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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HR9U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00292

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245120**

2.STATE VENDOR OR MEDICAID NO.
(L2) **195487000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRACEPOINTE CROSSING GABLES EAST**
(L4) **548 FIRST AVENUE**
(L5) **CAMBRIDGE, MN** (L6) **55008**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/02/2007**

6. DATE OF SURVEY **04/18/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 05/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/17/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/09/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/11/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HR9U

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(L3) **GRACEPOINTE CROSSING GABLES EAST**
(L4) **548 FIRST AVENUE**
(L5) **CAMBRIDGE, MN** (L6) **55008**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/02/2007**

6. DATE OF SURVEY **03/02/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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Compliance Based On:

X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 04/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/11/2017 (L20)

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

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____ 2. Facility is not Eligible
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04/17/1967
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 04/11/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/27/17 to 3/2/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Gracepointe Crossing Gables - East was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. In addition, two complaint investigations were completed while on-site for the recertification survey. H5120045 was reviewed and found to be unsubstantiated. H5120044 was reviewed and substantiated with deficiencies cited at F157 and F309. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 157		4/10/17

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

Electronically Signed | 03/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the responsible party was notified timely of newly developed left knee pain for 1 of 1 residents (R31) reviewed for notification of change. Findings include: R31's BIMS and Delirium assessment dated 9/16/16, identified R31 had a, "Memory problem," with recall and a, "Severely impaired," ability to make decisions regarding tasks of daily life. R31's Admission Record dated 3/2/17, identified family member (FM)-A to be R31's, "Emergency contact # 1," and, "Responsible Party." During interview on 2/28/17, at 2:55 p.m. family member (FM)-A stated she was the responsible party for R31. FM-A stated R31 was not ambulatory and, "Hadn't walked in years," relying on staff for all of her transfers. FM-A stated in the early morning hours of 11/3/16, R31 had been found in bed with her knee bent, "In this odd position," causing the bottom of her foot to be facing her shoulders. FM-A stated R31 had developed significant left knee and leg pain after being found in this position which was later identified to be a fracture in her leg. FM-A stated she was not notified of R31's newly developed leg pain until, "Just before 4 o'clock [p.m.]" on 11/3/16, adding this was, "Upsetting," staff had started treatment of R31's fractured and leg pain before she, as R31's responsible party, had ever been notified of the incident. Further, FM-A	F 157	R31 is no longer a resident of GracePointe Crossing Gables East. The policy for Family or Responsible Party Notification on Change of Condition was reviewed and is current. All residents are assessed for change of condition upon admission, minimally quarterly and with change of status. Family members and physicians are notified with change of status as per the facility policy, resident and or family request and as indicated by the care plan. Education will be completed for staff responsible for updating the family or responsible party of a change in condition by 4/5/17. Facility will monitor and sustain correction by completing audits on 5% of residents weekly for two months. Results of audits will be reviewed at the QAA meeting and will be determined the need for ongoing monitoring. Clinical Administrator or designee will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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stated staff should not have been, "Making decisions without involving me."

R31's provided closed record contained two single, undated notes. The first note identified, "DO NOT ADD, D/C [discontinue] OR CHANGE ANYTHING WITHOUT [FM-A] APPROVAL!!!!!!!" The second note directed staff to, "Notify [FM-A] of ANY med/insulin changes," or, " ... if no [bowel movement] in 3 days."

R31's progress notes dated 10/26/16 through 11/4/16, identified R31 had no prior complaints of left leg pain in the days leading up to 11/3/16. Further, the progress notes identified the following entries:

On 11/3/16, at 3:33 a.m. R31 was first identified with, "C/o [complaints of] left leg pain," and was given Tylenol.

At 5:10 a.m. R31 was noted as, "Continuing to call out for help and c/o pain, resident repositioned and warm blanket given." No notification of family was identified in the note after R31 had been having complaints of knee pain for nearly two hours.

At 9:25 a.m. R31 was identified to have continued complaints of left leg pain and now, "Had swelling in the left knee," with the nurse placing a call to the clinic and, "Left a message for [R31's primary physician] regarding left knee pain and swelling." A subsequent note at 12:28 p.m. identified, "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

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	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

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was identified to have newly doucmented left leg pain) a note identified, " ... x-ray came back positive for distal femur fracture. [FM-A] notified and will be going out of town ..."

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 family members after speaking with the physician adding she had no concerns with how FM-A had been notified of R31's developed leg pain.

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F 157	Continued From page 5 A facility Change of Condition Family of Responsible Party Notification policy dated 11/16, identified a purpose to, "Notify family and/or resident representative any time there is a," and listed several options which included, "Change in condition." The policy identified a procedure which included, "From 10:00 p.m. to 8:00 a.m. the designated party will be notified if more than a nursing intervention is needed. Check the medical record for specific family/responsible party instructions regarding notification. Designated party should be notified the next day in a timely manner." Further, the policy directed staff to, "Document, in the resident's medical record, the time called, the person spoke with, what was reported and their response, if any," adding if staff were unable to reach the responsible party to, " ... continue to call in 2-hour increments until party has received the message," and, "Document each time you call."	F 157		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		4/10/17

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F 225	Continued From page 6 or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 7 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential misappropriation of resident funds were immediately reported to the State agency for 1 of 5 residents (R94) whose allegations were reviewed. Findings include: R94's quarterly Minimum Data Set (MDS) dated 2/3/17, identified R94 had moderate cognitive impairment and displayed no behavioral symptoms (i.e. physical, verbal or other behavioral symptoms). R94's Presbyterian Homes & Services Report of Missing/Damaged Item(s) form dated 11/15/16, identified R94 had reported, "$70 cash [$50 dollar bill and $20 dollar bill]" to be missing. The money had been, "Wrapped in a pink receipt, inside her wallet which she placed under her pillow," and was last seen on 11/9/16, at 8:00 p.m. according to the report. Further, the report identified a search had been completed with an, "Outcome of Search," being identified as, "Money not found." The report was signed and dated on 11/10/16, at 8:15 p.m. by the, "Person Taking Report." R94's Incident Report - Submission Completed form dated 11/11/16, identified spacing labeled,	F 225	R94□s initial OHFC incident report was filed on 11/11/16. A further investigation was completed and final OHFC report was filed on 11/16/16 and was determined by OHFC that no further action was necessary from their office on 12/23/16. R 94□s care plan was reviewed and is current. The policy and procedure for Vulnerable Adult Reporting and Missing Items was reviewed and is current. All missing items and/or vulnerable adult concerns for any resident is immediately reported to the appropriate state agency as per the facility policy and investigated to ensure the protection of vulnerable adults. Education will be completed for all staff on the expectations for Vulnerable Adult Reporting and Missing Item policy by 4/5/17. Facility will audit all vulnerable adult concerns for timeliness of reporting and for consistency with following the policy. Results of audits will be reviewed by the	

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F 225	Continued From page 8 "Date Submitted to MDH/OHFC [State agency]," and listed it reported on, "11/11/2016 [the following day after the allegation was reported to staff]." R94's Investigative Report Submission Completed form dated 11/16/16, identified an investigation of the allegation had been completed by the facility. The investigation identified, "After the supper meal on 11/10/16, [R94] returned from the dining room to find some of her insurance cards lying on the floor next to her bed. [R94] checked in her wallet which she had hidden under her pillow and noticed that $70.00 was missing from her wallet." R94 reported the missing money, "at approximately 7:30 p.m." and staff completed a search, however, "The money was not found." The clinical administrator, leader in training and campus administrator was notified according to the report. Further, the report identified, "[R94] does have some forgetfulness but is a credible source," adding, "No alleged perpetrator has been identified." When interviewed on 3/1/17, at 9:01 a.m. the director of nursing (DON) stated R94 was a credible source of information. The DON stated the campus administrator (no longer at the facility) had been notified of R94's allegation of misappropriation of funds immediately on 11/10/16 according to the investigation notes, however the State agency had not been notified until, "The following morning," on 11/11/16. During interview on 3/2/17, at 9:03 a.m. the current administrator stated she would have expected the staff to have reported R94's missing money to the State agency, "That evening	F 225	facility Quality Assurance Committee to ensure ongoing compliance. Administrator, Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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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 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (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		4/10/17

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F 226	Continued From page 10 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to ensure allegations of potential misappropriation of resident funds were immediately reported to the State agency for 1 of 5 residents (R94) whose allegations were reviewed. Findings include: The facility Vulnerable Adult Abuse Prevention Plan policy dated 12/2016, identified a purpose to, "Establish the policies, procedures and responsibilities for protecting all adults who are dependent upon this facility for health services and/or a safe environment in which to live," adding the plan was developed, "In accordance with state and federal regulations." The policy identified each resident, " ... has the right to be free from verbal, sexual, physical, and mental abuse" and listed several examples including misappropriation of resident property. The policy identified a section labeled, "III. Identification," and listed several, "Other Definitions of Abuse," with a heading of, "Financial or Material Exploitation (Misappropriation of resident property)" being included. The text under the heading provided a definition of, "Illegal or improper use of an individual's funds, property or assets without informed consent and resulting in monetary, personal, or other benefit, gain, or	F 226	R94□s initial OHFC incident report was filed on 11/11/16. A further investigation was completed and final OHFC report was filed on 11/16/16 and was determined by OHFC that no further action was necessary from their office on 12/23/16. R 94□s care plan was reviewed and is current. The policy and procedure for Vulnerable Adult Reporting and Missing Items was reviewed and is current. All missing items and/or vulnerable adult concerns for any resident is immediately reported to the appropriate state agency as per the facility policy and investigated to ensure the protection of vulnerable adults. Education will be completed for all staff on the expectations for Vulnerable Adult Reporting and Missing Item policy by 4/5/17. Facility will audit all vulnerable adult concerns for timeliness of reporting and for consistency with following the policy. Results of audits will be reviewed by the facility Quality Assurance Committee to	

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F 226	Continued From page 11 profit for the perpetrator ..." Further, the policy directed, "All cases of maltreatment or potential maltreatment must be reported immediately ...," including, "An initial report must be completed and submitted to the State Agency via state specific contact point." R94's quarterly Minimum Data Set (MDS) dated 2/3/17, identified R94 had moderate cognitive impairment and displayed no behavioral symptoms (i.e. physical, verbal or other behavioral symptoms). R94's Presbyterian Homes & Services Report of Missing/Damaged Item(s) form dated 11/15/16, identified R94 had reported, "$70 cash [$50 dollar bill and $20 dollar bill]" to be missing. The money had been, "Wrapped in a pink receipt, inside her wallet which she placed under her pillow," and was last seen on 11/9/16, at 8:00 p.m. according to the report. Further, the report identified a search had been completed with an, "Outcome of Search," being identified as, "Money not found." The report was signed and dated on 11/10/16, at 8:15 p.m. by the, "Person Taking Report." R94's Incident Report - Submission Completed form dated 11/11/16, identified spacing labeled, "Date Submitted to MDH/OHFC [State agency]," and listed it reported on, "11/11/2016 [the following day after the allegation was reported to staff]." R94's Investigative Report Submission Completed form dated 11/16/16, identified an investigation of the allegation had been completed by the facility. The investigation identified, "After the supper meal on 11/10/16, [R94] returned from the dining room to find some	F 226	ensure ongoing compliance. Administrator, Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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F 226	Continued From page 12 of her insurance cards lying on the floor next to her bed. [R94] checked in her wallet which she had hidden under her pillow and noticed that $70.00 was missing from her wallet." R94 reported the missing money, "at approximately 7:30 p.m." and staff completed a search, however, "The money was not found." The clinical administrator, leader in training and campus administrator was notified according to the report. Further, the report identified, "[R94] does have some forgetfulness but is a credible source," adding, "No alleged perpetrator has been identified." When interviewed on 3/1/17, at 9:01 a.m. the director of nursing (DON) stated R94 was a credible source of information. The DON stated the campus administrator (not longer at the facility) had been notified of R94's allegation of misappropriation of funds immediately on 11/10/16 according to the investigation notes, however, the State agency had not been notified until, "The following morning," on 11/11/16 which was not in accordance with the facility policy. During interview on 3/2/17, at 9:03 a.m. the current administrator stated she would have expected the staff to have reported R94's missing money to the State agency, "That evening [11/10/16]."	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		4/10/17

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F 309	Continued From page 13 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on 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:	F 309	R31 is no longer a resident of GracePointe Crossing Gables East. The policy for Change of Condition was reviewed and is current. All residents are assessed for change of condition upon admission, minimally	

