CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P57Z

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

	PART I - TO BE COMPLETED BY THE STAT					TATE SURVEY AGENCY Facility ID: 00292		
1. MEDICARE/MEDICAID PROVIDER N (L1) 245120 2.STATE VENDOR OR MEDICAID NO. (L2) 195487000	0.	3. NAME AND ADD (L3) GRACEPOII (L4) 548 FIRST A (L5) CAMBRIDG	NTE CROSSING VENUE			55008	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 01/02/2007		7. PROVIDER/SUI	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other Complaint
6. DATE OF SURVEY 05/04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	90 (L18) 90 (L17)	B. Not in Com	equirements	1	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements:	ctor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 90	19 SNF	ICF	IID		15. FACILITY MI 1861 (e) (1) or		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39)	(L42) HOW LTC CANCELL	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY API	PROVAL	Date:
Brenda Fischer,	HFE NE II		05/04/2015	(L19)	Kate Johns	Ton, Enfo	orcement Specia	alist 05/04/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Part 2. Facility is not Eligible	ticipate		IPLIANCE WITH C HTS ACT:	CIVIL	2. (ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	FA-1513)
22. ORIGINAL DATE	(L21) 23. LTC AGREEMI	FNT 2	24. LTC AGREEME	FNT	26. TERMINAT	ION ACTION:		(L30)
OF PARTICIPATION 04/17/1967	BEGINNING I		ENDING DATE		VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	re a W/ Reimbursemer	INVOLUN 05-Fail to M	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of	of Admissions:	(L25) (L44)		03-Risk of Involui 04-Other Reason f		<u>OTHER</u>	r Status Change
(127)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539		DETERMINATION 0 05/04/2015	OF APPROVAL DA			07/2015 Co.		
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	



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

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 245120	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4)	Item	(Yŧ	5)	Date	(Y4)	Item	(Y5)	Date
		Correction				(Correction				Correction
		Completed					Completed				Completed
ID Prefix	F0225	_04/20/2015		ID Prefix	F0226	'	04/20/2015		ID Prefix	F0279	04/20/2015
	483.13(c)(1)(ii)-(iii), (c)(2) -				483.13(c)					483.20(d), 483.20(k)(1)	
LSC				LSC		_			LSC		
		Correction					Correction				Correction
ID Prefix	F0282	Completed 04/20/2015		ID Prefix	F0309		Completed 04/20/2015		ID Prefix	F0314	Completed 04/20/2015
	483.20(k)(3)(ii)				483.25					483.25(c)	
LSC		_		LSC	403.23	_				403.25(C)	
		_	┼			_		+-			
		Correction				(Correction				Correction
		Completed					Completed				Completed
ID Prefix	F0315	04/20/2015		ID Prefix					ID Prefix		
•	483.25(d)			Reg. #					Reg. #		
LSC		-		LSC					LSC		
		Correction				(Correction				Correction
ID Prefix		Completed		ID Profix		(Completed		ID Profix		Completed
		_									
Reg. # LSC		_		Reg. # LSC					Reg. #		
	-	_	-	Loc		_		┿-	LSC		
		Correction				(Correction				Correction
		Completed					Completed				Completed
ID Prefix				ID Prefix			oop.o.ou		ID Prefix		
Reg. #				Reg. #					Reg. #		
LSC		- -		LSC					LSC		<u> </u>
Reviewed By	Reviewed	Ву	Dat	te:	Signature of Surv	vey	or:			Date:	
State Agency	,	BF/KJ	5	/4/201	5		105	62		5/	4/2015
Reviewed By	Reviewed	Ву	Dat	te:	Signature of Surv	vey	or:			Date:	
CMS RO											
Followup to	Survey Completed on:				Check for an	ıy l	Jncorrected [Defici	encies. Was	a Summary of	
	3/12/2015					-				to the Facility? YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P57Z

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

	PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID: 00292			
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14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY MI		(L15)		
90 (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE	7. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:								
Carol Bode,	HFE NE II		04/07/2015	(L19)				ialist 05/01/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY	icipate		IPLIANCE WITH O	CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
2. Facility is not Engine	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 04/17/1967	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMI ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00	05-Fail to	(L30) UNTARY Meet Health/Safety Meet Agreement	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI	E SANCTIONS	(L25)		03-Risk of Involu		OTHER	, meet rigiteement	
(L27)	A. Suspension of B. Rescind Susp		(L44) (L45)		04-Other Reason i	for Withdrawal	07-Provid 00-Activ	der Status Change e	
28. TERMINATION DATE:	29	. INTERMEDIARY/C.	ARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DA	ΛΤΕ	Posted 05	/04/2015 Co			
	(L32)			(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;

