crossing Gables East 548 First Avenue Cambridge, MN 55008

RE: Project Number S5120027 & H5120044

Dear Ms. Barthel:

On March 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 March 2, 2017 that included an investigation of complaint number H5120044. 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 April 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 2, 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 March 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2017, effective April 10, 2017 and therefore remedies outlined in our letter to you dated March 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,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Email: kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: HR9U

### ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PARI	I - IO BE COM	PLETED BY I	HE STATI	E SURVEY AGENCY	F	acility ID: 00292
MEDICARE/MEDICAID PROVIDER N     (L1) 245120  2.STATE VENDOR OR MEDICAID NO.     (L2) 195487000	0.	3. NAME AND ADI (L3) GRACEPOIN (L4) 548 FIRST A' (L5) CAMBRIDG	NTE CROSSING VENUE		(L6) 55008	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 01/02/2007	NERSHIP	7. PROVIDER/SUF		Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other
6. DATE OF SURVEY 03/02 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	90 (L18) 90 (L17)	B. Not in Com	nce With quirements Based On: acceptable POC	n	And/Or Approved Waivers Of The  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF)  5. Life Safety Code	6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 90 (L37) (L38)	19 SNF (L39)	ICF (L42)	and/or Applied Waiv IID (L43)	ers:	* Code: A1*  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L12) (L15)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	.ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL	Date:
Austin Fry, I	HFE NE II		04/05/2017	(L19)	Kate JohnsTon, Pr	ogram Specialis	04/11/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	TE AGENCY	
DETERMINATION OF ELIGIBILITY	icipate (L21)		IPLIANCE WITH C	CIVIL	21. 1. Statement of Financ 2. Ownership/Control 3. Both of the Above :	Interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE  OF PARTICIPATION  04/17/1967	23. LTC AGREEME BEGINNING I		4. LTC AGREEME		26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure	<u>INVOLUNT</u>	ARY et Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATIVE  A. Suspension of  B. Rescind Susp	of Admissions:	(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	et Agreement Status Change
28. TERMINATION DATE:	29	INTERMEDIARY/C	(L45)		30. REMARKS		
25. 13	(L28)	03001	THE REST.	(L31)			
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION (	OF APPROVAL DAT	ГЕ	Posted 04/11/2017 Co.		
	(L32)			(L33)	DETERMINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 17, 2017

Mr. Timothy Samuelson, Administrator Gracepointe Crossing Gables East 548 First Avenue Cambridge, MN 55008

RE: Project Number S5120027, H5120044 & H5120045

Dear Mr. Samuelson:

On March 2, 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. In addition, at the time of the March 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5120044.

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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5120045 that was 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:

<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;

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

#### **DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing & Certification Health Regulation Division Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338

Fax: (320)223-7348

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 11, 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 April 11, 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 June 2, 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 September 2, 2017 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

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

Enclosure

cc: Licensing and Certification File

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 04/05/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245120	B. WING _		C <b>03/02/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/02/2017
GRACEP	OINTE CROSSING G	ABLES EAST		548 FIRST AVENUE CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	rs	F 00	00	
	completed by surve Department of Hea Crossing Gables - I compliance with the	17, a recertification survey was eyors from the Minnesota lth (MDH). Gracepointe East was found to not be in e regulations at 42 CFR Part uirements for Long Term Care			
	completed while on survey. H5120045 unsubstantiated. H	nplaint investigations were i-site for the recertification was reviewed and found to be 15120044 was reviewed and deficiencies cited at F157 and			
	as your allegation of Department's acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 157 SS=D	on-site revisit of you validate that substa		F 18	57	4/10/17
	(g)(14) Notification	,			
	consult with the res	mediately inform the resident; ident's physician; and notify, or her authority, the resident then there is-			
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
	ically Signed	an actorick (*) donotos a doficionou wh	ich the inst	itution may be excused from correcting providing	03/30/2017

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_

Any deticiency statement ending with an asterisk (\*) denotes a deticiency 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG			SURVEY PLETED
		245120	B. WING _			03/0	) 2/2017
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP 548 FIRST AVENUE CAMBRIDGE, MN 55008	CODE	00/0	,2,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E	3E	(X5) COMPLETION DATE
F 157	Continued From pa	ge 1 olving the resident which	F 1	57			
	results in injury and physician intervention	has the potential for requiring on;					
	mental, or psychosodeterioration in hea	ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or ns);					
	a need to discontinutreatment due to ad	treatment significantly (that is, ue an existing form of liverse consequences, or to orm of treatment); or					
		ansfer or discharge the cility as specified in					
	(14)(i) of this sectio all pertinent informa	otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the					
		t also promptly notify the sident representative, if any,					
	(A) A change in roo as specified in §483	m or roommate assignment 3.10(e)(6); or					
		ident rights under Federal or ions as specified in paragraph on.					
	(iv) The facility mus	t record and periodically					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245120	B. WING		C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	00/02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 157	phone number of the This REQUIREMENT by: Based on interview facility failed to ensonotified timely of new for 1 of 1 residents of change.  Findings include: R31's BIMS and Degards of change.  Findings include: R31's Admission Regards and a, "Somake decisions regar	e (mailing and email) and the resident representative(s). NT is not met as evidenced of and document review, the ture the responsible party was evily developed left knee pain (R31) reviewed for notification (R31) remarks (R31) remarks (R31) remarks (R31) relying responsible (R31) relying remarks (	F 157	R31 is no longer a resident of GracePointe Crossing Gables East The policy for Family or Responsible Notification on Change of Condition reviewed and is current.  All residents are assessed for change condition upon admission, minimall quarterly and with change of status Family members and physicians ar notified with change of status as perfacility policy, resident and or family request and as indicated by the car Education will be completed for state responsible for updating the family responsible party of a change in completing audits on 5% of residuely for two months. Results of a will be reviewed at the QAA meeting will be determined the need for ong monitoring.  Clinical Administrator or designee we responsible for ongoing compliance.	de Party n was  ge of y eer the re plan.  ff or ndition  rection dents audits g and loing
	started treatment o before she, as R31	was, "Upsetting," staff had f R31's fractured and leg pain 's responsible party, had ever incident. Further, FM-A			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245120	B. WING			C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, 2 548 FIRST AVENUE CAMBRIDGE, MN 55008		03/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE AC'  CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	decisions without in R31's provided clossingle, undated not "DO NOT ADD, D/O ANYTHING WITHOThe second note diof ANY med/insulin movement] in 3 day R31's progress not 11/4/16, identified Fleft leg pain in the cFurther, the progrefollowing entries:  On 11/3/16, at 3:33 with, "C/o [complain given Tylenol.  At 5:10 a.m. R31 w call out for help and repositioned and w notification of family after R31 had been pain for nearly two  At 9:25 a.m. R31 w complaints of left leg in the left knee," with clinic and, "Left physician] regarding A subsequent note "Telephone order reknee xray due to legarding and in the left clinic	not have been, "Making hvolving me."  sed record contained two es. The first note identified, C [discontinue] OR CHANGE DUT [FM-A] APPROVAL!!!!!!" rected staff to, "Notify [FM-A] changes," or, " if no [bowel ys."  es dated 10/26/16 through R31 had no prior complaints of days leading up to 11/3/16. ss notes identified the  a.m. R31 was first identified hts of] left leg pain," and was ras noted as, "Continuing to d c/o pain, resident arm blanket given." No y was identified in the note having complaints of knee	F1	57		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) E C	DATE SURVEY COMPLETED
		245120	B. WING			C 03/02/2017
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008	<b>-</b>	33/02/2317
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	pain) a note identification positive for distal feand will be going out the positive for distal feand will be going out the positive for distal feand will be going out the positive of the newly 11/3/16, at 3:10 p.m started. Further, Riparty should be note change in status," a contacted before [3]  When interviewed of stated she was the shift of 11/3/16. RN staff notified her, "A [am]," of R31's left is stated FM-A was Rivery much so," involved the shift of the stated FM-A was Rivery much so," involved the stated FM-A, "Right away, this in the medical roone of those crazy her attempt to contarecorded in the medical recorded	we newly doucmented left leg ed, " x-ray came back mur fracture. [FM-A] notified at of town"  3/1/17, at 12:22 p.m. N)-A stated R31's medical efirst time FM-A had been developed leg pain was on a fiter treatment had been N-A stated the responsible lified with, "Any significant and FM-A, "Should of been	F1	57		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245120	B. WING			C / <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225 SS=D	Responsible Party identified a purpose resident represental listed several option condition." The pol which included, "Fridesignated party winursing intervention medical record for a party instructions reduced party slin a timely manner. staff to, "Document record, the time cal what was reported adding if staff were responsible party to increments until pamessage," and, "Documents until pamessage," and, "Docume	Notification policy dated 11/16, eto, "Notify family and/or ative any time there is a," and as which included, "Change in icy identified a procedure om 10:00 p.m. to 8:00 a.m. the ill be notified if more than a is needed. Check the specific family/responsible egarding notification. Hould be notified the next day "Further, the policy directed in the resident's medical led, the person spoke with, and their response, if any," unable to reach the policy directed the policy directed in the resident's medical led, the person spoke with, and their response, if any," unable to reach the policy directed the	F 1			4/10/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	CON	TE SURVEY MPLETED
		245120	B. WING			C / <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP C 548 FIRST AVENUE CAMBRIDGE, MN 55008	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	body as a result of exploitation, mistre misappropriation of (4) Report to the Stilicensing authorities actions by a court of which would indica nurse aide or other (c) In response to a exploitation, or mis (1) Ensure that all a abuse, neglect, exploitation, or mis (1) Ensure that all a abuse, neglect, exploitation or reported immediate after the allegation cause the allegation cause the allegation cause that cau abuse and do not reported immediate after the administrator of officials (including the administrator of its administ	license by a state licensure a finding of abuse, neglect, atment of residents or atment of residents or any knowledge it has of of law against an employee, the unfitness for service as a facility staff.  Allegations of abuse, neglect, treatment, the facility must:  Alleged violations involving poloitation or mistreatment, funknown source and a fresident property, are ply, but not later than 2 hours is made, if the events that an involve abuse or result in any, or not later than 24 hours if the facility and to other to the State Survey Agency and the facility and to other to the State Survey Agency and the facilities of the state law provides and the facilities of the state law through established that all alleged violations are atted.  Potential abuse, neglect, treatment while the	F 2	25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245120	B. WING		C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST	5	STREET ADDRESS, CITY, STATE, ZIP CODE 648 FIRST AVENUE CAMBRIDGE, MN 55008	, 30,02,20
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE COMPLÉTION
F 225	(4) Report the result administrator or his representative and with State law, incluaded Agency, within 5 woif the alleged violatic corrective action mathematically failed to ensimisappropriation of immediately reported 5 residents (R94) was reviewed.  Findings include:  R94's quarterly Min 2/3/17, identified R9 impairment and dissymptoms (i.e. physobehavioral symptoms (i.e. physobehavioral symptoms (i.e. physobehavioral symptoms) and \$20 dollar behavioral symptoms (i.e. physobehavioral symptoms) and \$20 dollar behavioral symptoms (i.e. physobehavioral symptoms) and seen on 1 to the report. Furth search had been on Search," being identified R94 had been consultations and search had been on 1 to the report. Furth search had been consultations are played in the report was sign 8:15 p.m. by the, "F	Its of all investigations to the or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken.  NT is not met as evidenced and document review, the ure allegations of potential resident funds were ed to the State agency for 1 of whose allegations were	F 225	R94 s initial OHFC incident report filed on 11/11/16. A further investigation was completed and final OHFC report was filed on 11/16/16 and was deter by OHFC that no further action was necessary from their office on 12/2 R 94 s care plan was reviewed an current.  The policy and procedure for Vulner Adult Reporting and Missing Items reviewed and is current.  All missing items and/or vulnerable concerns for any resident is immediately provided to the appropriate state agas per the facility policy and investito ensure the protection of vulnerable adults.  Education will be completed for all the expectations for Vulnerable Add Reporting and Missing Item policy 4/5/17.  Facility will audit all vulnerable adult concerns for timeliness of reporting for consistency with following the presults of audits will be reviewed by	ation port ermined s 3/16.  ad is erable was eadult diately gency gated pole staff on ult by lt g and olicy.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		245120	B. WING				C <b>02/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	02/2017
GRACEP	OINTE CROSSING G	ABLES EAST			48 FIRST AVENUE AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 8	F 2	25			
	"Date Submitted to and listed it reporte following day after is staff]."  R94's Investigative Completed form da investigation of the completed by the faidentified, "After the [R94] returned from of her insurance caher bed. [R94] chehad hidden under h\$70.00 was missing reported the missin 7:30 p.m." and staff however, "The more clinical administrate campus administrate the report. Further does have some for source," adding, "Nobeen identified."  When interviewed of director of nursing of credible source of ithe campus adminifacility) had been not misappropriation of	MDH/OHFC [State agency]," d on, "11/11/2016 [the the allegation was reported to the allegation had been acility. The investigation is supper meal on 11/10/16, in the dining room to find some ords lying on the floor next to cked in her wallet which she are pillow and noticed that g from her wallet." R94 g money, "at approximately form to a search, ney was not found." The for, leader in training and tor was notified according to the report identified, "[R94] argetfulness but is a credible of alleged perpetrator has another than the (DON) stated R94 was a formation. The DON stated strator (no longer at the otified of R94's allegation of funds immediately on			facility Quality Assurance Committeensure ongoing compliance.  Administrator, Clinical Administrator and/or designee will be responsible ongoing compliance.	or	
	however the State a until, "The following During interview on current administrate expected the staff t	to the investigation notes, agency had not been notified morning," on 11/11/16.  3/2/17, at 9:03 a.m. the or stated she would have o have reported R94's missing agency, "That evening					

