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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P57Z
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 **05/04/2015** (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, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/04/2015 (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 05/07/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/04/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245120
May 4, 2015

Ms. Julie Spiers, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Dear Ms. Spiers:

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

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

Effective the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 4, 2015

Ms. Julie Spiers, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

RE: Project Number S5120025

Dear Ms.. Spiers:

On March 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 20, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2015, effective April 20, 2015 and therefore remedies outlined in our letter to you dated March 27, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245120	A. Building B. Wing	5/4/2015

Name of Facility	Street Address, City, State, Zip Code
GRACEPOINTE CROSSING GABLES EAST	548 FIRST AVENUE CAMBRIDGE, MN 55008

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	04/20/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	04/20/2015	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	04/20/2015
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	04/20/2015	ID Prefix F0309 Reg. # 483.25 LSC	04/20/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	04/20/2015
ID Prefix F0315 Reg. # 483.25(d) LSC	04/20/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 5/4/2015	Signature of Surveyor: 10562	Date: 5/4/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/12/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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(L4) **548 FIRST AVENUE**
(L5) **CAMBRIDGE, MN** (L6) **55008**

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5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

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(L9) **01/02/2007**

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

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2 AOA 3 Other

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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
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To (b) :

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

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

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

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	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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17. SURVEYOR SIGNATURE Date :
Carol Bode, HFE NE II 04/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/01/2015 (L20)

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

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04/17/1967
(L24)

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(L41)

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(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 05/04/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 27, 2015

Ms. Julie Spiers, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

RE: Project Number S5120025

Dear Ms. Spiers:

On March 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> <u>**Opportunity to Correct**</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>**Electronic Plan of Correction**</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>**Remedies**</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> <u>**Potential Consequences**</u> **- the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 21, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 12, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 2015 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

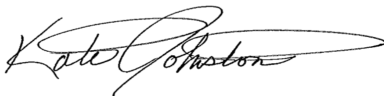
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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 ______	03/12/2015

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 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		4/20/15

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

Electronically Signed — 04/02/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING ______ B. WING ______	03/12/2015

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 all alleged violations involving misappropriation of property were reported immediately to the administrator and the state agency for 1 of 3 resident (R13) allegations reviewed. Findings include: R13's quarterly Minimum Data Set (MDS) dated 2-6-15, indicated intact cognition, required extensive assistance for activities of daily living and transfers, and demonstrated no behaviors. The MDS indicated diagnoses of cerebral vascular accident (CVA), hemiplegia, and depression. R13's care plan dated 1/14/13, indicated at risk for abuse/neglect and the goal was to be free from abuse/neglect by others. Further, the care plan indicates "this is my home now" with an	F 225	On 3/11/15 an OHFC/CEP report was filed for R13. On 3/18/2015, it was determined by OHFC that no further action was necessary from their office. All potential vulnerable adult situations are reviewed and will be reported to the Administrator per policy. The interdisciplinary team will review all occurrence reports and 24 hour communication reports to ensure allegations are brought forward and investigated per policy. Policy and Procedure for Vulnerable Adult Reporting was reviewed and is current. Education on the Vulnerable Adult Reporting Policy was provided to staff on 4/1/2015 and is ongoing.	

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 ______	03/12/2015

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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F 225	Continued From page 2	F 225		

intervention of "encourage me to bring personal belongings...".

On 03/11/2015 at 12:11 p.m., R13 stated, "I went to bingo and when I came back someone had broke the lock on my drawer and stole three sapphire rings and a variety of other jewelry. I told the household coordinator [HHC] but he has since left. The clinical coordinator discussed it with me and they took pictures of what jewelry I have left. I had so much jewelry, I don't even know what I'm missing but I am sure I'm missing three sapphire rings, the rings were important to me." R13 pointed to the top drawer of a cabinet next to her bed while she spoke.

On 03/11/2015, at 12:19 p.m. HHC-A stated she was not in her current position at that time and directed inquiries to the administrator. The administrator was interviewed at that time and stated on 1/6/15, R13 reported to HHC-B "someone was digging through her stuff" and said she was "missing some jewelry." The administrator further stated they took pictures of what jewelry was left in the drawer, and her understanding was that the drawer was pried open but she did not investigate herself. The administrator said she signed "the missing item report on January 8th, 2015, so that must be when I was informed of the incident" and "it was not reported to state agency."

On 03/11/2015, at 1:25 p.m. maintenance staff (MS)-F stated he replaced the drawer/lock and said, "maybe I saw pry marks, I'm not sure." R13 is the only one that had a key.

Although R13 informed the facility of the misappropriation of property, the administrator

Provider's plan of correction (F 225):

Administrator, Clinical Administrator and/or designee will be responsible for ongoing compliance.

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F 225	Continued From page 3 was not informed until two days later, and no report was made to state survey agency at that time. The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 8/5/14, included a definition of abuse, "Financial or Material exploitation: and under section B "---Stealing, cashing of checks without permission, forging signatures, missing money or resident possessions or belongings." Under E. internal reporting and investigation procedures, "All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator..." Under I, State Agency "Immediately make a report to the State Agency."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy related to immediate reporting of misappropriation of property to the administrator and State agency for 1 of 3 resident (R13) allegations reviewed Findings include:	F 226	On 3/11/15 an OHFC/CEP report was filed for R13. On 3/18/2015, it was determined by OHFC that no further action was necessary from their office. All potential vulnerable adult situations are reviewed and will be reported to the Administrator per policy. The interdisciplinary team will review all	4/20/15