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

Gracepointe Crossing Gables East March 27, 2015 Page 2

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

Gracepointe Crossing Gables East March 27, 2015 Page 4

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

Gracepointe Crossing Gables East March 27, 2015 Page 5

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

PRINTED: 05/04/2015 FORM APPROVED OMB NO. 0938-0391

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 225 483.1g.(1)(1)(i)(i)(i)(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 unfiltness 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).	_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
GRACEPOINTE CROSSING GABLES EAST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE (PACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE) PREPRIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE) TAGE PROVIDERS PLAN OF CORRECTION (CASHOLD BE CORDS) (EACH CORRECTIVE ACTION SHOULD BE CORDS) (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) FOOD INITIAL COMMENTS FOOD PREPRIX TAGE PROVIDERS PLAN OF CORRECTION (CASHOLD BE DEFICIENCY)			245120	B. WING			03/	12/2015
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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 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D 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).	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE .	COMPLETION
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 225 SS=D 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 000	The facility's plan	of correction (POC) will serve	F C	000			
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 225		Department's acceenrolled in ePOC, yat the bottom of the form. Your electron	ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will					
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).		on-site revisit of yo validate that substate regulations has been your verification.	ur facility may be conducted to antial compliance with the en attained in accordance with	-				1/20/12
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).		INVESTIGATE/RE	PORT	F 2	225			4/20/15
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).		been found guilty of mistreating resident had a finding enter registry concerning of residents or mist and report any kno court of law agains indicate unfitness fother facility staff to	If abusing, neglecting, or lats by a court of law; or have led into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or to the State nurse aide registry					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and co	nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					(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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING		03/12/2015	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST	ţ	STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 225	violations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (includent and if the appropriate correct This REQUIREMENT by: Based on interview facility failed to ensinvolving misappropreported immediate state agency for 1 or reviewed. Findings include: R13's quarterly Min 2-6-15, indicated in extensive assistance and transfers, and of the MDS indicated vascular accident (indepression.	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported to other officials in accordance uding to the State survey and to within 5 working days of the alleged violation is verified inverse action must be taken. NT is not met as evidenced and document review, the ure all alleged violations oriation of property were ely to the administrator and the of 3 resident (R13) allegations imum Data Set (MDS) dated tact cognition, required the for activities of daily living demonstrated no behaviors. diagnoses of cerebral CVA), hemiplegia, and	F 225	On 3/11/15 an OHFC/CEP report will filed for R13. On 3/18/2015, it was determined by OHFC that no furthe action was necessary from their offi. All potential vulnerable adult situation 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 Reporting was reviewed and is currently added to the control of	r ce. ons are e Adult ent.	
	for abuse/neglect a from abuse/neglect	nd the goal was to be free by others. Further, the care is my home now" with an		Reporting Policy was provided to sta 4/1/2015 and is ongoing.	aff on	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		54	TREET ADDRESS, CITY, STATE, ZIP CODE 18 FIRST AVENUE AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 225	intervention of "ence belongings". On 03/11/2015 at 1 to bingo and when broke the lock on mapphire rings and told the household since left. The clini with me and they to have left. I had so know what I'm miss three sapphire rings me." R13 pointed next to her bed whith to her bed whith the same of the was not in her curred directed inquiries to administrator was instated on 1/6/15, R "someone was digg she was "missing sadministrator further what jewelry was left understanding was open but she did not administrator said steport on January 8 when I was informed not reported to state On 03/11/2015, at 16 (MS)-F stated he resaid, "maybe I saw is the only one that	2:11 p.m., R13 stated, "I went I came back someone had by drawer and stole three a variety of other jewelry. I coordinator [HHC] but he has cal coordinator discussed it book pictures of what jewelry I much jewelry, I don't even sing but I am sure I'm missing states, the rings were important to to the top drawer of a cabinet le she spoke. I 2:19 p.m. HHC-A stated she ent position at that time and the administrator. The enterviewed at that time and 13 reported to HHC-B ging through her stuff" and said ome jewelry." The er stated they took pictures of fit in the drawer, and her that the drawer was pried of investigate herself. The she signed "the missing item state, 2015, so that must be ad of the incident" and "it was a agency." I:25 p.m. maintenance staff eplaced the drawer/lock and pry marks, I'm not sure." R13	F 2	25	Administrator, Clinical Administrator and/or designee will be responsible ongoing compliance.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245120	B. WING _		03/12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 226 SS=D	report was made to time. The facility policy end Prevention Plan who included a definition Material exploitation "Stealing, cashing permission, forging resident possession internal reporting an "All cases of maltre immediately to an edesignee) who will the Administrator" "Immediately make 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negle and misappropriation. This REQUIREMENT by: Based on interview facility failed to follo immediate reporting property to the administration.	ntil two days later, and no state survey agency at that ntitled Vulnerable Adult Abuse ich was revised on 8/5/14, nof abuse, "Financial or n: and under section B g of checks without signatures, missing money or ns or belongings." Under E. nd investigation procedures, atment must be reported employee's supervisor (or then report it immediately to 'Under I, State Agency a report to the State Agency." P/IMPLMENT, ETC POLICIES	F 22		э.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING			03/	12/2015
_	PROVIDER OR SUPPLIER			548 FIF	T ADDRESS, CITY, STATE, ZIP CODE RST AVENUE BRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	The facility policy of Prevention Plan wincluded a definition Material exploitation "Stealing, cashing permission, forging resident possession internal reporting a "All cases of maltrimmediately to an designee) who will the Administrator "Immediately maked the Administrator" Immediately maked the MDS indicated in extensive assistant and transfers, and The MDS indicated vascular accident depression. R13's care plan day for abuse/neglect of the MDS indicated vascular accident depression. R13's care plan day for abuse/neglect of the MDS indicated vascular accident depression. R13's care plan day for abuse/neglect of the MDS indicated vascular accident depression. R13's care plan day for abuse/neglect of the MDS indicates "this intervention of "entitle belongings". On 03/11/2015 at to bingo and when broke the lock on a sapphire rings and told the household since left. The clir with me and they thave left. I had so	entitled Vulnerable Adult Abuse hich was revised on 8/5/14, on of abuse, "Financial or on: and under section Bing of checks without gisignatures, missing money or ons or belongings." Under E. and investigation procedures, eatment must be reported employee's supervisor (or then report it immediately to" Under I, State Agency e a report to the State Agency." Inimum Data Set (MDS) dated near to cognition, required ce for activities of daily living demonstrated no behaviors. In diagnoses of cerebral (CVA), hemiplegia, and steed 1/14/13, indicated at risk and the goal was to be free to by others. Further, the care is my home now" with an acourage me to bring personal at 12:11 p.m., R13 stated, "I went I came back someone had my drawer and stole three I a variety of other jewelry. I coordinator [HHC] but he has nical coordinator discussed it ook pictures of what jewelry I much jewelry, I don't even sing but I am sure I'm missing	F 2	occ con alle inv Po Re Ed Re 4/1 Ad	currence reports and 24 hour mmunication reports to ensure egations are brought forward an restigated per policy. licy and Procedure for Vulnerable porting was reviewed and is curucation on the Vulnerable Adult porting Policy was provided to sel/2015 and is ongoing. ministrator, Clinical Administrate d/or designee will be responsible going compliance.	ole Adult rrent. staff on	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER OINTE CROSSING G	ABLES EAST	:	STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	three sapphire rings me." R13 pointed next to her bed whi On 03/11/2015, at 1 was not in her curredirected inquiries to administrator was it stated on 1/6/15, R "someone was digg she was "missing sadministrator further what jewelry was le understanding was open but she did not administrator said streport on January 8	s, the rings were important to to the top drawer of a cabinet le she spoke. 2:19 p.m. HHC-A stated she ent position at that time and the administrator. The enterviewed at that time and 13 reported to HHC-B ging through her stuff" and said ome jewelry." The er stated they took pictures of ft in the drawer, and her that the drawer was pried on investigate herself. The she signed "the missing item with, 2015, so that must be and of the incident" and "it was	F 226			
F 279 SS=D	(MS)-F stated he resaid, "maybe I saw is the only one that Although R13 informmisappropriation of was not informed ureport was made to time. 483.20(d), 483.20(k COMPREHENSIVE A facility must use to develop, review a comprehensive plane.	med the facility of the property, the administrator ntil two days later, and no State survey agency at that (x)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 279			4/20/15