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F 309	Continued From page 14 R31's quarterly Minimum Data Set (MDS) dated 9/7/16, identified R31 required extensive assistance with activities of daily living (ADLs), and had dementia but with no current infections. Further, the MDS identified a section labeled, "Prognosis," with a question listed as, "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" This was answered as, "No." R31's Provider Orders for Life Sustaining Treatment (POLST) dated 9/10/14, identified R31 was DNR (Do Not Resuscitate) and included a section labeled, "Goals of Treatment," with several options to be checked to identify the resident's corresponding wishes. A hand written, "X" marking was placed next to, "Limit interventions and treat reversible conditions." Further documentation at that section included, "Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions." The option of, "Comfort Care" was left unchecked. R31's BIMS (Brief Interview for Mental Status) and Delirium assessment dated 9/16/16, identified R31 had a "Memory problem" with recall and a "Severely impaired" ability to make decisions regarding tasks of daily life. During interview on 2/28/17, at 2:55 p.m. family member (FM)-A stated she was power of attorney (POA) and the responsible party for R31's care. FM-A stated (R31) had not been on comfort care at any time and wanted treatments for reversible conditions adding R31 had seen her primary physician, "About a month prior [to her death]." FM-A said R31's primary physician had commented at that time that he was "amazed at	F 309	quarterly and with change of status. Family members and physicians are notified with change of status as per the facility policy, resident and or family request and as indicated by the care plan. The interventions related to the change of condition include an interdisciplinary approach including representation from the resident and family as appropriate as well as the physician. Interventions are reviewed with the family and IDT minimally at care conferences and as indicated. Education will be completed for staff responsible for recognizing and assessing for a change of condition and updating the physician and family by 4/10/17. Facility will monitor and sustain correction by completing audits on 5% of residents weekly for two months. Results of audits will be reviewed at the QAA meeting and will be determined the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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her health." FM-A stated on the weekend of 11/5/16, R31 had developed, "Some kind of infection" with several symptoms including an unrelieved fever and rash. FM-A said it demonstrated, "Something bad is going on and it needs to be addressed." FM-A stated she had received a call on 11/7/16, from staff in which R31 was described to be, "Not acting herself," and FM-A advised staff R31 needed, "To go to the hospital right away." FM-A stated R31 was transferred to the hospital where the physician identified she had sepsis (a massive immune response to a infection in the blood) infection, and then died. FM-A stated was upset and felt the nursing home staff should have recognized the signs and symptoms of infection in R31.

R31's care plan dated 9/21/16, identified R31 had an self care performance deficit and required assistance to complete all ADLs (activities of daily living) with impaired mobility and cognition adding R31 to be, "Resistive to care,"' at times. The care plan identified R31 had high blood pressure, heart failure, and at risk for fluid volume deficit directing staff to monitor R31 for, "Electrolyte imbalance which may include weak pulse, changes in cognition, changes in my blood pressure," and report these to the physician, "As needed." R31 was identified with, "Impaired cognitive function/dementia," and identified, "I [R31] need my POA with all decision making." R31's developed care plan did not identify R31 was on comfort care or had a terminal condition with a life expectancy of less then six months.

R31's Progress Notes dated 9/20/16, identified R31 had been seen in the clinic by her primary physician. The physician identified R31 to be, "Eating and drinking fairly well," with pulse

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recorded at 60 beats per minute, and her, "Chest is clear, no wheezing or rales." Further, the note identified R31 was to return for a recheck in two months. The note did not identify R31 was to be on comfort cares, have a life limiting illness, or have a life expectancy of less than six months.

R31's CMC (Cambridge Medical Center) Discharge Summary dated 11/3/16, identified R31 was an elderly female, "With dementia on comfort care," who had persistant left leg pain in which a "Spiral, displaced fracture of the distal femoral diaphysis," was identified on X-ray. The summary identified no surgery was performed and R31 returned to the nursing home. R31's condition was identified at the time of discharge as, "Stabilized," and provided recommendations to follow up with appointment(s) to address, "Wt [weight] bearing advancement and splint discontinuation plans." R31's rehabilitation potential was listed as, "Fair," and directed, "At the skilled nursing facility let your healthcare providers know if you notice any changes in your condition." Further, R31's, "Discharge Day Exam," identified her lung sounds as, "CTA [clear to auscultation] bilaterally," and R31's vital signs were recorded as: Blood Pressure 202/126; Pulse 90; Temperature 97.8 (F); and Respirations 20. The discharge summary lacked any dictation of R31's responsible party having wished for comfort cares, or any dictation on changing her POLST from her prior identified wishes on her POLST dated 9/10/14.

R31's facility report labeled Follow Up Question Report dated 11/1/16 through 11/7/16, identified recorded meal intakes for R31 during the review period. R31 had consumed, "76-100%" for two of three meals provided daily from 11/1/16, to

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F 309	Continued From page 17 11/3/16. On 11/4/16, R31 refused breakfast but consumed, "26-50%" of lunch and, "0-25%" of the evening meal. On 11/5/16, R31 was identified as, "Resident refused," for all three meals. On 11/6/16, R31 was identified as consuming, "76-100%" of breakfast but only, "0-25%" of the lunch meal and refused the evening meal. R31 consumed no meals on 11/7/16, according to the provided report. R31's Medication Administration Record (MAR) dated 11/1/16 through 11/7/16, identified R31 had orders for, "Lantus Solution [long acting insulin] ... Inject 6 units subcutaneously one time a day ...," and was administered as ordered from 11/1/16, through 11/5/16. The MAR identified the ordered insulin was not administered on 11/6/16 and directed, "Other / See Nurses Notes." The MAR had no active orders identified for antibiotic (medication used to inhibit the growth of, or destry microorganisms) therapy administration from 11/1/16, through 11/7/16. Further, the MAR identified R31 had orders for, "NovoLOG Solution [short acting insulin, often lasting a total of six to eight hours] ... Inject per sliding scale: if 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 900 = 10 units," and directed staff to, "Notify MD [medical doctor] if over 500." The order identified the dose administered with the corresponding blood glucose (BG) reading as below: - In the morning of 11/3/16, R31 had a BG reading of 102 mg/dl (milligrams per deciliter; normal fasting BG range is 70-100mg/dl) and was not administered insulin. In the afternoon of 11/3/16, R31 had a BG reading of 319 and was	F 309		

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F 309	Continued From page 18 administered eight units of Novolog. - In the morning of 11/4/16, R31 had a BG reading of 272 and was administered six units of Novolog. In the afternoon of 11/4/16, R31 had a BG reading of 329 and was administered eight units of Novolog. - In the morning of 11/5/16, R31 did not have a BG obtained, instead the MAR directed, "Parameters out of range," with no treatment being identified. In the afternoon of 11/5/16, R31 had a BG reading of 402 and was administered 10 units of Novolog. - In the morning of 11/6/16, R31 again did not have a BG obtained, instead the MAR directed, "Parameters out of range," with no further information was identified. In the afternoon of 11/5/16, R31 had a BG reading of 593 and was administered 10 units of Novolog. Further, on 11/6/16, two additional, "One Time," orders were identified which identified R31 had an additional 20 units of Novolog administered at 5:19 p.m. with an additional 10 units of Lantus being administered at 8:35 p.m. to R31. - In the morning of 11/7/16, R31 had a BG reading of 461 and was administered 10 units of Novolog. In the afternoon of 11/7/16, R31 did not have insulin administered and was identified as, "Hospitalized." R31's medical record identified to the following progress note(s) and fax communications after R31's return from the hospital on 11/4/16: - On 11/4/16, R31 arrived back from the ER at 1:30 a.m. with, "Confirmed Left spiral displaced	F 309		

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fracture of distal femoral diaphysis." R31 was identified to, "Have c/o [complaints of] pain with minimal movement." Further, R31 had a, "Pinpoint rash from fingertips to just above the elbow."

- On 11/4/16, R31 was identified to be, "On comfort cares - no therapy ordered." Further, the note identified R31, "Was in a lot of pain and hurting," however, refused to take medications, including a single dose of insulin, when offered.

- On 11/5/16, R31 was identified as, "C/o pain in left leg, repeatedly calling out for help."

- On 11/5/16, a "Culinary," note identified R31 had been in bed for meals, along with a subsequent note which identified, "[R31] ate less than 25% of meal," however, ate some ice cream at bedtime.

- On 11/6/16, R31 was identified to eat, "Less than 25% of meals," and staff were encouraging fluids. Further, on 11/6/16 at 2:35 p.m. an entry identified, "[R31] had slight fever on [night] shift. In AM had fever of 100.7 tympanic (ear). After lunch resident had increased respiratory rate of 28. Other vs [vital signs] were as follows: Pulse 102. Oximeter saturation 94%. Temp 100.3 tympanic. B/P 118/54. Lung sounds sonorous [low pitched, coarse, loud sound caused by narrowing of the airways or an obstruction]. No crackles. Resident was up in wheelchair for 4 hours." Further, on the same date at 5:18 p.m. R31 received, "One time only order of 20 units [Novolog, a fast action insulin] given for BG [blood glucose] 593," and six units of Lantus (another insulin) for a, "One time only order due to hyperglycemia [high blood sugar]."

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- On 11/6/16, "On-call physician called due to resident being febrile and hyperglycemia. Temp of 100.3F at [2:00 p.m.], Temp of 100F at [4:30 p.m.]. Resident's BG at [4:30 p.m.] was 593. On call [name identified] gave orders to give 20 units of Novolog instead of sliding scale and to give 10 units of Lantus at HS [bedtime] instead of 6 units. Resident's temp at [8:30 p.m.] was 99.9F and BG was 202. Resident had perspiration [sweating] all shift." The note identified staff provided water to R31 and schedule pain medications adding, "Will continue to monitor." The note lacked information if the physician had been informed of R31's elevated respiratory rate, coarse lung sounds, or the elevated blood sugar readings in the absence of substantial intake.

No fax communications were identified in R31's medical record regarding the notification of the on-call physician in the progress note on 11/6/16.

- A MD/NP Order Form fax communication dated 11/4/16, identified staff faxed regarding, "Resident came back from ER with pinpoint rash on [right] arm from fingertips to elbow." The physician' response was hand written as, "No recommendation," and signed with a response date of 11/7/16 and time stamped as being sent at 9:16 a.m.

- On 11/7/17, R31 was visited by the activities aide who identified at 2:35 p.m. to be, "Not feeling well," with a nurse telling them, "[R31] isn't doing good."

- A MD/NP (medical doctor / nurse practitioner) Order Form fax communication dated 11/7/16, at 11:30 a.m. identified R31 had a fever which, "Began on weekend with 99. + [above] on 11/5/16

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F 309	Continued From page 21 early AM - [increased] 100.7 + before noon, [decreased] 100.3 [increased] on 11/6/16 ... Tylenol ineffective. Now diaphoretic with decreased responsiveness. Not eating or drinking. Left message for [FM-A]. Blood glucose 593 at [4:00 p.m.] on 11/6/16 and 461 at [7:30 a.m.] on 11/7/16. Both covered with sliding scale insulin." R31's primary physician responded on 11/7/17, with the following hand-written note, "My suggestion if she is comfort cares to use comfort cares. If family wants agressive [sic] treatment she them need to be sent to the ED [emergency department]." The faxed physician response was not time stamped. - On 11/7/17, at 2:44 p.m. R31 was identified to have, "Not reacted well to her broken femur. She had fevers on the weekend of 99. [sic] tympanic on 11/5 [night], increased up to 100.7 in AM and 11/6 temp was 100.3. On 11/7 temp was 99 and resident was diaphoretic. Level of conscious (LOC) was decreased throughout shift. Resident did not get out of bed. Resident ate very little due to decreas3ed [sic] LOC. Resident only drank honey thick juice with spoon feeding. Blood glucose 593 at [4:30 p.m.] on 11/6 and 461 at [7:30 a.m.] on 11/7. Both covered with sliding scale insulin. Message left for [FM-A] in AM without response until afternoon. Dr. was notified with fax and suggested comfort care. If family wants aggressive treatment she will need to be sent to the ED [emergency department]. This was explained to [FM-A], who said she would call Dr's office and call us back with answer about transfer to ED." - On 11/7/17, at 3: 25 p.m. R31 was identified as, "Being transported to the ED," with her vital signs listed as, "B/P 88/48, pulse 91, resp 28, temp	F 309		

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98.3 tympanic, Oximeter saturation 97%." The note identified R31 had, "Pinpoint rash on right arm," and was, "Diaphortic [sic] and cool to touch." Further, a subsequent note on 11/7/16, identified, "CMC [medical center] called at [9:05 p.m.] to notify us that resident passes away at [8:34 p.m.]."