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F 226	Continued From page 4 The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 8/5/14, included a definition of abuse, "Financial or Material exploitation: and under section B "---Stealing, cashing of checks without permission, forging signatures, missing money or resident possessions or belongings." Under E. internal reporting and investigation procedures, "All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator..." Under I, State Agency "Immediately make a report to the State Agency." R13's quarterly Minimum Data Set (MDS) dated 2-6-15, indicated intact cognition, required extensive assistance for activities of daily living and transfers, and demonstrated no behaviors. The MDS indicated diagnoses of cerebral vascular accident (CVA), hemiplegia, and depression. R13's care plan dated 1/14/13, indicated at risk for abuse/neglect and the goal was to be free from abuse/neglect by others. Further, the care plan indicates "this is my home now" with an intervention of "encourage me to bring personal belongings...". On 03/11/2015 at 12:11 p.m., R13 stated, "I went to bingo and when I came back someone had broke the lock on my drawer and stole three sapphire rings and a variety of other jewelry. I told the household coordinator [HHC] but he has since left. The clinical coordinator discussed it with me and they took pictures of what jewelry I have left. I had so much jewelry, I don't even know what I'm missing but I am sure I'm missing	F 226	occurrence reports and 24 hour communication reports to ensure allegations are brought forward and investigated per policy. Policy and Procedure for Vulnerable Adult Reporting was reviewed and is current. Education on the Vulnerable Adult Reporting Policy was provided to staff on 4/1/2015 and is ongoing. Administrator, Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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F 226	Continued From page 5 three sapphire rings, the rings were important to me." R13 pointed to the top drawer of a cabinet next to her bed while she spoke. On 03/11/2015, at 12:19 p.m. HHC-A stated she was not in her current position at that time and directed inquiries to the administrator. The administrator was interviewed at that time and stated on 1/6/15, R13 reported to HHC-B "someone was digging through her stuff" and said she was "missing some jewelry." The administrator further stated they took pictures of what jewelry was left in the drawer, and her understanding was that the drawer was pried open but she did not investigate herself. The administrator said she signed "the missing item report on January 8th, 2015, so that must be when I was informed of the incident" and "it was not reported to State agency." On 03/11/2015, at 1:25 p.m. maintenance staff (MS)-F stated he replaced the drawer/lock and said, "maybe I saw pry marks, I'm not sure." R13 is the only one that had a key. Although R13 informed the facility of the misappropriation of property, the administrator was not informed until two days later, and no report was made to State survey agency at that time.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		4/20/15

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F 279	Continued From page 6 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan included the provision of hospice services for 1 of 1 resident (R39) reviewed for hospice services. Findings include: R39's quarterly Minimum Data Set (MDS) dated 2/5/15, indicated moderately impaired cognition, required extensive assistance for activities of daily living, dependent for transfers, and demonstrated no behaviors or mood difficulties. The MDS indicated diagnoses of cerebral vascular accident and multiple sclerosis. The care plan dated 9/2/14, nor the St Croix hospice team care plan dated 3/4/15, addressed coordination of resident care. An untitled, undated nursing assistant sheet instructed staff of resident needs but did not address hospice involvement.	F 279	R39's care plan was updated with hospice involvement on 4/1/2015. Nursing Assistant Care Sheets for R39 were reviewed and updated for hospice involvement on 4/1/2015. All other hospice care plans were reviewed for integration of hospice services on 4/1/2015. Staff education on integration of hospice care and the care plan was completed on 4/1/2015 and is ongoing. The facility will monitor and sustain correction by completing hospice audits on 10% of residents enrolled in hospice services. Audits will be completed weekly for 2 months. The results of the audits will be reviewed in QAA and determination will be made for continued audits.	

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F 279	Continued From page 7 On 03/11/2015, at 8:53 a.m. registered nurse (RN)-A said R39 went on hospice on 3/4/15. After looking for the temporary care plan RN-A said, " I guess, I don't have a temporary care plan." On 03/11/2015, at 9:01 a.m. nursing assistant (NA)-B stated, "We follow our own care plan. I know the hospice aids come here but I do not know when or what they do for [R39]. I just follow our own care plan." On 03/11/2015, at 9:13 a.m. hospice RN-B stated, "I don't know how the nursing home nursing assistants know what the hospice nursing assistants will do when they are here. I don't know for sure how it happens." On 3/11/2015, at 1:48 p.m. the director of nursing (DON) stated they will look at better coordination with hospice, and provided their contract with St Croix hospice. The DON verified there was not a coordination of care policy with hospice.	F 279	Clinical Administrator and/or designee will be responsible for ensuring ongoing compliance.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 3 of 13 residents (R97, R48 and R35) who	F 282	R97, R48 and R35 have monitoring for Wangerguard checks on their treatment records. All other residents with	4/20/15

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F 282	Continued From page 8 utilized Wander Guards (a system used to alert facility staff when residents attempt to leave the facility). In addition, the facility failed to provide timely positioning for 1 of 3 residents (R73) reviewed for pressure ulcers, and timely toileting assistance for 1 of 4 residents (R73) reviewed for urinary incontinence. Findings include: R97's Minimum Data Set (MDS) dated 1/28/15, listed diagnosis of Non- Alzheimer's dementia. The MDS indicated presence and frequency of wandering, behavior occurred 1-2 times during assessment period and places resident at significant risk of getting to a potentially dangerous place. R97's care plan dated 2/10/15, indicated primary mode of locomotion is walking, steady with balance and may require cueing/limited assist due to severely impaired cognition. Care plan identified R97 at risk for elopement related to memory loss, car/wife seeking behaviors. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily. Review of R97's treatment records lacked documentation of daily monitoring for proper function of Wander Guard as directed by the care plan. On 03/11/2015, at 11:58 a.m. nursing assistant (NA)-C and NA-D stated that R97 wears a Wander Guard. When asked if they were aware of the Wander Guard function monitoring NA-C stated. "I believe so, I think nurses or management do that." On 03/11/2015, at 12:02 p.m. registered nurse (RN)-A stated the Wander Guard should be	F 282	Wanderguards were reviewed and have monitoring for Wanderguard checks on their treatment records. Skin Risk and Braden Assessment and Bowel and Bladder Evaluation was completed on R73. Toileting and repositioning plan for R73 was reassessed; the care plan was reviewed and updated. Toileting and repositioning schedules for all residents were reviewed and revised as necessary. Toileting and Repositioning Policy was reviewed and is current. The Policy and Procedure for Wanderguard Monitoring was reviewed and is current. Education was provided on toileting and repositioning on April 1, 2015 and is ongoing. Education was provided on April 1, 2015 and is ongoing; to ensure Wanderguard monitoring checks are recurring on monthly TARs. The facility will monitor and sustain correction by completing Wanderguard audits on 10% of residents who utilize the Wanderguard system. The facility will also complete toileting and repositioning audits on 5% of residents. The audits will be completed weekly for 2 months. The results of the audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator and/or designee will be responsible for ongoing compliance.	