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245120	B. WING _		03/1	12/2015	
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CO 548 FIRST AVENUE CAMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	objectives and time medical, nursing, a needs that are ider assessment. The care plan mus to be furnished to a highest practicable psychosocial well-b §483.25; and any significant being the second of the second	ent that includes measurable etables to meet a resident's and mental and psychosocial attified in the comprehensive at describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment at the right to refuse treatment and document review, the sure the care plan included the se services for 1 of 1 resident	F 2	R39's care plan was update hospice involvement on 4/1/2 Nursing Assistant Care Shee were reviewed and updated	2015. ets for R39		
	2/5/15, indicated m required extensive daily living, depend demonstrated no b The MDS indicated vascular accident a The care plan date hospice team care coordination of res nursing assistant s	nimum Data Set (MDS) dated coderately impaired cognition, assistance for activities of lent for transfers, and ehaviors or mood difficulties. I diagnoses of cerebral and multiple sclerosis. d 9/2/14, nor the St Croix plan dated 3/4/15, addressed ident care. An untitled, undated heet instructed staff of resident address hospice involvement.		involvement on 4/1/2015. Al hospice care plans were revi integration of hospice service 4/1/2015. Staff education on integration care and the care plan was 6 4/1/2015 and is ongoing. The facility will monitor and s correction by completing hos on 10% of residents enrolled services. Audits will be completed for 2 months. The results of be reviewed in QAA and determined audits.	ewed for es on n of hospice completed on sustain spice audits in hospice pleted weekly the audits will ermination will		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (:	X3) DATE SURVEY COMPLETED
		245120	B. WING		03/12/2015
	PROVIDER OR SUPPLIER OINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 279	Continued From pa	ge 7	F 279		
	(RN)-A said R39 we After looking for the	3:53 a.m. registered nurse ent on hospice on 3/4/15. e temporary care plan RN-A n't have a temporary care		Clinical Administrator and/or designe be responsible for ensuring ongoing compliance.	
	(NA)-B stated, "We know the hospice a	9:01 a.m. nursing assistant follow our own care plan. I ids come here but I do not they do for [R39]. I just follow			
	stated, "I don't knownursing assistants is	9:13 a.m. hospice RN-B w how the nursing home know what the hospice nursing hen they are here. I don't it happens."			
F 282 SS=D	(DON) stated they with hospice, and p Croix hospice. The coordination of care	48 p.m. the director of nursing will look at better coordination rovided their contract with St DON verified there was not a policy with hospice. RVICES BY QUALIFIED ARE PLAN	F 282	2	4/20/15
	must be provided b	ded or arranged by the facility y qualified persons in ich resident's written plan of			
	by: Based on observat review, the facility for	NT is not met as evidenced tion, interview and document ailed to follow the plan of care is (R97, R48 and R35) who		R97, R48 and R35 have monitoring Wangerguard checks on their treatm records. All other residents with	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245120	B. WING			03/-	12/2015
	PROVIDER OR SUPPLIER			54	TREET ADDRESS, CITY, STATE, ZIP CODE 48 FIRST AVENUE AMBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	utilized Wander G facility staff when facility). In addition timely positioning reviewed for press assistance for 1 ourinary incontinent. Findings include: R97's Minimum D listed diagnosis of The MDS indicate wandering, behave assessment periodignificant risk of edangerous place. indicated primary steady with balance cueing/limited assecognition. Care pelopement related seeking behaviors staff to make sure monitor for function. Review of R97's to documentation of function of Wander Guard. Wander Guard. Wander Guard. Woof the Wander Gustated. "I believe smanagement do to On 03/11/2015, at 07.11/2015, at 07.11/2015	uards (a system used to alert residents attempt to leave the n, the facility failed to provide for 1 of 3 residents (R73) sure ulcers, and timely toileting f 4 residents (R73) reviewed for ce. ata Set (MDS) dated 1/28/15, Non- Alzheimer's dementia. d presence and frequency of ior occurred 1-2 times during d and places resident at getting to a potentially R97's care plan dated 2/10/15, mode of locomotion is walking, ce and may require ist due to severely impaired lan identified R97 at risk for to memory loss, car/wife and the Wander Guard is on and and daily. The care plan indicated for the Wander Guard is on and and and aliy. The care plan indicated for eatment records lacked daily monitoring for proper er Guard as directed by the care ard function monitoring NA-C so, I think nurses or	F2	282	Wanderguards were reviewed and monitoring for Wanderguard check their treatment records. Skin Risk and Braden Assessment Bowel and Bladder Evaluation was completed on R73. Toileting and repositioning plan for R73 was reassessed; the care plan was reviand updated. Toileting and reposit schedules for all residents were reand revised as necessary. Toileting and Repositioning Policy reviewed and is current. The Polici Procedure for Wanderguard Monitowas reviewed and is current. Education was provided on toileting repositioning on April 1, 2015 and is ongoing. Education was provided 1, 2015 and is ongoing; to ensure Wanderguard monitoring checks a recurring on monthly TARs. The facility will monitor and sustain correction by completing Wandergaudits on 10% of residents who uti Wanderguard system. The facility also complete toileting and reposition audits on 5% of residents. The audits on 5% of residents. The audits completed weekly for 2 months results of the audits will be reviewed QAA and determination will be made continued audits. Clinical Administrator and/or design be responsible for ongoing compliance.	and lewed ioning viewed was y and oring g and s on April re n uard lize the will oning dits will. The ed in de for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245120	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		54	REET ADDRESS, CITY, STATE, ZIP CODE 18 FIRST AVENUE AMBRIDGE, MN 55008	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	checked every night documented in treat stated she could not R97's Wander Guat treatment record. R48's Quarterly ME had non- Alzheime assist of one for loc plan dated 3/9/15, it related to wanderind diagnosis of demer for staff to make suand monitor for fun. Review of R48's tredocumentation of documentation of documentation of documentation of documentation.	of the on NOC shift and should be attend to not record. RN-A then not find documentation that are was documented in the one of the or stype dementia and required comotion off unit. R48's care indicated risk for elopement g, impaired mobility and intia. The care plan indicated are the Wander Guard is on	F 2	82			
	had severe cognitive further indicated here assist of one and understanding and has plan indicated for such as the company of the care plan. On 03/12/2015, at nursing (DON) stated documentation indicated indicated for such as the care plan.	DS dated 2/2/15, indicated he re impairment. The MDS ambulated with extensive sed a walker and wheelchair. ted 3/9/15, indicated he had as at risk for elopement due to a Wander Guard. The care taff to make sure the Wander onitor for function daily. Eatment record did not indicate was being tested as directed 10:07 a.m. the director of ed there was no cating they were checking ensure functionality except for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245120	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER		,	5	TREET ADDRESS, CITY, STATE, ZIP CODE 48 FIRST AVENUE CAMBRIDGE, MN 55008	, 30	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	in March 2015 on A stated they just stated and Procedure reversity for all residents wandering will utilize monitoring and out logs on all pictures of all residents are sponsitive event of a missing resident policy)."	Avalon Top. The DON further arted adding the checks to their and the four residents had dering And Elopement Policy ised 8/09, indicated "The ise least restrictive environment ite recognizing the potential of ag from the facility. The facility ing and alarm systems; sign in households, and maintain lents. This facility will also se plan for implementation in sing resident (refer to missing The policy indicated "Nursing ident safety devices/alarms	F 2	282			
	2/11/2015, indicate physical assistance and was frequently bladder. The MDS severely, cognitive Assessment (CAA assessment [a too risk] identified he voreakdown. The Chad very limited se incontinent of bowelimited mobility. The required staff assist toilet, and that current R73's care plan dates.	dinimum Data Set (MDS) dated and he required extensive, with transferring and toileting, incontinent of bowel and also indicated R73 was ly impaired. The Care Area of for skin risk and Braden of the for predicting pressure ulcer was at moderate risk for skin AA further identified that R73 channes are land bladder, and had very the CAA further indicated R73 stance to turn, reposition and tently his skin was intact.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245120	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
F 282	schedule, which wa upon request." During continuous of from 6:55 a.m. until minutes), R73 remachair, without any ohim toileting assista 6:55 a.m. R73's chathe nursing station R73 remained in from 8:20 a.m. when a sthe main dining roo assistance to eat be still seated in his withe dining area and in front of the Avalo 10:06 a.m. RN-B are (OT)-A assisted R7 provided him with the assisted R73 to stawith use of a gait be his clothing and income and subsequently FO On 3/11/2015, at 10 (NA)-B said R73 " repositioned every last repositioned every last repositioned "a the surveyors got how was not toileted or moved him before when "[RN-B] toileted aides responsibility and that it was on the it got missed."	observation on 3/11/2015, 10:06 a.m. (3 hours and 11 ained seated in his wheel ffer to reposition, or provide ance during this entire time. At air was positioned in front of on the Avalon Gardens unit. Ont of the nursing station until taff member wheeled him into m, and there provided R73 reakfast. At 8:52 a.m. R73, neel chair, was removed from returned to the same location in Garden's nursing station. At and occupational therapist 3 to the bathroom, and oileting assistance. OT-A then and and transfer onto the toilet elt, and RN-B assisted to lower ontinent brief, which was dry,	F 2	82		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 282	currently on a 2-houschedule. On 3/12/2015, at 10 nursing (DON) state assessed need, the interventions. The "expect, of course, A facility policy, Rep 6/03, defined its pur repositioning as ide Plan." The policy ir "receive the requinursing staff and wirepositioning scheduled A facility policy, Toil 6/03, defined its pur toileting as identified The policy indicated requiring assistance the required assistate will be monitored viut 483.25 PROVIDE CHIGHEST WELL Blue Each resident must provide the necessor maintain the high mental, and psycholaccordance with the and plan of care.	D:56 a.m. the director of ed regardless of a resident's bre should be care planned DON stated she would the care plan be followed." Dosition of Resident, modified repose as "To ensure timely ntified in the resident's Care indicated residents would red repositioning by the ll be monitored via the ule." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan." Deting of Resident, modified repose as "To ensure timely din the resident's care plan."	F 24			4/20/15	