R31's History & Physical (H&P) dated 11/7/16, at 8:06 p.m. identified R31 had, "Presented to [medical center] for evaluation," for a chief complaint of, "Fever," adding FM-A as R31's identified POA. R31 was identified as, "... less responsive and febrile." R31 was, "Found to be in multisystem organ failure and met severe sepsis criteria [lactate 7.9 (normal range in unstressed patient is 0.5 - 1 mmol/L)]," adding R31 was admitted to the hospital. The assessment identified a review of systems (ROS) was unable to be completed, "Secondary to unresponsive state," and listed a, "Patient Active Problem List" which included, "Severe sepsis with acute organ dysfunction," "Multi-organ failure with heart failure," "Acute hypernatremia [elevated sodium level]," and, "Metabolic acidosis." The identified, "Date Noted," for each diagnosis was listed as 11/7/16. The assessment listed a physical examination completed by the physician which included a blood pressure of 83/45, pulse 127, temperature of 99.2, and respirations of 26 adding R31 to be, "Non responsive," and her skin to appear, "Mottled and lacy rash of right medial thigh." The assessment identified several laboratory values which were collected on 11/7/16, and compared them to the laboratory values collected on 11/3/16, which included a white blood cell (WBC) count of 24.5 (normal range 4.5 to 10) compared to 11.2 prior on 11/3/16, and a sodium level of 152 compared to

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140 prior on 11/3/16. Further, an assessment and plan was listed for, "Severe sepsis with acute organ dysfunction," and identified R31 would be admitted to the hospital which was, "Discussed at length with [FM-A] the poor prognosis given her age and multisystem failure," adding, "Family would like minimally invasive measures such as antibiotics and IVF [IV fluid] ..."

R31's undated Minnesota Department of Health (MDH) Documentation of Death record identified R31 expired while, "Inpatient," at a hospital and listed the, "Immediate Cause [final disease or condition resulting in death]," as, "Sepsis."

When interviewed on 3/1/17, at 9:51 a.m. nursing assistant (NA)-B stated she frequently worked with R31. NA-B stated on the weekend of 11/5/16, she noticed R31, "Wasn't feeling good," and to be, "Pale," and, "Not herself." R31 was warm to touch, and was not eating or drinking like she had been before. NA-B stated the nurses were involved in her care that weekend, and added, she was not aware of R31 to have a terminal condition or be on comfort cares during the last weeks of her stay at the facility.

During interview on 3/1/17, at 12:22 p.m. registered nurse (RN)-A stated she had been the nurse who contacted the physician on 11/6/16, as recorded in the progress note entered into R31's medical record, "That was me." RN-A stated she reported to the physician R31's elevated blood sugars, elevated temperature and diaphoresis (sweating). RN-A stated it to be, "Unheard of [R31] to be in the 400's [blood sugar]," and recalled R31 to be, "Not herself at all that day," adding R31 had a newly visible, "Pinpoint red rash," on her lower forearms as well. However,

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RN-A stated she did not verbally report R31's additional abnormal symptoms to the physician including the elevated respiratory rate, the developed rash since R31's return from the hospital, coarse lung sounds, or the fact in which R31's blood sugars were elevated despite consistent meal intake adding, "No, I did not." RN-A stated any completed nursing assessments of R31's condition would be documented in the progress notes; however, RN-A stated she was unable to locate any assessment which comprehensively addressed all of R31's identified changes. RN-A stated she should have completed a, "Full nursing assessment before I contact[ed] them [physician]." RN-A stated R31 was not on comfort care or considered to be in a terminal condition when she notified the physician on 11/6/16, adding R31's death at the hospital on 11/7/16, to be, "A complete surprise."

When interviewed on 3/1/17, at 2:03 p.m. RN-B stated she was the assigned care manager for R31 during the final weeks of her life in the facility. RN-B stated R31 was not on comfort care and had no identified terminal condition. RN-B reviewed R31's progress notes in the medical record and stated R31 appeared to of, "Fevered through the weekend," starting on 11/5/16. RN-B stated there was, "No defined plan of care," for how staff should have treated R31 from reviewing progress notes in the record. RN-B stated their was no evidence a comprehensive assessment of R31's condition had been completed in the medical record to ensure appropriate medical treatment was sought or implemented. RN-B stated the documented information presented to the physician over the telephone on 11/6/16 was, "Not completely" accurate and lacked the increased respirations,

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coarse lung sounds and continued hyperglycemia in the absence of substantial meal intake adding, "Better information could be given."

On 3/2/17, at 1:05 p.m. the director of nursing (DON) was interviewed. The DON stated R31's signed POLST identified R31 to be a DNR, however, further listed R31 wanted treatment of potentially reversible conditions adding the POLST did not provide any direction to not hospitalize R31 for any reason. The DON stated R31 was not treated prior to her hospitalization on 11/7/16, as her health care directive (HCD) identified she wanted to have a natural death in the event of a terminal condition. The DON stated R31 had, "A change in condition," adding the on-call physician contacted on 11/6/16, was not R31's primary physician and she expected, "The nurse taking care of [R31]," to, "Give an assessment of the resident at that time." The DON stated the on-call physician was responsible, not the nursing home staff, to review R31's past information to be included in their assessment of the residents condition. The DON stated she was unsure if the on-call physician was aware of the entire clinical picture R31 displayed. The DON stated R31's progress notes reflected what, "Could be a sign of infection," and she expected her staff, "Would include pertinent information," in speaking to the physician when trying to determine treatment options.

During a telephone interview on 3/3/17, at 1:16 p.m. MD-A stated he had been the primary physician for R31 for the past couple years and knew her, "Very well." R31 had been last seen in the clinic for examination on 9/20/16, and was noted to be eating and drinking well, have no abnormal vital signs and be, "Kinda her baseline

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self." MD-A stated R31 was not on comfort cares, "At that time," nor had he ever discussed comfort cares with R31's family before adding, "[I] don't remember ever putting her on comfort care." MD-A stated R31's hospital discharge (dated 11/3/16) identified R31 to be on comfort care, however, MD-A stated he was not sure where the directive came from, adding if the hospital physicians discussed comfort care with R31's family during her hospitalization on 11/3/16, it should be documented on the discharge summary. MD-A stated the hospital physician, "May have assumed she was on comfort care." Further, MD-A stated sepsis infection can be reversible if identified and treated.

A facility Change of Condition Physician Notification Policy dated 11/16, identified a purpose, "To notify the physician any time there is," and listed several examples which included a, "Significant change in clinical condition ...," and, "Any other time there has been a significant change in status from the plan of care." The policy listed a procedure which included, "Any significant change in status must be reported to the medical team immediately which may be life threatening in nature or risk to self or others," and advised, "A 911 call may be initiated without a physician's order according to the nurse's discretion if the emergency is life threatening ...." The policy directed staff to, "Document, in the resident's medical record, the time called, the person spoke with, what was reported and their response if any." Further, the policy provided several examples of a resident' potential change in condition and corresponding interventions which included an example of, "Any unusual Change in Status and/or New Onset of behavior Requiring Interventions ...," and directed, "Monitor

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F 309	Continued From page 27 for symptoms of infection. Look for precipitating factors that could have led to the behavior, implement interventions and monitor effectiveness." A facility policy on comprehensive nursing assessment with changes in condition was requested, but none was provided.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This 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. Findings include:	F 314	R96 is no longer a resident of GracePointe Crossing Gables East. The policy on Skin Integrity Management was reviewed and is current. All residents with current wounds were reviewed for appropriate interventions and revised as necessary.	4/10/17

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F 314	Continued From page 28 R96's admission Minimum Data Set (MDS) dated 11/14/16, identified R96 had moderate cognitive impairment, and required extensive assistance with activities of daily living (ADLs). Further, the MDS identified R96 had renal insufficiency, was on palliative care, and was at risk for pressure ulcer development, however, had no current pressure ulcers. R96's Body Audit dated 11/8/16, identified the audit was R96's, "Admission body audit," and described several areas of bruising on R96's abdomen, elbow and forearm. The audit did not identify R96 had any pressure ulcers or areas or reddened skin. R96's pressure ulcer Care Area Assessment (CAA) dated 11/21/16, identified the CAA, "Triggered due to level of assist with bed mobility, bowel incontinence and high risk for pressure ulcers," listing R96 to have, "Potential," for pressure ulcer development. Further, the CAA identified the risk of pressure ulcers would be addressed on R96's care plan and directed the, "Overall objective," was to, "Minimize risks." R96's Skin Risk and Braden assessment dated 11/9/16, identified R96 was at, "High Risk" of pressure ulcer formation with several risk factors listed including, "Assistance required with ADL's," and, "Uses medication which impact skin conditions ..." The assessment contained a section labeled, "Lower Extremity Concerns," and identified R96 had no signs of symptoms of arterial disease, venous insufficiency or neuropathy and contained an, "Analysis and Summary," section which identified, "[R96] is an A1 [assist of one] Q3H [every 3 hour]	F 314	All residents are assessed for skin risk upon admission, weekly for alterations in skin risk and care plans are updated minimally quarterly or with a change in condition in conjunction with the RAI process. Nursing assistants observe skin integrity daily with cares and report to the nurse any potential alterations. The care plan is updated to reflect any new interventions. Education will be completed for nursing staff responsible for monitoring and managing skin integrity by 4/5/17. Facility will monitor and sustain correction by auditing all residents with wounds weekly for appropriate interventions for two months. Results of audits will be reviewed at the QAA meeting and will be determined the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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repositioning, unable to make frequent and major positional changes [independently]. Pressure reduction mattress in bed. Currently on bed rest." Further, the assessment identified an "Interventions," field and listed, "A1 Q3H repositioning, pressure reduction mattress in bed," with those being identified as, "New interventions," under a subsequent, "Evaluation of interventions," field.

R96's progress note dated 11/21/16, identified R96 developed, " ... a non-open, red, non-blanchable area on coccyx measuring 2cm [centimeters] [by] 2cm," and listed a treatment of barrier cream.

MDS definition: Stage one pressure ulcer, an observable, pressure- related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Non-blanchable: Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

R96's Body Audit dated 11/22/16, identified R96 had a bed bath completed with her coccyx being red.

R96's care plan dated 11/28/16, identified R96 was admitted to hospice after sustaining a fall with subsequent fractures and required assistance with dressing, bed mobility and

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transfers. Further, the care plan identified R96 was, " ... at risk for impaired skin integrity," and directed staff to assess R96's risk status, "Per policy, upon admission, quarterly and as needed," and apply a dermasaver (skin care device) under her right leg while in bed. The care plan did not identify R96 had any current pressure ulcers or history of pressure ulcers, despite the identified pressure ulcer on the progress note dated 11/21/16.

R96's medical record identified the following subsequent Body Audit(s) had been completed:
- On 12/6/16, identified no red areas on R96's skin with, "No skin integrity issues noted," and;
- On 12/20/16, identified R96 had, "No new skin integrity issue [sic] noted," and;
- On 1/3/17, again identified R96 had, " ... no new skin integrity issue noted."

Review of R96's progress notes dated 11/22/16 through 1/9/17, did not identify skin monitoring had been completed besides the completed Body Audit(s) identified above. There was no indication of when the 11/21/16 pressure ulcer healed, or if it had not healed, along with a description of the pressure ulcer. The skin assessments were completed every 2 weeks and not weekly even though R96 as at risk for pressure ulcer development and had a pressure ulcer on 11/21/16.

R96's Body Audit dated 1/10/17, identified R96 had an, "Area of alterations in skin integrity," and listed her, "Coccyx," to have, "1.2 cm]by] 1.2 cm stage 2 [partial thickness skin loss] pressure ulcer has been earlier documented. Area covered with Tegaderm."

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A subsequent Skin Risk and Braden assessment dated 1/10/17, identified R96 remained at, "High Risk" for pressure ulcer development and again listed several risk factors including, "Assistance required with ADL's," and, "Uses medication which impact skin conditions ..." A section labeled, "Tissue Tolerance and Evaluation of Support Services," identified R96 had no preferences or resistance to any particular positions, and staff were, "Unable to determine," R96's preferences for sleeping during the night. R96 was identified to use pillows and pressure reduction mattress in bed, and had no changes in tissue sensation from the previous assessment(s). An, "Analysis and Summary," section identified, "[R96] is an A1 Q3H repositioning, unable to make frequent and major positional changes [independently]. Pressure reduction mattress in bed. Currently on bed rest resident has the option to get out of bed. Resident prefers to remain in bed." Further, the identified, "Interventions," listed, "A1 Q3H repositioning, pressure reduction mattress in bed. Pillows utilized for repositioning." with, "New open area to coccyx," being identified in the spacing labeled, "Evaluation of interventions."