PREFIX   TAG   PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   S48 FIRST AVENUE   CAMBRIDGE, MN 55008		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
AMME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST   (X4) ID PREFIX TAG  (EACH DEFICIENCY MIXTER PROPERTION OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  F 225  Continued From page 9  [11/10/16]."  The facility Vulnerable Adult Abuse Prevention Plan dated 12/2016, identified the administrator or designee, "Will make an initial report of the incident or the suspected incident, immediately in accordance with the law," and directed, "An initial report must be completed and submitted to the State Agency via state specific contact point."  F 226  SS=D  STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008  PROVIDER'S PLAN OF CORRECTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTION SHOULD BE (CACH CORREC							С
GRACEPOINTE CROSSING GABLES EAST  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 225  Continued From page 9 [11/10/16]."  The facility Vulnerable Adult Abuse Prevention Plan dated 12/2016, identified the administrator or designee, "Will make an initial report of the incident or the suspected incident, immediately in accordance with the law," and directed, "An initial report must be completed and submitted to the State Agency via state specific contact point."  F 226  SS=D  DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  SUMMARY STATEMENT SEASON  PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX CAMBRIDGE, MN 55008  F 225  F 225  F 225  F 225  F 225  F 225  F 226  A/10/17			245120	B. WING		03/	02/2017
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 225  Continued From page 9  [11/10/16]."  The facility Vulnerable Adult Abuse Prevention Plan dated 12/2016, identified the administrator or designee, "Will make an initial report of the incident or the suspected incident, immediately in accordance with the law," and directed, "An initial report must be completed and submitted to the State Agency via state specific contact point."  F 226  SS=D  DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES			ABLES EAST		548 FIRST AVENUE		
[11/10/16]."  The facility Vulnerable Adult Abuse Prevention Plan dated 12/2016, identified the administrator or designee, "Will make an initial report of the incident or the suspected incident, immediately in accordance with the law," and directed, "An initial report must be completed and submitted to the State Agency via state specific contact point."  F 226 SS=D  DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
(b) The facility must develop and implement written policies and procedures that:  (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  (2) Establish policies and procedures to investigate any such allegations, and  (3) Include training as required at paragraph §483.95,  483.95  (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226	[11/10/16]."  The facility Vulnera Plan dated 12/2016 or designee, "Will nincident or the suspaccordance with the report must be comstate Agency via st 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES  483.12 (b) The facility muswritten policies and (1) Prohibit and preexploitation of resident property, (2) Establish policies investigate any successident property, (2) Establish policies investigate any successident property, (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to the ducates staff on-(c)(1) Activities that exploitation, and missing the support of the suppor	ble Adult Abuse Prevention 5, identified the administrator nake an initial report of the pected incident, immediately in e law," and directed, "An initial apleted and submitted to the ate specific contact point."  33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC  t develop and implement procedures that:  event abuse, neglect, and dents and misappropriation of the allegations, and as required at paragraph  and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum		225		4/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245120	B. WING		C <b>03/02</b> /	/2017
	PROVIDER OR SUPPLIER	ABLES EAST	5	STREET ADDRESS, CITY, STATE, ZIP CODE 648 FIRST AVENUE CAMBRIDGE, MN 55008	03/02/	72017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE C	(X5) COMPLETION DATE
F 226	(c)(2) Procedures in neglect, exploitation resident property  (c)(3) Dementia may prevention.  This REQUIREME by:  Based on interview facility failed to imperocedures to ensure misappropriation of immediately report 5 residents (R94) where were reviewed.  Findings include:  The facility Vulnerary Plan policy dated 1 to, "Establish the phan was with state and federidentified each resification of identified a section and listed several, with a heading of," Exploitation (Misapproperty)" being into the property in the proper	age 10 or reporting incidents of abuse, in, or the misappropriation of an agement and resident abuse.  NT is not met as evidenced or and document review, the element policies and are allegations of potential for resident funds were eled to the State agency for 1 of whose allegations were.  Able Adult Abuse Prevention 2/2016, identified a purpose olicies, procedures and protecting all adults who are is facility for health services onment in which to live," is developed, "In accordance ral regulations." The policy dent, " has the right to be exual, physical, and mental everal examples including for resident property. The policy labeled, "III. Identification," "Other Definitions of Abuse," Financial or Material propriation of resident cluded. The text under the adefinition of, "Illegal or	F 226	R94 s initial OHFC incident report filed on 11/11/16. A further investigat was completed and final OHFC reports was filed on 11/16/16 and was deter by OHFC that no further action was necessary from their office on 12/23. R 94 s care plan was reviewed and current.  The policy and procedure for Vulner Adult Reporting and Missing Items was reviewed and is current.  All missing items and/or vulnerable a concerns for any resident is immediately reported to the appropriate state agains per the facility policy and investig to ensure the protection of vulnerable adults.  Education will be completed for all seporting and Missing Item policy be 4/5/17.  Facility will audit all vulnerable adult concerns for timeliness of reporting	tion ort rmined //16. I is able vas adult ately ency ated le taff on lt	
	improper use of an assets without info	individual's funds, property or rmed consent and resulting in I, or other benefit, gain, or		for consistency with following the po Results of audits will be reviewed by facility Quality Assurance Committee	licy. the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245120	B. WING				C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	02/2011
CDACE	OINTE ODOCCINO (	SARI EC EACT	548 FIRST AVENUE		18 FIRST AVENUE		
GRACER	POINTE CROSSING (	ABLES EAST		C	AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	profit for the perpedirected, "All cases maltreatment musincluding, "An initia and submitted to the specific contact por R94's quarterly Mi 2/3/17, identified Fimpairment and dissymptoms (i.e. phybehavioral symptoms (i.e. phybehavioral symptoms)	trator" Further, the policy of maltreatment or potential to be reported immediately," all report must be completed the State Agency via state sint."  Inimum Data Set (MDS) dated the splayed no behavioral ysical, verbal or other ms).  In Homes & Services Report of Item(s) form dated 11/15/16, reported, "\$70 cash [\$50 dollar bill]" to be missing. The money the din a pink receipt, inside her laced under her pillow," and 1/9/16, at 8:00 p.m. according ther, the report identified a completed with an, "Outcome of the notified as, "Money not found." and and dated on 11/10/16, at Person Taking Report."  Doort - Submission Completed 6, identified spacing labeled, of MDH/OHFC [State agency]," and on, "11/11/2016 [the the allegation was reported to the Report Submission	F 2	226	ensure ongoing compliance.  Administrator, Clinical Administrator and/or designee will be responsible ongoing compliance.		
	investigation of the completed by the f identified, "After th	ated 11/16/16, identified an eallegation had been acility. The investigation e supper meal on 11/10/16, m the dining room to find some					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245120	B. WING _		C <b>03/02/2017</b>	
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	1 00/1	02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 226	of her insurance ca her bed. [R94] che had hidden under h \$70.00 was missing reported the missin 7:30 p.m." and staff however, "The mon clinical administrate campus administrate campus administrate the report. Further, does have some for source," adding, "N been identified."  When interviewed of director of nursing ( credible source of in the campus administration of 11/10/16 according however, the State until, "The following was not in accordar	ge 12 rds lying on the floor next to cked in her wallet which she er pillow and noticed that grom her wallet." R94 g money, "at approximately completed a search, ey was not found." The or, leader in training and tor was notified according to the report identified, "[R94] rgetfulness but is a credible o alleged perpetrator has on 3/1/17, at 9:01 a.m. the DON) stated R94 was a information. The DON stated strator (not longer at the otified of R94's allegation of funds immediately on to the investigation notes, agency had not been notified morning," on 11/11/16 which note with the facility policy.  3/2/17, at 9:03 a.m. the	F 22	26		
F 309 SS=D	current administrate expected the staff to money to the State [11/10/16]." 483.24, 483.25(k)(l)	or stated she would have to have reported R94's missing agency, "That evening PROVIDE CARE/SERVICES	F 30	09		4/10/17
	applies to all care a residents. Each res	e indamental principle that nd services provided to facility sident must receive and the the necessary care and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245120	B. WING				) 02/2017
	PROVIDER OR SUPPLIER	ABLES EAST		548	EET ADDRESS, CITY, STATE, ZIP CODE FIRST AVENUE MBRIDGE, MN 55008		_,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	practicable physical well-being, consisted comprehensive assessment of a restrict that residents receated accordance with properation of the facility must end the facility must end the comprehensive and the residents with protection of the comprehensive and the residents who requised to the comprehensive and the preferences. This REQUIREME by:  Based on interview facility failed to the comprehensively and the residents who comprehensively as the comprehensive as t	r maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care.  are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in ofessional standards of rehensive person-centered residents' choices, including ne following:  ent.  Insure that pain management is not swho require such services, fessional standards of practice, a person-centered care plan, goals and preferences.  Cility must ensure that hire dialysis receive such not with professional standards in prehensive person-centered residents' goals and  NT is not met as evidenced and document review, the roughly recognize, ssess and implement medical or for 1 of 1 resident (R31) who	F3		R31 is no longer a resident of GracePointe Crossing Gables Eas: The policy for Change of Condition reviewed and is current. All residents are assessed for charcondition upon admission, minimal	was	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C <b>02/2017</b>	
	PROVIDER OR SUPPLIER	ADI ES EAST		STREET ADDRESS, CITY, STATE, ZIP C 548 FIRST AVENUE	<u> </u>	<u> </u>	
GNACE	OINTE CHOSSING G	IABLES EAST		CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	R31's quarterly Mir 9/7/16, identified R assistance with act and had demential Further, the MDS id "Prognosis," with a resident have a cormay result in a life months?" This was R31's Provider Ord Treatment (POLST was DNR (Do Not I section labeled, "G several options to be resident's correspon "X" marking was plinterventions and treatment and the reversible illness chronic conditions. Care" was left unch R31's BIMS (Brief I and Delirium assessidentified R31 had and a "Severely im decisions regarding During interview or member (FM)-A stated (R31) at any time and was conditions adding Fphysician, "About a FM-A said R31's present the said R31's present and the responsible illness in the resp	nimum Data Set (MDS) dated 31 required extensive ivities of daily living (ADLs), but with no current infections. dentified a section labeled, question listed as, "Does the ndition or chronic disease that expectancy of less than 6 is answered as, "No."  Hers for Life Sustaining (1) dated 9/10/14, identified R31 (2) Resuscitate) and included a oals of Treatment," with the checked to identify the ending wishes. A hand written, acced next to, "Limit reat reversible conditions." Intion at that section included, one aimed at treatment of new solinjury or non-life threatening (2) The option of, "Comfort necked.  Interview for Mental Status) is ment dated 9/16/16, a "Memory problem" with recall paired" ability to make	F3	quarterly and with change of Family members and physic notified with change of statu facility policy, resident and crequest and as indicated by The interventions related to condition include an interdis approach including represent the resident and family as a well as the physician. Interverviewed with the family and minimally at care conference indicated.  Education will be completed responsible for recognizing for a change of condition and physician and family by 4/10.  Facility will monitor and sust by completing audits on 5% weekly for two months. Reswill be reviewed at the QAA will be determined the need monitoring.  Clinical Administrator and/or be responsible for ongoing of the same and sust on the physician and sust on the physician and sust on the physician and family by 4/10.	cians are us as per the or family the care plan. the change of ciplinary ntation from ppropriate as entions are d IDT es and as  If for staff and assessing d updating the 0/17.  tain correction of residents ults of audits meeting and for ongoing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG	CON	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C / <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008		/OZ/2311
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	her health." FM-A sin 11/5/16, R31 had dinfection" with sever unrelieved fever and demonstrated, "Some needs to be address received a call on 1 was described to be FM-A advised staff hospital right away. transferred to the hidentified she had some response to a infect and then died. FM-the nursing home some the signs and sympostal right away. R31's care plan data an self care perform assistance to compliving) with impaired R31 to be, "Resistive plan identified R31 heart failure, and addirecting staff to make the signs and symposition of the signs and symposition with impaired R31 heart failure, and addirecting staff to make the signs and reponseded." R31 was cognitive function/d[R31] need my PO/R31's developed can was on comfort car with a life expectan R31's Progress Nor R31 had been seen physician. The physician.	age 15 stated on the weekend of eveloped, "Some kind of ral symptoms including an d rash. FM-A said it mething bad is going on and it sed." FM-A stated she had 1/7/16, from staff in which R31 e, "Not acting herself," and R31 needed, "To go to the "FM-A stated R31 was ospital where the physician sepsis (a massive immune tion in the blood) infection, -A stated was upset and felt taff should have recognized of one of infection in R31.  Ited 9/21/16, identified R31 had nance deficit and required of the all ADLs (activities of daily deposite all ADLs (activities of daily deposite and high blood pressure, trisk for fluid volume deficit onitor R31 for, "Electrolyte ay include weak pulse, on, changes in my blood out these to the physician, "As identified with, "Impaired lementia," and identified, "I havith all decision making." are plan did not identify R31 e or had a terminal condition cy of less then six months.  Ites dated 9/20/16, identified in the clinic by her primary resician identified R31 to be, grairly well," with pulse	F3	09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING		0:	C 3/ <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008		)(CL) LOTT
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	is clear, no wheezir identified R31 was months. The note on comfort cares, have a life expectar R31's CMC (Camb Discharge Summar was an elderly femacare," who had persummary identified and R31 returned to condition was ident as, "Stabilized," and to follow up with ap [weight] bearing ad discontinuation plan potential was listed the skilled nursing the providers know if you condition." Further Exam," identified he to auscultation] bilat were recorded as: Pulse 90; Temperar 20. The discharge of R31's responsible comfort cares, or a POLST from her preduction. R31's facility report Report dated 11/1/recorded meal intal period. R31 had continuation R31 had continuation.	Its per minute, and her, "Chest and or rales." Further, the note to return for a recheck in two did not identify R31 was to be lave a life limiting illness, or noty of less than six months.  Indige Medical Center)  Indige	F3	09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245120	B. WING _			C / <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP COD 548 FIRST AVENUE CAMBRIDGE, MN 55008		702/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	consumed, "26-509 evening meal. On 1 "Resident refused," 11/6/16, R31 was id "76-100%" of break lunch meal and refuconsumed no meal provided report.  R31's Medication A dated 11/1/16 throu orders for, "Lantus Inject 6 units subcutand was administer through 11/5/16. Tinsulin was not admidirected, "Other / S  The MAR had no a antibiotic (medication, or destry microbadministration from Further, the MAR id "NovoLOG Solution lasting a total of six sliding scale: if 150 units; 250 - 299 = 6 - 900 = 10 units," a [medical doctor] if of the dose administer blood glucose (BG) - In the morning of reading of 102 mg/mormal fasting BG in not administered in	6, R31 refused breakfast but %" of lunch and, "0-25%" of the 1/5/16, R31 was identified as, or for all three meals. On dentified as consuming, stast but only, "0-25%" of the used the evening meal. R31 is on 11/7/16, according to the dentified R31 had Solution [long acting insulin] itaneously one time a day," red as ordered from 11/1/16, he MAR identified the ordered inistered on 11/6/16 and ee Nurses Notes."  In the corders identified for on used to inhibit the growth organisms) therapy 11/1/16, through 11/7/16.  Identified R31 had orders for, in [short acting insulin, often to eight hours] Inject per 199 = 2 units; 200 - 249 = 4 is units; 300 - 349 = 8 units; 350 and directed staff to, "Notify MD over 500." The order identified red with the corresponding	F 30	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245120	B. WING				C <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		548	REET ADDRESS, CITY, STATE, ZIP CODE 8 FIRST AVENUE AMBRIDGE, MN 55008	1 00/1	02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	administered eight  - In the morning of reading of 272 and Novolog. In the aft BG reading of 329 units of Novolog.  - In the morning of BG obtained, instead "Parameters out of being identified. In had a BG reading of 10 units of Novolog.  - In the morning of have a BG obtained "Parameters out of information was identified which	units of Novolog.  11/4/16, R31 had a BG was administered six units of ernoon of 11/4/16, R31 had a and was administered eight  11/5/16, R31 did not have a ad the MAR directed, range," with no treatment the afternoon of 11/5/16, R31 of 402 and was administered b.  11/6/16, R31 again did not d, instead the MAR directed, range," with no further entified. In the afternoon of BG reading of 593 and was its of Novolog. Further, on onal, "One Time," orders were entified R31 had an additional of administered at 5:19 p.m. 0 units of Lantus being	F3	09			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245120	B. WING	·····	03	C / <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008		, 0 = , = 0 : 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	identified to, "Have minimal movement "Pinpoint rash from elbow."  - On 11/4/16, R31 v comfort cares - no note identified R31 hurting," however, including a single described to	moral diaphysis." R31 was c/o [complaints of] pain with ." Further, R31 had a, fingertips to just above the was identified to be, "On therapy ordered." Further, the "Was in a lot of pain and refused to take medications, ose of insulin, when offered. was identified as, "C/o pain in calling out for help."  linary," note identified R31 had als, along with a subsequent d, "[R31] ate less than 25% of e some ice cream at bedtime.  was identified to eat, "Less " and staff were encouraging 11/6/16 at 2:35 p.m. an entry and slight fever on [night] shift. 100.7 tympanic (ear). After increased respiratory rate of signs] were as follows: Pulse uration 94%. Temp 100.3 (54. Lung sounds sonorous e, loud sound caused by tways or an obstruction]. No was up in wheelchair for 4 the same date at 5:18 p.m. etime only order of 20 units ion insulin] given for BG B," and six units of Lantus ra, "One time only order due	F 3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245120	B. WING				C <b>02/2017</b>
	PROVIDER OR SUPPLIER			548 I	EET ADDRESS, CITY, STATE, ZIP CODE FIRST AVENUE IBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	resident being febrof 100.3F at [2:00 p.m.]. Resident's Ecall [name identified of Novolog instead units of Lantus at Hesident's temp at was 202. Resident's temp at was 202. Resident's temp at was 202. Resident's temp at was 203. Resident's temp at was 204. Resident's temp at was 204. Resident's temp at was 205. Resident's temp at was 206. Resident's temp at was 20	call physician called due to ille and hyperglycemia. Temp p.m.], Temp of 100F at [4:30 as at [4:30 p.m.] was 593. On d] gave orders to give 20 units of sliding scale and to give 10 as [bedtime] instead of 6 units. [8:30 p.m.] was 99.9F and BG thad perspiration [sweating] all entified staff provided water to pain medications adding, "Will r." The note lacked information d been informed of R31's y rate, coarse lung sounds, or sugar readings in the absence e.  Itions were identified in R31's arding the notification of the the progress note on 11/6/16.  Form fax communication dated staff faxed regarding, "Resident R with pinpoint rash on [right] is to elbow." The physician'	F3	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING		05	C 3/ <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008		702/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 309	[decreased] 100.3 [Tylenol ineffective. decreased respons drinking. Left mess glucose 593 at [4:0 [7:30 a.m.] on 11/7/scale insulin." R31 responded on 11/7/hand-written note, 'comfort cares to us wants agressive [si be sent to the ED [6 faxed physician research of the end on 11/5 [night], incressident was diapher (LOC) was decreased in the end of the	ed] 100.7 + before noon, increased] on 11/6/16 Now diaphoretic with iveness. Not eating or sage for [FM-A]. Blood 0 p.m.] on 11/6/16 and 461 at 16. Both covered with sliding 's primary physician 17, with the following My suggestion if she is e comfort cares. If family c] treatment she them need to emergency department]." The ponse was not time stamped.  4 p.m. R31 was identified to well to her broken femur. She reekend of 99. [sic] tympanic eased up to 100.7 in AM and 3. On 11/7 temp was 99 and pretic. Level of conscious ed throughout shift. Resident ed. Resident ate very little due LOC. Resident only drank th spoon feeding. Blood 0 p.m.] on 11/6 and 461 at Both covered with sliding sage left for [FM-A] in AM antil afternoon. Dr. was notified sted comfort care. If family reatment she will need to be ergency department]. This im-A], who said she would call us back with answer about	F3	09		
		to the ED," with her vital signs 8, pulse 91, resp 28, temp				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING				C <b>02/2017</b>
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST			STREET ADDRESS, CITY, STATE, ZIP COD 548 FIRST AVENUE CAMBRIDGE, MN 55008			-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	note identified R31 arm," and was, "Dia touch." Further, a sidentified, "CMC [mp.m.] to notify us th [8:34 p.m.]."  R31's History & Phy 8:06 p.m. identified [medical center] for complaint of, "Feve identified POA. R3 responsive and feb in multisystem orgasepsis criteria [lacta unstressed patient R31 was admitted tassessment identified was unable to be counresponsive state Problem List" which acute organ dysfun heart failure," "Acut sodium level]," and identified, "Date No listed as 11/7/16. Thy physical examination which included a black 127, temperature of adding R31 to be, "to appear, "Mottled thigh." The assess laboratory values was unable to del (Warange 4.5 to 10) con white blood cell (Warange 4.5 to 10).	meter saturation 97%." The had, "Pinpoint rash on right aphortic [sic] and cool to subsequent note on 11/7/16, edical center] called at [9:05 at resident passes away at resident passes away at sical (H&P) dated 11/7/16, at R31 had, "Presented to evaluation," for a chief r," adding FM-A as R31's 1 was identified as, " less rile." R31 was, "Found to be an failure and met severe ate 7.9 (normal range in is 0.5 - 1 mmol/L)]," adding to the hospital. The ed a review of systems (ROS) completed, "Secondary to "and listed a, "Patient Active in included, "Severe sepsis with ction," "Multi-organ failure with the hypernatremia [elevated, "Metabolic acidosis." The ted," for each diagnosis was the assessment listed a concompleted by the physician cood pressure of 83/45, pulse f 99.2, and respirations of 26 Non responsive," and her skin and lacy rash of right medial ment identified several hich were collected on ared them to the laboratory 11/3/16, which included a BC) count of 24.5 (normal mared to 11.2 prior on the level of 152 compared to 152 compared to 152 compared to 152 compared to 153 compared to 154 compared to 155 com	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING _			C / <b>02/2017</b>	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST				STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	and plan was listed organ dysfunction, admitted to the hos length with [FM-A] age and multisyste would like minimall antibiotics and IVF R31's undated Min (MDH) Documenta R31 expired while, listed the, "Immedicondition resulting When interviewed assistant (NA)-B st with R31. NA-B st 11/5/16, she notice and to be, "Pale," a warm to touch, and she had been befowere involved in he added, she was not terminal condition of the last weeks of h During interview or registered nurse (Fourse who contacted recorded in the promedical record, "The reported to the phy sugars, elevated to the phy sugars, elevated to the phy sugars, elevated to the phy sugars, and an adding R31 to be, adding R31 had a second supplementation of the last weeks of the last we	6. Further, an assessment If for, "Severe sepsis with acute " and identified R31 would be spital which was, "Discussed at the poor prognosis given her m failure," adding, "Family y invasive measures such as	F 30				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING _			C / <b>02/2017</b>	
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		<b>32</b> /2011	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	additional abnormal including the elevated developed rash sinhospital, coarse lur R31's blood sugars consistent meal inta RN-A stated any coof R31's condition of progress notes; how unable to locate an comprehensively achanges. RN-A stated angles. RN-A stated angles. RN-A stated angles. RN-A stated angles. RN-A stated and completed a, "Full recontact[ed] them [pwas not on comfort terminal condition on 11/6/16, adding 11/7/16, to be, "A column with the R31 during the final facility. RN-B stated and had no ide RN-B reviewed R3 medical record and "Fevered through the 11/5/16. RN-B stated from reviewing programmed and been complete ensure appropriate or implemented. R information present telephone on 11/6/16.	d not verbally report R31's I symptoms to the physician red respiratory rate, the ce R31's return from the g sounds, or the fact in which were elevated despite ake adding, "No, I did not." Impleted nursing assessments would be documented in the wever, RN-A stated she was y assessment which ddressed all of R31's identified ated she should have nursing assessment before I shysician]." RN-A stated R31 care or considered to be in a when she notified the physician R31's death at the hospital on omplete surprise."  On 3/1/17, at 2:03 p.m. RN-B assigned care manager for I weeks of her life in the d R31 was not on comfort entified terminal condition. It's progress notes in the stated R31 appeared to of, ne weekend," starting on ed there was, "No defined plan aff should have treated R31 gress notes in the record.	F 30	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C / <b>02/2017</b>
NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	in the absence of s "Better information  On 3/2/17, at 1:05 p (DON) was intervie signed POLST ider however, further lis potentially reversibl POLST did not prov hospitalize R31 for R31 was not treate 11/7/16, as her hea identified she wante the event of a term stated R31 had, "A the on-call physicia not R31's primary p "The nurse taking of assessment of the DON stated the on- responsible, not the R31's past informat assessment of the stated she was uns was aware of the e displayed. The DO reflected what, "Co she expected her s information," in spet trying to determine  During a telephone p.m. MD-A stated h physician for R31 fo knew her, "Very we the clinic for examin noted to be eating a	and continued hyperglycemia ubstantial meal intake adding, could be given."  D.m. the director of nursing wed. The DON stated R31's ntified R31 to be a DNR, ted R31 wanted treatment of e conditions adding the vide any direction to not any reason. The DON stated d prior to her hospitalization on lith care directive (HCD) ed to have a natural death in inal condition. The DON change in condition," adding n contacted on 11/6/16, was obysician and she expected, eare of [R31]," to, "Give an resident at that time." The call physician was a nursing home staff, to review tion to be included in their residents condition. The DON cure if the on-call physician nurice clinical picture R31 on stated R31's progress notes and taff, "Would include pertinent taking to the physician when	F 309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245120	B. WING				C <b>02/2017</b>	
_	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZII 548 FIRST AVENUE CAMBRIDGE, MN 55008	P CODE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE	
F 309	cares, "At that time comfort cares with don't remember ever care." MD-A stated (dated 11/3/16) ider care, however, MD-Where the directive hospital physicians R31's family during it should be docume summary. MD-A state "May have assume Further, MD-A state reversible if identified A facility Change of Notification Policy opurpose, "To notify is," and listed sever "Significant change "Any other time the change in status from policy listed a processignificant change in the medical team in threatening in natural advised, "A 911 call physician's order and discretion if the ememory of the policy directed resident's medical response if any." For several examples of in condition and conwhich included an end change in Status and construction in the condition and conwhich included an end change in Status and construction in Status	R31 was not on comfort ," nor had he ever discussed R31's family before adding, "[I] er putting her on comfort I R31's hospital discharge ntified R31 to be on comfort A stated he was not sure came from, adding if the discussed comfort care with her hospitalization on 11/3/16, ented on the discharge ated the hospital physician, d she was on comfort care."	F3	09				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	COMPLETED	
		245120	B. WING _		C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE  548 FIRST AVENUE  CAMBRIDGE, MN 55008	, 00,022011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLÉTION
F 309	factors that could h implement interven effectiveness."	ection. Look for precipitating ave led to the behavior,	F 30	9	
F 314 SS=D	requested, but none 483.25(b)(1) TREA PREVENT/HEAL P	•	F 31	4	4/10/17
	(1) Pressure ulcers	sessment of a resident, the			
	professional standa pressure ulcers and ulcers unless the in	res care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and			
	necessary treatment professional standar healing, prevent inform developing. This REQUIREMED by:  Based on interview facility failed to comprevise interventions or worsening press	oressure ulcers receives at and services, consistent with ards of practice, to promote ection and prevent new ulcers  NT is not met as evidenced and document review, the aprehensively reassess, and to help reduce the risk of new ure ulcer formation for 1 of 2 ose closed records were ure ulcer care.		R96 is no longer a resident of GracePointe Crossing Gables Eas  The policy on Skin Integrity Manag was reviewed and is current. All re with current wounds were reviewed appropriate interventions and revisinecessary.	ement sidents d for