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F 309	review, the facility hospice services for reviewed for hospic Findings include: R39's quarterly Mi 2/5/15, indicated in required extensive daily living, dependemonstrated no limit to the MDS indicated vascular accident. The care plan date hospice team care coordination of resulting assistants needs but did not an eds but did not seed but did	ation, interview and document failed to provide coordination of or 1 of 1 resident (R39) ce services. Inimum Data Set (MDS) dated noderately impaired cognition, assistance for activities of dent for transfers, and behaviors or mood difficulties. diagnoses of cerebral and multiple sclerosis. In the detailed of the d	F3	309	R39's care plan was updated with hospice involvement on 4/1/2015. Nursing Assistant Care Sheets for were reviewed and updated for hospice care plans were reviewed integration of hospice services on 4/1/2015. Staff education on integration of hocare, the care plan and location of hospice calendar of visits to ensure integration of hospice care was coron 4/1/2015 and is ongoing. The facility will monitor and sustain correction by completing hospice a on 10% of residents enrolled in hospices. Audits will be completed for 2 months. The results of the auditor enviewed in QAA and determinate made for continued audits. Clinical Administrator and/or design be responsible for ensuring ongoing compliance.	spice for spice the mpleted udits spice weekly idits will tion will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 314 4 SS=D F	consider the sure how in the scale of the schedule of the sche	nen they are here. I don't thappens." a.m. RN-C said there is a tof the notebook of when the facility. RN-C nursing assistants will not look the facility. RN-C nursing assistants will not look the facility. Both the facility is located and the people but not what they will find the facility. Both the facility is sident while in facility. Both the firmed communication is not facility and hospice agency. 48 p.m. the director of nursing will look at better coordination that they will look at better coordination that they will look at better coordination that they will be policy with hospice. Services agreement with Star coordination and evaluation in responsibility for the facility for atting and administering the sell as ensuring the Hospice Patients"	F3			4/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	prevent new sores to This REQUIREMENT by:	from developing.	F 3	14			
	review, the facility farepositioning for 1 c	ion, interview and document ailed to provide timely of 3 residents (R73) reviewed fied as at risk for development			Skin Risk and Braden Assessment Bowel and Bladder Evaluation were completed on R73. Toileting and repositioning plan on R73 was reassessed; the care plan was reviand updated. Toileting and repositions schedules were reviewed for all resund revised as necessary.	ewed ioning	
	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				The policy and procedure was revie and is current. Education was provon the toileting and repositioning placare on 4/1/2015 and is ongoing. The facility will monitor and sustain correction by completing toileting a repositioning audits on 5% of reside These audits will be weekly for 2 m. The results of the audits will be revin QAA and determination will be m. continued audits. Clinical Administrator and/or design be responsible for ensuring ongoing compliance.	nd ents. oonths. iewed nade for	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	from 6:55 a.m. untiminutes), R73 remaininutes), R73 remaininutes), R73 remaininutes), R73 remaininutes), R73 remaininutes, R73 remaininute	observation on 3/11/2015, I 10:06 a.m. (3 hours and 11 ained seated in his wheel chair reposition, or provide him during this entire time. At air was positioned in front of on the Avalon Gardens unit. a newspaper, making ersation with himself, and with I staff passing by, frequently lew his brother. R73 remained and station until 8:20 a.m. when eeled him into the main dining ovided R73 assistance to eat a.m. R73 still seated in his amoved from the dining area same location in front of the arsing station. At 9:32 a.m. and cations, along with a drink. At and occupational therapist is to the bathroom, and coileting assistance. OT-A then and and transfer onto the toilet elt, and RN-B assisted to lower continent brief, which was dry, R73 voided. At 10:12 a.m. d assessed R73's skin, and and ton his buttocks, gluteal e, back or shoulder blades. Formal color and there was no redness or creasing. RN-B in is intact." After providing was assisted by RN-B and I chair, and was returned to	F 314					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245120	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 548 FIRST AVENUE CAMBRIDGE, MN 55008		
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F 314	toileted and reposit said was R73 last r seven, shortly after that she moved R7 front of the nursing R73 was not toilete she moved him, be a.m., when "[RN-B] was the aides respondener, and that it was guess it got missed On 3/12/2015, at 10 manager/registered currently on a 2-hor RN-C said when he a mechanical lift to to assist with his cle RN-C stated there R73's condition, he and understanding receiving therapy, a program. Based on RN-C stated R73 w issues based on a his limited mobility appropriately place repo schedule. RN mobility and streng "this baseline 2-hor [repositioning] schedule on 3/12/2015, at 10 nursing (DON) stat assessed need, the interventions. The	NA)-B said R73 "should be ioned every 2 hours." NA-B epositioned "about ten to the surveyors got here," and 3 from the front room to "in station." NA-B acknowledged d or repositioned from the time fore 7:00 a.m., until after 10 toileted him." NA-B said it onsibility to make sure that got as on our "aide sheets, and I	F 31	4		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245120	B. WING	····	03/1	12/2015
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F 314 F 315 SS=D	6/03, defined its purepositioning as ide Plan." The policy in "receive the requirement and serving staff and with repositioning schedus 483.25(d) NO CATE RESTORE BLADD Based on the reside assessment, the fair resident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servinfections and to refunction as possible This REQUIREMED by: Based on observations as ideal of the policy in the p	cosition of Resident, modified rpose as "To ensure timely entified in the resident's Care endicated residents would ired repositioning by the ill be monitored via the fulle." HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that a necessary; and a resident of bladder receives appropriate ites to prevent urinary tract store as much normal bladder execution, interview and document	F 314	Skin Risk and Braden Assessment	t and	4/20/15
	assistance for 1 of sample reviewed for Findings include: R73's diagnoses, a progress note, date Alzheimer's type degeneralized weakned Minimum Data Set	ailed to provide timely toileting 4 residents (R73) in the or urinary continence. s identified on a physician's ed 2/11/2015, included ementia, gait disorder and ess. R73's admission (MDS), dated 2/11/2015, equently incontinent of bowel		Bowel and Bladder Evaluation were completed on R73. Toileting and repositioning plan on R73 was reassessed; the care plan was revie and updated. Toileting and repositi schedules were reviewed for all resund revised as necessary. The policy and procedure was reviewed is current. Education was provon the toileting and repositioning placare on 4/1/2015 and is ongoing.	ewed oning sidents, ewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 315	physical assistance. The MDS also indicognitively impaire (CAA) for urinary indicated R73 was and bladder, and the anticipated because impairment and vaccommunicate his reducted R73 requested thinking and period had "functional indicated R73 requested thinking and period had "functional indicated thinking as CAA further indicated incontinent care/to Q2H [every 2 hour care plan dated 2/toileting/urinal plans During continuous from 6:55 a.m. untiminutes), R73 remainments, R73 rem	hat he required extensive, e with transferring and toileting. Icated R73 was severely, ed. The Care Area Assessment incontinence, dated 2/18/2015, a frequently incontinent of bowel that his needs had to be see of severe, cognitive ariable ability to identify and need for help. The CAA also uired staff to manage his brief, are for toilet use, and that he continence r/t [related to] and mobility limitations." The ted R73 was "assisted with silet/urinal use (as appropriate) and per request." R73's 5/2015, indicated his in was "q 2hr (every 2 hours)." observation on 3/11/2015, til 10:06 a.m. (3 hours and 11 hained seated in his wheel offer during this time to ide him toileting assistance. At nair was positioned in front of in on the Avalon Gardens unit. It a newspaper, making ersation with himself, and with did staff passing by, frequently new his brother. R73 remained ing station until 8:20 a.m. when neeled him into the main dining rovided R73 assistance to eat a.m. R73, still seated in his emoved from the dining area as same location in front of the nursing station. At 9:32 a.m. RN)-A approached R73 and	F3	15	The facility will monitor and sustain correction by completing toileting a repositioning audits on 5% of resid. These audits will be weekly for 2 m. The results of the audits will be revin QAA and determination will be m continued audits. Clinical Administrator and/or design be responsible for ensuring ongoin compliance.	nd ents. ionths. iewed nade for	