Although the facility did an assessment after P96's pressure ulcer developed, the assessment did not identify any changes to the interventions that she had previously despite R96 re-developing a pressure ulcer on her coccyx on 1/10/17.

R96's Wound Assessment Flow Sheet dated 1/17/17, identified R96 had a stage 2 pressure ulcer on her coccyx which measured 1.3 cm by 1.0 cm in size. The space to record depth was left blank. The ulcer was identified to have 50%

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granulation tissue (healthy, red tissue) and 50% slough (dead tissue) in the wound bed, with no tunneling or undermining. Further, the flow sheet identified R96 was on a, "Positioning plan," and used a , "Pressure Relieving Mattress/Device." There were no changes to the interventions for R96's pressure ulcer.

R96's PCC (PointClickCare; a system of medical record) Skin & Wound - Wound Assessment dated 1/25/17, identified R96 to have a pressure ulcer on her coccyx having developed, "In-House," on 1/10/17. The pressure ulcer was measured at 2.2 cm (area) by 1.88 cm (length) by 1.6 cm (width) having no recorded depth, undermining or tunneling. The wound bed was described as 10% (percent) granulation tissue (healthy, red tissue) and 90% slough (dead tissue) with no eschar being present. The ulcer had light drainage with no odor; and R96 denied pain at the site. The assessment identified a, "Goal of Care," to be, "Monitor/Manage," and listed a treatment of cleansing with normal saline and application of a foam dressing and, "Additional Care," options including a, "Mattress with pump," and, "Turning/Repositioning program." The note identified these measurements were recorded using an, "Electronic method," and some discrepancies were expected from previous measurements.

When interviewed on 3/2/17, at 11:02 a.m. nursing assistant (NA)-C stated R96 admitted to the facility with several fractures and, "Did not like to get out of bed." NA-C added R96 was repositioned, "Every two or three hours," on her shift adding R96 did not like to be positioned on her back. NA-C stated timely repositioning had, "Probably not," been completed for R96

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consistently as staff were, "Not following the care sheets," at times adding she had noticed on several occasions the repositioning tracking sheets were left blank from other shifts.

The repositioning sheets identified by NA-C were requested; however, the facility would not provide them.

During interview on 3/2/17, at 2:30 p.m. licensed practical nurse clinical coordinator (LPN)-A stated a comprehensive assessment of pressure ulcer risk would include, "All systems of the body," with a review of the current interventions being used. LPN-A stated R96 should have had a skin assessment completed weekly, however, this was not completed.

When interviewed on 3/2/17, at 3:13 p.m. the director of nursing (DON) stated nursing staff should, "Look at her [R96] interventions," as part of the completed assessments with, "This new wound." Further, DON stated she expected staff to update R96's interventions after developing a new pressure ulcer as, "Clearly what we had needed a change."

A facility Skin Integrity Management Policy dated 1/17, identified the facility would, " ... properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injuries," and directed staff to complete a Braden Scale, Skin Risk Assessment and Tissue Tolerance Evaluation upon admission and, "...with new onset of pressure ulcer/injury and with a significant change in status." Further, the policy directed the collected information, " ... will be included in the assessment process as

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F 314	Continued From page 34 conducted on admission to the facility, annually, with significant change ... and with the emergence of a new pressure ulcer/injury."	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		4/10/17

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F 329	Continued From page 35 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on 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. Findings include: R66's admission Minimum Data Set (MDS) dated 4/13/16, identified R66 had moderate cognitive impairment and had no trouble falling or staying asleep. During interview on 3/1/17, at 9:04 a.m. R66 stated she slept, "Wonderfully" during the night, adding she typically went to bed around 8:00 p.m.,watched television for a couple hours and fell asleep without trouble. Further, R66 stated she takes, "A lot of medications," and added she was unable to remember what they all were or why she takes them. R66's Medication Administration Record (MAR) for December 2016, identified an order for "Trazodone HCL [hydrochloride] tablet [antidepressant medication used for insomnia]," with a dose of 25 mg (milligrams) taken by mouth as needed for Insomnia [inability to sleep]. Further, the MAR directed, "Document non-drug interventions tried prior to administering the PRN	F 329	R66 was comprehensively re-assessed for the need for prn sleep medication and appropriate non-pharmacological interventions and care plan updated with new non- pharmacological interventions. The policy for Psychoactive Medication and Unnecessary Medication use was reviewed and is current. All residents currently taking a psychotropic medication for sleep were reviewed for appropriate non-pharmacological interventions and medication use and care plans revised as necessary. All residents are assessed for appropriateness of psychoactive medications and prn medications upon admission, and minimally monthly in conjunction with pharmacy reviews and IDT reviews. Education on policy will be completed for staff by 4/5/17. Facility will monitor and sustain correction by completing psychotropic medication use audits on 5% of residents for two months. Results of audits will be reviewed at the QAA meeting and will be	

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F 329	Continued From page 36 medication. Document if tried warm milk, warm blanket, snack and if it was effective or not effective." Further, the MAR identified the following administrations of PRN Trazodone to R66: In December 2016, R66 received PRN Trazodone five times, on 12/3/16, 12/4/16, 12/16/16, 12/26/16, and 12/30/16. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the administration of PRN Trazodone 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. In February 2017, R66 received PRN Trazodone six times, on 2/2/17, 2/4/17, 2/5/17, 2/16/17, 2/19/17, and 2/22/17. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the administration of PRN Trazodone for all of the dates it was administered in February. R66's medical record was reviewed and lacked a comprehensive assessment of R66's sleep to demonstrate the need for a PRN medication for sleep. R66's care plan dated 2/8/17, lacked any identified focus, goals or interventions to address R66's sleep despite her being on an as needed medication for sleep.	F 329	determined the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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F 329	Continued From page 37 When interviewed on 3/2/17, at 2:07 p.m. registered nurse (RN)-C stated R66 was currently taking Trazodone as needed for sleep, being started on the medication back in September 2016. RN-C stated the medication was used when non-pharmacological interventions such as warm milk and snacks were not effective to help R66 sleep. RN-C reviewed R66's MAR with administration dates and acknowledged the lack of documented non-pharmacological interventions despite the MAR directing staff to document them adding staff, "Should be," recording their interventions and effectiveness prior to administering R66 the PRN Trazodone. During interview on 3/2/17, at 2:43 p.m. licensed practical nurse clinical coordinator (LPN)-A stated nursing staff should be attempting to provide non-pharmacological interventions, like warm milk and snacks, before the as needed Trazodone was administered and document them accordingly. LPN-A reviewed R66's MAR and stated it lacked documentation of non-pharmacological interventions attempted prior to the administration of the Trazodone. Further, LPN-A stated R66's progress notes lacked documentation of any non-pharmacological interventions attempted prior to the medication administration adding, "The progress notes should show the entire picture." In a subsequent interview on 3/2/17, at 3:41 p.m. LPN-A stated the facility did not have a formal sleep assessment because R66 continued to occasionally request Trazodone for insomnia, so they felt R66 continued to need the Trazodone. When interviewed on 3/2/17, at 3:22 p.m. director	F 329		

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F 329	Continued From page 38 of nursing (DON) stated staff should be documenting non-pharmacological interventions prior to giving the as needed medication for sleep. A facility Psychoactive Medication and Unnecessary Medication Use Policy, last reviewed 11/2016, indicated each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used without adequate monitoring.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 371		4/10/17

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F 371	Continued From page 39 This 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. Findings include: During the initial tour of the kitchen on 2/27/17, at 9:36 a.m. dairy products were noted to be outside of the parameters of the Best By date identified on the product in 2 of 2 day room refrigerators. North Haven: During the initial tour, on 2/27/17, at 9:40 a.m. the following was noted in the refrigerator: *A half gallon container of skim milk, with one half of the container remaining (one quart) with a Best By date of 2/17/17. The carton was undated as to when this was opened. *One half gallon container of skim milk, unopened, with a Best By date of 2/21/17. *One gallon of whole milk with 1/2 remaining with a Best By date of 2/22/17. The carton was undated as to date opened. *One gallon of whole milk-1 gallon container, unopened, with the Best by date of 2/26/17. On 3/1/17, at 9:12 a.m. the following was noted: *One half gallon of fat free milk, with approximately 1 serving missing with the Best By date of 2/21/17. The carton was undated as to date opened. Dellwood : On initial tour 2/27/17, at 9:45 a.m. noted the	F 371	All milk dates were checked and milk was discarded as necessary. The Milk Dating Policy was reviewed and updated. Education on food dating will be completed for staff by 4/5/17. Facility will monitor and sustain correction by completing audits of all milk dating and storage daily for 2 months. Results of audits will be reviewed at the QAA meeting and will be determined the need for ongoing monitoring. Nutrition and Culinary Director and/or designee will be responsible for ongoing compliance.	

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	245120	A. BUILDING _____ B. WING _____	C 03/02/2017

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GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 40 following: *One gallon of whole milk, with 1/2 gallon remaining, with a Best By date of 2/26/17. There was no date indicated when opened. *One gallon of 1% milk, with 1/4 gallon remaining (approximately one quart), with the Best By date of 2/23/17. The carton was not dated to indicate date opened. On 2/28/17, at 3:08 p.m. noted the following dairy products were available for resident: *One gallon of 1% milk, with 1/8 gallon remaining (approximately one quart), with the Best By date of 2/23/17. The carton was not dated to indicate date opened. *Whole milk- 1 gallon container-approximately 2/3 full-Best By date of 2/22/17. Carton was undated as to date opened. On 3/1/17, at 9:25 a.m. noted the following: *One gallon of 1% milk,with only small amount remaining barely covering the bottom with a Best By date of 2/22/17. Carton was undated as to date opened. *One gallon of whole milk-1 gallon container-approximately 1/2 gallon remaining (two quarts) with a Best By date of 2/22/17. The carton was undated as to date opened. During initial tour of the kitchen on 2/27/17, at 9:36 a.m., the culinary director (CD), stated milk may be used for 7 days after the "Best By" date. The CD stated milk cartons are not dated, but the Best By date is used as reference date. During interview on 3/1/17, at 9:56 a.m. while reviewing the supplies in the refrigerator, nursing assistant (NA)-D stated the food in the kitchenette's were available for resident use. The	F 371		

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F 371	Continued From page 41	F 371		

refrigerator is stocked by the dietary department. NA-D stated anything opened is dated with a permanent marker. NA-D stated that if an item is undated, it should be discarded. At this time, no food items were removed by staff.

During interview on 3/1/17, at 10:02 a.m. registered nurse (RN)-A reviewed refrigerator items in the Dellwood and North Haven kitchenettes and identified these items were available for resident consumption. RN-A stated items are dated when opened or prepared. RN-A stated dietary staff checked products, replenished the supply in the refrigerators and monitored for the appropriate temperatures. RN-A did remove, and dispose of, a gallon container of 1% milk, however, did not remove container of whole milk with approximately 1/2 gallon remaining.

During interview at 3/1/17, at 1:21 p.m., cook-A stated milk products should be dated as soon as they are opened. Milk products can be used seven days after best by date if unopened. If the carton is opened, it may be used seven days after date opened. Cook-A stated that milk cartons are to be labeled with the date opened, however, if one is found that is not dated, it is to be thrown out.

During interview on 3/1/17, at 2:19 p.m. the registered dietitian (RD) stated her role at the facility was as clinical consultant, and that food storage was not her expertise. RD stated that she deferred to the facility policy as to food storage guidelines.

During interview on 3/2/17, at 9:05 a.m. the culinary assistant direct (CAD) stated cartons/containers are to be dated when opened.