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F 282	Continued From page 9 checked every night on NOC shift and should be documented in treatment record. RN-A then stated she could not find documentation that R97's Wander Guard was documented in the treatment record. R48's Quarterly MDS dated 2/20/15, indicated he had non- Alzheimer's type dementia and required assist of one for locomotion off unit. R48's care plan dated 3/9/15, indicated risk for elopement related to wandering, impaired mobility and diagnosis of dementia. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily. Review of R48's treatment records lacked documentation of daily monitoring for proper function of Wander Guard as directed by the care plan. R35's admission MDS dated 2/2/15, indicated he had severe cognitive impairment. The MDS further indicated he ambulated with extensive assist of one and used a walker and wheelchair. R35's care plan dated 3/9/15, indicated he had dementia and he was at risk for elopement due to wandering and has a Wander Guard. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily. Review of R35's treatment record did not indicate his Wander Guard was being tested as directed by the care plan. On 03/12/2015, at 10:07 a.m. the director of nursing (DON) stated there was no documentation indicating they were checking Wander Guards to ensure functionality except for	F 282		

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F 282	Continued From page 10 in March 2015 on Avalon Top. The DON further stated they just started adding the checks to their computer program and the four residents had been missed. The facility's Wandering And Elopement Policy and Procedure revised 8/09, indicated "The facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering from the facility. The facility will utilize monitoring and alarm systems; sign in and out logs on all households, and maintain pictures of all residents. This facility will also maintain a response plan for implementation in the event of a missing resident (refer to missing resident policy)." The policy indicated "Nursing will ensure that resident safety devices/alarms are tested." R73's admission Minimum Data Set (MDS) dated 2/11/2015, indicated he required extensive, physical assistance with transferring and toileting, and was frequently incontinent of bowel and bladder. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for skin risk and Braden assessment [a tool for predicting pressure ulcer risk] identified he was at moderate risk for skin breakdown. The CAA further identified that R73 had very limited sensory perception, was incontinent of bowel and bladder, and had very limited mobility. The CAA further indicated R73 required staff assistance to turn, reposition and toilet, and that currently his skin was intact. R73's care plan dated 2/5/2015, indicated his repositioning plan was reposition per toileting	F 282		

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Continued From page 11
schedule, which was "q [every] 2 hrs [hours] and upon request."

During continuous observation on 3/11/2015, from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair, without any offer to reposition, or provide him toileting assistance during this entire time. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73, still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided.

On 3/11/2015, at 10:38 a.m. nursing assistant (NA)-B said R73 "...should be toileted and repositioned every 2 hours." NA-B said R73 was last repositioned "about ten to seven, shortly after the surveyors got here." NA-B acknowledged R73 was not toileted or repositioned from the time she moved him before 7:00 a.m. until after 10 a.m. when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done and that it was on their "aide sheets, and I guess it got missed."

On 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was

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F 282	Continued From page 12 currently on a 2-hour toileting and repositioning schedule. On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed." A facility policy, Reposition of Resident, modified 6/03, defined its purpose as "To ensure timely repositioning as identified in the resident's Care Plan." The policy indicated residents would "...receive the required repositioning by the nursing staff and will be monitored via the repositioning schedule." A facility policy, Toileting of Resident, modified 6/03, defined its purpose as "To ensure timely toileting as identified in the resident's care plan." The policy indicated all residents, assessed as requiring assistance toileting, would "...receive the required assistance by the nursing staff and will be monitored via the toileting schedule."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		4/20/15

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F 309	Continued From page 13	F 309		

Based on observation, interview and document review, the facility failed to provide coordination of hospice services for 1 of 1 resident (R39) reviewed for hospice services.

Findings include:

R39's quarterly Minimum Data Set (MDS) dated 2/5/15, indicated moderately impaired cognition, required extensive assistance for activities of daily living, dependent for transfers, and demonstrated no behaviors or mood difficulties. The MDS indicated diagnoses of cerebral vascular accident and multiple sclerosis.

The care plan dated 9/2/14, nor the St Croix hospice team care plan dated 3/4/15, addressed coordination of resident care. An untitled, undated nursing assistant sheet instructed staff of resident needs but did not address hospice involvement.

An observation on 03/11/2015, at 7:28 a.m. R39 said he was okay and offered no complaints.

On 03/11/2015, at 8:53 a.m. registered nurse (RN)-A said R39 went on hospice on 3/4/15. After looking for the temporary care plan RN-A said, " I guess, I don't have a temporary care plan."

On 03/11/2015, at 9:01 a.m. nursing assistant (NA)-B stated, "We follow our own care plan. I know the hospice aids come here but I do not know when or what they do for [R39]. I just follow our own care plan."

On 03/11/2015, at 9:13 a.m. hospice RN-B stated, "I don't know how the nursing home nursing assistants know what the hospice nursing

R39's care plan was updated with hospice involvement on 4/1/2015. Nursing Assistant Care Sheets for R39 were reviewed and updated for hospice involvement on 4/1/2015. All other hospice care plans were reviewed for integration of hospice services on 4/1/2015.

Staff education on integration of hospice care, the care plan and location of the hospice calendar of visits to ensure integration of hospice care was completed on 4/1/2015 and is ongoing.

The facility will monitor and sustain correction by completing hospice audits on 10% of residents enrolled in hospice services. Audits will be completed weekly for 2 months. The results of the audits will be reviewed in QAA and determination will be made for continued audits.