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING				C 0 <b>2/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	<i>32/2011</i>
				54	8 FIRST AVENUE		
GRACEF	POINTE CROSSING G	ABLES EAST		CA	AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 28	F 3	14			
	11/14/16, identified impairment, and rewith activities of da MDS identified R96 on palliative care, a ulcer development pressure ulcers.  R96's Body Audit daudit was R96's, "Adescribed several abdomen, elbow a identify R96 had arreddened skin.  R96's pressure ulcer (CAA) dated 11/21, "Triggered due to lebowel incontinence ulcers," listing R96 pressure ulcer devidentified the risk of addressed on R96' "Overall objective,"  R96's Skin Risk and 11/9/16, identified I pressure ulcer form listed including, "As and, "Uses medical conditions" The section labeled, "Leidentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease, veneuropathy and conditions and residentified R96 had arterial disease,	linimum Data Set (MDS) dated 1 R96 had moderate cognitive equired extensive assistance cily living (ADLs). Further, the 5 had renal insufficiency, was and was at risk for pressure, however, had no current lated 11/8/16, identified the Admission body audit," and areas of bruising on R96's and forearm. The audit did not my pressure ulcers or areas or ler Care Area Assessment logical for a sist with bed mobility, and high risk for pressure to have, "Potential," for elopment. Further, the CAA of pressure ulcers would be so care plan and directed the, was to, "Minimize risks."  In did Braden assessment dated R96 was at, "High Risk" of mation with several risk factors assistance required with ADL's," attion which impact skin assessment contained a cower Extremity Concerns," and no signs of symptoms of enous insufficiency or nationed an, "Analysis and which identified, "[R96] is an			All residents are assessed for skin upon admission, weekly for alteratiskin risk and care plans are update minimally quarterly or with a chang condition in conjunction with the Reprocess. Nursing assistants obserintegrity daily with cares and report nurse any potential alterations. The plan is updated to reflect any new interventions.  Education will be completed for nurstaff responsible for monitoring and managing skin integrity by 4/5/17.  Facility will monitor and sustain corby auditing all residents with wound weekly for appropriate interventions two months. Results of audits will be reviewed at the QAA meeting and determined the need for ongoing monitoring.  Clinical Administrator and/or design be responsible for ongoing compliance.	ons in ed e in Al ve skin to the e care rsing d	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245120	B. WING _		03	C 3/ <b>02/2017</b>	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	repositioning, unab positional changes reduction mattress Further, the assess "Interventions," field repositioning, press bed," with those be interventions," unde interventions," field R96's progress not R96 developed, " non-blanchable are [centimeters] [by] 2 barrier cream.  MDS definition: Sta observable, pressu skin, whose indicate adjacent or oppositionlude changes in parameters: skin te coolness); tissue consensation (pain, itcl persistent redness whereas in darker sappear with persist Non-blanchable: Redo not turn white or a finger or device.  R96's Body Audit dahad a bed bath con red.  R96's care plan dat was admitted to how with subsequent fra	le to make frequent and major [independently]. Pressure in bed. Currently on bed rest." ment identified an d and listed, "A1 Q3H sure reduction mattress in ing identified as, "New er a subsequent, "Evaluation of the dated 11/21/16, identified	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE  548 FIRST AVENUE  CAMBRIDGE, MN 55008		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	was, " at risk for directed staff to ass policy, upon admiss and apply a dermasher right leg while in identify R96 had an history of pressure pressure ulcer on the 11/21/16.  R96's medical recosubsequent Body A-On 12/6/16, identiskin with, "No skin ison 12/20/16, identiskin with, "No skin ison 12/20/16, identification of the passessments were not weekly even the pressure ulcer development of the passessments were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the pressure ulcer development of the passessment were not weekly even the	the care plan identified R96 impaired skin integrity," and sess R96's risk status, "Per sion, quarterly and as needed," saver (skin care device) under n bed. The care plan did not y current pressure ulcers or ulcers, despite the identified ne progress note dated  rd identified the following udit(s) had been completed: fied no red areas on R96's integrity issues noted," and; tified R96 had, "No new skin noted," and; dentified R96 had, " no new	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING		<del> </del>		C <b>02/2017</b>
	PROVIDER OR SUPPLIER			548	EET ADDRESS, CITY, STATE, ZIP CODE FIRST AVENUE MBRIDGE, MN 55008	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	dated 1/10/17, ide Risk" for pressure listed several risk required with ADL' which impact skin labeled, "Tissue To Support Services, preferences or respositions, and staf R96's preferences R96 was identified reduction mattress tissue sensation frassessment(s). A section identified, repositioning, unal positional changes reduction mattress resident has the operation of Resident prefers to identified, "Intervere repositioning, prespillows utilized for area to coccyx," but labeled, "Evaluation of Italian and the service of the s	n Risk and Braden assessment intified R96 remained at, "High ulcer development and again factors including, "Assistance s," and, "Uses medication conditions" A section olerance and Evaluation of identified R96 had no istance to any particular f were, "Unable to determine," for sleeping during the night. It to use pillows and pressure in bed, and had no changes in om the previous n, "Analysis and Summary," [R96] is an A1 Q3H ole to make frequent and major in findependently]. Pressure in bed. Currently on bed rest option to get out of bed. The previous of the previous mattress in bed. The previous of the previous	F3	314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, S 548 FIRST AVENUE CAMBRIDGE, MN 550	STATE, ZIP CODE	03/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 314	granulation tissue (slough (dead tissue tunneling or undernidentified R96 was used a , "Pressure There were no chair R96's pressure ulcourecord) Skin & Wood dated 1/25/17, identicer on her coccyx "In-House," on 1/10 measured at 2.2 cm 1.6 cm (width) havi undermining or tunidescribed as 10% (healthy, red tissue) with no eschad light drainage with pain at the site. The "Goal of Care," to blisted a treatment of an application of a "Additional Care," of with pump," and, "The program." The note measurements were "Electronic method were expected from When interviewed of nursing assistant (Note that the site is the facility with severe to get out of bed." repositioned, "Ever shift adding R96 did her back. NA-C states."	healthy, red tissue) and 50% e) in the wound bed, with no mining. Further, the flow sheet on a, "Positioning plan," and Relieving Mattress/Device." nges to the interventions for er.  lickCare; a system of medical and - Wound Assessment tified R96 to have a pressure a having developed, 1/17. The pressure ulcer was in (area) by 1.88 cm (length) by ing no recorded depth, neling. The wound bed was apercent) granulation tissue and 90% slough (dead har being present. The ulcer with no odor; and R96 denied e assessment identified a, i.e., "Monitor/Manage," and f cleansing with normal saline a foam dressing and, options including a, "Mattress furning/Repositioning	F3	14		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245120	B. WING		03	C / <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP COL 548 FIRST AVENUE CAMBRIDGE, MN 55008	•	/OZ/2311
(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 CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	sheets," at times ac several occasions to sheets were left blatch.  The repositioning so requested; howeve them.  During interview on practical nurse clinical a comprehensive acrisk would include, a review of the currous LPN-A stated R96 so assessment complete.	ge 33 If were, "Not following the care dding she had noticed on he repositioning tracking ank from other shifts.  The facility would not provide a 3/2/17, at 2:30 p.m. licensed cal coordinator (LPN)-A stated seessment of pressure ulcer "All systems of the body," with ent interventions being used. Should have had a skin eted weekly, however, this was	F3	,		
	director of nursing (should, "Look at he of the completed as wound." Further, D to update R96's intenew pressure ulcer needed a change."  A facility Skin Integration of the identify, assess and clinical conditions in skin integrity, and produced staff to corn Risk Assessment a Evaluation upon ad onset of pressure usignificant change is directed the collected as would be should be sho	on 3/2/17, at 3:13 p.m. the (DON) stated nursing staff r [R96] interventions," as part assessments with, "This new oON stated she expected staff erventions after developing a as, "Clearly what we had rity Management Policy dated facility would, " properly dimonitor residents whose acrease the risk for impaired aressure ulcers/injuries," and implete a Braden Scale, Skin and Tissue Tolerance mission and, "with new alcer/injury and with a n status." Further, the policy and information, " will be assment process as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C (02/2017	
NAME OF I	PROVIDER OR SUPPLIER	240120		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/02/2017	
GRACEF	OINTE CROSSING G	ABLES EAST		548 FIRST AVENUE CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	with significant cha	ssion to the facility, annually,	F 3	14			
F 329 SS=D		DRUG REGIMEN IS FREE	F 3	29		4/10/17	
	Each resident's dru	sary Drugs-General. Ig regimen must be free from . An unnecessary drug is any					
	(1) In excessive do therapy); or	se (including duplicate drug					
	(2) For excessive d	luration; or					
	(3) Without adequa	te monitoring; or					
	(4) Without adequa	te indications for its use; or					
		of adverse consequences dose should be reduced or					
	. ,	ns of the reasons stated in hrough (5) of this section.					
		opic Drugs. ehensive assessment of a must ensure that					
	drugs are not given medication is neces	have not used psychotropic these drugs unless the ssary to treat a specific used and documented in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245120	B. WING		03/0	; 2/2017
	PROVIDER OR SUPPLIER	ABLES EAST	5	STREET ADDRESS, CITY, STATE, ZIP CODE 648 FIRST AVENUE CAMBRIDGE, MN 55008	1 00/0	2/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	gradual dose reduce interventions, unless an effort to discontice. This REQUIREMED by: Based on interview facility failed to comfor a PRN (as need provide non-pharm to administering a F5 residents (R66) remedication use.  Findings include: R66's admission M4/13/16, identified Fimpairment and had asleep.  During interview on stated she slept, "Vadding she typically p.m., watched televifell asleep without the she takes, "A lot of was unable to remewhy she takes then R66's Medication Afor December 2016 "Trazodone HCL [h [antidepressant mewith a dose of 25 medication she interview on stated she slept, "Vadding she typically p.m., watched televifell asleep without the takes, "A lot of was unable to remewhy she takes then R66's Medication Afor December 2016 "Trazodone HCL [h [antidepressant mewith a dose of 25 medication she interview on state of 25 medication she interview on state of the inter	use psychotropic drugs receive tions, and behavioral is clinically contraindicated, in nue these drugs; NT is not met as evidenced and document review, the aprehensively assess the need led) sleep medication and accological interventions prior PRN sleep medication for 1 of eviewed for unnecessary.  Inimum Data Set (MDS) dated and moderate cognitive dono trouble falling or staying  3/1/17, at 9:04 a.m. R66 Wonderfully" during the night, went to bed around 8:00 sion for a couple hours and rouble. Further, R66 stated medications," and added she ember what they all were or and diministration Record (MAR) is, identified an order for ydrochloride] tablet dication used for insomnia]," and (milligrams) taken by mouth	F 329	R66 was comprehensively re-asse for the need for prn sleep medicatic appropriate non-pharmacological interventions and care plan update new non- pharmacological intervent.  The policy for Psychoactive Medica and Unnecessary Medication use we reviewed and is current.  All residents currently taking a psychotropic medication for sleep were reviewed for appropriate non-pharmacological interventions medication use and care plans revinecessary.  All residents are assessed for appropriateness of psychoactive medications and prn medications admission, and minimally monthly is conjunction with pharmacy reviews IDT reviews.  Education on policy will be completed staff by 4/5/17.  Facility will monitor and sustain comby completing psychotropic medical	on and d with ntions. ation was were and ised as upon in and ted for	
	as needed for Insor Further, the MAR d	mnia [inability to sleep]. irected, "Document non-drug brior to administering the PRN		use audits on 5% of residents for to months. Results of audits will be re at the QAA meeting and will be	wo	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245120	B. WING			0 <b>2/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	blanket, snack and effective." Further, following administra R66:  In December 2016, five times, on 12/3/12/26/16, and 12/3/documentation of n interventions attem of PRN Trazodone and 12/26/16.  In January 2017, Retwo times, on 1/1/1 lacked any documentation-pharmacologic prior to the adminis 1/1/17 and 1/25/17.  In February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/1 documentation of n interventions attem of PRN Trazodone administered in February 2017, Fix times, on 2/2/17/2/19/17, and 2/22/17/2/19/17, and 2/22/17/2/19/17/2/19/17, and 2/22/17/2/19/17/	ment if tried warm milk, warm if it was effective or not the MAR identified the ations of PRN Trazodone to R66 received PRN Trazodone 16, 12/4/16, 12/16/16, 0/16. The MAR lacked any on-pharmacological pted prior to the administration on 12/3/16, 12/4/16, 12/16/16, 66 received PRN Trazodone 7 and 1/25/17. The MAR entation of all interventions attempted tration of PRN Trazodone on R66 received PRN Trazodone on on PRN Trazodone on PRN PRN Trazodone on PR	F 329	determined the need for ongoing monitoring.  Clinical Administrator and/or desibe responsible for ongoing comp	ignee will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245120	B. WING				C <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZII 548 FIRST AVENUE CAMBRIDGE, MN 55008	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 329	registered nurse (R taking Trazodone a started on the medi 2016. RN-C stated when non-pharmac warm milk and snac R66 sleep. RN-C radministration dates of documented non interventions despit document them addrecording their interprior to administerir During interview on practical nurse clininursing staff should non-pharmacologic milk and snacks, be Trazodone was adraccordingly. LPN-A stated it lacked documentation-pharmacologic prior to the administ Further, LPN-A stat lacked documentation-pharmacologic prior to the medicat "The progress note picture."  In a subsequent into LPN-A stated the fasleep assessment is occasionally request they felt R66 contin	on 3/2/17, at 2:07 p.m.  N)-C stated R66 was currently is needed for sleep, being cation back in September the medication was used ological interventions such as eks were not effective to help eviewed R66's MAR with and acknowledged the lack-pharmacological e the MAR directing staff to ding staff, "Should be," ventions and effectivenessing R66 the PRN Trazodone.  3/2/17, at 2:43 p.m. licensed cal coordinator (LPN)-A stated libe attempting to provide al interventions, like warm effore the as needed ministered and document them a reviewed R66's MAR and umentation of al interventions attempted tration of the Trazodone.	F3	29			