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F 371	Continued From page 42 The CAD went on to state dairy products are used quickly and they have not had the concern with milk products going beyond the date. The CAD stated refrigerators are checked by dietary staff twice daily. During interview on 3/2/17, at 9:22 a.m., the CD affirmed that dairy products are not labeled, but the date used for determining product use is the "Best By" date, discarding the products which exceed seven days beyond the date. Although the facilty had multiple items in their kitchenette's refrigerators. The facility was inconsistent in identifying there process if items were to be dated when opened or not, or only to use the best by date. Items in the kitchenette were not consistently labeled when opened, and there were items in the kitchenettes which were seven days beyond the best by date that were available for resident consumption. A policy, titled "GracePointe Crossings FRESHNESS HOW LONG TO KEEP EACH ITEM", dated 5/17/12, identified that "Milk 7 days past 'best by date' on carton." The Minnesota Department of Health Fact Sheet, Date Marking, dated December of 2010, identified under:Date marking of food prepared and packaged in a food processing plant and served in a food establishment. These foods shall be clearly marked with the date the original container is opened and they shall be consumed or discarded within seven days including the day the container is opened.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		4/10/17

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F 441	Continued From page 43 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 44 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed appropriate hand hygiene while providing cares for a resident (R92) and prior to serving coffee to another resident (R42) during 2 of 4 observations of cares on the North Haven unit. Findings include: During observation on the North Haven unit on 3/1/17 at 7:32 a.m., nursing assistant (NA)-A began morning cares for R92. With un-gloved	F 441	Education was immediately provided to staff identified in survey sample. The policy for Hand Hygiene and Glove Use was reviewed and is current. Education on hand hygiene and glove use will be completed for staff by 4/5/17. All staff are educated on infection control practices upon hire, minimally annually and as indicated.	

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F 441	Continued From page 45 hands, NA-A first placed R92's urine-filled catheter bag into the cloth privacy pouch under the wheel chair, then quickly pulled the bag out. NA-A donned (placed on) a pair of gloves and empted R92's catheter bag into a graduate. Still wearing gloves, NA-A cleansed the bag drain tube with an alcohol prep pad and closed bag port, then measured, emptied and flushed the urine into the toilet. NA-A removed her soiled gloves, and without first washing her hands, placed R92's stockings and foot boot on, then gathered a shirt, T-shirt and new pants from his closet. After combing R92's hair and placing his glasses, NA-A bagged and knotted R92's soiled clothing and bed linens, then placed the call light on R92's lap. NA-A clutched the bagged, soiled laundry in her arms and hands, and exited R92's room at 7:45 a.m.. NA-A had not performed any hand washing during cares for R92. Continuing the observation in the North Haven hallway, at 7:45 a.m. while still clutching the soiled bags, NA-A greeted R42, and asked if she wanted a cup of coffee. NA-A entered the soiled utility room and deposited the bags from R92's cares down the laundry chute. Without washing hands, NA-A went from the soiled utility room into the North Haven dining area, retrieved a mug, filled it with coffee from a machine, and served R42, who was seated in a wheel chair in an adjacent dining area, across from the utility room. NA-A had not performed hand hygiene after assisting R92, nor prior to assisting R42. Continuing observation at 7:50 a.m., NA-A returned to R92 in the resident's room, who now requested to use the toilet. NA-A transferred R92 onto the toilet, and with un-gloved hands, removed the catheter bag out of the pouch and	F 441	Facility will monitor and sustain correction by completing hand hygiene and glove use audits on 5% of residents weekly for 2 months. Results of audits will be reviewed at the QAA meeting and will be determined the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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F 441	Continued From page 46	F 441		

positioned R92 over the stool, having lowered his pants and incontinent brief. NA-A then donned gloves, and assisted R92 with face washing, groin and catheter care, peri area cleansing, and application of barrier cream to R92's buttocks. Before transferring R92 back into the wheel chair, NA-A removed her soiled gloves, but did not wash hands. NA-A gathered, bagged then tied additional soiled laundry, linens and garbage into three more bags. Holding the soiled bags in one hand, NA-A pushed R92 in his wheel chair into the hallway, then carried the bags into the soiled utility room for disposal down the laundry chute. Once in the utility room at 8:07 a.m., NA-A disposed of laundry and refuse, then washed her hands.

During an interview on 3/1/17 at 8:10 a.m., NA-A stated she "should have" washed her hands after providing cares for R92, and especially before getting (R42) a cup of coffee. NA-A stated she "never knows" if she can wash her hands in a resident's room, but also stated she at least should use hand sanitizer when going from one resident room to the next. NA-A stated she should have washed her hands after washing and completing catheter cares for R92 and removing her gloves.

In an interview on 3/1/17 at 9:11 a.m., licensed practical nurse (LPN)-A stated hands should be washed when you come to work, when you remove gloves, and really between each resident you help, especially following catheter care. LPN-A stated staff can never wash their hands "too many times."

During interview on 3/1/17 at 2:13 p.m. the director of nursing (DON) stated staff were

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F 441	Continued From page 47 trained on infection control procedures and provided frequent reminders about good hand hygiene. The DON stated staff should have washed hands after providing cares, but certainly before having served food or beverages to a resident, and added when improper hand hygiene was witnessed, there was an "opportunity to discuss" appropriate infection control procedures with staff. A facility policy, Infection Control, Hand Hygiene, dated 2015, indicated appropriate hand hygiene was essential in preventing transmission of infections agents, and was to be performed after touching bodily fluids, secretions, and contaminated items, and whether or not gloves were worn. The document cited specific examples of when hands were to be washed, which included before and after direct resident care, and before and after touching medication of food to be given a resident.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Gracepointe Crossing Gables East was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2017

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 90 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect 12 of 72 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 1:00 p.m. on 03/01/2017, observations revealed that there are two power strips that are being daisy chained	K 511	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. Administrator, Engineering Director and/or designee will be responsible for ongoing compliance.	4/10/17

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K 511	Continued From page 3 and an extension cord found in the Avalon central hall nurses office. This deficient condition was verified by a Maintenance Supervisor.	K 511		
K 712 SS=F	NFPA 101 Fire Drills 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 interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 72 of 72 residents, as well as an undetermined number of staff, and visitors. 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	K 712	Fire drills will be scheduled and conducted quarterly, on each shift. Review of drills will be conducted quarterly by Maintenance to ensure compliance. Administrator, Engineering Director, Maintenance and/or designee will be responsible for ongoing compliance.	4/10/17

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	245120	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2017**

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GRACEPOINTE CROSSING GABLES EAST	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not conducted the Evening Shift fire drill in the second calendar quarter. This deficient condition was verified by a Maintenance Supervisor.	K 712		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag 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."	K 923		4/10/17

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K 923	Continued From page 5 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 the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (12) section 5.1.3.3.4.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 12 of 72 residents as well as an undetermined number of staff, and visitors to the facility. 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.	K 923	Storage shelf was installed to securely store oxygen cylinders that are not in use. Education on proper storage of oxygen cylinders provided to staff on 4/5/17. Administrator, Engineering Director, Maintenance and/or designee will be responsible for ongoing compliance.	

MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00292	A. BUILDING: _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING GABLES EAST	**548 FIRST AVENUE CAMBRIDGE, MN 55008**

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/27/17 through 3/2/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigation(s) were also completed at the time of the licensing survey. An investigation of complaint/s H5120044 and H5120045 was completed. H5120044 was substantiated with correction orders being issued at 4658.0085 and 4658.0520. H5120045 was found to be unsubstantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and	2 000		

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2 000	Continued From page 2 Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		4/10/17

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the responsible party was notified timely of newly developed left knee pain for 1 of 1 residents (R31) reviewed for notification of change. Findings include: R31's BIMS and Delirium assessment dated 9/16/16, identified R31 had a, "Memory problem," with recall and a, "Severely impaired," ability to make decisions regarding tasks of daily life. R31's Admission Record dated 3/2/17, identified family member (FM)-A to be R31's, "Emergency contact # 1," and, "Responsible Party." During interview on 2/28/17, at 2:55 p.m. family member (FM)-A stated she was the responsible party for R31. FM-A stated R31 was not ambulatory and, "Hadn't walked in years," relying on staff for all of her transfers. FM-A stated in the early morning hours of 11/3/16, R31 had been found in bed with her knee bent, "In this odd position," causing the bottom of her foot to be facing her shoulders. FM-A stated R31 had developed significant left knee and leg pain after being found in this position which was later identified to be a fracture in her leg. FM-A stated	2 265	Corrected	

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2 265	Continued From page 4 she was not notified of R31's newly developed leg pain until, "Just before 4 o'clock [p.m.]" on 11/3/16, adding this was, "Upsetting," staff had started treatment of R31's fractured and leg pain before she, as R31's responsible party, had ever been notified of the incident. Further, FM-A stated staff should not have been, "Making decisions without involving me." R31's provided closed record contained two single, undated notes. The first note identified, "DO NOT ADD, D/C [discontinue] OR CHANGE ANYTHING WITHOUT [FM-A] APPROVAL!!!!!!!" The second note directed staff to, "Notify [FM-A] of ANY med/insulin changes," or, " ... if no [bowel movement] in 3 days." R31's progress notes dated 10/26/16 through 11/4/16, identified R31 had no prior complaints of left leg pain in the days leading up to 11/3/16. Further, the progress notes identified the following entries: On 11/3/16, at 3:33 a.m. R31 was first identified with, "C/o [complaints of] left leg pain," and was given Tylenol. At 5:10 a.m. R31 was noted as, "Continuing to call out for help and c/o pain, resident repositioned and warm blanket given." No notification of family was identified in the note after R31 had been having complaints of knee pain for nearly two hours. At 9:25 a.m. R31 was identified to have continued complaints of left leg pain and now, "Had swelling in the left knee," with the nurse placing a call to the clinic and, "Left a message for [R31's primary physician] regarding left knee pain and swelling." A subsequent note at 12:28 p.m. identified,	2 265		

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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 and will be going out of town ..." 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		

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2 265	Continued From page 6 family members after speaking with the physician adding she had no concerns with how FM-A had been notified of R31's developed leg pain. A facility Change of Condition Family of Responsible Party Notification policy dated 11/16, identified a purpose to, "Notify family and/or resident representative any time there is a," and listed several options which included, "Change in condition." The policy identified a procedure which included, "From 10:00 p.m. to 8:00 a.m. the designated party will be notified if more than a nursing intervention is needed. Check the medical record for specific family/responsible party instructions regarding notification. Designated party should be notified the next day in a timely manner." Further, the policy directed staff to, "Document, in the resident's medical record, the time called, the person spoke with, what was reported and their response, if any," adding if staff were unable to reach the responsible party to, " ... continue to call in 2-hour increments until party has received the message," and, "Document each time you call." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding the timely notification of family members with changes in health status; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		4/10/17

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2 830	Continued From page 7 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on 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: R31's quarterly Minimum Data Set (MDS) dated 9/7/16, identified R31 required extensive assistance with activities of daily living (ADLs), and had dementia but with no current infections. Further, the MDS identified a section labeled, "Prognosis," with a question listed as, "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" This was answered as, "No." R31's Provider Orders for Life Sustaining Treatment (POLST) dated 9/10/14, identified R31 was DNR (Do Not Resuscitate) and included a section labeled, "Goals of Treatment," with several options to be checked to identify the resident's corresponding wishes. A hand written,	2 830	Corrected	

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2 830	Continued From page 8 "X" marking was placed next to, "Limit interventions and treat reversible conditions." Further documentation at that section included, "Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions." The option of, "Comfort Care" was left unchecked. R31's BIMS (Brief Interview for Mental Status) and Delirium assessment dated 9/16/16, identified R31 had a "Memory problem" with recall and a "Severely impaired" ability to make decisions regarding tasks of daily life. During interview on 2/28/17, at 2:55 p.m. family member (FM)-A stated she was power of attorney (POA) and the responsible party for R31's care. FM-A stated (R31) had not been on comfort care at any time and wanted treatments for reversible conditions adding R31 had seen her primary physician, "About a month prior [to her death]." FM-A said R31's primary physician had commented at that time that he was "amazed at her health." FM-A stated on the weekend of 11/5/16, R31 had developed, "Some kind of infection" with several symptoms including an unrelieved fever and rash. FM-A said it demonstrated, "Something bad is going on and it needs to be addressed." FM-A stated she had received a call on 11/7/16, from staff in which R31 was described to be, "Not acting herself," and FM-A advised staff R31 needed, "To go to the hospital right away." FM-A stated R31 was transferred to the hospital where the physician identified she had sepsis (a massive immune response to a infection in the blood) infection, and then died. FM-A stated was upset and felt the nursing home staff should have recognized the signs and symptoms of infection in R31.	2 830		