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		245120	B. WING		03.	/12/2015	
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES EAST				STREET ADDRESS, CITY, STATE, ZIP 548 FIRST AVENUE CAMBRIDGE, MN 55008	•		
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F 315	administered his m At 10:06 a.m. RN-E (OT)-A assisted R7 provided him with the assisted R73 to stawith use of a gait behis clothing and incompand subsequently FO (NA)-B said R73 was repositioned every not sure when R73 acknowledged R73 repositioned from the front room to the before 7:00 a.m. ur toileted him." NA-E responsibility to mathat it was on their got missed." During an interview the clinical manage R73 was currently and explained that based on number of his initial 3-day bow the resident's weak admission, and his he first got to the famechanical lift to the assist with his cloth RN-C stated there R73's condition, the and was placed on added that staff we from R73 when he	edications, along with a drink. B and occupational therapist 3 to the bathroom, and oileting assistance. OT-A then and and transfer onto the toilet elt, and RN-B assisted to lower ontinent brief, which was dry,	F3	15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES EAST				STREET ADDRESS, CITY, STATE, ZIP 548 FIRST AVENUE CAMBRIDGE, MN 55008		
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F 315	would re-assess hir also said R73 was a toileting and repo [r that "needed to be care plan." On 3/12/2015, at 10 nursing (DON) state assessed need, the interventions. The "expect, of course, A facility policy, Toil 6/03, defined its put toileting as identified The policy indicated requiring assistance the required assistance the required assistance.	ge 21 In for his toileting needs, but on "this baseline 2-hour epositioning] schedule," and followed through, as in his 0:56 a.m. the director of ed regardless of a resident's ere should be care planned DON stated she would the care plan be followed." eting of Resident, modified rpose as "To ensure timely d in the resident's care plan." If all residents, assessed as et toileting, would "receive ance by the nursing staff and a the toileting schedule."	F3			

Printed: 03/13/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
2		245120	120 B. WING			03/11/2015	
GRACEPOINTE CROSSING GABLES EAST 548 FIR			DRESS, CITY, STATE, ZIP CODE RST AVENUE RIDGE, MN 55008				
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1 ABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESE	NTATIVE'S SIG	NATURE	TITLE		(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

Gracepointe Crossing Gables East March 27, 2015 Page 2

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

Yale Tomoton

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

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 05/04/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00292		B. WING		03/12/2015			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRACEF	GRACEPOINTE CROSSING GABLES EAST 548 FIRST AVENUE CAMBRIDGE, MN 55008						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	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.						
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

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

04/02/15 **Electronically Signed**

TITLE

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00292		B. WING		03/	12/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ARI ES FAST	548 FIRST	ORESS, CITY, S AVENUE GE, MN 550	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. The state states in the "Summer column and replace the correction order the findings which a statute after the states as evidence by." For are the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	Ith orders being submit Although no plan of coate Statutes/Rules, plearected" in the box avail indicate in the electronices, under the heading edate your orders will ectronically submitting tent of Health. 15, surveyors of this visited the above provisited the above provition orders are issued our electronic plan of have reviewed these of when they will be considered in the easigned tag numbers have been of a state statutes/rules as a signed tag number the column entitled "ID tute/rule out of compliances the "To Comply" por this column also include the in violation of the statement, "This Rule is resulted of Correction and the surveyors of the state of the statement, "This Rule is resulted of Correction and the surveyors of the statement, "This Rule is rection.	rrection ase lable for nic g be to the lider and larders, mpleted. In enting larger from the l	2 000			

Minnesota Department of Health

STATE FORM P57Z11 If continuation sheet 2 of 26

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB			E CONSTRUCTION		E SURVEY PLETED
		00292		B. WING		03 /·	12/2015
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ARI FS FAST		ΓAVENUE IGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2 CTION FOR VIOLATIO	NS OF	2 000			
	MINNESOTA STATE STATUTES/RULES.						
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents		ive	2 560			4/20/15
	comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassion of the contast include the incompassion of the contast include the incompassion objects.	of plan of care. The n of care must list meastables to meet the resident goals for medical, nutychosocial needs that an aprehensive resident comprehensive plan of dividual abuse preventionta Statutes, section 62 agraph (b).	dent's rsing, re care on plan				
	by: Based on interview facility failed to ens	ent is not met as evide and document review, ure the care plan include e services for 1 of 1 res hospice services.	the led the		Corrected		
	Findings include:						
	2/5/15, indicated merequired extensive daily living, dependent demonstrated no be the MDS indicated	imum Data Set (MDS) oderately impaired cog assistance for activities ent for transfers, and ehaviors or mood difficing diagnoses of cerebraind multiple sclerosis.	inition, of ulties.				
	hospice team care coordination of resi- nursing assistant sh	d 9/2/14, nor the St Cro plan dated 3/4/15, addr dent care. An untitled, uneet instructed staff of r ddress hospice involve	essed undated esident				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00292	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ARIESEASI	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 3	2 560			
	(RN)-A said R39 we After looking for the	3:53 a.m. registered nurse ent on hospice on 3/4/15. e temporary care plan RN-A n't have a temporary care				
	(NA)-B stated, "We know the hospice a	9:01 a.m. nursing assistant follow our own care plan. I aids come here but I do not t they do for [R39]. I just follow				
	stated, "I don't knownursing assistants I	9:13 a.m. hospice RN-B w how the nursing home know what the hospice nursing hen they are here. I don't it happens."				
	(DON) stated they with hospice, and p Croix hospice. The	48 p.m. the director of nursing will look at better coordination provided their contract with St DON verified there was not a policy with hospice.				
	The director of nurs inservice staff rega	THOD OF CORRECTION: sing or designee could rding the development and are plan, and audit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			4/20/15
	Subp. 3. Use. A co	omprehensive plan of care				