	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		E SURVEY PLETED				
		245120	B. WING				0 <b>2/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		548 F	ET ADDRESS, CITY, STATE, ZIP CODE FIRST AVENUE BRIDGE, MN 55008	1 00/1	02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	documenting non-p	ge 38 tated staff should be harmacological interventions s needed medication for	F 3	29			
F 371 SS=F	reviewed 11/2016, i regimen must be frounecessary drugs without adequate m 483.60(i)(1)-(3) FO	cation Use Policy, last ndicated each resident's drug ee from unnecessary drugs. are any drug when used nonitoring.	F 3	71			4/10/17
	considered satisfact authorities.  (i) This may include	d from sources approved or story by federal, state or local e food items obtained directly es, subject to applicable State					
	(ii) This provision defacilities from using gardens, subject to	oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices.					
		loes not preclude residents ods not procured by the facility.					
		re, distribute and serve food in ofessional standards for food					
	foods brought to re-	regarding use and storage of sidents by family and other afe and sanitary storage, umption.					

	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM		(X3) DATE COMI	E SURVEY PLETED			
		245120	B. WING			03/0	) 2/2017
	PROVIDER OR SUPPLIER	ABLES EAST		54	REET ADDRESS, CITY, STATE, ZIP CODE 18 FIRST AVENUE AMBRIDGE, MN 55008	00/0	,2,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	by: Based on observat review, the facility fawere used or discardate to reduce the pillness. This practic residents, staff and Findings include: During the initial tou 9:36 a.m. dairy proof of the parameters on the product in 2  North Haven: During the initial tou following was noted *A half gallon conta of the container ren By date of 2/17/17. when this was oper *One half gallon counopened, with a B *One gallon of whole a Best By date of 2/2 undated as to date *One gallon of whole unopened, with the  On 3/1/17, at 9:12 a *One half gallon of approximately 1 seridate of 2/21/17. The date opened.  Dellwood:	ion, interview and document ailed to ensure dairy products reded before their expiration potential risk of foodborne se had potential to affect all 72 visitors in the facility.  It of the kitchen on 2/27/17, at ducts were noted to be outside if the Best By date identified of 2 day room refrigerators.  In, on 2/27/17, at 9:40 a.m. the lin the refrigerator: iner of skim milk, with one half naining (one quart) with a Best The carton was undated as to ned.  Intainer of skim milk, est By date of 2/21/17. The carton was opened.  In milk with 1/2 remaining with 1/22/17. The carton was opened.  In milk gallon container, Best by date of 2/26/17.  In milk the following was noted:	F3	71	All milk dates were checked and madiscarded as necessary.  The Milk Dating Policy was reviewed updated.  Education on food dating will be completed for staff by 4/5/17.  Facility will monitor and sustain corby completing audits of all milk datistorage daily for 2 months. Results audits will be reviewed at the QAA meeting and will be determined the for ongoing monitoring.  Nutrition and Culinary Director and designee will be responsible for ongompliance.	rection ng and of need	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		COM	E SURVEY IPLETED
		245120	B. WING				C <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, 548 FIRST AVENU CAMBRIDGE, M		1 00/	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOUL FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	remaining, with a B was no date indicat *One gallon of 1% (approximately one of 2/23/17. The cardate opened.  On 2/28/17, at 3:08 products were avai *One gallon of 1% (approximately one of 2/23/17. The cardate opened.  *Whole milk- 1 gall full-Best By date of as to date opened.  On 3/1/17, at 9:25 a *One gallon of 1% remaining barely composed by date of 2/22/17. date opened.  *One gallon of who container-approxim (two quarts) with a carton was undated.  During initial tour of 9:36 a.m., the culin may be used for 7 of The CD stated milks.	le milk, with 1/2 gallon lest By date of 2/26/17. There ted when opened. milk, with 1/4 gallon remaining quart), with the Best By date ton was not dated to indicate a p.m. noted the following dairy lable for resident: milk, with 1/8 gallon remaining quart), with the Best By date ton was not dated to indicate on container-approximately 2/3 2/22/17. Carton was undated a.m. noted the following: milk, with only small amount overing the bottom with a Best Carton was undated as to		71			
	reviewing the suppl assistant (NA)-D st	3/1/17, at 9:56 a.m. while lies in the refrigerator, nursing ated the food in the available for resident use. The					

	NT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245120	B. WING		03	C / <b>02/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 548 FIRST AVENUE CAMBRIDGE, MN 55008	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	NA-D stated anythin permanent marker undated, it should food items were reundated, it should food items were reundated, it should food items were reundated nurse (Fitems in the Dellwok kitchenettes and id available for reside items are dated which stated dietary staff the supply in the return and dispose of, a genome of the province of the appropriate tem and dispose of, a genome of the province	ked by the dietary department. ing opened is dated with a r. NA-D stated that if an item is be discarded. At this time, no moved by staff.  13/1/17, at 10:02 a.m. RN)-A reviewed refrigerator od and North Haven dentified these items were ent consumption. RN-A stated nen opened or prepared. RN-A checked products, replenished efrigerators and monitored for inperatures. RN-A did remove, gallon container of 1% milk, emove container of whole milk of 1/2 gallon remaining.  13/1/17, at 1:21 p.m., cook-A its should be dated as soon as fill for the time of time of the time of time of the time of t	F3	71		

-			E SURVEY IPLETED			
		245120	B. WING			C <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE  548 FIRST AVENUE  CAMBRIDGE, MN 55008		02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	used quickly and the with milk products of CAD stated refriger staff twice daily.  During interview on affirmed that dairy put the date used for de "Best By" date, disc exceed seven days.  Although the facilty kitchenette's refriger inconsistent in iden were to be dated were used the best by date were not consistent there were items in seven days beyond available for resider A policy, titled "Grace FRESHNESS HON ITEM", dated 5/17/past 'best by date' of The Minnesota Dep Date Marking, date identified under: Date and packaged in a served in a food es	o state dairy products are ey have not had the concern going beyond the date. The ators are checked by dietary  3/2/17, at 9:22 a.m., the CD products are not labeled, but etermining product use is the earding the products which beyond the date.  had multiple items in their erators. The facility was tifying there process if items then opened or not, or only to be. Items in the kitchenette the labeled when opened, and the kitchenettes which were the best by date that were the consumption.  DePointe Crossings W LONG TO KEEP EACH 12, identified that "Milk 7 days on carton."  Deartment of Health Fact Sheet, and December of 2010, the marking of food prepared food processing plant and tablishment. These foods shall	F 37			
F 441 SS=D	container is opened or discarded within the container is ope	e)(f) INFECTION CONTROL,	F 44	1		4/10/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245120	B. WING _			C / <b>02/2017</b>
	PROVIDER OR SUPPLIER	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008		02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 43	F 44	11		
	(a) Infection preven	tion and control program.				
		tablish an infection prevention (IPCP) that must include, at owing elements:				
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted according	d upon the facility assessment ng to §483.70(e) and following standards (facility assessment				
		ds, policies, and procedures nich must include, but are not				
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the				
		nom possible incidents of ease or infections should be				
		ansmission-based precautions event spread of infections;				
	(iv) When and how resident; including t	isolation should be used for a out not limited to:				
		uration of the isolation, e infectious agent or organism				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	COMPLETED
		245120	B. WING		C <b>03/02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 441	least restrictive post circumstances.  (v) The circumstant must prohibit employing disease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for required the facility's lactions taken by the (e) Linens. Person process, and transpared of infection.  (f) Annual review. annual review of its program, as necess This REQUIREMED by:  Based on observation review, the facility fappropriate hand here a resident (R92) another resi	hat the isolation should be the sible for the resident under the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct and the disease; and the disease; and the procedures to be followed direct resident contact.  Cording incidents identified IPCP and the corrective efacility.  The facility will conduct an and IPCP and update their sary.  Not is not met as evidenced tion, interview and document ailed to ensure staff followed ygiene while providing cares and prior to serving coffee to 142) during 2 of 4 observations	F 44	Education was immediately provide staff identified in survey sample.  The policy for Hand Hygiene and G Use was reviewed and is current.  Education on hand hygiene and glo will be completed for staff by 4/5/17  All staff are educated on infection of practices upon hire, minimally annumers.	ve use 7.
		es for R92. With un-gloved		and as indicated.	lany