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2 830	Continued From page 9 R31's care plan dated 9/21/16, identified R31 had an self care performance deficit and required assistance to complete all ADLs (activities of daily living) with impaired mobility and cognition adding R31 to be, "Resistive to care,"' at times. The care plan identified R31 had high blood pressure, heart failure, and at risk for fluid volume deficit directing staff to monitor R31 for, "Electrolyte imbalance which may include weak pulse, changes in cognition, changes in my blood pressure," and report these to the physician, "As needed." R31 was identified with, "Impaired cognitive function/dementia," and identified, "I [R31] need my POA with all decision making." R31's developed care plan did not identify R31 was on comfort care or had a terminal condition with a life expectancy of less then six months. R31's Progress Notes dated 9/20/16, identified R31 had been seen in the clinic by her primary physician. The physician identified R31 to be, "Eating and drinking fairly well," with pulse recorded at 60 beats per minute, and her, "Chest is clear, no wheezing or rales." Further, the note identified R31 was to return for a recheck in two months. The note did not identify R31 was to be on comfort cares, have a life limiting illness, or have a life expectancy of less than six months. R31's CMC (Cambridge Medical Center) Discharge Summary dated 11/3/16, identified R31 was an elderly female, "With dementia on comfort care," who had persistant left leg pain in which a "Spiral, displaced fracture of the distal femoral diaphysis," was identified on X-ray. The summary identified no surgery was performed and R31 returned to the nursing home. R31's condition was identified at the time of discharge as, "Stabilized," and provided recommendations to follow up with appointment(s) to address, "Wt	2 830		

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	00292	A. BUILDING: _____ B. WING _____	C 03/02/2017

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2 830	Continued From page 10 [weight] bearing advancement and splint discontinuation plans." R31's rehabilitation potential was listed as, "Fair," and directed, "At the skilled nursing facility let your healthcare providers know if you notice any changes in your condition." Further, R31's, "Discharge Day Exam," identified her lung sounds as, "CTA [clear to auscultation] bilaterally," and R31's vital signs were recorded as: Blood Pressure 202/126; Pulse 90; Temperature 97.8 (F); and Respirations 20. The discharge summary lacked any dictation of R31's responsible party having wished for comfort cares, or any dictation on changing her POLST from her prior identified wishes on her POLST dated 9/10/14. R31's facility report labeled Follow Up Question Report dated 11/1/16 through 11/7/16, identified recorded meal intakes for R31 during the review period. R31 had consumed, "76-100%" for two of three meals provided daily from 11/1/16, to 11/3/16. On 11/4/16, R31 refused breakfast but consumed, "26-50%" of lunch and, "0-25%" of the evening meal. On 11/5/16, R31 was identified as, "Resident refused," for all three meals. On 11/6/16, R31 was identified as consuming, "76-100%" of breakfast but only, "0-25%" of the lunch meal and refused the evening meal. R31 consumed no meals on 11/7/16, according to the provided report. R31's Medication Administration Record (MAR) dated 11/1/16 through 11/7/16, identified R31 had orders for, "Lantus Solution [long acting insulin] ... Inject 6 units subcutaneously one time a day ...," and was administered as ordered from 11/1/16, through 11/5/16. The MAR identified the ordered insulin was not administered on 11/6/16 and directed, "Other / See Nurses Notes."	2 830		

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2 830	Continued From page 11 The MAR had no active orders identified for antibiotic (medication used to inhibit the growth of, or destry microorganisms) therapy administration from 11/1/16, through 11/7/16. Further, the MAR identified R31 had orders for, "NovoLOG Solution [short acting insulin, often lasting a total of six to eight hours] ... Inject per sliding scale: if 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 900 = 10 units," and directed staff to, "Notify MD [medical doctor] if over 500." The order identified the dose administered with the corresponding blood glucose (BG) reading as below: - In the morning of 11/3/16, R31 had a BG reading of 102 mg/dl (milligrams per deciliter; normal fasting BG range is 70-100mg/dl) and was not administered insulin. In the afternoon of 11/3/16, R31 had a BG reading of 319 and was administered eight units of Novolog. - In the morning of 11/4/16, R31 had a BG reading of 272 and was administered six units of Novolog. In the afternoon of 11/4/16, R31 had a BG reading of 329 and was administered eight units of Novolog. - In the morning of 11/5/16, R31 did not have a BG obtained, instead the MAR directed, "Parameters out of range," with no treatment being identified. In the afternoon of 11/5/16, R31 had a BG reading of 402 and was administered 10 units of Novolog. - In the morning of 11/6/16, R31 again did not have a BG obtained, instead the MAR directed, "Parameters out of range," with no further information was identified. In the afternoon of 11/5/16, R31 had a BG reading of 593 and was	2 830		

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2 830	Continued From page 12 administered 10 units of Novolog. Further, on 11/6/16, two additional, "One Time," orders were identified which identified R31 had an additional 20 units of Novolog administered at 5:19 p.m. with an additional 10 units of Lantus being administered at 8:35 p.m. to R31. - In the morning of 11/7/16, R31 had a BG reading of 461 and was administered 10 units of Novolog. In the afternoon of 11/7/16, R31 did not have insulin administered and was identified as, "Hospitalized." R31's medical record identified to the following progress note(s) and fax communications after R31's return from the hospital on 11/4/16: - On 11/4/16, R31 arrived back from the ER at 1:30 a.m. with, "Confirmed Left spiral displaced fracture of distal femoral diaphysis." R31 was identified to, "Have c/o [complaints of] pain with minimal movement." Further, R31 had a, "Pinpoint rash from fingertips to just above the elbow." - On 11/4/16, R31 was identified to be, "On comfort cares - no therapy ordered." Further, the note identified R31, "Was in a lot of pain and hurting," however, refused to take medications, including a single dose of insulin, when offered. - On 11/5/16, R31 was identified as, "C/o pain in left leg, repeatedly calling out for help." - On 11/5/16, a "Culinary," note identified R31 had been in bed for meals, along with a subsequent note which identified, "[R31] ate less than 25% of meal," however, ate some ice cream at bedtime. - On 11/6/16, R31 was identified to eat, "Less	2 830		

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2 830	Continued From page 13	2 830		

than 25% of meals," and staff were encouraging fluids. Further, on 11/6/16 at 2:35 p.m. an entry identified, "[R31] had slight fever on [night] shift. In AM had fever of 100.7 tympanic (ear). After lunch resident had increased respiratory rate of 28. Other vs [vital signs] were as follows: Pulse 102. Oximeter saturation 94%. Temp 100.3 tympanic. B/P 118/54. Lung sounds sonorous [low pitched, coarse, loud sound caused by narrowing of the airways or an obstruction]. No crackles. Resident was up in wheelchair for 4 hours." Further, on the same date at 5:18 p.m. R31 received, "One time only order of 20 units [Novolog, a fast action insulin] given for BG [blood glucose] 593," and six units of Lantus (another insulin) for a, "One time only order due to hyperglycemia [high blood sugar]."

- On 11/6/16, "On-call physician called due to resident being febrile and hyperglycemia. Temp of 100.3F at [2:00 p.m.], Temp of 100F at [4:30 p.m.]. Resident's BG at [4:30 p.m.] was 593. On call [name identified] gave orders to give 20 units of Novolog instead of sliding scale and to give 10 units of Lantus at HS [bedtime] instead of 6 units. Resident's temp at [8:30 p.m.] was 99.9F and BG was 202. Resident had perspiration [sweating] all shift." The note identified staff provided water to R31 and schedule pain medications adding, "Will continue to monitor." The note lacked information if the physician had been informed of R31's elevated respiratory rate, coarse lung sounds, or the elevated blood sugar readings in the absence of substantial intake.

No fax communications were identified in R31's medical record regarding the notification of the on-call physician in the progress note on 11/6/16.

- A MD/NP Order Form fax communication dated

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2 830	Continued From page 14 11/4/16, identified staff faxed regarding, "Resident came back from ER with pinpoint rash on [right] arm from fingertips to elbow." The physician' response was hand written as, "No recommendation," and signed with a response date of 11/7/16 and time stamped as being sent at 9:16 a.m. - On 11/7/17, R31 was visited by the activities aide who identified at 2:35 p.m. to be, "Not feeling well," with a nurse telling them, "[R31] isn't doing good." - A MD/NP (medical doctor / nurse practitioner) Order Form fax communication dated 11/7/16, at 11:30 a.m. identified R31 had a fever which, "Began on weekend with 99. + [above] on 11/5/16 early AM - [increased] 100.7 + before noon, [decreased] 100.3 [increased] on 11/6/16 ... Tylenol ineffective. Now diaphoretic with decreased responsiveness. Not eating or drinking. Left message for [FM-A]. Blood glucose 593 at [4:00 p.m.] on 11/6/16 and 461 at [7:30 a.m.] on 11/7/16. Both covered with sliding scale insulin." R31's primary physician responded on 11/7/17, with the following hand-written note, "My suggestion if she is comfort cares to use comfort cares. If family wants agressive [sic] treatment she them need to be sent to the ED [emergency department]." The faxed physician response was not time stamped. - On 11/7/17, at 2:44 p.m. R31 was identified to have, "Not reacted well to her broken femur. She had fevers on the weekend of 99. [sic] tympanic on 11/5 [night], increased up to 100.7 in AM and 11/6 temp was 100.3. On 11/7 temp was 99 and resident was diaphoretic. Level of conscious (LOC) was decreased throughout shift. Resident did not get out of bed. Resident ate very little due	2 830		

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2 830	Continued From page 15 to decreas3ed [sic] LOC. Resident only drank honey thick juice with spoon feeding. Blood glucose 593 at [4:30 p.m.] on 11/6 and 461 at [7:30 a.m.] on 11/7. Both covered with sliding scale insulin. Message left for [FM-A] in AM without response until afternoon. Dr. was notified with fax and suggested comfort care. If family wants aggressive treatment she will need to be sent to the ED [emergency department]. This was explained to [FM-A], who said she would call Dr's office and call us back with answer about transfer to ED." - On 11/7/17, at 3: 25 p.m. R31 was identified as, "Being transported to the ED," with her vital signs listed as, "B/P 88/48, pulse 91, resp 28, temp 98.3 tympanic, Oximeter saturation 97%." The note identified R31 had, "Pinpoint rash on right arm," and was, "Diaphortic [sic] and cool to touch." Further, a subsequent note on 11/7/16, identified, "CMC [medical center] called at [9:05 p.m.] to notify us that resident passes away at [8:34 p.m.]." R31's History & Physical (H&P) dated 11/7/16, at 8:06 p.m. identified R31 had, "Presented to [medical center] for evaluation," for a chief complaint of, "Fever," adding FM-A as R31's identified POA. R31 was identified as, "... less responsive and febrile." R31 was, "Found to be in multisystem organ failure and met severe sepsis criteria [lactate 7.9 (normal range in unstressed patient is 0.5 - 1 mmol/L)]," adding R31 was admitted to the hospital. The assessment identified a review of systems (ROS) was unable to be completed, "Secondary to unresponsive state," and listed a, "Patient Active Problem List" which included, "Severe sepsis with acute organ dysfunction," "Multi-organ failure with heart failure," "Acute hypernatremia [elevated	2 830		

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2 830	Continued From page 16	2 830		

sodium level]," and, "Metabolic acidosis." The identified, "Date Noted," for each diagnosis was listed as 11/7/16. The assessment listed a physical examination completed by the physician which included a blood pressure of 83/45, pulse 127, temperature of 99.2, and respirations of 26 adding R31 to be, "Non responsive," and her skin to appear, "Mottled and lacy rash of right medial thigh." The assessment identified several laboratory values which were collected on 11/7/16, and compared them to the laboratory values collected on 11/3/16, which included a white blood cell (WBC) count of 24.5 (normal range 4.5 to 10) compared to 11.2 prior on 11/3/16, and a sodium level of 152 compared to 140 prior on 11/3/16. Further, an assessment and plan was listed for, "Severe sepsis with acute organ dysfunction," and identified R31 would be admitted to the hospital which was, "Discussed at length with [FM-A] the poor prognosis given her age and multisystem failure," adding, "Family would like minimally invasive measures such as antibiotics and IVF [IV fluid] ..."

R31's undated Minnesota Department of Health (MDH) Documentation of Death record identified R31 expired while, "Inpatient," at a hospital and listed the, "Immediate Cause [final disease or condition resulting in death]," as, "Sepsis."