Clinical Administrator and/or designee will be responsible for ensuring ongoing compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING ______ B. WING ______	03/12/2015

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 309	Continued From page 14 assistants will do when they are here. I don't know for sure how it happens." 03/11/2015 at 9:16 a.m. RN-C said there is a calendar in the front of the notebook of when hospice is coming to the facility. RN-C acknowledged the nursing assistants will not look at the schedule where it is located and the schedule only lists people but not what they will be doing for R39. RN-D stated when the hospice nursing assistants arrive, they tell them what they want to do for the resident while in facility. Both RN-C and RN-D confirmed communication is not good between the facility and hospice agency. On 3/11/2015, at 1:48 p.m. the director of nursing (DON) stated they will look at better coordination with hospice, and provided their contract with St Croix hospice. The DON verified there was not a coordination of care policy with hospice. The nursing facility services agreement with St Croix hospice, under coordination and evaluation "Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients..."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		4/20/15

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 ______	03/12/2015

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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 314	Continued From page 15 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 3 residents (R73) reviewed in the sample identified as at risk for development of pressure ulcers. Findings include: R73's diagnoses, as identified on a physician's progress note, dated 2/11/2015, included Alzheimer's type dementia, gait disorder and generalized weakness. R73's admission Minimum Data Set (MDS) dated 2/11/2015, indicated he required extensive, physical assistance with transferring and toileting, and was frequently incontinent of bowel and bladder. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for skin risk and Braden assessment [a tool for predicting pressure ulcer risk] identified he was at moderate risk for skin breakdown. The CAA further identified that R73 had very limited sensory perception, was incontinent of bowel and bladder, and had very limited mobility. The CAA further indicated R73 required staff assistance to turn, reposition and toilet, and that currently his skin was intact. R73's care plan, dated 2/5/2015, indicated his repositioning plan was reposition per toileting schedule, which was "q [every] 2 hrs [hours] and upon request." The Avalon Group A1 nursing assistant sheet, updated 3/5/2015, indicated R73's toileting and repositioning schedule was "A2 [assist of 2] q [every] 2hrs."	F 314	Skin Risk and Braden Assessment and Bowel and Bladder Evaluation were completed on R73. Toileting and repositioning plan on R73 was reassessed; the care plan was reviewed and updated. Toileting and repositioning schedules were reviewed for all residents, and revised as necessary. The policy and procedure was reviewed and is current. Education was provided on the toileting and repositioning plan of care on 4/1/2015 and is ongoing. The facility will monitor and sustain correction by completing toileting and repositioning audits on 5% of residents. These audits will be weekly for 2 months. The results of the audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator and/or designee will be responsible for ensuring ongoing compliance.	

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	245120	A. BUILDING ______ B. WING ______	03/12/2015

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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F 314	Continued From page 16	F 314		

During continuous observation on 3/11/2015, from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair without any offer to reposition, or provide him toileting assistance during this entire time. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 was looking at a newspaper, making non-sensical conversation with himself, and with other residents and staff passing by, frequently asking if anyone knew his brother. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73 still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 9:32 a.m. registered nurse (RN)-A approached R73 and administered medications, along with a drink. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided. At 10:12 a.m. RN-B inspected and assessed R73's skin, and found no impairment on his buttocks, gluteal folds, coccyx, spine, back or shoulder blades. R73's skin was of normal color and there was no unusual warmth or redness or creasing. RN-B stated, "[R73's] skin is intact." After providing perineal care, R73 was assisted by RN-B and OT-A into his wheel chair, and was returned to the nursing station area.

In an interview on 3/11/2015, at 10:38 a.m.,

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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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F 314	Continued From page 17 nursing assistant (NA)-B said R73 "...should be toileted and repositioned every 2 hours." NA-B said was R73 last repositioned "about ten to seven, shortly after the surveyors got here," and that she moved R73 from the front room to "in front of the nursing station." NA-B acknowledged R73 was not toileted or repositioned from the time she moved him, before 7:00 a.m., until after 10 a.m., when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done, and that it was on our "aide sheets, and I guess it got missed." On 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was currently on a 2-hour repositioning schedule. RN-C said when he first got to facility R73 needed a mechanical lift to transfer, and another person to assist with his clothing when in the bathroom. RN-C stated there had been improvement in R73's condition, he was verbally more responsive and understanding, and also that he was receiving therapy, and was placed on a walking program. Based on R73's initial assessments RN-C stated R73 was at risk to develop skin issues based on a number of factors, including his limited mobility and cognition, and that he was appropriately placed on the standard turning and repo schedule. RN-C said even though R73's mobility and strength were improving, he was on "this baseline 2-hour toileting and repo [repositioning] schedule," and that "needed it to be followed through, as in his care plan." On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed."	F 314		

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 ______	03/12/2015

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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F 314	Continued From page 18 A facility policy, Reposition of Resident, modified 6/03, defined its purpose as "To ensure timely repositioning as identified in the resident's Care Plan." The policy indicated residents would "...receive the required repositioning by the nursing staff and will be monitored via the repositioning schedule."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 4 residents (R73) in the sample reviewed for urinary continence. Findings include: R73's diagnoses, as identified on a physician's progress note, dated 2/11/2015, included Alzheimer's type dementia, gait disorder and generalized weakness. R73's admission Minimum Data Set (MDS), dated 2/11/2015, indicated he was frequently incontinent of bowel	F 315	Skin Risk and Braden Assessment and Bowel and Bladder Evaluation were completed on R73. Toileting and repositioning plan on R73 was reassessed; the care plan was reviewed and updated. Toileting and repositioning schedules were reviewed for all residents, and revised as necessary. The policy and procedure was reviewed and is current. Education was provided on the toileting and repositioning plan of care on 4/1/2015 and is ongoing.	4/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRACEPOINTE CROSSING GABLES EAST	**548 FIRST AVENUE CAMBRIDGE, MN 55008**

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F 315	Continued From page 19 and bladder, and that he required extensive, physical assistance with transferring and toileting. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for urinary incontinence, dated 2/18/2015, indicated R73 was frequently incontinent of bowel and bladder, and that his needs had to be anticipated because of severe, cognitive impairment and variable ability to identify and communicate his need for help. The CAA also indicated R73 required staff to manage his brief, clothing and peri-care for toilet use, and that he had "functional incontinence r/t [related to] impaired thinking and mobility limitations." The CAA further indicated R73 was "assisted with incontinent care/toilet/urinal use (as appropriate) Q2H [every 2 hours] and per request." R73's care plan dated 2/5/2015, indicated his toileting/urinal plan was "q 2hr (every 2 hours)." During continuous observation on 3/11/2015, from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair, without any offer during this time to reposition, or provide him toileting assistance. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 was looking at a newspaper, making non-sensical conversation with himself, and with other residents and staff passing by, frequently asking if anyone knew his brother. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73, still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 9:32 a.m. registered nurse (RN)-A approached R73 and	F 315	The facility will monitor and sustain correction by completing toileting and repositioning audits on 5% of residents. These audits will be weekly for 2 months. The results of the audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator and/or designee will be responsible for ensuring ongoing compliance.	

