

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QG9H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00294

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245432		3. NAME AND ADDRESS OF FACILITY (L3) GRACEPOINTE CROSSING GABLES (L4) 1601 RIVERHILLS PARKWAY NORTHWEST (L5) CAMBRIDGE, MN (L6) 55008		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 893042200		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 09/25/2018 (L34)		8. ACCREDITATION STATUS: ____ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: ☒ A. In Compliance With Program Requirements Compliance Based On: ____ 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12) And/Or Approved Waivers Of The Following Requirements: ____ 2. Technical Personnel ____ 6. Scope of Services Limit ____ 3. 24 Hour RN ____ 7. Medical Director ____ 4. 7-Day RN (Rural SNF) ____ 8. Patient Room Size ____ 5. Life Safety Code ____ 9. Beds/Room			
12.Total Facility Beds 141 (L18)		13.Total Certified Beds 141 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 141 (L37) (L38) (L39) (L42) (L43)	
		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)			

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

17. SURVEYOR SIGNATURE <u>Susie Haben, Unit Supervisor</u> (L19)		Date : 10/11/2018		18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Sr. Health Program Rep</u> (L20)		Date: 10/11/2018	
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY ____ 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION 03/01/1987 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) VOLUNTARY <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 10, 2018

Administrator
Gracepointe Crossing Gables
1601 Riverhills Parkway Northwest
Cambridge, MN 55008

RE: Project Number S5432027

Dear Administrator:

On September 5, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 16, 2018. 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 September 25, 2018, 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 August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 19, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 16, 2018, effective September 19, 2018 and therefore remedies outlined in our letter to you dated September 5, 2018, 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245432

October 10, 2018

Administrator
Gracepointe Crossing Gables
1601 Riverhills Parkway Northwest
Cambridge, MN 55008

Dear Administrator:

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 September 16, 2018 the above facility is certified for:

141 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 141 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QG9H

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11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements ____ 2. Technical Personnel ____ 6. Scope of Services Limit Compliance Based On: ____ 3. 24 Hour RN ____ 7. Medical Director ____ 1. Acceptable POC ____ 4. 7-Day RN (Rural SNF) ____ 8. Patient Room Size ____ 5. Life Safety Code ____ 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 141 (L18)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 141 (L37) (L38) (L39) (L42) (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
13.Total Certified Beds 141 (L17)					

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

17. SURVEYOR SIGNATURE Cynthia Wentkiewicz, HFE NE II (L19)	Date : 09/17/2018	18. STATE SURVEY AGENCY APPROVAL Kamala Fiske-Downing, Sr. Health Program Rep (L20)	Date: 10/10/2018
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 5, 2018

Gracepointe Crossing Gables
Attn: Administrator
1601 Riverhills Parkway Northwest
Cambridge, MN 55008

RE: Project Numbers S5432027, H5432047

Dear Administrator:

On August 16, 2018, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the August 16, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5432047 that was found to be unsubstantiated.

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

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

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

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

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

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

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 16, 2018 (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 February 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

Gracepointe Crossing Gables

September 5, 2018

Page 6

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 09/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2018
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted August 13-16, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000			
F 000	INITIAL COMMENTS A recertification survey was conducted August 13, 14, 15, and 16, 2018. At the time of the survey, an investigation of complaint #H5432047 was completed and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550			9/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/12/2018

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.

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

PRINTED: 09/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2018
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote self determination and dignity for 1 of 1 resident (R22) reviewed for dignity. Findings include:	F 550	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an		

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

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NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 550	Continued From page 2 On 8/13/18, at 2:40 p.m. R22 was observed laying on his bed with the door open. R22 was wearing an incontinence product, but no clothing covering his brief such as pants, shorts or pajama bottoms. There was no sheet or blanket covering R22. At 5:55 p.m., R22 was again observed with the door open, wearing an incontinence brief but no other clothing covering his brief. R22 had no blanket or sheet covering him. On 8/14/18, at 8:43 a.m. R22 was observed in his room eating breakfast. R22's door was open. R22 was wearing an incontinence brief with no clothing to cover his brief. R22 had no sheet or blanket covering him. On 8/14/18, at 3:57 p.m. R22's door was closed. After knocking, upon entrance R22 was observed on his bed, uncovered again wearing only an incontinence brief without any clothing covering the brief. At that time, R22 stated he does not wear pants due to staff preference, not his own. On 8/15/18, at 7:59 a.m. nursing assistant (NA)-A and NA-B were observed to assist R22 with changing his brief and washing up. NA-A and NA-B helped dress R22 with a shirt. NA-A and NA-B did not offer to help R22 put any pants, shorts or pajama bottoms, but did put a blanket over R22. On 8/15/18, at 3:14 p.m. the director of nursing (DON) reported she would look into why R22 was not wearing any type of clothing over his incontinence brief. The DON stated staff should offer to assist R22 with putting on lower extremity clothing unless directed otherwise by the care plan.	F 550	admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. R22 was interviewed regarding his preference for clothing. During the interview, he was inconsistent with his preference for clothing. Care Plan and group sheets were updated to include to ask resident his preference with dressing before assisting him. All residents will be interviewed with their next quarterly assessment and ongoing following the RAI schedule regarding their preference with dressing. Care plan and group sheets will be updated as needed. The policy and procedure was reviewed and is current. Education will be completed for staff on offering and honoring residents' choice/rights. All nursing staff are educated on residents' rights upon hire, annually and as needed. The facility will monitor and sustain correction by completing audits on 5% of residents weekly for 2 months. The results of these audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible to ensuring		