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		` '	E CONSTRUCTION		SURVEY PLETED
		00292		B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	ABLES EAST	548 FIRS	DRESS, CITY, STAVENUE DGE, MN 550	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa must be used by al care of the resident	l personnel involved	I in the	2 565			
	This MN Requirements: Based on observation review, the facility for 3 of 13 residents utilized Wander Gurfacility staff when refacility). In addition, timely positioning for reviewed for pressures assistance for 1 of urinary incontinence.	ion, interview and dailed to follow the pass (R97, R48 and R3 ards (a system use esidents attempt to the facility failed to part of 3 residents (lare ulcers, and time 4 residents (R73) residents (R73) residents (R73)	ocument lan of care 35) who d to alert leave the provide R73) ly toileting		Corrected		
	Findings include: R97's Minimum Da listed diagnosis of I The MDS indicated wandering, behavior assessment period significant risk of go dangerous place. F	Non- Alzheimer's de presence and frequer occurred 1-2 time and places residen etting to a potentially	ementia. uency of es during ut at y				
	indicated primary m steady with balance cueing/limited assis cognition. Care pla elopement related to seeking behaviors. staff to make sure to monitor for function	node of locomotion e and may require st due to severely in in identified R97 at to memory loss, car The care plan indiction the Wander Guard in	is walking, npaired risk for /wife sated for				
	Review of R97's tre documentation of d function of Wander	aily monitoring for p	oroper				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEI	POINTE CROSSING G	ABI FS FAST	ΓAVENUE)GE, MN 55(008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	plan. On 03/11/2015, at 1 (NA)-C and NA-D s Wander Guard. Who of the Wander Guardstated. "I believe so management do the On 03/11/2015, at 1 (RN)-A stated the Nonecked every night documented in treastated she could not R97's Wander Guarteatment record. R48's Quarterly ME had non- Alzheimer assist of one for looplan dated 3/9/15, i related to wanderind diagnosis of demer for staff to make sure and monitor for fundance of R48's treastance of	I1:58 a.m. nursing assistant stated that R97 wears a nen asked if they were aware rd function monitoring NA-Co, I think nurses or at." I2:02 p.m. registered nurse Wander Guard should be at on NOC shift and should be at monitoring that record. RN-A then not find documentation that rd was documented in the comotion off unit. R48's care indicated risk for elopement g, impaired mobility and intia. The care plan indicated are the Wander Guard is on	2 565			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00292	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST 548 FIRST CAMBRID	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
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.					
	nursing (DON) state documentation indi- Wander Guards to in March 2015 on A stated they just state	10:07 a.m. the director of ed there was no cating they were checking ensure functionality except for valon Top. The DON further ted adding the checks to their and the four residents had				
	and Procedure revifacility promotes the for all residents whis residents wandering will utilize monitoring and out logs on all pictures of all resident maintain a responsitive event of a miss resident policy)." T	ering And Elopement Policy sed 8/09, indicated "The eleast restrictive environment le recognizing the potential of g from the facility. The facility g and alarm systems; sign in households, and maintain ents. This facility will also e plan for implementation in ing resident (refer to missing he policy indicated "Nursing dent safety devices/alarms				
	2/11/2015, indicated physical assistance and was frequently bladder. The MDS severely, cognitively Assessment (CAA) assessment [a tool risk] identified he w breakdown. The CA had very limited ser	inimum Data Set (MDS) dated the required extensive, with transferring and toileting, incontinent of bowel and also indicated R73 was y impaired. The Care Area for skin risk and Braden for predicting pressure ulcer as at moderate risk for skin AA further identified that R73 asory perception, was all and bladder, and had very				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00292		B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST		T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	limited mobility. The required staff assist toilet, and that curred R73's care plan date repositioning plan with schedule, which was upon request." During continuous of from 6:55 a.m. until minutes), R73 remained in from toileting assistates 6:55 a.m. R73's charthen ursing station R73 remained in from the main dining room assistance to eat be still seated in his with the dining area and in front of the Avalous 10:06 a.m. RN-B area (OT)-A assisted R7 provided him with the assisted R73 to state with use of a gait be his clothing and incand subsequently For the surveyors got him was not toileted or moved him before the when "[RN-B] toileted when "[RN-B] toileted with toileted or moved him before the when "[RN-B] toileted with the surveyors got him as not toileted or moved him before the moved him b	e CAA further indicate tance to turn, repositionally his skin was intained 2/5/2015, indicate was reposition per toil is "q [every] 2 hrs [hotobservation on 3/11/2 10:06 a.m. (3 hours ained seated in his wiffer to reposition, or pance during this entire air was positioned in front he Avalon Garder ont of the nursing state aff member wheeled m, and there provide the same of the call of the same of Garden's nursing state of the bathroom, are sileting assistance. Ond and transfer onto left, and RN-B assiste continent brief, which we have sained assistance ontinent brief, which we have sained assistance on the sained assistance of the sained assistance on the sained assistance of the sained assistan	on and act. d his eting urs] and 015, and 11 neel provide etime. At front of as unit. aion until him into d R73. R73, red from etation. At pist and DT-A then the toilet d to lower was dry, istant ad R73 was ortly after dged R73 time she 0 a.m. awas the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI FS FAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From page 8		2 565			
	and that it was on their "aide sheets, and I guess it got missed."					
	manager/registered	0:16 a.m. the clinical I nurse (RN)-C said R73 was ur toileting and repositioning				
	nursing (DON) state assessed need, the interventions. The	0:56 a.m. the director of ed regardless of a resident's ere should be care planned DON stated she would 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."					
	6/03, defined its pur toileting as identified. The policy indicated requiring assistance the required assistance.	eting of Resident, modified rpose as "To ensure timely d in the resident's care plan." d all residents, assessed as e toileting, would "receive ance by the nursing staff and a the toileting schedule."				
	The director of nurs (s)could review and procedures related each individual resi of nursing or design to educate staff and	THOD OF CORRECTION: sing (DON) or designee I revise policies and to ensuring the care plan for dent is followed. The director nee (s)could develop a system d develop a monitoring system providing care as directed by eare.				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI FS FAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			4/20/15
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide coordination of 1 of 1 resident (R39) e services.		Corrected		
	Findings include:					
	2/5/15, indicated morequired extensive a daily living, dependent demonstrated no be The MDS indicated	imum Data Set (MDS) dated oderately impaired cognition, assistance for activities of ent for transfers, and ehaviors or mood difficulties. diagnoses of cerebral and multiple sclerosis.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST 548 FIRST CAMBRID	TAVENUE GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 10 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.		2 830			
	An observation on 03/11/2015, at 7:28 a.m. R39 said he was okay and offered no complaints.					
	(RN)-A said R39 we After looking for the	3:53 a.m. registered nurse ent on hospice on 3/4/15. e temporary care plan RN-A n't have a temporary care				
	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."					
	stated, "I don't knownursing assistants k	9:13 a.m. hospice RN-B w how the nursing home know what the hospice nursing hen they are here. I don't it happens."				
	calendar in the fron hospice is coming to acknowledged the nat the schedule who schedule only lists poedoing for R39. Find to do for the real RN-C and RN-D coming to some the schedule only lists poedoing for R39.	a.m. RN-C said there is a t of the notebook of when to the facility. RN-C nursing assistants will not look ere it is located and the people but not what they will RN-D stated when the hospice arrive, they tell them what they esident while in facility. Both infirmed communication is not acility and hospice agency.				
	On 3/11/2015, at 1:	48 p.m. the director of nursing				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00292	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARIESEASI	ΓAVENUE)GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	(DON) stated they with hospice, and p Croix hospice. The coordination of care The nursing facility Croix hospice, unde "Hospice shall retai coordinating, evaluations pice program, a	will look at better coordination provided their contract with St DON verified there was not a policy with hospice. services agreement with St per coordination and evaluation				
	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.					
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			4/20/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	rho has pressure sores y treatment and services to revent infection, and prevent				