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F 315	Continued From page 20	F 315		

administered his medications, along with a drink. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided.

On 3/11/2015, at 10:38 a.m. nursing assistant (NA)-B said R73 was to be toileted and repositioned every 2 hours. NA-B said she was not sure when R73 was last toileted. NA-B acknowledged R73 was not toileted or repositioned from the time she moved him from the front room to the front of the nursing station before 7:00 a.m. until after 10 a.m. when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done, and that it was on their "aide sheets, and I guess it got missed."

During an interview on 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was currently on a 2-hour toileting schedule, and explained that determination was made based on number of factors for [R73]", including his initial 3-day bowel and bladder observation, the resident's weakness and confusion upon admission, and his dementia. RN-C said when he first got to the facility R73 needed a mechanical lift to transfer, and another person to assist with his clothing when in the bathroom. RN-C stated there had been improvement in R73's condition, that he was receiving therapy, and was placed on a walking program. RN-C added that staff were getting non-verbal clues from R73 when he needed to toilet, and also that he would say "pot or the stool." RN-C said she

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	245120	A. BUILDING ______ B. WING ______	03/12/2015

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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F 315	Continued From page 21 would re-assess him for his toileting needs, but also said R73 was on "this baseline 2-hour toileting and repo [repositioning] schedule," and that "needed to be followed through, as in his care plan." On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed." A facility policy, Toileting of Resident, modified 6/03, defined its purpose as "To ensure timely toileting as identified in the resident's care plan." The policy indicated all residents, assessed as requiring assistance toileting, would "...receive the required assistance by the nursing staff and will be monitored via the toileting schedule."	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5120023
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/11/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grace Pointe Crossing Gables East was found in not substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Graceponit 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 wwas constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 90 beds and had a census of 76 at the time of the survey.	K 000		

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 27, 2015

Ms. Julie Spiers, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5120025

Dear Ms. Spiers:

The above facility was surveyed on March 9, 2015 through March 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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.

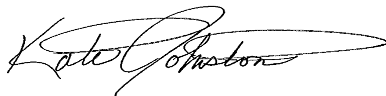
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00292	A. BUILDING: ____ B. WING ____	03/12/2015

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) COMPLETE DATE
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		

Minnesota Department of Health

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 ______	03/12/2015

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) COMPLETE DATE
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 March 9-12, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A	2 000		

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2 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan included the provision of hospice services for 1 of 1 resident (R39) reviewed for hospice services. Findings include: R39's quarterly Minimum Data Set (MDS) dated 2/5/15, indicated moderately impaired cognition, required extensive assistance for activities of daily living, dependent for transfers, and demonstrated no behaviors or mood difficulties. The MDS indicated diagnoses of cerebral vascular accident and multiple sclerosis. The care plan dated 9/2/14, nor the St Croix hospice team care plan dated 3/4/15, addressed coordination of resident care. An untitled, undated nursing assistant sheet instructed staff of resident needs but did not address hospice involvement.	2 560	Corrected	4/20/15

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2 560	Continued From page 3 On 03/11/2015, at 8:53 a.m. registered nurse (RN)-A said R39 went on hospice on 3/4/15. After looking for the temporary care plan RN-A said, " I guess, I don't have a temporary care plan." On 03/11/2015, at 9:01 a.m. nursing assistant (NA)-B stated, "We follow our own care plan. I know the hospice aids come here but I do not know when or what they do for [R39]. I just follow our own care plan." On 03/11/2015, at 9:13 a.m. hospice RN-B stated, "I don't know how the nursing home nursing assistants know what the hospice nursing assistants will do when they are here. I don't know for sure how it happens." On 3/11/2015, at 1:48 p.m. the director of nursing (DON) stated they will look at better coordination with hospice, and provided their contract with St Croix hospice. The DON verified there was not a coordination of care policy with hospice. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding the development and use of a resident care plan, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care	2 565		4/20/15

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2 565	Continued From page 4 must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 3 of 13 residents (R97, R48 and R35) who utilized Wander Guards (a system used to alert facility staff when residents attempt to leave the facility). In addition, the facility failed to provide timely positioning for 1 of 3 residents (R73) reviewed for pressure ulcers, and timely toileting assistance for 1 of 4 residents (R73) reviewed for urinary incontinence. Findings include: R97's Minimum Data Set (MDS) dated 1/28/15, listed diagnosis of Non- Alzheimer's dementia. The MDS indicated presence and frequency of wandering, behavior occurred 1-2 times during assessment period and places resident at significant risk of getting to a potentially dangerous place. R97's care plan dated 2/10/15, indicated primary mode of locomotion is walking, steady with balance and may require cueing/limited assist due to severely impaired cognition. Care plan identified R97 at risk for elopement related to memory loss, car/wife seeking behaviors. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily. Review of R97's treatment records lacked documentation of daily monitoring for proper function of Wander Guard as directed by the care	2 565	Corrected	

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2 565	Continued From page 5 plan. On 03/11/2015, at 11:58 a.m. nursing assistant (NA)-C and NA-D stated that R97 wears a Wander Guard. When asked if they were aware of the Wander Guard function monitoring NA-C stated. "I believe so, I think nurses or management do that." On 03/11/2015, at 12:02 p.m. registered nurse (RN)-A stated the Wander Guard should be checked every night on NOC shift and should be documented in treatment record. RN-A then stated she could not find documentation that R97's Wander Guard was documented in the treatment record. R48's Quarterly MDS dated 2/20/15, indicated he had non- Alzheimer's type dementia and required assist of one for locomotion off unit. R48's care plan dated 3/9/15, indicated risk for elopement related to wandering, impaired mobility and diagnosis of dementia. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily. Review of R48's treatment records lacked documentation of daily monitoring for proper function of Wander Guard as directed by the care plan. R35's admission MDS dated 2/2/15, indicated he had severe cognitive impairment. The MDS further indicated he ambulated with extensive assist of one and used a walker and wheelchair. R35's care plan dated 3/9/15, indicated he had dementia and he was at risk for elopement due to wandering and has a Wander Guard. The care plan indicated for staff to make sure the Wander Guard is on and monitor for function daily.	2 565		

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2 565	Continued From page 6	2 565		

Review of R35's treatment record did not indicate his Wander Guard was being tested as directed by the care plan.