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PRINTED: 09/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2018
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 550	Continued From page 3 On 8/15/18, at 2:45 p.m. registered nurse manager (RN)-A stated it was R22's preference not to wear pants. Then RN-A added, RN-A stated she had not seen R22 with clothing bottoms on but was not aware of a reason. RN-A stated if there was a concern or reason for R22 not to wear any clothing over his incontinence brief, it should be identified in the care plan or on the NA care sheets. RN-A reviewed the care plan and care sheets and verified there was nothing documented about R22 not wearing clothing over his incontinence brief. On 8/15/18, at 2:59 p.m. R22 again told the surveyor he would prefer to wear pants, especially if he was not covered by a sheet or blanket. R22's most recent admission minimum data set (MDS) assessment dated 5/23/18, indicated R22 was moderately cognitively impaired, did not refuse care and had no behaviors that were disturbing to him or others. The MDS further indicated R22 required extensive assistance from two staff to dress as his diagnoses included paraplegia and a traumatic brain injury. On 8/15/18, at 3:02 p.m. licensed practical nurse (LPN)-A stated, "as far as I know it is his preference not to wear pants." LPN-A reported she had worked with R22 for three days and he was typically wearing incontinence briefs and not covered. On 8/16/18, at 9:44 a.m. NA-C stated R22 refuses to wear pants as he gets hot and will rip the blanket off. NA-C stated she had reported this to the nurse manager (RN)-A.	F 550	ongoing compliance.		

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F 550	Continued From page 4 On 8/16/18, at 9:47 a.m. RN-A reported the nursing assistants should offer R22 clothing for his lower body to cover the incontinence brief. On 8/16/18, at 3:28 p.m. NA-A reported staff were not in the habit of offering R22 clothing for his lower body because R22 refused. NA-A also stated R22 would remove blankets and sheets put over him. NA-A reported he'd informed RN-A about R22 not wearing lower body clothing "yesterday." R22's care guide undated, included no directions related to R22 not wearing lower body clothing. R22's care plan last revised 4/19/18, included: "Assist me to choose simple, comfortable clothing that is easy to put on." and "Dressing: I require 1 staff participation to dress." There were no problems, goals or intervention related to R22 not wearing lower body clothing.	F 550			
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625			9/19/18

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F 625	Continued From page 5 plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a Notice of Bed Hold and Readmission for 2 of 2 residents (R22 and R112) who were transferred to a hospital. Findings include: R22's medical record, including progress notes and hospital documentation from 7/22/18 to 7/25/18, revealed R22 had been hospitalized related to a urinary tract infection. Further review of R22's record revealed no indication R22 or his resident representative had been provided with a copy of the facility's bed hold policy upon transfer. On 8/16/18, at 11:48 a.m., registered nurse (RN)-A reviewed R22's record and verified there was no evidence the facility's bed hold policy was provided to R22 or his resident representative upon transfer to the hospital. Further, RN-A stated the bed hold policy was provided at the time of admission, but stated she was unsure if it	F 625	R22 and R112 both had their beds held during their hospital stay and have since readmitted to the facility. All other residents have the potential to be effected due to their potential to be transferred out of the facility. Since survey, a system has been put in place to ensure all residents that have been transferred out, receive the facility's bed hold policy. The policy and procedure was reviewed and is current. The transfer out checklist used by nursing was updated to include to document in the medical record that the bed hold policy was sent with the resident and/or resident representative upon transfer. The change in condition template in the electronic medical record was updated to include documentation of bed hold policy being sent with resident and/or		

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F 625	Continued From page 6 was provided at the time of hospital transfer. RN-A explained the facility would automatically hold the bed for 18 days for R22 since his care was paid for by the state's medical assistance program. R112's face sheet indicated the resident had diagnoses including Parkinson's disease and COPD (chronic obstructive pulmonary disease). Review of a progress note dated 5/8/18, indicated R112's temperature had increased and oxygen level decreased with labored breathing, and an order for transfer to the hospital had been obtained. Review of the progress notes lacked evidence of the facility providing R112 or the responsible representative bed hold information at the time of hospital transfer. During an interview on 8/16/18, at 12:10 p.m. licensed practical nurse (LPN)-B stated she expected the family to be notified of a bed hold, and that information should have been documented in the 5/8/18 progress note. On 8/16/18, at 1:17 p.m. the director of nursing (DON) confirmed the facility protocol was for staff to "notify residents or their family of a bed hold." The facility's Bed Hold policy dated June 2014 included: .. "1. Upon admission, resident or resident representative will sign Bed Hold and Readmission Policy... 3. Before a resident leaves for hospitalization or therapeutic leave, the facility will attempt to give the resident a copy of the bed	F 625	resident representative at the time of transfer. Staff was educated on the policy and procedure and updates in checklist and template. The facility will monitor and sustain correction by completing audits for 2 months on 50% of residents transferred out of the facility for bed hold policy being followed. The results of these audits will be reviewed in QAA and determination will be made for continued audits. Clinical Administrator or designee will be responsible to ensuring ongoing compliance.		

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F 625	Continued From page 7 hold policy... 5. Discussion regarding bed hold will be documented in the progress notes".	F 625			

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Printed: 04/30/2018
FORM APPROVED
OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GRACEPOINTE CROSSING B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2018
NAME OF PROVIDER OR SUPPLIER GRACEPOINTE CROSSING GABLES			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 RIVERHILLS PARKWAY NORTHWEST CAMBRIDGE, MN 55008		
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K 000	INITIAL COMMENTS FIRE SAFETY An initial Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Gracepointe Crossing was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Gracepointe Crossing is a 3 story building without a basement built in 2018 and was determined to be Type II(111) construction. The building plans and the building codes were reviewed under the 2012 Edition of the NFPA Life Safety Code after to 07/05/2015 the facility was inspected under new construction. The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 141 beds and had a census of 0 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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