Minnesota Department of Health

STATE FORM P57Z11 If continuation sheet 12 of 26

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE	,1 00,1	
GRACEP	POINTE CROSSING G	ARIESEASI	ST AVENUE RIDGE, MN 55	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 12	2 900			
	new sores from developing.					
	by: Based on observati review, the facility for repositioning for 1 of	ent is not met as evidenced ion, interview and document ailed to provide timely of 3 residents (R73) reviewed ified as at risk for developme		Corrected		
	Findings include:					
	progress note, date Alzheimer's type de generalized weakne Minimum Data Set indicated he require assistance with trar frequently incontine MDS also indicated impaired. The Care skin risk and Brade predicting pressure moderate risk for sl further identified the sensory perception bladder, and had vefurther indicated R7 turn, reposition and skin was intact. R7 indicated his repositioleting schedule, velocity [hours] and upon renursing assistant sl indicated R73's toile schedule was "A2 [s identified on a physician's ad 2/11/2015, included ementia, gait disorder and ess. R73's admission (MDS) dated 2/11/2015, ad extensive, physical ansferring and toileting, and was ent of bowel and bladder. The IR73 was severely, cognitive a Area Assessment (CAA) for a succer risk] identified he was kin breakdown. The CAA at R73 had very limited, was incontinent of bowel and ery limited mobility. The CAA at R73 had very limited in a required staff assistance to a toilet, and that currently his litioning plan was reposition powhich was "q [every] 2 hrs equest." The Avalon Group Ameet, updated 3/5/2015, eting and repositioning assist of 2] q [every] 2hrs."	e ly ly late of the late of th			

Minnesota Department of Health

Minneso	Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		00292	B. WING		03/1	2/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
GRACEPOINTE CROSSING GABLES EAST CAMBR			T AVENUE DGE, MN 550	008					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
2 900	from 6:55 a.m. until minutes), R73 remay without any offer to toileting assistance 6:55 a.m. R73's charthe nursing station R73 was looking at non-sensical conveother residents and asking if anyone knin front of the nursing a staff member wheroom, and there probreakfast. At 8:52 wheel chair, was reand returned to the Avalon Garden's nuregistered nurse (Radministered medication 10:06 a.m. RN-B are (OT)-A assisted R7 provided him with the assisted R73 to stawith use of a gait be his clothing and incand subsequently FRN-B inspected and found no impairment folds, coccyx, spine R73's skin was of nunusual warmth or stated, "[R73's] skir perineal care, R73's	In 10:06 a.m. (3 hours and 11 ained seated in his wheel chair reposition, or provide him during this entire time. At air was positioned in front of on the Avalon Gardens unit. a newspaper, making reation with himself, and with staff passing by, frequently ew his brother. R73 remained and station until 8:20 a.m. when eled him into the main dining evided R73 assistance to eat a.m. R73 still seated in his moved from the dining area same location in front of the ursing station. At 9:32 a.m. (N)-A approached R73 and eations, along with a drink. At and occupational therapist 3 to the bathroom, and boileting assistance. OT-A then and transfer onto the toilet elt, and RN-B assisted to lower ontinent brief, which was dry, R73 voided. At 10:12 a.m. dassessed R73's skin, and and to his buttocks, gluteal e, back or shoulder blades. Formal color and there was no redness or creasing. RN-B in is intact." After providing was assisted by RN-B and I chair, and was returned to	2 900						
	nursing assistant (Note toileted and reposite	N/11/2015, at 10:38 a.m., NA)-B said R73 "should be ioned every 2 hours." NA-B epositioned "about ten to							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	ABI ES EAST 548 FIRS	DDRESS, CITY, S ST AVENUE DGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	seven, shortly after that she moved R75 front of the nursing R73 was not toilete she moved him, be a.m., when "[RN-B] was the aides respondence, and that it was guess it got missed On 3/12/2015, at 10 manager/registered currently on a 2-hor RN-C said when he a mechanical lift to to assist with his closure R73's condition, he and understanding, receiving therapy, a program. Based on RN-C stated R73 wissues based on an his limited mobility appropriately placed repo schedule. RN mobility and strengs "this baseline 2-hor [repositioning] schebe followed through On 3/12/2015, at 10 nursing (DON) state assessed need, the interventions. The "expect, of course, A facility policy, Reg 6/03, defined its put	the surveyors got here," and 3 from the front room to "in station." NA-B acknowledged or repositioned from the time fore 7:00 a.m., until after 10 toileted him." NA-B said it onsibility to make sure that go as on our "aide sheets, and I d." 10:16 a.m. the clinical and nurse (RN)-C said R73 was ar repositioning schedule. If first got to facility R73 needed transfer, and another person othing when in the bathroom. In the bathroom, and been improvement in was verbally more responsive and also that he was and was placed on a walking and R73's initial assessments as at risk to develop skin number of factors, including and cognition, and that he was don the standard turning and 1-C said even though R73's the were improving, he was on				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
GRACEP	POINTE CROSSING G	ABLES FAST	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 15	2 900			
	"receive the requirements of the requirements of the requirements of the requirements of the reduce the risk of presents of the reduce the risk of the reduce the risk of the reduce the risk of the requirements of the requirement	THOD OF CORRECTION: The r designee could inservice staffing timely repositioning to pressure ulcer formation, and				
ı	audit to ensure con	npliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			4/20/15
	have a continuous management to recunnecessary use of comprehensive results home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident which without an individual that catheterization because appropriate prevent urinary traces.	program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: The enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to continent of the continent of				
	by: Based on observat	ent is not met as evidenced ion, interview and document ailed to provide timely toileting		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	ABLES FAST 548	ET ADDRESS, CITY, S FIRST AVENUE IBRIDGE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	assistance for 1 of sample reviewed for sample reviewed for Findings include: R73's diagnoses, a progress note, date Alzheimer's type degeneralized weakned Minimum Data Set indicated he was frought and bladder, and the physical assistance The MDS also indicated R73 was and bladder, and the anticipated because impairment and var communicate his not indicated R73 required thinking and pericated thinking and compaired thinking and CAA further indicated incontinent care/toil Q2H [every 2 hours care plan dated 2/5 toileting/urinal plan During continuous of from 6:55 a.m. until minutes), R73 remains chair, without any or reposition, or provice 6:55 a.m. R73's chathen ursing station R73 was looking at	ge 16 4 residents (R73) in the or urinary continence. Is identified on a physician's d 2/11/2015, included ementia, gait disorder and ess. R73's admission (MDS), dated 2/11/2015, equently incontinent of boviat he required extensive, with transferring and toile cated R73 was severely, d. The Care Area Assessing continence, dated 2/18/20 frequently incontinent of both at his needs had to be expected ability to identify and even for toilet use, and that in the formal use (as appropriated R73 was "assisted with elet/urinal use (as appropriated R73 was "q 2hr (every 2 hours) observation on 3/11/2015, and of the Avalon Gardens unit a newspaper, making treation with himself, and we are seated in himself, and we are seated with himself.	vel ting. nent 15, pwel orief, ne ne ste) ." 11 . At of it.			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00292	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ABLES EAST 548 FIRST CAMBRID	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	other residents and asking if anyone knin front of the nursin a staff member wheroom, and there probreakfast. At 8:52 wheel chair, was reand returned to the Avalon Garden's nuregistered nurse (Radministered his m At 10:06 a.m. RN-E (OT)-A assisted R7 provided him with the assisted R73 to stawith use of a gait be his clothing and incand subsequently FOn 3/11/2015, at 10 (NA)-B said R73 warepositioned every not sure when R73 acknowledged R73 repositioned from the front room to the before 7:00 a.m. ur toileted him." NA-E responsibility to mathat it was on their got missed." During an interview the clinical manage R73 was currently of and explained that based on number of his initial 3-day bow the resident's weak	I staff passing by, frequently lew his brother. R73 remained ng station until 8:20 a.m. when eeled him into the main dining ovided R73 assistance to eat a.m. R73, still seated in his amoved from the dining area same location in front of the arsing station. At 9:32 a.m. and edications, along with a drink. and occupational therapist at the bathroom, and colleting assistance. OT-A then and and transfer onto the toilet elt, and RN-B assisted to lower ontinent brief, which was dry, ary voided. D:38 a.m. nursing assistant as to be toileted and 2 hours. NA-B said she was was last toileted. NA-B	2 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00292	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRACEP	OINTE CROSSING G	ABLES EAST 548 FIRST	AVENUE GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 910	mechanical lift to tra assist with his cloth RN-C stated there IR73's condition, that and was placed on added that staff we from R73 when he he would say "pot owould re-assess hir also said R73 was toileting and repo [r that "needed to be care plan." On 3/12/2015, at 10 nursing (DON) state assessed need, the interventions. The "expect, of course, A facility policy, Toil 6/03, defined its put toileting as identified The policy indicated requiring assistance the required assistation will be monitored view SUGGESTED MET director of nursing ostaff regarding proversidents, and auditations.	ge 18 cility R73 needed a ansfer, and another person to ing when in the bathroom. That he was receiving therapy, a walking program. RN-C are getting non-verbal clues needed to toilet, and also that or the stool." RN-C said she or for his toileting needs, but on "this baseline 2-hour epositioning] schedule," and followed through, as in his 0:56 a.m. the director of ed regardless of a resident's ere should be care planned DON stated she would the care plan be followed." eting of Resident, modified rpose as "To ensure timely d in the resident's care plan." d all residents, assessed as e toileting, would "receive ance by the nursing staff and a the toileting schedule." THOD OF CORRECTION: The or designee could inservice riding toileting assistance to to ensure compliance.	2 910			
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990			4/20/15