On 03/12/2015, at 10:07 a.m. the director of nursing (DON) stated there was no documentation indicating they were checking Wander Guards to ensure functionality except for in March 2015 on Avalon Top. The DON further stated they just started adding the checks to their computer program and the four residents had been missed.

The facility's Wandering And Elopement Policy and Procedure revised 8/09, indicated "The facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering from the facility. The facility will utilize monitoring and alarm systems; sign in and out logs on all households, and maintain pictures of all residents. This facility will also maintain a response plan for implementation in the event of a missing resident (refer to missing resident policy)." The policy indicated "Nursing will ensure that resident safety devices/alarms are tested."

R73's admission Minimum Data Set (MDS) dated 2/11/2015, indicated he required extensive, physical assistance with transferring and toileting, and was frequently incontinent of bowel and bladder. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for skin risk and Braden assessment [a tool for predicting pressure ulcer risk] identified he was at moderate risk for skin breakdown. The CAA further identified that R73 had very limited sensory perception, was incontinent of bowel and bladder, and had very

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2 565	Continued From page 7	2 565		

limited mobility. The CAA further indicated R73 required staff assistance to turn, reposition and toilet, and that currently his skin was intact.

R73's care plan dated 2/5/2015, indicated his repositioning plan was reposition per toileting schedule, which was "q [every] 2 hrs [hours] and upon request."

During continuous observation on 3/11/2015, from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair, without any offer to reposition, or provide him toileting assistance during this entire time. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73, still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided.

On 3/11/2015, at 10:38 a.m. nursing assistant (NA)-B said R73 "...should be toileted and repositioned every 2 hours." NA-B said R73 was last repositioned "about ten to seven, shortly after the surveyors got here." NA-B acknowledged R73 was not toileted or repositioned from the time she moved him before 7:00 a.m. until after 10 a.m. when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done

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2 565	Continued From page 8	2 565		

and that it was on their "aide sheets, and I guess it got missed."

On 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was currently on a 2-hour toileting and repositioning schedule.

On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed."

A facility policy, Reposition of Resident, modified 6/03, defined its purpose as "To ensure timely repositioning as identified in the resident's Care Plan." The policy indicated residents would "...receive the required repositioning by the nursing staff and will be monitored via the repositioning schedule."

A facility policy, Toileting of Resident, modified 6/03, defined its purpose as "To ensure timely toileting as identified in the resident's care plan." The policy indicated all residents, assessed as requiring assistance toileting, would "...receive the required assistance by the nursing staff and will be monitored via the toileting schedule."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

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2 565	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide coordination of hospice services for 1 of 1 resident (R39) reviewed for hospice services. Findings include: R39's quarterly Minimum Data Set (MDS) dated 2/5/15, indicated moderately impaired cognition, required extensive assistance for activities of daily living, dependent for transfers, and demonstrated no behaviors or mood difficulties. The MDS indicated diagnoses of cerebral vascular accident and multiple sclerosis.	2 830	Corrected	4/20/15

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2 830	Continued From page 10	2 830		

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The care plan dated 9/2/14, nor the St Croix hospice team care plan dated 3/4/15, addressed coordination of resident care. An untitled, undated nursing assistant sheet instructed staff of resident needs but did not address hospice involvement.

An observation on 03/11/2015, at 7:28 a.m. R39 said he was okay and offered no complaints.

On 03/11/2015, at 8:53 a.m. registered nurse (RN)-A said R39 went on hospice on 3/4/15. After looking for the temporary care plan RN-A said, " I guess, I don't have a temporary care plan."

On 03/11/2015, at 9:01 a.m. nursing assistant (NA)-B stated, "We follow our own care plan. I know the hospice aids come here but I do not know when or what they do for [R39]. I just follow our own care plan."

On 03/11/2015, at 9:13 a.m. hospice RN-B stated, "I don't know how the nursing home nursing assistants know what the hospice nursing assistants will do when they are here. I don't know for sure how it happens."

03/11/2015 at 9:16 a.m. RN-C said there is a calendar in the front of the notebook of when hospice is coming to the facility. RN-C acknowledged the nursing assistants will not look at the schedule where it is located and the schedule only lists people but not what they will be doing for R39. RN-D stated when the hospice nursing assistants arrive, they tell them what they want to do for the resident while in facility. Both RN-C and RN-D confirmed communication is not good between the facility and hospice agency.

On 3/11/2015, at 1:48 p.m. the director of nursing

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2 830	Continued From page 11 (DON) stated they will look at better coordination with hospice, and provided their contract with St Croix hospice. The DON verified there was not a coordination of care policy with hospice. The nursing facility services agreement with St Croix hospice, under coordination and evaluation "Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients..." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding coordination of care with outside providers, and 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 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	2 900		4/20/15

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2 900	Continued From page 12 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 3 residents (R73) reviewed in the sample identified as at risk for development of pressure ulcers. Findings include: R73's diagnoses, as identified on a physician's progress note, dated 2/11/2015, included Alzheimer's type dementia, gait disorder and generalized weakness. R73's admission Minimum Data Set (MDS) dated 2/11/2015, indicated he required extensive, physical assistance with transferring and toileting, and was frequently incontinent of bowel and bladder. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for skin risk and Braden assessment [a tool for predicting pressure ulcer risk] identified he was at moderate risk for skin breakdown. The CAA further identified that R73 had very limited sensory perception, was incontinent of bowel and bladder, and had very limited mobility. The CAA further indicated R73 required staff assistance to turn, reposition and toilet, and that currently his skin was intact. R73's care plan, dated 2/5/2015, indicated his repositioning plan was reposition per toileting schedule, which was "q [every] 2 hrs [hours] and upon request." The Avalon Group A1 nursing assistant sheet, updated 3/5/2015, indicated R73's toileting and repositioning schedule was "A2 [assist of 2] q [every] 2hrs." During continuous observation on 3/11/2015,	2 900	Corrected	