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245120	B. WING				C 0 <b>2/2017</b>
NAME OF	PROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	32/2017
					548 FIRST AVENUE		
GRACE	POINTE CROSSING O	GABLES EAST			CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICED TO THE APPROPRICE (CROSS-REFERENCE)	) BE	(X5) COMPLETION DATE
F 441	catheter bag into the the wheel chair, the NA-A donned (place empted R92's cathe wearing gloves, NA tube with an alcohoport, then measure urine into the toilet gloves, and without placed R92's stock gathered a shirt, Tocloset. After combiglasses, NA-A bag clothing and bed lift on R92's lap. NA-A laundry in her arms room at 7:45 a.m., hand washing during the obstallway, at 7:45 a.m., hand say the North Haven diffilled it with coffee R42, who was sear adjacent dining are NA-A had not perform assisting R92, nor Continuing observation to the toilet, and the	placed R92's urine-filled he cloth privacy pouch under en quickly pulled the bag out. Leed on) a pair of gloves and leter bag into a graduate. Still A-A cleansed the bag drain of prep pad and closed bag ed, emptied and flushed the . NA-A removed her soiled t first washing her hands, sings and foot boot on, then e-shirt and new pants from his bing R92's hair and placing his ged and knotted R92's soiled hens, then placed the call light A clutched the bagged, soiled is and hands, and exited R92's NA-A had not performed any	F 4	141	Facility will monitor and sustain co by completing hand hygiene and g use audits on 5% of residents wee months. Results of audits will be reat the QAA meeting and will be determined the need for ongoing monitoring.  Clinical Administrator and/or design be responsible for ongoing compliance.	love kly for 2 eviewed nee will	

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245120	B. WING		03	C / <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP C 548 FIRST AVENUE CAMBRIDGE, MN 55008	•	702/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	pants and incontine gloves, and assiste groin and catheter application of barrie Before transferring NA-A removed her wash hands. NA-A additional soiled lat three more bags. I hand, NA-A pushed the hallway, then cautility room for disponce in the utility rodisposed of laundry hands.  During an interview stated she "should providing cares for getting (R42) a cup "never knows" if sh resident's room, bushould use hand sa resident room to the should have washed completing cathete her gloves.  In an interview on a practical nurse (LP) washed when you or remove gloves, and you help, especially LPN-A stated staff "too many times."	ge 46 If the stool, having lowered his ent brief. NA-A then donned d R92 with face washing, care, peri area cleansing, and er cream to R92's buttocks. It R92 back into the wheel chair, soiled gloves, but did not agathered, bagged then tied undry, linens and garbage into holding the soiled bags in one if R92 in his wheel chair into arried the bags into the soiled osal down the laundry chute. From at 8:07 a.m., NA-A and refuse, then washed her of coffee. NA-A stated she er can wash her hands in a trainitizer when going from one er next. NA-A stated she dher hands after washing and recares for R92 and removing and reares for R92 and removing the really between each resident of following catheter care. Can never wash their hands  3/1/17 at 2:13 p.m. the follow) stated staff were	F 4	41		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			C / <b>02/2017</b>	
	PROVIDER OR SUPPLIER	1 1		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008	•	02/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	provided frequent rehygiene. The DON washed hands after before having server resident, and added was witnessed, their discuss" appropriation with staff.  A facility policy, Infedated 2015, indicate was essential in preinfections agents, a touching bodily fluic contaminated items were worn. The doexamples of when hybrich included before	control procedures and eminders about good hand stated staff should have reproviding cares, but certainly ed food or beverages to a diwhen improper hand hygiene re was an "opportunity to e infection control procedures exterior control, Hand Hygiene, ed appropriate hand hygiene eventing transmission of and was to be performed after ds, secretions, and and whether or not gloves cument cited specific nands were to be washed, ore and after direct resident and after touching medication of	F 4	41			

F 5120025

PRINTED: 03/29/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245120	B. WING			03/	01/2017
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 648 FIRST AVENUE CAMBRIDGE, MN 55008	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K	000			
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT ( CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Division Gracepointe Crossi in compliance with participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, and Gables East was found not the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the fonal Fire Protection Standard 101, Life Safety er 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY			EPOC	7	
	HEALTH CARE FIF STATE FIRE MARS 445 MINNESOTA S						
ABODATOD	V DIDECTORIS OR BROVIE	PEDIGLIDDI IED DEDDESENTATIVE'S SIG	MATURE		TITI F		(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.

**Electronically Signed** 

03/28/2017

PRINTED: 03/29/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245120 B. WING 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **548 FIRST AVENUE GRACEPOINTE CROSSING GABLES EAST** CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) K 000 | Continued From page 1 K 000 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us 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 Gracepointe Crossing Gables East is a 1-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1956 and was determined to be of Type II(111) construction. In 1982, an addition was 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. This building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			MPLETED
		245120	B. WING		3/01/2017
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	census of 72 at the	age 2 apacity of 90 beds and had a time of the survey.	K 000		
K 511 SS=D	Utilities - Gas and I Equipment using g complies with NFP electrical wiring and NFPA 70, National	Electric as or related gas piping A 54, National Fuel Gas Code, d equipment complies with Electric Code. Existing ntinue in service provided no	K 51		4/10/17
	Based on observa the facility had multaffecting the facility not in accordance of Safety Code" 2012 and the NFPA 70 "I edition. This defici	s not met as evidenced by: tion and interview with the staff tiple deficient conditions 's electrical system that were with the NFPA 101 "The Life edition (LSC) section 9.1.2 National Electrical Code" 2011 ent practice could affect 12 of ell as an undetermined number s.		Extension cord being used in Avalon central hall nurses station was removed.  Power strips that were found to be daisy-chained were removed.  Education on use of electrical extension cords and power strips provided to staff on 4/5/17.	
	on 03/01/2017, obs	veen 10:00 a.m. to 1:00 p.m. servations revealed that there s that are being daisy chained		Administrator, Engineering Director and/o designee will be responsible for ongoing compliance.	Of

PRINTED: 03/29/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING 01 - MAIN BUILDING 01 245120 B. WING 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **548 FIRST AVENUE GRACEPOINTE CROSSING GABLES EAST** CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 511 | Continued From page 3 K 511 and an extension cord found in the Avalon central hall nurses office. This deficient condition was verified by a Maintenance Supervisor. K 712 NFPA 101 Fire Drills K 712 4/10/17 SS=F Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff Fire drills will be scheduled and interview, it was determined that the facility failed conducted quarterly, on each shift. to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 Review of drills will be conducted quarterly edition (LSC) section 19.7.1.6. during the last by Maintenance to ensure compliance. 12-month period. This deficient practice could affect 72 of 72 residents, as well as an Administrator, Engineering Director, undetermined number of staff, and visitors. Maintenance and/or designee will be responsible for ongoing compliance. Findings include: On facility tour between 10:00 a.m. to 1:00 p.m. on 03/01/2017, during the review of all available

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - Main Building 01	COMPLETED		
		245120	B. WING		03/	/01/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETION	
K 712	Maintenance Supe	ation and interview with the ervisor it was revealed that the ducted the Evening Shift fire	K 71:	2		
	Maintenance Supe NFPA 101 Gas Eq	dition was verified by a ervisor. uipment - Cylinder and	K 92	3		4/10/17
	Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.  >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.  Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.  A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."					

PRINTED: 03/29/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245120 B WING 03/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **548 FIRST AVENUE GRACEPOINTE CROSSING GABLES EAST** CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 923 Continued From page 5 K 923 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that Storage shelf was installed to securely the oxygen storage room was not maintained in store oxygen cylinders that are not in use. accordance with NFPA 99 Standards for Health Care Facilities (12) section 5.1.3.3.4.2. This Education on proper storage of oxygen cylinders provided to staff on 4/5/17. deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 12 Administrator, Engineering Director, of 72 residents as well as an undetermined Maintenance and/or designee will be number of staff, and visitors to the facility. responsible for ongoing compliance. Findings include: On facility tour between 10:00 a.m. to 1:00 p.m. on 03/01/2017, observations revealed that there are four oxygen cylinders that have not been secured located in the oxygen storage room. This deficient condition was verified by a Maintenance Supervisor.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted March 17, 2017

Mr. Timothy Samuelson, Administrator Gracepointe Crossing Gables East 548 First Avenue Cambridge, MN 55008

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5120027, H5120044 & H5120045

Dear Mr. Samuelson:

The above facility was surveyed on February 27, 2017 through March 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbered H5120044 & H5120045. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Gracepointe Crossing Gables East March 17, 2017 Page 2

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 Fischer, Unit Supervisor at (320)223-7338.

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

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

Enclosure(s)

cc: Licensing and Certification File

PRINTED: 04/05/2017 FORM APPROVED

Minnesota Department of Health

<u>  ` '</u>		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00292			03/0	; 2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 03/0	2/2017
GRACEF	POINTE CROSSING G	ABLES EAST 548 FIRST	AVENUE GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and many of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

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

03/30/17 **Electronically Signed** 

STATE FORM 6899 HR9U11 If continuation sheet 1 of 41

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
71101 1211	OF CONTILOTION	IDENTIFICATION NONDETT.	A. BUILDING:			
		00292	B. WING			C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARIESEASI	T AVENUE	200		
	T		OGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, th corrected prior to e Minnesota Department" On 2/27/17 through Department's staff, the following correction that you and identify the dat In addition, compla	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	An investigation of H5120045 was con substantiated with at 4658.0085 and 4 found to be unsubs	complaint/s H5120044 and npleted. H5120044 was correction orders being issued 658.0520. H5120045 was				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far leading. The state states in the "Summ column and replace the correction order the findings which a statute after the states as evidence by." For assignment of the states as evidence by the states are states as evidence as evidence by the states are states as evidence by the states are states as evidence as evidence by the states are states as evidence as	Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number eft column entitled "ID Prefix attute/rule out of compliance is hary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state attement, "This Rule is not met collowing the surveyors findings Method of Correction and				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 2 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00292	B. WING			C <b>02/2017</b>
NAME OF				TATE ZID CODE	1 00/1	02/2011
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S ST AVENUE	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST	DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	Time period for Cor					
2 265	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.  5 Notification of Chg in				4/10/17
	policies to guide staphysicians, physicians, physicians practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica  A. an accident results in injury and physician intervention.  B. a significant physician, mental, of example, a deterior psychosocial status conditions or clinical.  C. a need to all	involving the resident which has the potential for requiring on;  change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening	t			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED		
		00292		B. WING		03/0	) 2/2017
NAME OF I	PROVIDER OR SUPPLIER	5	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GBACER	POINTE CROSSING G	ARI ES EAST	48 FIRST	AVENUE	,		
GNACE	OINTE CHOSSING G	ABLES EAST	CAMBRID	GE, MN 550	008		
(X4) ID PREFIX TAG					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	E ACTION SHOULD BE COMPLETI O TO THE APPROPRIATE DATE	
2 265	Continued From pa	ge 3		2 265			
	of treatment due to begin a new form o	adverse consequence f treatment;	s, or to				
	D. a decision t resident from the nu	o transfer or discharge ursing home; or	the				
	E. expected an	d unexpected resident	deaths.				
	by: Based on interview facility failed to ensinotified timely of ne	ent is not met as evide and document review, ure the responsible pa wly developed left kne (R31) reviewed for not	the rty was e pain		Corrected		
	Findings include:						
	9/16/16, identified F with recall and a, "S	elirium assessment dat R31 had a, "Memory pr Severely impaired," abi arding tasks of daily lif	oblem," lity to				
		ecord dated 3/2/17, ide )-A to be R31's, "Eme Responsible Party."					
	member (FM)-A sta party for R31. FM- ambulatory and, "H on staff for all of he early morning hours found in bed with he position," causing the facing her shoulder developed significa being found in this p	2/28/17, at 2:55 p.m. fited she was the responsated R31 was not adn't walked in years," r transfers. FM-A states of 11/3/16, R31 had been knee bent, "In this one bottom of her foot to s. FM-A stated R31 hant left knee and leg paroosition which was later acture in her leg. FM-A	relying ed in the been dd be ad in after er				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 4 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
	00292	B. WING			02/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GRACEPOINTE CROSSING GABL	ES EAST	ΓAVENUE DGE, MN 550	008			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL SENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
pain until, "Just before 4 11/3/16, adding this was started treatment of R3 before she, as R31's re been notified of the inci stated staff should not h decisions without involve R31's provided closed r single, undated notes. "DO NOT ADD, D/C [dis ANYTHING WITHOUT The second note directe of ANY med/insulin cha movement] in 3 days."  R31's progress notes d 11/4/16, identified R31 l left leg pain in the days Further, the progress note following entries:  On 11/3/16, at 3:33 a.m with, "C/o [complaints of given Tylenol.  At 5:10 a.m. R31 was in call out for help and c/o repositioned and warm notification of family wa after R31 had been hav pain for nearly two hour  At 9:25 a.m. R31 was in complaints of left leg pain the left knee," with th the clinic and, "Left a m	R31's newly developed leg 4 o'clock [p.m.]" on s, "Upsetting," staff had 1's fractured and leg pain sponsible party, had ever dent. Further, FM-A nave been, "Making ring me."  record contained two The first note identified, scontinue] OR CHANGE [FM-A] APPROVAL!!!!!!" ed staff to, "Notify [FM-A] anges," or, " if no [bowel ated 10/26/16 through had no prior complaints of leading up to 11/3/16. otes identified the  a. R31 was first identified of left leg pain," and was noted as, "Continuing to pain, resident blanket given." No is identified in the note ring complaints of knee					