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00292	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARIESEASI	ΓAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 19	21990			
	immediately make entry point. Use of for the deaf or othe considered an oral point may not requiextent possible, the content to identify the caregiver, the natural maltreatment, any emaltreatment, the reporter, the time, or incident, and any or reporter believes must be suspected malt reporter may disclosin section 13.02, and	an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient the vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined and medical records under the extent necessary to bdivision.				
	by: Based on interview facility failed to ensinvolving misappropreported immediate state agency for 1 dreviewed. Findings include: R13's quarterly Min 2-6-15, indicated in extensive assistant and transfers, and the MDS indicated	and document review, the ure all alleged violations oriation of property were ely to the administrator and the of 3 resident (R13) allegations simum Data Set (MDS) dated tact cognition, required be for activities of daily living demonstrated no behaviors. diagnoses of cerebral CVA), hemiplegia, and		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00292		B. WING	·	03/1	12/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ABLES EAST		ΓAVENUE OGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21990	R13's care plan dat for abuse/neglect a from abuse/neglect a from abuse/neglect plan indicates "this intervention of "enc belongings". On 03/11/2015 at 1 to bingo and when broke the lock on m sapphire rings and told the household since left. The clini with me and they to have left. I had so know what I'm miss three sapphire rings me." R13 pointed next to her bed whill On 03/11/2015, at 1 was not in her curredirected inquiries to administrator was in stated on 1/6/15, R	red 1/14/13, indicated and the goal was to be by others. Further, the by other state of the back someoned and stole the variety of other jew coordinator [HHC] but cal coordinator discussion of the by other jew of the top drawer of a state of the administrator. The terviewed at that times the administrator. The terviewed at that times the top drawer of a state of the top drawer of the top dra	e free he care he care h an hersonal d, "I went he had here he elry. I he has here he had here he as here he and	21990			
	administrator furthe what jewelry was le understanding was open but she did no administrator said s report on January 8	er stated they took pictin the drawer, and that the drawer was of investigate herself. She signed "the mission, 2015, so that must do of the incident" and	her pried The ng item st be				
	(MS)-F stated he re	:25 p.m. maintenand placed the drawer/lo pry marks, I'm not su had a key.	ck and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S F AVENUE	STATE, ZIP CODE		
GRACEP	POINTE CROSSING G	ABI FS FAST	GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	ige 21	21990			
	misappropriation of was not informed u report was made to time.	med the facility of the property, the administrator ntil two days later, and no state survey agency at that ntitled Vulnerable Adult Abuse				
	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."					
	The director of nurs inservice staff rega procedures for repo mistreatment imme	THOD OF CORRECTION: sing or designee could rding the facility policies and orting allegations of abuse and ediately to the administrator and then audit to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
22000		5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			4/20/15
	facility, except hom	prevention plans. (a) Each e health agencies and dant services providers, shall				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00292	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRACE	POINTE CROSSING G	ARI FS FAST	T AVENUE DGE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	establish and enforprevention plan. The assessment of the environment, and it factors which may earn a statement of to minimize the risk comply with any rulpromulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or the plan shall contain the plan shall contain the purple of the facility, of a dults. For the purple term "abuse" include the purple of the facility, of and personal care as knows that the vuln violent crime or an toward others, the inflammation that the plan must detail the minimize the risk the reasonably be experiently and persons unsupervised. Undo of a vulnerable adurisconduct or physical information from authority or through	ce an ongoing written abuse the plan shall contain an physical plant, its is population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services relop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the to person and other vulnerable poses of this paragraph, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00292		B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER POINTE CROSSING G	ABLES EAST	548 FIRST		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	•	ge 23 g assessments of the)	22000			
	by: Based on interview facility failed to follo immediate reporting property to the adm	ent is not met as evident and document review their policy related of misappropriation inistrator and State as allegations reviewed.	w, the to of agency for		Corrected		
	Prevention Plan whincluded a definition Material exploitation "Stealing, cashing permission, forging resident possession internal reporting ar "All cases of maltre immediately to an edesignee) who will the Administrator'	ntitled Vulnerable Addich was revised on 8 in of abuse, "Financian: and under section g of checks without signatures, missing ins or belongings." Under I was supervisor then report it immediate a report to the State	/5/14, I or B money or nder E. edures, orted r (or ately to ncy				
	2-6-15, indicated in extensive assistance and transfers, and of The MDS indicated	imum Data Set (MDS tact cognition, require se for activities of dail demonstrated no beh diagnoses of cerebi CVA), hemiplegia, an	ed ly living naviors. ral				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GRACEF	POINTE CROSSING G	ARI ES EAST	ST AVENUE IDGE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
22000	Continued From page 24		22000			
	for abuse/neglect a from abuse/neglect plan indicates "this	red 1/14/13, indicated at risk nd the goal was to be free by others. Further, the care is my home now" with an ourage me to bring personal				
	to bingo and when broke the lock on m sapphire rings and told the household since left. The clini with me and they to have left. I had so know what I'm miss three sapphire rings	2:11 p.m., R13 stated, "I went I came back someone had by drawer and stole three a variety of other jewelry. I coordinator [HHC] but he has cal coordinator discussed it bok pictures of what jewelry I much jewelry, I don't even sing but I am sure I'm missing s, the rings were important to to the top drawer of a cabinet le she spoke.				
	was not in her curredirected inquiries to administrator was instated on 1/6/15, R "someone was diggshe was "missing sadministrator further what jewelry was leunderstanding was open but she did not administrator said streport on January 8 when I was informent reported to State	er stated they took pictures of ft in the drawer, and her that the drawer was pried of investigate herself. The she signed "the missing item th, 2015, so that must be d of the incident" and "it was e agency."				
	(MS)-F stated he re	:25 p.m. maintenance staff placed the drawer/lock and pry marks, I'm not sure." R1:	3			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00292	B. WING		03/1	2/2015
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
22000	Continued From page 25		22000			
	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.					
	The director of nurs abuse prevention p inservice staff rega	THOD OF CORRECTION: sing or designee could review olicies and procedures, rding prompt reporting to the tate agency, and audit for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				