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from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair without any offer to reposition, or provide him toileting assistance during this entire time. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 was looking at a newspaper, making non-sensical conversation with himself, and with other residents and staff passing by, frequently asking if anyone knew his brother. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73 still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 9:32 a.m. registered nurse (RN)-A approached R73 and administered medications, along with a drink. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided. At 10:12 a.m. RN-B inspected and assessed R73's skin, and found no impairment on his buttocks, gluteal folds, coccyx, spine, back or shoulder blades. R73's skin was of normal color and there was no unusual warmth or redness or creasing. RN-B stated, "[R73's] skin is intact." After providing perineal care, R73 was assisted by RN-B and OT-A into his wheel chair, and was returned to the nursing station area.

In an interview on 3/11/2015, at 10:38 a.m., nursing assistant (NA)-B said R73 "...should be toileted and repositioned every 2 hours." NA-B said was R73 last repositioned "about ten to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14	2 900		

seven, shortly after the surveyors got here," and that she moved R73 from the front room to "in front of the nursing station." NA-B acknowledged R73 was not toileted or repositioned from the time she moved him, before 7:00 a.m., until after 10 a.m., when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done, and that it was on our "aide sheets, and I guess it got missed."

On 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was currently on a 2-hour repositioning schedule. RN-C said when he first got to facility R73 needed a mechanical lift to transfer, and another person to assist with his clothing when in the bathroom. RN-C stated there had been improvement in R73's condition, he was verbally more responsive and understanding, and also that he was receiving therapy, and was placed on a walking program. Based on R73's initial assessments RN-C stated R73 was at risk to develop skin issues based on a number of factors, including his limited mobility and cognition, and that he was appropriately placed on the standard turning and repo schedule. RN-C said even though R73's mobility and strength were improving, he was on "this baseline 2-hour toileting and repo [repositioning] schedule," and that "needed it to be followed through, as in his care plan."

On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed."

A facility policy, Reposition of Resident, modified 6/03, defined its purpose as "To ensure timely repositioning as identified in the resident's Care

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	00292	A. BUILDING: ______ B. WING ______	03/12/2015

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2 900	Continued From page 15 Plan." The policy indicated residents would "...receive the required repositioning by the nursing staff and will be monitored via the repositioning schedule." SUGGESTED METHOD OF CORRECTION: The diretor of nursing or designee could inservice staff regarding completing timely repositioning to reduce the risk of pressure ulcer formation, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting	2 910	Corrected	4/20/15

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2 910	Continued From page 16	2 910		

assistance for 1 of 4 residents (R73) in the sample reviewed for urinary continence.

Findings include:

R73's diagnoses, as identified on a physician's progress note, dated 2/11/2015, included Alzheimer's type dementia, gait disorder and generalized weakness. R73's admission Minimum Data Set (MDS), dated 2/11/2015, indicated he was frequently incontinent of bowel and bladder, and that he required extensive, physical assistance with transferring and toileting. The MDS also indicated R73 was severely, cognitively impaired. The Care Area Assessment (CAA) for urinary incontinence, dated 2/18/2015, indicated R73 was frequently incontinent of bowel and bladder, and that his needs had to be anticipated because of severe, cognitive impairment and variable ability to identify and communicate his need for help. The CAA also indicated R73 required staff to manage his brief, clothing and peri-care for toilet use, and that he had "functional incontinence r/t [related to] impaired thinking and mobility limitations." The CAA further indicated R73 was "assisted with incontinent care/toilet/urinal use (as appropriate) Q2H [every 2 hours] and per request." R73's care plan dated 2/5/2015, indicated his toileting/urinal plan was "q 2hr (every 2 hours)."

During continuous observation on 3/11/2015, from 6:55 a.m. until 10:06 a.m. (3 hours and 11 minutes), R73 remained seated in his wheel chair, without any offer during this time to reposition, or provide him toileting assistance. At 6:55 a.m. R73's chair was positioned in front of the nursing station on the Avalon Gardens unit. R73 was looking at a newspaper, making non-sensical conversation with himself, and with

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2 910	Continued From page 17	2 910		

other residents and staff passing by, frequently asking if anyone knew his brother. R73 remained in front of the nursing station until 8:20 a.m. when a staff member wheeled him into the main dining room, and there provided R73 assistance to eat breakfast. At 8:52 a.m. R73, still seated in his wheel chair, was removed from the dining area and returned to the same location in front of the Avalon Garden's nursing station. At 9:32 a.m. registered nurse (RN)-A approached R73 and administered his medications, along with a drink. At 10:06 a.m. RN-B and occupational therapist (OT)-A assisted R73 to the bathroom, and provided him with toileting assistance. OT-A then assisted R73 to stand and transfer onto the toilet with use of a gait belt, and RN-B assisted to lower his clothing and incontinent brief, which was dry, and subsequently R73 voided.

On 3/11/2015, at 10:38 a.m. nursing assistant (NA)-B said R73 was to be toileted and repositioned every 2 hours. NA-B said she was not sure when R73 was last toileted. NA-B acknowledged R73 was not toileted or repositioned from the time she moved him from the front room to the front of the nursing station before 7:00 a.m. until after 10 a.m. when "[RN-B] toileted him." NA-B said it was the aides responsibility to make sure that got done, and that it was on their "aide sheets, and I guess it got missed."