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 5 of 41

NAME OF PROVIDER OR SUPPLIER  GRACEPOINTE CROSSING GABLES EAST   STREET ADDRESS, CITY, STATE, ZIP CODE  548 FIRST AVENUE CAMBRIDGE, MN 55008   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265  Continued From page 5  "Telephone order received from [physician] for left knee xray due to left knee pain and swelling." No notification of family was identified in these notes.  At 3:10 p.m. (nearly 12 hours after R31 originally was identified, " x-ray came back positive for distal femur fracture. [FM-A] notified and will be going out of fown"	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
GRACEPOINTE CROSSING GABLES EAST  548 FIRST AVENUE CAMBRIDGE, MN 55008  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265  Continued From page 5  "Telephone order received from [physician] for left knee xray due to left knee pain and swelling." No notification of family was identified in these notes.  At 3:10 p.m. (nearly 12 hours after R31 originally was identified, " x-ray came back positive for distal femur fracture. [FM-A] notified			00292	B. WING			-
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265 Continued From page 5  "Telephone order received from [physician] for left knee xray due to left knee pain and swelling." No notification of family was identified in these notes.  At 3:10 p.m. (nearly 12 hours after R31 originally was identified to have newly doucmented left leg pain) a note identified, " x-ray came back positive for distal femur fracture. [FM-A] notified	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  COMPLÉTE DATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 265  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  COMPLÉTE DATE  CALLER DATE  COMPLÉTE DATE  COMP	GRACE	POINTE CROSSING G	ARI ES EAST		08		
"Telephone order received from [physician] for left knee xray due to left knee pain and swelling." No notification of family was identified in these notes.  At 3:10 p.m. (nearly 12 hours after R31 originally was identified to have newly doucmented left leg pain) a note identified, " x-ray came back positive for distal femur fracture. [FM-A] notified	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
During interview on 3/1/17, at 12:22 p.m. registered nurse (RN)-A stated R31's medical record identified the first time FM-A had been notified of the newly developed leg pain was on 11/3/16, at 3:10 p.m. after treatment had been started. Further, RN-A stated the responsible party should be notified with, "Any significant change in status," and FM-A, "Should of been contacted before [3:10 p.m.]."  When interviewed on 3/2/17, at 9:21 a.m. RN-C stated she was the nurse working on the morning shift of 11/3/16. RN-C stated the nurse aide (NA) staff notified her, "Around that nine o'clock hour [am]," of R31's left leg pain and swelling. RN-C stated FM-A was R31's responsible party and, "Very much so," involved in her care and wanting to be kept abreast of new concerns pertaining to R31. RN-C stated she had attempted to contact FM-A, "Right away," however failed to document this in the medical record because it had been, "One of those crazy days." Further, RN-C stated her attempt to contact FM-A should have been recorded in the medical record adding she would, "Certainly document that," going forward.  During interview on 3/2/17, at 1:05 p.m. the director of nursing (DON) stated FM-A was the known responsible party for R31. The DON stated she expected the nursing staff to notify	2 265	"Telephone order reknee xray due to le notification of family At 3:10 p.m. (nearly was identified to ha pain) a note identifipositive for distal feand will be going or During interview on registered nurse (Rrecord identified the notified of the newly 11/3/16, at 3:10 p.m started. Further, Rparty should be not change in status," a contacted before [3] When interviewed a stated she was the shift of 11/3/16. RN staff notified her, "A [am]," of R31's left stated FM-A was R "Very much so," inv to be kept abreast a R31. RN-C stated FM-A, "Right away, this in the medical in "One of those crazy her attempt to contine recorded in the medical in the med	eceived from [physician] for left knee pain and swelling." Now your identified in these notes of 12 hours after R31 originally eve newly doucmented left legged, " x-ray came back emur fracture. [FM-A] notified at of town"  13/1/17, at 12:22 p.m. at 12:22 p.m. at 12:22 p.m. at 12:22 p.m. at 13/1/17, at 13/1/18 p.m. and been on a first time FM-A had been on a first time FM-A had been on at 14/18 p.m. at 14/18 p.	it o			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 6 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00292	B. WING	_		C 0 <b>2/2017</b>
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE	03/0	02/2017
GRACEF	POINTE CROSSING G	ARI FS FAST	RST AVENUE RIDGE, MN 55	nna		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 265	family members aft adding she had no been notified of R3:  A facility Change of Responsible Party I identified a purpose resident representa listed several option condition." The pol which included, "Frodesignated party winursing intervention medical record for sparty instructions reduced party shin a timely manner." staff to, "Document record, the time cal what was reported adding if staff were responsible party to increments until party to increments unt	er speaking with the physicial concerns with how FM-A hard's developed leg pain.  Condition Family of Notification policy dated 11/1 eto, "Notify family and/or ative any time there is a," and as which included, "Change icy identified a procedure om 10:00 p.m. to 8:00 a.m. till be notified if more than a in is needed. Check the specific family/responsible egarding notification. Included the next date of the person spoke with, and their response, if any," unable to reach the policy directed the person spoke with, and their response, if any," unable to reach the policy directed the person spoke with, and their response, if any," unable to reach the policy directed the person spoke with, and their response, if any," unable to reach the policy directed the person spoke with, and their response, if any," unable to reach the policy directed the person spoke with the person s	d 6, In he			
2 830	Proper Nursing Car		2 830			4/10/17
		general. A resident must e and treatment, personal a	nd			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 7 of 41

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292			03/0	
NAME 05.					03/0	2/2017
	PROVIDER OR SUPPLIER	548 FIRST		STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES EAST	GE, MN 55	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly recognize, comprehensively assess and implement medical interventions timely for 1 of 1 resident (R31) who had a change in condition.  Findings include:			Corrected		
	R31's quarterly Min 9/7/16, identified R3 assistance with acti and had dementia between Further, the MDS is "Prognosis," with a resident have a commay result in a life of months?" This was R31's Provider Ord Treatment (POLST was DNR (Do Not Fisection labeled, "Go several options to be	imum Data Set (MDS) dated 31 required extensive ivities of daily living (ADLs), but with no current infections. Identified a section labeled, question listed as, "Does the adition or chronic disease that expectancy of less than 6 answered as, "No."  ers for Life Sustaining dated 9/10/14, identified R31 Resuscitate) and included a bals of Treatment," with the checked to identify the anding wishes. A hand written.				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 8 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00292	B. WING	·····		C <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G.	ABI ES EAST 548 FI	ADDRESS, CITY, RST AVENUE RIDGE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	"X" marking was plainterventions and transferred to the had sresponse to a infectant way. transferred to the had sresponse to a infectant way. transferred to the had sresponse to a infectant way. transferred to the had sresponse to a infectant was response to a infectant way. The way. transferred to the had sresponse to a infectant way. The way. The way the nursing home s	aced next to, "Limit eat reversible conditions." tion at that section included, ns aimed at treatment of ne /injury or non-life threatening." The option of, "Comfort lecked.  Interview for Mental Status) sment dated 9/16/16, a "Memory problem" with recoaired" ability to make	ey ee t			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
				C		
00292	2	B. WING	· · · · · · · · · · · · · · · · · · ·	03/0	2/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GRACEPOINTE CROSSING GABLES EAS	T	r avenue Oge, MN 550	008			
(X4) ID SUMMARY STATEMENT OF DI PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
R31's care plan dated 9/21/16, an self care performance deficial assistance to complete all ADL living) with impaired mobility and R31 to be, "Resistive to care," plan identified R31 had high ble heart failure, and at risk for fluid directing staff to monitor R31 for imbalance which may include with changes in cognition, changes pressure," and report these to the needed." R31 was identified with cognitive function/dementia," at [R31] need my POA with all demended. R31's developed care plan did was on comfort care or had at with a life expectancy of less the R31's Progress Notes dated 9/R31 had been seen in the clinic physician. The physician ident "Eating and drinking fairly well," recorded at 60 beats per minut is clear, no wheezing or rales." identified R31 was to return for months. The note did not ident on comfort cares, have a life lift have a life expectancy of less the R31's CMC (Cambridge Medic Discharge Summary dated 11/3 was an elderly female, "With decare," who had persistant left letters as an elderly female, "With decare," who had persistant left letters as an elderly female, "With decare," who had persistant left letters and provided in the condition was identified at the tas, "Stabilized," and provided in the follow up with appointment(see the condition was identified at the tas, "Stabilized," and provided in the follow up with appointment(see the condition was identified at the tas, "Stabilized," and provided in the follow up with appointment(see the condition was identified at the tas, "Stabilized," and provided in the follow up with appointment(see the care," and provided in the follow up with appointment(see the care, and provided in the follow up with appointment(see the care, and provided in the follow up with appointment(see the care, and provided in the follow up with appointment(see the care, and provided in the follow up with appointment (see the care, and the ca	it and required is (activities of daily and cognition adding at times. The care cood pressure, divolume deficition, "Electrolyte weak pulse, in my blood the physician, "As with, "Impaired and identified, "I cision making." not identify R31 erminal condition are six months.  20/16, identified by her primary ified R31 to be, "with pulse are check in two tify R31 was to be miting illness, or than six months.  al Center) 3/16, identified R31 ementia on comforting illness, or than six months.  al Center) 3/16, identified R31 ementia on comforting pain in which a e distal femoral eray. The was performed g home. R31's time of discharge ecommendations					

Minnesota Department of Health

STATEMENT OF DEFICE AND PLAN OF CORRECT		(X1) PROVIDER/SU IDENTIFICATIO		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
				A. BUILDING.			С	
		00292		B. WING			02/2017	
NAME OF PROVIDER O	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GRACEPOINTE CR	OSSING G	ABLES EAST	548 FIRST	TAVENUE GE, MN 550	008			
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
[weight] k discontin potential the skille providers condition Exam," ic to auscul were rece Pulse 90 20. The of R31's comfort of POLST of R31's fact Report de recorded period. F three me 11/3/16. consume evening i "Residen 11/6/16, i "76-100% lunch me consume provided R31's Me dated 11, orders fo Inject 6 u and was through f insulin was	uation pla was listed d nursing know if y "Further dentified h tation] bila orded as: Tempera discharge responsib cares, or a rom her pr lated 9/10 cility report ated 11/1/ meal inta 331 had co als provid On 11/4/1 dd, "26-50" meal. On t refused, R31 was in company dentified no meal report. edication A 1/1/16 throug r, "Lantus nits subcut administe 1/5/16. T as not adr	Ivancement and ans." R31's rehable as, "Fair," and offacility let your he ou notice any charger lung sounds and atterally," and R31 Blood Pressure ture 97.8 (F); and summary lacked le party having wony dictation on crior identified wis	collitation directed, "At ealthcare anges in your rge Day is, "CTA [clear l's vital signs 202/126; d Respirations d any dictation rished for hanging her hes on her  Up Question 16, identified ing the review 10%" for two of 1/16, to preakfast but "0-25%" of the identified as, als. On suming, 25%" of the great. R31 cording to the ecord (MAR) tified R31 had being insulin] me a day," rom 11/1/16, and the ordered 6/16 and	2 830				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00292	B. WING			C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	The MAR had no ac antibiotic (medication of, or destry microon administration from Further, the MAR in "NovoLOG Solution lasting a total of six sliding scale: if 150 units; 250 - 299 = 6 - 900 = 10 units," as [medical doctor] if the dose administer blood glucose (BG) - In the morning of reading of 102 mg/mormal fasting BG mot administered in 11/3/16, R31 had a administered eight	ctive orders identified for on used to inhibit the growth rganisms) therapy 11/1/16, through 11/7/16.  Identified R31 had orders for, Ishort acting insulin, often to eight hours] Inject per - 199 = 2 units; 200 - 249 = 4 units; 300 - 349 = 8 units; 350 and directed staff to, "Notify MD over 500." The order identified red with the corresponding reading as below:  11/3/16, R31 had a BG and (milligrams per deciliter; range is 70-100mg/dl) and was sulin. In the afternoon of BG reading of 319 and was units of Novolog.				
	reading of 272 and Novolog. In the after BG reading of 329 aunits of Novolog.  - In the morning of BG obtained, instead "Parameters out of being identified. In had a BG reading of 10 units of Novolog.  - In the morning of have a BG obtained "Parameters out of information was identified."	11/4/16, R31 had a BG was administered six units of ernoon of 11/4/16, R31 had a and was administered eight  11/5/16, R31 did not have a ad the MAR directed, range," with no treatment the afternoon of 11/5/16, R31 of 402 and was administered .  11/6/16, R31 again did not d, instead the MAR directed, range," with no further entified. In the afternoon of BG reading of 593 and was				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 12 of 41

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00292	B. WING		03/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST 548 FIRST CAMBRID	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	11/6/16, two addition identified which identified which identified which identified which identified which identified with an additional 1 administered at 8:33 - In the morning of reading of 461 and Novolog. In the aftention administered insulin administered in	its of Novolog. Further, on nal, "One Time," orders were ntified R31 had an additional administered at 5:19 p.m. 0 units of Lantus being	2 830	BEI IGIENOT)		
	- On 11/6/16, R31 v	vas identified to eat, "Less				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 13 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	·		C
		00292	B. WING			02/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	than 25% of meals fluids. Further, on identified, "[R31] ha In AM had fever of lunch resident had 28. Other vs [vital 102. Oximeter sati tympanic. B/P 118. [low pitched, coars: narrowing of the air crackles. Resident hours." Further, or R31 received, "One [Novolog, a fast act [blood glucose] 593 (another insulin) for to hyperglycemia [https://district.org/li>	"and staff were encouraging 11/6/16 at 2:35 p.m. an entry ad slight fever on [night] shift. 100.7 tympanic (ear). After increased respiratory rate of signs] were as follows: Pulse uration 94%. Temp 100.3 /54. Lung sounds sonorous e, loud sound caused by rways or an obstruction]. No twas up in wheelchair for 4 in the same date at 5:18 p.m. et time only order of 20 units tion insulin] given for BG 3," and six units of Lantus ra, "One time only order due high blood sugar]."  call physician called due to ite and hyperglycemia. Temp of 100F at [4:30 at [4:30 p.m.] was 593. On d] gave orders to give 20 units of sliding scale and to give 10 dS [bedtime] instead of 6 units. [8:30 p.m.] was 99.9F and BG thad perspiration [sweating] all entified staff provided water to pain medications adding, "Will r." The note lacked information is been informed of R31's y rate, coarse lung sounds, or sugar readings in the absence				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/0	) 2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ABLES EAST 548 FIRST	CAVENUE GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	11/4/16, identified s came back from EF arm from fingertips response was hand recommendation," adate of 11/7/16 and at 9:16 a.m.  - On 11/7/17, R31 v aide who identified well," with a nurse t good."  - A MD/NP (medica Order Form fax cor 11:30 a.m. identified "Began on weekendearly AM - [increase [decreased] 100.3 [Tylenol ineffective. decreased respons drinking. Left mess glucose 593 at [4:00 [7:30 a.m.] on 11/7/ scale insulin." R31 responded on 11/7/ hand-written note, "comfort cares to us wants agressive [sie be sent to the ED [6 faxed physician reserved had fevers on the won 11/5 [night], increased had fevers on the won 11/5 [night], increased had fevers on the won 11/6 temp was 100 resident was diapho (LOC) was decreased responsed had fevers on the won 11/6 temp was 100 resident was diapho (LOC) was decreased responsed had fevers on the won 11/6 temp was 100 resident was diapho (LOC) was decreased responsed had fevers on the won 11/6 temp was diapho (LOC) was decreased responsed had fevers on the won 11/5 [night], increased had fevers on the won 11/5 [night].	taff faxed regarding, "Resident R with pinpoint rash on [right] to elbow." The physician'	2 830			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 15 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		00292	B. WING	<del></del>	03/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST 548 FIRST	AVENUE			
GIIAGLI	OINTE OHOSSING G	CAMBRID	GE, MN 550	008		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	honey thick juice wi glucose 593 at [4:3 [7:30 a.m.] on 11/7. scale insulin. Mess without response un with fax and sugges wants aggressive to sent to the ED [eme was explained to [F	LOC. Resident only drank ith spoon feeding. Blood 0 p.m.] on 11/6 and 461 at Both covered with sliding sage left for [FM-A] in AM intil afternoon. Dr. was notified sted comfort care. If family reatment she will need to be ergency department]. This iM-A], who said she would call us back with answer about				
	"Being transported listed as, "B/P 88/4 98.3 tympanic, Oxin note identified R31 arm," and was, "Dia touch." Further, a sidentified, "CMC [m	25 p.m. R31 was identified as, to the ED," with her vital signs 8, pulse 91, resp 28, temp meter saturation 97%." The had, "Pinpoint rash on right aphortic [sic] and cool to subsequent note on 11/7/16, edical center] called at [9:05 at resident passes away at				
	8:06 p.m. identified [medical center] for complaint of, "Feve identified POA. R3 responsive and feb in multisystem orga sepsis criteria [lacta unstressed patient R31 was admitted t assessment identifi was unable to be counresponsive state Problem List" which acute organ dysfun	ysical (H&P) dated 11/7/16, at R31 had, "Presented to evaluation," for a chief r," adding FM-A as R31's 1 was identified as, " less rile." R31 was, "Found to be an failure and met severe ate 7.9 (normal range in is 0.5 - 1 mmol/L)]," adding to the hospital. The ed a review of systems (ROS) completed, "Secondary to "and listed a, "Patient Active in included, "Severe sepsis with ction," "Multi-organ failure with e hypernatremia [elevated]				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 16 of 41