When interviewed on 3/1/17, at 9:51 a.m. nursing assistant (NA)-B stated she frequently worked with R31. NA-B stated on the weekend of 11/5/16, she noticed R31, "Wasn't feeling good," and to be, "Pale," and, "Not herself." R31 was warm to touch, and was not eating or drinking like she had been before. NA-B stated the nurses were involved in her care that weekend, and added, she was not aware of R31 to have a terminal condition or be on comfort cares during

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2 830	Continued From page 17 the last weeks of her stay at the facility. During interview on 3/1/17, at 12:22 p.m. registered nurse (RN)-A stated she had been the nurse who contacted the physician on 11/6/16, as recorded in the progress note entered into R31's medical record, "That was me." RN-A stated she reported to the physician R31's elevated blood sugars, elevated temperature and diaphoresis (sweating). RN-A stated it to be, "Unheard of [R31] to be in the 400's [blood sugar]," and recalled R31 to be, "Not herself at all that day," adding R31 had a newly visible, "Pinpoint red rash," on her lower forearms as well. However, RN-A stated she did not verbally report R31's additional abnormal symptoms to the physician including the elevated respiratory rate, the developed rash since R31's return from the hospital, coarse lung sounds, or the fact in which R31's blood sugars were elevated despite consistent meal intake adding, "No, I did not." RN-A stated any completed nursing assessments of R31's condition would be documented in the progress notes; however, RN-A stated she was unable to locate any assessment which comprehensively addressed all of R31's identified changes. RN-A stated she should have completed a, "Full nursing assessment before I contact[ed] them [physician]." RN-A stated R31 was not on comfort care or considered to be in a terminal condition when she notified the physician on 11/6/16, adding R31's death at the hospital on 11/7/16, to be, "A complete surprise." When interviewed on 3/1/17, at 2:03 p.m. RN-B stated she was the assigned care manager for R31 during the final weeks of her life in the facility. RN-B stated R31 was not on comfort care and had no identified terminal condition. RN-B reviewed R31's progress notes in the	2 830		

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2 830	Continued From page 18 medical record and stated R31 appeared to of, "Fevered through the weekend," starting on 11/5/16. RN-B stated there was, "No defined plan of care," for how staff should have treated R31 from reviewing progress notes in the record. RN-B stated their was no evidence a comprehensive assessment of R31's condition had been completed in the medical record to ensure appropriate medical treatment was sought or implemented. RN-B stated the documented information presented to the physician over the telephone on 11/6/16 was, "Not completely" accurate and lacked the increased respirations, coarse lung sounds and continued hyperglycemia in the absence of substantial meal intake adding, "Better information could be given." On 3/2/17, at 1:05 p.m. the director of nursing (DON) was interviewed. The DON stated R31's signed POLST identified R31 to be a DNR, however, further listed R31 wanted treatment of potentially reversible conditions adding the POLST did not provide any direction to not hospitalize R31 for any reason. The DON stated R31 was not treated prior to her hospitalization on 11/7/16, as her health care directive (HCD) identified she wanted to have a natural death in the event of a terminal condition. The DON stated R31 had, "A change in condition," adding the on-call physician contacted on 11/6/16, was not R31's primary physician and she expected, "The nurse taking care of [R31]," to, "Give an assessment of the resident at that time." The DON stated the on-call physician was responsible, not the nursing home staff, to review R31's past information to be included in their assessment of the residents condition. The DON stated she was unsure if the on-call physician was aware of the entire clinical picture R31 displayed. The DON stated R31's progress notes	2 830		

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2 830	Continued From page 19 reflected what, "Could be a sign of infection," and she expected her staff, "Would include pertinent information," in speaking to the physician when trying to determine treatment options. During a telephone interview on 3/3/17, at 1:16 p.m. MD-A stated he had been the primary physician for R31 for the past couple years and knew her, "Very well." R31 had been last seen in the clinic for examination on 9/20/16, and was noted to be eating and drinking well, have no abnormal vital signs and be, "Kinda her baseline self." MD-A stated R31 was not on comfort cares, "At that time," nor had he ever discussed comfort cares with R31's family before adding, "[I] don't remember ever putting her on comfort care." MD-A stated R31's hospital discharge (dated 11/3/16) identified R31 to be on comfort care, however, MD-A stated he was not sure where the directive came from, adding if the hospital physicians discussed comfort care with R31's family during her hospitalization on 11/3/16, it should be documented on the discharge summary. MD-A stated the hospital physician, "May have assumed she was on comfort care." Further, MD-A stated sepsis infection can be reversible if identified and treated. A facility Change of Condition Physician Notification Policy dated 11/16, identified a purpose, "To notify the physician any time there is," and listed several examples which included a, "Significant change in clinical condition ...," and, "Any other time there has been a significant change in status from the plan of care." The policy listed a procedure which included, "Any significant change in status must be reported to the medical team immediately which may be life threatening in nature or risk to self or others," and advised, "A 911 call may be initiated without a	2 830		

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2 830	Continued From page 20 physician's order according to the nurse's discretion if the emergency is life threatening ...." The policy directed staff to, "Document, in the resident's medical record, the time called, the person spoke with, what was reported and their response if any." Further, the policy provided several examples of a resident' potential change in condition and corresponding interventions which included an example of, "Any unusual Change in Status and/or New Onset of behavior Requiring Interventions ...," and directed, "Monitor for symptoms of infection. Look for precipitating factors that could have led to the behavior, implement interventions and monitor effectiveness." A facility policy on comprehensive nursing assessment with changes in condition was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop/review the facility policy on comprehensive nursing assessment then inservice staff regarding ensuring a comprehensive nursing assessment is completed with any change in condition and medical staff are consulted timely to implement treatment. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		4/10/17

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GRACEPOINTE CROSSING GABLES EAST	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. 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. Findings include: R96's admission Minimum Data Set (MDS) dated 11/14/16, identified R96 had moderate cognitive impairment, and required extensive assistance with activities of daily living (ADLs). Further, the MDS identified R96 had renal insufficiency, was on palliative care, and was at risk for pressure ulcer development, however, had no current pressure ulcers. R96's Body Audit dated 11/8/16, identified the audit was R96's, "Admission body audit," and described several areas of bruising on R96's abdomen, elbow and forearm. The audit did not identify R96 had any pressure ulcers or areas or	2 900	Corrected	

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2 900	Continued From page 22 reddened skin. R96's pressure ulcer Care Area Assessment (CAA) dated 11/21/16, identified the CAA, "Triggered due to level of assist with bed mobility, bowel incontinence and high risk for pressure ulcers," listing R96 to have, "Potential," for pressure ulcer development. Further, the CAA identified the risk of pressure ulcers would be addressed on R96's care plan and directed the, "Overall objective," was to, "Minimize risks." R96's Skin Risk and Braden assessment dated 11/9/16, identified R96 was at, "High Risk" of pressure ulcer formation with several risk factors listed including, "Assistance required with ADL's," and, "Uses medication which impact skin conditions ..." The assessment contained a section labeled, "Lower Extremity Concerns," and identified R96 had no signs of symptoms of arterial disease, venous insufficiency or neuropathy and contained an, "Analysis and Summary," section which identified, "[R96] is an A1 [assist of one] Q3H [every 3 hour] repositioning, unable to make frequent and major positional changes [independently]. Pressure reduction mattress in bed. Currently on bed rest." Further, the assessment identified an "Interventions," field and listed, "A1 Q3H repositioning, pressure reduction mattress in bed," with those being identified as, "New interventions," under a subsequent, "Evaluation of interventions," field. R96's progress note dated 11/21/16, identified R96 developed, " ... a non-open, red, non-blanchable area on coccyx measuring 2cm [centimeters] [by] 2cm," and listed a treatment of barrier cream.	2 900		

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2 900	Continued From page 23 MDS definition: Stage one pressure ulcer, an observable, pressure- related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Non-blanchable: Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. R96's Body Audit dated 11/22/16, identified R96 had a bed bath completed with her coccyx being red. R96's care plan dated 11/28/16, identified R96 was admitted to hospice after sustaining a fall with subsequent fractures and required assistance with dressing, bed mobility and transfers. Further, the care plan identified R96 was, " ... at risk for impaired skin integrity," and directed staff to assess R96's risk status, "Per policy, upon admission, quarterly and as needed," and apply a dermasaver (skin care device) under her right leg while in bed. The care plan did not identify R96 had any current pressure ulcers or history of pressure ulcers, despite the identified pressure ulcer on the progress note dated 11/21/16. R96's medical record identified the following subsequent Body Audit(s) had been completed: - On 12/6/16, identified no red areas on R96's skin with, "No skin integrity issues noted," and; - On 12/20/16, identified R96 had, "No new skin integrity issue [sic] noted," and;	2 900		

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2 900	Continued From page 24 - On 1/3/17, again identified R96 had, " ... no new skin integrity issue noted." Review of R96's progress notes dated 11/22/16 through 1/9/17, did not identify skin monitoring had been completed besides the completed Body Audit(s) identified above. There was no indication of when the 11/21/16 pressure ulcer healed, or if it had not healed, along with a description of the pressure ulcer. The skin assessments were completed every 2 weeks and not weekly even though R96 as at risk for pressure ulcer development and had a pressure ulcer on 11/21/16. R96's Body Audit dated 1/10/17, identified R96 had an, "Area of alterations in skin integrity," and listed her, "Coccyx," to have, "1.2 cm]by] 1.2 cm stage 2 [partial thickness skin loss] pressure ulcer has been earlier documented. Area covered with Tegaderm." A subsequent Skin Risk and Braden assessment dated 1/10/17, identified R96 remained at, "High Risk" for pressure ulcer development and again listed several risk factors including, "Assistance required with ADL's," and, "Uses medication which impact skin conditions ..." A section labeled, "Tissue Tolerance and Evaluation of Support Services," identified R96 had no preferences or resistance to any particular positions, and staff were, "Unable to determine," R96's preferences for sleeping during the night. R96 was identified to use pillows and pressure reduction mattress in bed, and had no changes in tissue sensation from the previous assessment(s). An, "Analysis and Summary," section identified, "[R96] is an A1 Q3H repositioning, unable to make frequent and major positional changes [independently]. Pressure	2 900		

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2 900	Continued From page 25 reduction mattress in bed. Currently on bed rest resident has the option to get out of bed. Resident prefers to remain in bed." Further, the identified, "Interventions," listed, "A1 Q3H repositioning, pressure reduction mattress in bed. Pillows utilized for repositioning." with, "New open area to coccyx," being identified in the spacing labeled, "Evaluation of interventions." Although the facility did an assessment after P96's pressure ulcer developed, the assessment did not identify any changes to the interventions that she had previously despite R96 re-developing a pressure ulcer on her coccyx on 1/10/17. R96's Wound Assessment Flow Sheet dated 1/17/17, identified R96 had a stage 2 pressure ulcer on her coccyx which measured 1.3 cm by 1.0 cm in size. The space to record depth was left blank. The ulcer was identified to have 50% granulation tissue (healthy, red tissue) and 50% slough (dead tissue) in the wound bed, with no tunneling or undermining. Further, the flow sheet identified R96 was on a, "Positioning plan," and used a , "Pressure Relieving Mattress/Device." There were no changes to the interventions for R96's pressure ulcer. R96's PCC (PointClickCare; a system of medical record) Skin & Wound - Wound Assessment dated 1/25/17, identified R96 to have a pressure ulcer on her coccyx having developed, "In-House," on 1/10/17. The pressure ulcer was measured at 2.2 cm (area) by 1.88 cm (length) by 1.6 cm (width) having no recorded depth, undermining or tunneling. The wound bed was described as 10% (percent) granulation tissue (healthy, red tissue) and 90% slough (dead tissue) with no eschar being present. The ulcer	2 900		

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2 900	Continued From page 26 had light drainage with no odor; and R96 denied pain at the site. The assessment identified a, "Goal of Care," to be, "Monitor/Manage," and listed a treatment of cleansing with normal saline and application of a foam dressing and, "Additional Care," options including a, "Mattress with pump," and, "Turning/Repositioning program." The note identified these measurements were recorded using an, "Electronic method," and some discrepancies were expected from previous measurements. When interviewed on 3/2/17, at 11:02 a.m. nursing assistant (NA)-C stated R96 admitted to the facility with several fractures and, "Did not like to get out of bed." NA-C added R96 was repositioned, "Every two or three hours," on her shift adding R96 did not like to be positioned on her back. NA-C stated timely repositioning had, "Probably not," been completed for R96 consistently as staff were, "Not following the care sheets," at times adding she had noticed on several occasions the repositioning tracking sheets were left blank from other shifts. The repositioning sheets identified by NA-C were requested; however, the facility would not provide them. During interview on 3/2/17, at 2:30 p.m. licensed practical nurse clinical coordinator (LPN)-A stated a comprehensive assessment of pressure ulcer risk would include, "All systems of the body," with a review of the current interventions being used. LPN-A stated R96 should have had a skin assessment completed weekly, however, this was not completed. When interviewed on 3/2/17, at 3:13 p.m. the director of nursing (DON) stated nursing staff	2 900		