During an interview on 3/12/2015, at 10:16 a.m. the clinical manager/registered nurse (RN)-C said R73 was currently on a 2-hour toileting schedule, and explained that determination was made based on number of factors for [R73]", including his initial 3-day bowel and bladder observation, the resident's weakness and confusion upon admission, and his dementia. RN-C said when

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2 910	Continued From page 18 he first got to the facility R73 needed a mechanical lift to transfer, and another person to assist with his clothing when in the bathroom. RN-C stated there had been improvement in R73's condition, that he was receiving therapy, and was placed on a walking program. RN-C added that staff were getting non-verbal clues from R73 when he needed to toilet, and also that he would say "pot or the stool." RN-C said she would re-assess him for his toileting needs, but also said R73 was on "this baseline 2-hour toileting and repo [repositioning] schedule," and that "needed to be followed through, as in his care plan." On 3/12/2015, at 10:56 a.m. the director of nursing (DON) stated regardless of a resident's assessed need, there should be care planned interventions. The DON stated she would "expect, of course, the care plan be followed." A facility policy, Toileting of Resident, modified 6/03, defined its purpose as "To ensure timely toileting as identified in the resident's care plan." The policy indicated all residents, assessed as requiring assistance toileting, would "...receive the required assistance by the nursing staff and will be monitored via the toileting schedule." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding providing toileting assistance to residents, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults	21990		4/20/15

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21990	Continued From page 19 Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all alleged violations involving misappropriation of property were reported immediately to the administrator and the state agency for 1 of 3 resident (R13) allegations reviewed. Findings include: R13's quarterly Minimum Data Set (MDS) dated 2-6-15, indicated intact cognition, required extensive assistance for activities of daily living and transfers, and demonstrated no behaviors. The MDS indicated diagnoses of cerebral vascular accident (CVA), hemiplegia, and depression.	21990	Corrected	

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21990	Continued From page 20	21990		

R13's care plan dated 1/14/13, indicated at risk for abuse/neglect and the goal was to be free from abuse/neglect by others. Further, the care plan indicates "this is my home now" with an intervention of "encourage me to bring personal belongings...".

On 03/11/2015 at 12:11 p.m., R13 stated, "I went to bingo and when I came back someone had broke the lock on my drawer and stole three sapphire rings and a variety of other jewelry. I told the household coordinator [HHC] but he has since left. The clinical coordinator discussed it with me and they took pictures of what jewelry I have left. I had so much jewelry, I don't even know what I'm missing but I am sure I'm missing three sapphire rings, the rings were important to me." R13 pointed to the top drawer of a cabinet next to her bed while she spoke.

On 03/11/2015, at 12:19 p.m. HHC-A stated she was not in her current position at that time and directed inquiries to the administrator. The administrator was interviewed at that time and stated on 1/6/15, R13 reported to HHC-B "someone was digging through her stuff" and said she was "missing some jewelry." The administrator further stated they took pictures of what jewelry was left in the drawer, and her understanding was that the drawer was pried open but she did not investigate herself. The administrator said she signed "the missing item report on January 8th, 2015, so that must be when I was informed of the incident" and "it was not reported to state agency."

On 03/11/2015, at 1:25 p.m. maintenance staff (MS)-F stated he replaced the drawer/lock and said, "maybe I saw pry marks, I'm not sure." R13 is the only one that had a key.

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21990	Continued From page 21 Although R13 informed the facility of the misappropriation of property, the administrator was not informed until two days later, and no report was made to state survey agency at that time. The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 8/5/14, included a definition of abuse, "Financial or Material exploitation: and under section B "---Stealing, cashing of checks without permission, forging signatures, missing money or resident possessions or belongings." Under E. internal reporting and investigation procedures, "All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator..." Under I, State Agency "Immediately make a report to the State Agency." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding the facility policies and procedures for reporting allegations of abuse and mistreatment immediately to the administrator and state agency, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		
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	22000		4/20/15

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22000	Continued From page 22 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 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	22000		

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22000	Continued From page 23 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 follow their policy related to immediate reporting of misappropriation of property to the administrator and State agency for 1 of 3 resident (R13) allegations reviewed Findings include: The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 8/5/14, included a definition of abuse, "Financial or Material exploitation: and under section B "---Stealing, cashing of checks without permission, forging signatures, missing money or resident possessions or belongings." Under E. internal reporting and investigation procedures, "All cases of maltreatment must be reported immediately to an employee's supervisor (or designee) who will then report it immediately to the Administrator..." Under I, State Agency "Immediately make a report to the State Agency." R13's quarterly Minimum Data Set (MDS) dated 2-6-15, indicated intact cognition, required extensive assistance for activities of daily living and transfers, and demonstrated no behaviors. The MDS indicated diagnoses of cerebral vascular accident (CVA), hemiplegia, and depression.	22000	Corrected	

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22000	Continued From page 24 R13's care plan dated 1/14/13, indicated at risk for abuse/neglect and the goal was to be free from abuse/neglect by others. Further, the care plan indicates "this is my home now" with an intervention of "encourage me to bring personal belongings...". On 03/11/2015 at 12:11 p.m., R13 stated, "I went to bingo and when I came back someone had broke the lock on my drawer and stole three sapphire rings and a variety of other jewelry. I told the household coordinator [HHC] but he has since left. The clinical coordinator discussed it with me and they took pictures of what jewelry I have left. I had so much jewelry, I don't even know what I'm missing but I am sure I'm missing three sapphire rings, the rings were important to me." R13 pointed to the top drawer of a cabinet next to her bed while she spoke. On 03/11/2015, at 12:19 p.m. HHC-A stated she was not in her current position at that time and directed inquiries to the administrator. The administrator was interviewed at that time and stated on 1/6/15, R13 reported to HHC-B "someone was digging through her stuff" and said she was "missing some jewelry." The administrator further stated they took pictures of what jewelry was left in the drawer, and her understanding was that the drawer was pried open but she did not investigate herself. The administrator said she signed "the missing item report on January 8th, 2015, so that must be when I was informed of the incident" and "it was not reported to State agency." On 03/11/2015, at 1:25 p.m. maintenance staff (MS)-F stated he replaced the drawer/lock and said, "maybe I saw pry marks, I'm not sure." R13	22000		

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22000	Continued From page 25 is the only one that had a key. Although R13 informed the facility of the misappropriation of property, the administrator was not informed until two days later, and no report was made to State survey agency at that time. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review abuse prevention policies and procedures, inservice staff regarding prompt reporting to the administrator and state agency, and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		