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00292		B. WING			C <b>02/2017</b>
	PROVIDER OR SUPPLIER	ARI ES EAST		DRESS, CITY, S	STATE, ZIP CODE	-	
GRACEI	POINTE CHOSSING G	ADLES EAST	CAMBRID	GE, MN 550	800		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	sodium level]," and identified, "Date No listed as 11/7/16. The physical examination which included a bit 127, temperature of adding R31 to be, "to appear, "Mottled thigh." The assess laboratory values with 11/7/16, and compare values collected on white blood cell (Wind range 4.5 to 10) con 11/3/16, and a sodin 140 prior on 11/3/16 and plan was listed organ dysfunction," admitted to the host length with [FM-A] if age and multisystem would like minimally antibiotics and IVF.  R31's undated Minimally antibiotics and IVF.	, "Metabolic acidosis ted," for each diagnorme assessment lister on completed by the cood pressure of 83/4 f 99.2, and respiration Non responsive," and lacy rash of right ment identified seven thich were collected for them to the laborated them to the laborated them to 11/3/16, which inclus BC) count of 24.5 (numpared to 11.2 priorum level of 152 com 63. Further, an assession, "Severe sepsis and identified R31 vipital which was, "Disting poor prognosis gen failure," adding, "Fy invasive measures	osis was d a physician 5, pulse ns of 26 d her skin at medial ral on oratory ded a ormal on pared to sment with acute vould be cussed at iven her family such as of Health identified oital and ase or s."  n. nursing vorked of ng good," 31 was inking like nurses and ve a	2 830			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 17 of 41

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	;
		00292	B. WING		03/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEI	POINTE CROSSING G	ABLES EAST 548 FIRST		•••		
	OLINA AA DV OTA		GE, MN 550			0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 17	2 830			
	the last weeks of he	er stay at the facility.				
	During interview on registered nurse (Rurse who contacted recorded in the promedical record, "The reported to the physugars, elevated te (sweating). RN-As [R31] to be in the 4 recalled R31 to be, adding R31 had a rash," on her lower RN-A stated she diadditional abnormal including the elevated developed rash sinhospital, coarse lur R31's blood sugars consistent meal inta RN-A stated any coof R31's condition of R31's RN-B stated she was the R31 during the final facility. RN-B state care and had no ideal	a 3/1/17, at 12:22 p.m. a 3/1/17, at 12:22 p.m. a 18N)-A stated she had been the ed the physician on 11/6/16, as gress note entered into R31's nat was me." RN-A stated she sician R31's elevated blood imperature and diaphoresis stated it to be, "Unheard of 00's [blood sugar]," and "Not herself at all that day," newly visible, "Pinpoint red forearms as well. However, in dot verbally report R31's all symptoms to the physician red respiratory rate, the ce R31's return from the red sounds, or the fact in which is were elevated despite aske adding, "No, I did not." Impleted nursing assessments would be documented in the wever, RN-A stated she was y assessment which didressed all of R31's identified atted she should have nursing assessment before I shysician]." RN-A stated R31 care or considered to be in a when she notified the physician R31's death at the hospital on				

Minnesota Department of Health STATE FORM

STATE FORM HR9U11 If continuation sheet 18 of 41

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				-		
		00292	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST 548 FIRST		000		
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	GE, MN 550	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830			2 830			
	"Fevered through the 11/5/16. RN-B state of care," for how state of care," for how state of care, for reviewing programmers and their was comprehensive as a had been complete ensure appropriate or implemented. Representation presentation presentation presentation presentation accurate and lacke coarse lung sounds	sessment of R31's condition d in the medical record to medical treatment was sought N-B stated the documented sed to the physician over the 16 was, "Not completely" d the increased respirations, a and continued hyperglycemia substantial meal intake adding,				
	(DON) was intervied signed POLST ider however, further list potentially reversible POLST did not provide hospitalize R31 for R31 was not treated 11/7/16, as her heat identified she wanted the event of a terministated R31 had, "At the on-call physicial not R31's primary pure more taking of assessment of the DON stated the onresponsible, not the R31's past information assessment of the stated she was unswas aware of the exposition of the stated she was unswas aware of the responsible.	o.m. the director of nursing wed. The DON stated R31's ntified R31 to be a DNR, ted R31 wanted treatment of e conditions adding the vide any direction to not any reason. The DON stated d prior to her hospitalization on lth care directive (HCD) ed to have a natural death in inal condition. The DON change in condition," adding n contacted on 11/6/16, was obysician and she expected, eare of [R31]," to, "Give an resident at that time." The call physician was a nursing home staff, to review tion to be included in their residents condition. The DON cure if the on-call physician ntire clinical picture R31 N stated R31's progress notes				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 19 of 41

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00292	B. WING			)2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES FAST	ΓAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	reflected what, "Co she expected her s	uld be a sign of infection," and taff, "Would include pertinent aking to the physician when				
	p.m. MD-A stated h physician for R31 fc knew her, "Very we the clinic for examin noted to be eating a abnormal vital signs self." MD-A stated cares, "At that time comfort cares with don't remember eve care." MD-A stated (dated 11/3/16) idel care, however, MD- where the directive hospital physicians R31's family during it should be docum summary. MD-A st "May have assume	interview on 3/3/17, at 1:16 the had been the primary or the past couple years and II." R31 had been last seen in mation on 9/20/16, and was and drinking well, have no as and be, "Kinda her baseline R31 was not on comfort ," nor had he ever discussed R31's family before adding, "[I] er putting her on comfort IR31's hospital discharge ntified R31 to be on comfort -A stated he was not sure came from, adding if the discussed comfort care with her hospitalization on 11/3/16, ented on the discharge rated the hospital physician, d she was on comfort care." ed sepsis infection can be ed and treated.				
	Notification Policy of purpose, "To notify is," and listed sever "Significant change "Any other time the change in status from policy listed a procesignificant change in the medical team in threatening in nature.	Condition Physician dated 11/16, identified a the physician any time there ral examples which included a, in clinical condition," and, re has been a significant on the plan of care." The edure which included, "Any n status must be reported to mmediately which may be life re or risk to self or others," and I may be initiated without a				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 20 of 41

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		С	
		00292	B. WING			) 2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ARIESEASI	ΓAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	discretion if the em The policy directed resident's medical in person spoke with, response if any." F several examples of in condition and con which included an ef Change in Status a Requiring Intervent for symptoms of inf factors that could h implement interven effectiveness."  A facility policy on of assessment with ch requested, but none SUGGESTED MET The director of nurs develop/review the comprehensive nur inservice staff rega comprehensive nur with any change in consulted timely to DON could then au	ecording to the nurse's ergency is life threatening" staff to, "Document, in the record, the time called, the what was reported and their further, the policy provided of a resident' potential change responding interventions example of, "Any unusual nd/or New Onset of behavior ions," and directed, "Monitor ection. Look for precipitating ave led to the behavior, tions and monitor  comprehensive nursing manges in condition was a was provided.  THOD OF CORRECTION: sing (DON) or designee could facility policy on resing assessment then				
2 900	, ,	5 Subp. 3 Rehab - Pressure	2 900			4/10/17
	comprehensive res	sores. Based on the ident assessment, the director must coordinate the				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 21 of 41

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292			C <b>03/02/2017</b>	
NAME OF	PROVIDER OR SUPPLIER		<u>I</u>	STATE, ZIP CODE	03/0	2/2017
		548 FIRST		STATE, ZIF GODE		
GRACE	POINTE CROSSING G	ABLES EAST CAMBRID	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 21		2 900			
	development of a nursing care plan which provides that:					
	without pressure so pressure sores unle condition demonstr authenticates, that  B. a resident w receives necessary	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess, and revise interventions to help reduce the risk of new or worsening pressure ulcer formation for 1 of 2 residents (R96) whose closed records were reviewed for pressure ulcer care.			Corrected		
	Findings include:					
	11/14/16, identified impairment, and rewith activities of dai MDS identified R96 on palliative care, a	inimum Data Set (MDS) dated R96 had moderate cognitive quired extensive assistance ly living (ADLs). Further, the had renal insufficiency, was nd was at risk for pressure however, had no current				
	audit was R96's, "A described several a abdomen, elbow ar	ated 11/8/16, identified the dmission body audit," and treas of bruising on R96's and forearm. The audit did not by pressure ulcers or areas or				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 22 of 41

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00292	B. WING		_	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARIESEASI	ΓAVENUE )GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From page 22		2 900			
	reddened skin.					
	R96's pressure ulca (CAA) dated 11/21/ "Triggered due to le bowel incontinence ulcers," listing R96 pressure ulcer deve identified the risk of addressed on R96's "Overall objective," R96's Skin Risk and 11/9/16, identified Formalisted including, "As and, "Uses medical conditions" The section labeled, "Lot identified R96 had arterial disease, veneuropathy and con Summary," section A1 [assist of one] Contrepositioning, unab positional changes reduction mattress Further, the assess "Interventions," field repositioning, press bed," with those be interventions," under interventions," field R96's progress not R96 developed, " non-blanchable are	le to make frequent and major [independently]. Pressure in bed. Currently on bed rest." ment identified an d and listed, "A1 Q3H sure reduction mattress in ing identified as, "New er a subsequent, "Evaluation of the dated 11/21/16, identified				

6899

Minnesota Department of Health STATE FORM

HR9U11 If continuation sheet 23 of 41

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00292	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ABLES FAST	TAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	observable, pressuskin, whose indicated adjacent or opposite include changes in parameters: skin tecoolness); tissue consensation (pain, itcle persistent redness whereas in darkers appear with persist Non-blanchable: Redo not turn white or a finger or device.  R96's Body Audit dehad a bed bath conted.  R96's care plandar was admitted to howith subsequent from assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransfers. Further, was, " at risk for directed staff to assistance with dretransf	ge one pressure ulcer, an re- related alteration of intact ors as compared to an e area on the body may one or more of the following emperature (warmth or onsistency (firm or boggy); hing); and/or a defined area of in lightly pigmented skin, skin tones, the ulcer may ent red, blue, or purple hues. eddened areas of tissue that real pale when pressed firmly with atted 11/22/16, identified R96 apleted with her coccyx being ted 11/28/16, identified R96 apice after sustaining a fall actures and required ssing, bed mobility and the care plan identified R96 impaired skin integrity," and sess R96's risk status, "Per sion, quarterly and as needed," saver (skin care device) under n bed. The care plan did not by current pressure ulcers or ulcers, despite the identified he progress note dated  rd identified the following audit(s) had been completed: fied no red areas on R96's integrity issues noted," and; tified R96 had, "No new skin	2 900			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 24 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00202		B. WING			C
		00292		B. WIIVG		03/0	02/2017
	PROVIDER OR SUPPLIER  POINTE CROSSING G	ABLES EAST	548 FIRST	AVENUE	TATE, ZIP CODE		
			CAMBRID	GE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	- On 1/3/17, again is skin integrity issue in skin integrity issue in through 1/9/17, did had been complete. Audit(s) identified a indication of when the healed, or if it had rescription of the pressure ulcer development where the pressure ulcer development where the pressure ulcer development where the pressure ulcer on 11/21/16.  R96's Body Audit day had an, "Area of alt listed her, "Coccyx, stage 2 [partial thick has been earlier do Tegaderm."  A subsequent Skin dated 1/10/17, iden Risk" for pressure ulisted several risk for required with ADL's which impact skin clabeled, "Tissue Tol Support Services," preferences or resis positions, and staff R96's preferences of the skin of th	dentified R96 had, " .	1/22/16 itoring eted Body e ulcer n a kin reeks and or oressure ed R96 rity," and y] 1.2 cm sure ulcer rered with eessment at, "High ad again bistance ation on on of ol lar ermine," e night.	2 900	DEPICIENCY		
	tissue sensation fro assessment(s). An section identified, "[ repositioning, unabl	, "Analysis and Sumi	mary," and major				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 25 of 41

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00292	B. WING			C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES FAST	ST AVENUE DGE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	reduction mattress resident has the op Resident prefers to identified, "Interven repositioning, press Pillows utilized for rarea to coccyx," be labeled, "Evaluation Although the facility P96's pressure ulcedid not identify any that she had previo re-developing a pre 1/10/17.  R96's Wound Asse 1/17/17, identified Fulcer on her coccyx 1.0 cm in size. The left blank. The ulce granulation tissue (slough (dead tissue tunneling or undernidentified R96 was used a, "Pressure There were no chain R96's pressure ulce R96's PCC (PointC	in bed. Currently on bed rest tion to get out of bed. remain in bed." Further, the tions," listed, "A1 Q3H sure reduction mattress in bed epositioning." with, "New opering identified in the spacing of interventions."  I did an assessment after er developed, the assessment changes to the interventions usly despite R96 ssure ulcer on her coccyx on essment Flow Sheet dated R96 had a stage 2 pressure which measured 1.3 cm by a space to record depth was er was identified to have 50% the lither wound bed, with no mining. Further, the flow sheet on a, "Positioning plan," and Relieving Mattress/Device." inges to the interventions for				
	dated 1/25/17, iden ulcer on her coccyx "In-House," on 1/10 measured at 2.2 cm 1.6 cm (width) havin undermining or tunidescribed as 10% (healthy, red tissue)	tified R96 to have a pressure	<b>y</b>			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 26 of 41