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2 900	Continued From page 27 should, "Look at her [R96] interventions," as part of the completed assessments with, "This new wound." Further, DON stated she expected staff to update R96's interventions after developing a new pressure ulcer as, "Clearly what we had needed a change." A facility Skin Integrity Management Policy dated 1/17, identified the facility would, " ... properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injuries," and directed staff to complete a Braden Scale, Skin Risk Assessment and Tissue Tolerance Evaluation upon admission and, "...with new onset of pressure ulcer/injury and with a significant change in status." Further, the policy directed the collected information, " ... will be included in the assessment process as conducted on admission to the facility, annually, with significant change ... and with the emergence of a new pressure ulcer/injury." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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21080	Continued From page 28	21080		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. 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. Findings include: During the initial tour of the kitchen on 2/27/17, at 9:36 a.m. dairy products were noted to be outside of the parameters of the Best By date identified on the product in 2 of 2 day room refrigerators. North Haven: During the initial tour, on 2/27/17, at 9:40 a.m. the following was noted in the refrigerator: *A half gallon container of skim milk, with one half of the container remaining (one quart) with a Best By date of 2/17/17. The carton was undated as to when this was opened. *One half gallon container of skim milk, unopened, with a Best By date of 2/21/17. *One gallon of whole milk with 1/2 remaining with a Best By date of 2/22/17. The carton was undated as to date opened.	21080	Corrected	4/10/17

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21080	Continued From page 29 *One gallon of whole milk-1 gallon container, unopened, with the Best by date of 2/26/17. On 3/1/17, at 9:12 a.m. the following was noted: *One half gallon of fat free milk, with approximately 1 serving missing with the Best By date of 2/21/17. The carton was undated as to date opened. Dellwood : On initial tour 2/27/17, at 9:45 a.m. noted the following: *One gallon of whole milk, with 1/2 gallon remaining, with a Best By date of 2/26/17. There was no date indicated when opened. *One gallon of 1% milk, with 1/4 gallon remaining (approximately one quart), with the Best By date of 2/23/17. The carton was not dated to indicate date opened. On 2/28/17, at 3:08 p.m. noted the following dairy products were available for resident: *One gallon of 1% milk, with 1/8 gallon remaining (approximately one quart), with the Best By date of 2/23/17. The carton was not dated to indicate date opened. *Whole milk- 1 gallon container-approximately 2/3 full-Best By date of 2/22/17. Carton was undated as to date opened. On 3/1/17, at 9:25 a.m. noted the following: *One gallon of 1% milk,with only small amount remaining barely covering the bottom with a Best By date of 2/22/17. Carton was undated as to date opened. *One gallon of whole milk-1 gallon container-approximately 1/2 gallon remaining (two quarts) with a Best By date of 2/22/17. The carton was undated as to date opened.	21080		

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21080	Continued From page 30 During initial tour of the kitchen on 2/27/17, at 9:36 a.m., the culinary director (CD), stated milk may be used for 7 days after the "Best By" date. The CD stated milk cartons are not dated, but the Best By date is used as reference date. During interview on 3/1/17, at 9:56 a.m. while reviewing the supplies in the refrigerator, nursing assistant (NA)-D stated the food in the kitchenette's were available for resident use. The refrigerator is stocked by the dietary department. NA-D stated anything opened is dated with a permanent marker. NA-D stated that if an item is undated, it should be discarded. At this time, no food items were removed by staff. During interview on 3/1/17, at 10:02 a.m. registered nurse (RN)-A reviewed refrigerator items in the Dellwood and North Haven kitchenettes and identified these items were available for resident consumption. RN-A stated items are dated when opened or prepared. RN-A stated dietary staff checked products, replenished the supply in the refrigerators and monitored for the appropriate temperatures. RN-A did remove, and dispose of, a gallon container of 1% milk, however, did not remove container of whole milk with approximately 1/2 gallon remaining. During interview at 3/1/17, at 1:21 p.m., cook-A stated milk products should be dated as soon as they are opened. Milk products can be used seven days after best by date if unopened. If the carton is opened, it may be used seven days after date opened. Cook-A stated that milk cartons are to be labeled with the date opened, however, if one is found that is not dated, it is to be thrown out. During interview on 3/1/17, at 2:19 p.m. the	21080		

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21080	Continued From page 31 registered dietitian (RD) stated her role at the facility was as clinical consultant, and that food storage was not her expertise. RD stated that she deferred to the facility policy as to food storage guidelines. During interview on 3/2/17, at 9:05 a.m. the culinary assistant direct (CAD) stated cartons/containers are to be dated when opened. The CAD went on to state dairy products are used quickly and they have not had the concern with milk products going beyond the date. The CAD stated refrigerators are checked by dietary staff twice daily. During interview on 3/2/17, at 9:22 a.m., the CD affirmed that dairy products are not labeled, but the date used for determining product use is the "Best By" date, discarding the products which exceed seven days beyond the date. Although the facilty had multiple items in their kitchenette's refrigerators. The facility was inconsistent in identifying there process if items were to be dated when opened or not, or only to use the best by date. Items in the kitchenette were not consistently labeled when opened, and there were items in the kitchenettes which were seven days beyond the best by date that were available for resident consumption. A policy, titled "GracePointe Crossings FRESHNESS HOW LONG TO KEEP EACH ITEM", dated 5/17/12, identified that "Milk 7 days past 'best by date' on carton." The Minnesota Department of Health Fact Sheet, Date Marking, dated December of 2010, identified under:Date marking of food prepared and packaged in a food processing plant and	21080		

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21080	Continued From page 32 served in a food establishment. These foods shall be clearly marked with the date the original container is opened and they shall be consumed or discarded within seven days including the day the container is opened. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) or registered dietician (RD) could review and revise policies regarding safe milk storage and then inservice staff to ensure products are consumed or used by their 'best-by' dates; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,	21535		4/10/17

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21535	Continued From page 33 Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent 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. Findings include: R66's admission Minimum Data Set (MDS) dated 4/13/16, identified R66 had moderate cognitive impairment and had no trouble falling or staying asleep. During interview on 3/1/17, at 9:04 a.m. R66 stated she slept, "Wonderfully" during the night, adding she typically went to bed around 8:00 p.m.,watched television for a couple hours and fell asleep without trouble. Further, R66 stated she takes, "A lot of medications," and added she was unable to remember what they all were or why she takes them. R66's Medication Administration Record (MAR) for December 2016, identified an order for "Trazodone HCL [hydrochloride] tablet [antidepressant medication used for insomnia]," with a dose of 25 mg (milligrams) taken by mouth as needed for Insomnia [inability to sleep]. Further, the MAR directed, "Document non-drug	21535	Corrected	

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GRACEPOINTE CROSSING GABLES EAST	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 34	21535		

interventions tried prior to administering the PRN medication. Document if tried warm milk, warm blanket, snack and if it was effective or not effective." Further, the MAR identified the following administrations of PRN Trazodone to R66:

In December 2016, R66 received PRN Trazodone five times, on 12/3/16, 12/4/16, 12/16/16, 12/26/16, and 12/30/16. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the administration of PRN Trazodone 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.

In February 2017, R66 received PRN Trazodone six times, on 2/2/17, 2/4/17, 2/5/17, 2/16/17, 2/19/17, and 2/22/17. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the administration of PRN Trazodone for all of the dates it was administered in February.

R66's medical record was reviewed and lacked a comprehensive assessment of R66's sleep to demonstrate the need for a PRN medication for sleep.

R66's care plan dated 2/8/17, lacked any identified focus, goals or interventions to address R66's sleep despite her being on an as needed medication for sleep.

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21535	Continued From page 35 When interviewed on 3/2/17, at 2:07 p.m. registered nurse (RN)-C stated R66 was currently taking Trazodone as needed for sleep, being started on the medication back in September 2016. RN-C stated the medication was used when non-pharmacological interventions such as warm milk and snacks were not effective to help R66 sleep. RN-C reviewed R66's MAR with administration dates and acknowledged the lack of documented non-pharmacological interventions despite the MAR directing staff to document them adding staff, "Should be," recording their interventions and effectiveness prior to administering R66 the PRN Trazodone. During interview on 3/2/17, at 2:43 p.m. licensed practical nurse clinical coordinator (LPN)-A stated nursing staff should be attempting to provide non-pharmacological interventions, like warm milk and snacks, before the as needed Trazodone was administered and document them accordingly. LPN-A reviewed R66's MAR and stated it lacked documentation of non-pharmacological interventions attempted prior to the administration of the Trazodone. Further, LPN-A stated R66's progress notes lacked documentation of any non-pharmacological interventions attempted prior to the medication administration adding, "The progress notes should show the entire picture." In a subsequent interview on 3/2/17, at 3:41 p.m. LPN-A stated the facility did not have a formal sleep assessment because R66 continued to occasionally request Trazodone for insomnia, so they felt R66 continued to need the Trazodone. When interviewed on 3/2/17, at 3:22 p.m. director of nursing (DON) stated staff should be	21535		

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21535	Continued From page 36 documenting non-pharmacological interventions prior to giving the as needed medication for sleep. A facility Psychoactive Medication and Unnecessary Medication Use Policy, last reviewed 11/2016, indicated each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used without adequate monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding the comprehensive assessment of sleep and providing non-pharmacological interventions prior to administering as needed medications; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services	22000		4/10/17

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22000	Continued From page 37 providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures to ensure allegations of potential	22000	Corrected	

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22000	Continued From page 38 misappropriation of resident funds were immediately reported to the State agency for 1 of 5 residents (R94) whose allegations were reviewed. Findings include: The facility Vulnerable Adult Abuse Prevention Plan policy dated 12/2016, identified a purpose to, "Establish the policies, procedures and responsibilities for protecting all adults who are dependent upon this facility for health services and/or a safe environment in which to live," adding the plan was developed, "In accordance with state and federal regulations." The policy identified each resident, " ... has the right to be free from verbal, sexual, physical, and mental abuse" and listed several examples including misappropriation of resident property. The policy identified a section labeled, "III. Identification," and listed several, "Other Definitions of Abuse," with a heading of, "Financial or Material Exploitation (Misappropriation of resident property)" being included. The text under the heading provided a definition of, "Illegal or improper use of an individual's funds, property or assets without informed consent and resulting in monetary, personal, or other benefit, gain, or profit for the perpetrator ..." Further, the policy directed, "All cases of maltreatment or potential maltreatment must be reported immediately ...," including, "An initial report must be completed and submitted to the State Agency via state specific contact point." R94's quarterly Minimum Data Set (MDS) dated 2/3/17, identified R94 had moderate cognitive impairment and displayed no behavioral symptoms (i.e. physical, verbal or other behavioral symptoms).	22000		

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22000	Continued From page 39 R94's Presbyterian Homes & Services Report of Missing/Damaged Item(s) form dated 11/15/16, identified R94 had reported, "$70 cash [$50 dollar bill and $20 dollar bill]" to be missing. The money had been, "Wrapped in a pink receipt, inside her wallet which she placed under her pillow," and was last seen on 11/9/16, at 8:00 p.m. according to the report. Further, the report identified a search had been completed with an, "Outcome of Search," being identified as, "Money not found." The report was signed and dated on 11/10/16, at 8:15 p.m. by the, "Person Taking Report." R94's Incident Report - Submission Completed form dated 11/11/16, identified spacing labeled, "Date Submitted to MDH/OHFC [State agency]," and listed it reported on, "11/11/2016 [the following day after the allegation was reported to staff]." R94's Investigative Report Submission Completed form dated 11/16/16, identified an investigation of the allegation had been completed by the facility. The investigation identified, "After the supper meal on 11/10/16, [R94] returned from the dining room to find some of her insurance cards lying on the floor next to her bed. [R94] checked in her wallet which she had hidden under her pillow and noticed that $70.00 was missing from her wallet." R94 reported the missing money, "at approximately 7:30 p.m." and staff completed a search, however, "The money was not found." The clinical administrator, leader in training and campus administrator was notified according to the report. Further, the report identified, "[R94] does have some forgetfulness but is a credible source," adding, "No alleged perpetrator has been identified."	22000		

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22000	Continued From page 40 When interviewed on 3/1/17, at 9:01 a.m. the director of nursing (DON) stated R94 was a credible source of information. The DON stated the campus administrator (not longer at the facility) had been notified of R94's allegation of misappropriation of funds immediately on 11/10/16 according to the investigation notes, however, the State agency had not been notified until, "The following morning," on 11/11/16 which was not in accordance with the facility policy. During interview on 3/2/17, at 9:03 a.m. the current administrator indicated she would have expected the staff to have reported R94's missing money to the State agency, as identifid by the policy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility abuse prevention policy with staff regarding timely reporting to the State agency any allegations of potential abuse, maltreatment, neglect, or misappropriations of resident funds; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		