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	).	,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A	. BUILDING:			C
		00292	В	B. WING			) 02/2017
NAME OF	PROVIDER OR SUPPLIER	STF	REET ADDRI	ESS, CITY, S	TATE, ZIP CODE		
GRACE	POINTE CROSSING G	IARLES EAST	S FIRST A	VENUE E, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	had light drainage opain at the site. The "Goal of Care," to be listed a treatment of and application of a "Additional Care," of with pump," and, "I program." The note measurements were expected from When interviewed on ursing assistant (If the facility with several of the facility with several of the sack. NA-C standard probably not," bee consistently as staff sheets, "at times accompositioning standard probably not," bee consistently as staff sheets were left blandard probably not, as several occasions of the current of the	with no odor; and R96 delete assessment identified a ce, "Monitor/Manage," and of cleansing with normal set foam dressing and, options including a, "Mattr Furning/Repositioning	nied a, d aline ress es s. ed to ot like her l on had, care were ovide nsed stated lcer " with sed. is was	2 900			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 27 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00292	B. WING			C <b>02/2017</b>
	PROVIDER OR SUPPLIER	ARI ES EAST 548 FIF	ADDRESS, CITY, S RST AVENUE RIDGE, MN 550	,	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	should, "Look at he of the completed as wound." Further, D to update R96's intenew pressure ulcer needed a change."  A facility Skin Integration of the identify, assess and clinical conditions in skin integrity, and p directed staff to corn Risk Assessment a Evaluation upon ad onset of pressure usignificant change id directed the collected included in the asseconducted on admit with significant change included in the asseconducted on admit with significant change in the identificant change in the ident	r [R96] interventions," as parts sessments with, "This new sessments with, "This new sessments with, "This new sessments with, "This new son stated she expected state erventions after developing a as, "Clearly what we had an erease the risk for impaired by the same and states," and mplete a Braden Scale, Skin and Tissue Tolerance and information, " with new alcer/injury and with a n status." Further, the policy and information, " will be be sment process as sion to the facility, annually and may be an experienced."  THOD OF CORRECTION: The pressure ulcers to assure the necessary to prevent pressure ulcers a do promote healing of the director of nursing or anduct random audits of the ensure appropriate care and nented; to reduce the risk for	official design of the control of th			
1						

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 28 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00292	B. WING _			C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY	, STATE, ZIP CODE	·	
GRACEF	POINTE CROSSING G	ARI FS FAST	FIRST AVENUE IBRIDGE, MN 5	5008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21080	Continued From pa	ge 28	21080			
21080	MN Rule 4658.0650 Clean,free from spo	Subp. 1 Food Supplies; bilage	21080			4/10/17
	wholesome, free from adulteration and mind human consumption which has been pro-	All food must be clean, om spoilage, free from sbranding, and safe for n. Canned or preserved focessed in a place other the processing establishment y nursing homes.	han			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dairy products were used or discarded before their expiration date to reduce the potential risk of foodborne illness. This practice had potential to affect all 72 residents, staff and visitors in the facility.		ent ucts n	Corrected		
	Findings include:					
	9:36 a.m. dairy prod of the parameters of	ur of the kitchen on 2/27/1 ducts were noted to be ou of the Best By date identifi of 2 day room refrigerator	tside ed			
	following was noted *A half gallon conta of the container ren By date of 2/17/17. when this was oper *One half gallon co- unopened, with a B *One gallon of who	iner of skim milk, with one naining (one quart) with a The carton was undated aned. Intainer of skim milk, est By date of 2/21/17. The milk with 1/2 remaining /22/17. The carton was	e half Best as to			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 29 of 41

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00292	B. WING			, 2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARIESEASI	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21080	Continued From pa	ige 29	21080			
		le milk-1 gallon container, Best by date of 2/26/17.				
	*One half gallon of approximately 1 se	a.m. the following was noted: fat free milk, with rving missing with the Best By ne carton was undated as to				
	following:  *One gallon of who remaining, with a B was no date indicat *One gallon of 1% (approximately one	17, at 9:45 a.m. noted the le milk, with 1/2 gallon lest By date of 2/26/17. There led when opened. milk, with 1/4 gallon remaining quart), with the Best By date ton was not dated to indicate				
	*One gallon of 1% (approximately one of 2/23/17. The car date opened.  *Whole milk- 1 gallon	p.m. noted the following dairy lable for resident: milk, with 1/8 gallon remaining quart), with the Best By date ton was not dated to indicate on container-approximately 2/3 2/22/17. Carton was undated				
	*One gallon of 1% remaining barely co By date of 2/22/17. date opened. *One gallon of who container-approxim (two quarts) with a	a.m. noted the following: milk,with only small amount overing the bottom with a Best Carton was undated as to  le milk-1 gallon lately 1/2 gallon remaining Best By date of 2/22/17. The d as to date opened.				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 30 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00292		B. WING			C <b>02/2017</b>
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST	548 FIRST	DRESS, CITY, S F AVENUE DGE, MN 550	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21080	During initial tour of 9:36 a.m., the culin may be used for 7 of The CD stated milk Best By date is used. During interview on reviewing the supply assistant (NA)-D stated anything permanent marker. Undated, it should be food items were refood items were refood items were refood items in the Dellwook itchenettes and ideavailable for reside items are dated who stated dietary staff the supply in the rethe appropriate tem and dispose of, a good however, did not rewith approximately. During interview at stated milk product they are opened. Moseven days after be carton is opened, it date opened. Cook to be labeled with the out.	f the kitchen on 2/27 ary director (CD), stays after the "Best cartons are not dated as reference dated 3/1/17, at 9:56 a.m. ies in the refrigerate ated the food in the available for residented by the dietary deng opened is dated NA-D stated that if oe discarded. At this	ated milk By" date. ed, but the ed, but the while or, nursing t use. The partment. with a an item is time, no on. lerator were -A stated red. RN-A eplenished tored for d remove, whole milk or, cook-A as soon as used led. If the or days after artons are vever, if or thrown	21080			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 31 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00292	B. WING			C <b>02/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI FS FAST	IRST AVENUE BRIDGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21080	registered dietitian of facility was as clinic storage was not her deferred to the facility guidelines.  During interview on culinary assistant dicartons/containers and the cartons/containers are the CAD went on the used quickly and the with milk products of CAD stated refriger staff twice daily.  During interview on affirmed that dairy put the date used for de "Best By" date, discended as exceed seven days.  Although the facility kitchenette's refriger inconsistent in identification were to be dated where to be dated where the best by date were not consistent there were items in seven days beyond available for resider A policy, titled "Grade FRESHNESS HOW ITEM", dated 5/17/1 past 'best by date' of the Minnesota Department of the Minnesota Departme	(RD) stated her role at the cal consultant, and that food rexpertise. RD stated that sity policy as to food storage 3/2/17, at 9:05 a.m. the irect (CAD) stated are to be dated when opened of state dairy products are ey have not had the concergoing beyond the date. The ators are checked by dietar 3/2/17, at 9:22 a.m., the Cloroducts are not labeled, but the termining product use is the carding the products which beyond the date.  The facility was tifying there process if items then opened or not, or only the labeled when opened, and the kitchenettes which were the best by date that were not consumption.  The consumption of the label of the carton."	ed. n y  O t ne so o d e y  ys			
	identified under:Dat	d December of 2010, te marking of food prepared food processing plant and	I			

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 32 of 41

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/0	) 2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GRACEF	POINTE CROSSING G	ARI FS FAST	T AVENUE DGE, MN 550	008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
21080	served in a food estable clearly marked we container is opened or discarded within the container is opened suggested of the container is opened of the container is opened suggested of the certified dietary registered dietician policies regarding subservice staff to enor used by their 'been ensure compliance.'  TIME PERIOD FOR (21) days.	tablishment. These foods shall with the date the original and they shall be consumed seven days including the day ened.  THOD OF CORRECTION:  manager (CDM) or (RD) could review and revise afe milk storage and then sure products are consumed st-by' dates; then audit to	21080			4/10/17	
21303	Drug Usage; General Subpart 1. General must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preservice which indicate the odiscontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fa	ral  al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug				4/10/17	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00202			03/0	
		00292			03/0	2/2017
	PROVIDER OR SUPPLIER	548 FIRST		STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 33	21535			
	This standard is incavailable through the	cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan tte Law Library. It is not change.				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess the need for a PRN (as needed) sleep medication and provide non-pharmacological interventions prior to administering a PRN sleep medication for 1 of 5 residents (R66) reviewed for unnecessary medication use.			Corrected		
	Findings include:					
	4/13/16, identified F	inimum Data Set (MDS) dated R66 had moderate cognitive d no trouble falling or staying				
	stated she slept, "W adding she typically p.m.,watched televi fell asleep without t she takes, "A lot of	3/1/17, at 9:04 a.m. R66 Vonderfully" during the night, went to bed around 8:00 ision for a couple hours and rouble. Further, R66 stated medications," and added she ember what they all were or				
	for December 2016 "Trazodone HCL [h [antidepressant me with a dose of 25 m as needed for Inson	dministration Record (MAR) is, identified an order for ydrochloride] tablet dication used for insomnia]," ing (milligrams) taken by mouth mnia [inability to sleep]. irected. "Document non-drug				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 34 of 41

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			,
		00292	B. WING			, 2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	OINTE CROSSING G	ABLES EAST 548 FIRST		100		
0/0.15	CLIMMA DV CTA		GE, MN 550		ON!	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 34	21535			
	medication. Documblanket, snack and effective." Further, following administrates:  In December 2016, five times, on 12/3/12/26/16, and 12/3/documentation of ninterventions attem of PRN Trazodone	orior to administering the PRN nent if tried warm milk, warm if it was effective or not the MAR identified the ations of PRN Trazodone to  R66 received PRN Trazodone 16, 12/4/16, 12/16/16, D/16. The MAR lacked any on-pharmacological pted prior to the administration on 12/3/16, 12/4/16, 12/16/16,				
	and 12/26/16.  In January 2017, R66 received PRN Trazodone two times, on 1/1/17 and 1/25/17. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the administration of PRN Trazodone on 1/1/17 and 1/25/17.					
	six times, on 2/2/17 2/19/17, and 2/22/1 documentation of n interventions attem	R66 received PRN Trazodone 7, 2/4/17, 2/5/17, 2/16/17, 7. The MAR lacked any on-pharmacological pted prior to the administration for all of the dates it was pruary.				
	comprehensive ass	rd was reviewed and lacked a sessment of R66's sleep to sed for a PRN medication for				
	identified focus, goa	red 2/8/17, lacked any als or interventions to address her being on an as needed p.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE : COMPI	
				C	,
	00292	B. WING		03/0	2/2017
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEPOINTE CROSSING G	ABLES EAST 548 FIRST	GE, MN 550	108		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
21535 Continued From pa	ge 35	21535			
When interviewed or registered nurse (Raking Trazodone a started on the medi 2016. RN-C stated when non-pharmac warm milk and sna R66 sleep. RN-C radministration date of documented non interventions despit document them addrecording their interprior to administering.  During interview on practical nurse clininursing staff should non-pharmacologic milk and snacks, but Trazodone was adraccordingly. LPN-A stated it lacked documentating in the administer further, LPN-A stated it lacked documentating prior to the administer further, LPN-A stated in the medical "The progress note picture."  In a subsequent int LPN-A stated the fasleep assessment loccasionally requesting the stated in t	on 3/2/17, at 2:07 p.m.  N)-C stated R66 was currently is needed for sleep, being action back in September in the medication was used sological interventions such as acks were not effective to help eviewed R66's MAR with is and acknowledged the lack in pharmacological interventions staff to ding staff, "Should be," eventions and effectivenessing R66 the PRN Trazodone.  3/2/17, at 2:43 p.m. licensed cal coordinator (LPN)-A stated is be attempting to provide all interventions, like warm effore the as needed ministered and document them a reviewed R66's MAR and sumentation of all interventions attempted tration of the Trazodone.	21535			
	on 3/2/17, at 3:22 p.m. director tated staff should be				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 36 of 41

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			A. BUILDING:			,
		00292	B. WING			)2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI FS FAST	ΓAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	age 36	21535			
		pharmacological interventions is needed medication for				
	reviewed 11/2016, regimen must be fr	cation Use Policy, last indicated each resident's drug ee from unnecessary drugs. s are any drug when used				
	The director of nurs inservice staff rega assessment of slee non-pharmacologic	cal interventions prior to eeded medications; then audit				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
22000		6.557 Subd. 14 (a)-(c) atment of Vulnerable Adults	22000			4/10/17
	facility, except hom personal care attendestablish and enfor prevention plan. The assessment of the environment, and it factors which may and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility,	is population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING	·		<u> </u>
		00292	B. WING		_	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	IARIESEASI	ST AVENUE DGE, MN 55	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indivulnerable adults; (other vulnerable adspecific measures risk of abuse to tha adults. For the purterm "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the inplan must detail the minimize the risk threasonably be experiently and persons unsupervised. Uncof a vulnerable adumisconduct or phy such information from authority or through another facility, and	velop an individual abuse each vulnerable adult eceiving services from them. ain an individualized the person's susceptibility to ividuals, including other (2) the person's risk of abusing dults; and (3) statements of the to be taken to minimize the at person and other vulnerable poses of this paragraph, the	6			
	by: Based on interview facility failed to imp	ent is not met as evidenced and document review, the element policies and lure allegations of potential		Corrected		

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 38 of 41

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00292	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ABLES FAST	ΓAVENUE )GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	nge 38	22000			
	misappropriation of immediately reported	f resident funds were ed to the State agency for 1 of whose allegations were				
	Findings include:					
	Plan policy dated 1 to, "Establish the poresponsibilities for pure dependent upon the and/or a safe envirous adding the plan waw with state and fede identified each residentified each residentified as ection and listed several, with a heading of, "Exploitation (Misapproperty)" being incheading provided a improper use of an assets without informonetary, personal profit for the perpet directed, "All cases maltreatment must including, "An initia and submitted to the specific contact points of the policy of the perpet directed," and submitted to the specific contact points of the perpet directed, and submitted to the specific contact points of the perpet directed, and submitted to the specific contact points.	nimum Data Set (MDS) dated 94 had moderate cognitive				
	impairment and dis	played no behavioral sical, verbal or other				

Minnesota Department of Health

STATE FORM 6899 HR9U11 If continuation sheet 39 of 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00292	B. WING		03/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI ES EAST	ST AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 39	22000			
	Missing/Damaged I identified R94 had rebill and \$20 dollar behad been, "Wrappe wallet which she plawas last seen on 11 to the report. Furth search had been con Search," being iden The report was sign 8:15 p.m. by the, "FR94's Incident Report of the Submitted to and listed it reported."	Homes & Services Report of tem(s) form dated 11/15/16, reported, "\$70 cash [\$50 dolla bill]" to be missing. The mone of in a pink receipt, inside her acced under her pillow," and 1/9/16, at 8:00 p.m. according er, the report identified a completed with an, "Outcome of tified as, "Money not found." and dated on 11/10/16, at Person Taking Report."  Ort - Submission Completed 5, identified spacing labeled, MDH/OHFC [State agency]," d on, "11/11/2016 [the the allegation was reported to	f			
	Completed form da investigation of the completed by the fa identified, "After the [R94] returned from of her insurance ca her bed. [R94] che had hidden under h \$70.00 was missing reported the missin 7:30 p.m." and staff however, "The mon clinical administrate campus administrate the report. Further, does have some fo	Report Submission ted 11/16/16, identified an allegation had been acility. The investigation is supper meal on 11/10/16, in the dining room to find some rds lying on the floor next to cked in her wallet which she her pillow and noticed that grom her wallet." R94 g money, "at approximately f completed a search, hey was not found." The por, leader in training and tor was notified according to the report identified, "[R94] rgetfulness but is a credible o alleged perpetrator has				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00292	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ABI FS FAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 40	22000			
	director of nursing of credible source of ithe campus adminitiated facility) had been not misappropriation of 11/10/16 according however, the State until, "The following was not in accordated During interview on current administrate expected the staff to	on 3/1/17, at 9:01 a.m. the (DON) stated R94 was a nformation. The DON stated strator (not longer at the otified of R94's allegation of funds immediately on to the investigation notes, agency had not been notified morning," on 11/11/16 which note with the facility policy.  3/2/17, at 9:03 a.m. the or indicated she would have o have reported R94's missing agency, as identifid by the				
	The director of nurs review the facility a staff regarding time agency any allegati maltreatment, negle resident funds; ther	THOD OF CORRECTION: sing (DON) or designee could buse prevention policy with ely reporting to the State ons of potential abuse, ect, or misappropriations of a audit to ensure compliance.  R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM