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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RGQB

Facility ID: 00292

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

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

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

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

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

6. DATE OF SURVEY **06/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Carol Bode, HFE NE II 06/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 07/01/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/02/2014 Co.
RePosted 07/07/2014

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/10/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number:
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 6/19/2014, the facility is certified for 90 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245120

July 1, 2014

Ms. Laurie Sykes, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

Dear Ms. Sykes:

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 May 28, 2014 the above facility is certified for for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

July 1, 2014

Ms. Laurie Sykes, Administrator
Gracepointe Crossing Gables East
548 First Avenue
Cambridge, Minnesota 55008

RE: Project Number S5120024

Dear Ms. Sykes:

On May 27, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 18, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 30, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 18, 2014, effective May 28, 2014 and therefore remedies outlined in our letter to you dated May 27, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245120	A. Building B. Wing	6/19/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	05/28/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	05/28/2014	ID Prefix F0241 Reg. # 483.15(a) LSC	05/28/2014
ID Prefix F0246 Reg. # 483.15(e)(1) LSC	05/28/2014	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	05/28/2014	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	05/28/2014
ID Prefix F0257 Reg. # 483.15(h)(6) LSC	05/28/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	05/28/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	05/28/2014
ID Prefix F0314 Reg. # 483.25(c) LSC	05/28/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	05/28/2014	ID Prefix F0332 Reg. # 483.25(m)(1) LSC	05/28/2014
ID Prefix F0353 Reg. # 483.30(a) LSC	05/28/2014	ID Prefix F0373 Reg. # 483.35(h) LSC	05/28/2014	ID Prefix F0441 Reg. # 483.65 LSC	05/28/2014

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	07/01/2014	33560	06/19/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/18/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245120	A. Building 01 - MAIN BUILDING 01 B. Wing	5/30/2014

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	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 05/05/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 07/01/2014	Signature of Surveyor: 03005	Date: 05/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/15/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RGQB
Facility ID: 00292

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

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

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

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

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

6. DATE OF SURVEY **04/18/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Karen Aldinger, HFE NE II — Date: 06/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Kate JohnsTon, Enforcement Specialist — Date: 06/05/2014 (L20)

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 **04/17/1967** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-5120
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 04/18/2014, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

This letter corrects and replaces the certification letter received by you 5/8/2014.

May 27, 2014

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

RE: Project Number S5120024

Dear Ms. Barthel:

On April 18, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 28, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 28, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 July 18, 2014 (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 October 18, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

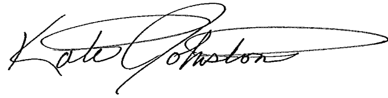
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING ______ B. WING	04/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable 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	**F000** **This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor an agreement with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations.**	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2)- (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F225** R26 had an initial investigation completed on 4/4/14 and found event happened 10+ years ago. FM-A was not active POA of finances since admission to facility. A further investigation and OHFC/CEP report was filed on 4/21/14 and was determined by OHFC that no further action was necessary from their office on 4/28/14. R26 was provided support by the Psychologist on 4/23/14. Care Plan was reviewed and updated. All potential vulnerable adult situations is reviewed and reported to the administrator immediately. The interdisciplinary team reviews all occurrence reports and daily communication board to ensure all allegations are brought forward and investigated per policy.	

6/2/14 accepted 67

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: Brandi Barthel, LNHA
TITLE: Administrator
(X6) DATE: 5/27/14

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.

* Additional information requested is enclosed.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that all alleged violations involving misappropriation of money and property were reported immediately to the state agency, and failed to ensure that these alleged violations were thoroughly investigated by the facility for 1 of 3 resident (R26) allegations reviewed. Findings include: R26's admission Minimum Data Set (MDS) dated 3/30/14, included a diagnosis of kidney disease, and indicated he was cognitively intact, had no behaviors problems, and was independent with activities of daily living. R26's care plan dated 4/2/14 indicated he has some short term memory loss, but no indication of any long term memory loss.	F 225	Policy and procedure for Vulnerable Adult Reporting was reviewed and is current. Administrator attended "Vulnerable Adults Act" education provided by DHS Policy Specialist on 4/30/14. Education on the Vulnerable Adult Reporting Policy is being provided to staff on 5/19/14 and is ongoing. Administrator, Clinical Administrator, and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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R26 was interviewed on 4/15/14, at 9:57a.m. and stated he had been abused. He went on to explain his family member (FM)-A stole his money and property, "I had a cabin and [FM-A] sold it, and took about $40,000 from me." R26 also stated he had reported this to staff at the facility but was unsure of who he had reported this to.

R26's progress note dated 4/4/14, included, "Spoke with [FM-A] regarding history of finances. [FM-A] stated that resident has a history of accusing [FM-A]/friends of stealing money from him. This has affected the relationship between them...."

R26's progress's note dated 4/9/14, included a resident interview, "...I will talk with them but I do not know if it will do any good because my [FM-A] already has stolen all my money."

R26's occupational therapy (OT) progress report dated 4/15/14, included an ACL (Allen Cognitive Level) test completed with the results of 4.2. The undated Interpretation of the Cognitive Performance Test (CPnAllen Cognitive Levels sheet, which measures short term memory loss, identified R26 score was 4.5 which included, "Memory, judgement, reasoning and planning show obvious impairment." This test was completed on 4/15/14, 21 days after the allegation of misappropriation of property was made by R26 on admission.

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When interviewed on 4/18/17, at 7:10a.m. household coordinator (HHC)-E, who was the designated social worker, stated she was on vacation when R26 was admitted to the facility. The administrator was covering for her while she was on vacation. She was informed about the concern when she returned. HHC-E stated, "I interviewed the [FM-A] to be thorough." She did not report the incident to the state agency because she thought her investigation was completed after talking to FM-A, whom the allegation had been made against.

When interviewed on 4/18/14, at 1:43 p.m. the administrator stated she did the initial social work admission process when R26 was admitted. R26 had made an allegation at the time of admission, about his money/property being misappropriated by FM-A The administrator verified this allegation was not reported to the state survey agency.

Although R26 informed the administrator on admission about the misappropriation of property and money. No report was made to state survey agency at that time, and as of 4/18/14, no report had been submitted to the state agency about the allegation of misappropriation of property/money.

The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 3/26/14, included a definition of abuse #15, "Financial or Material exploitation: Illegal or improper use of an individual's funds, property or assets without informed consent and resulting in monetary, personal, or other benefit, gain or profit for the

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F 225	Continued From page 4 perpetrator; or monetary or personal loss by the individual..." The policy also identified under Internal Investigative Steps for Reporting: "The facility must investigate and report suspected abuse or neglect which may have occurred prior to a resident's admission...." The policy also directed the person designated to complete the investigation under I, "Immediately make a report to the State Agency."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow their abuse prevention plan to ensure all allegations of abuse were immediately reported to the state agency (SA) and thoroughly investigated, for 1 of 3 residents (R26) allegations reviewed. Findings include: The facility policy entitled Vulnerable Adult Abuse Prevention Plan which was revised on 3/26/14, included a definition of abuse #15, "Financial or Material exploitation: Illegal or improper use of an individual's funds, property or assets without informed consent and resulting in monetary,	F 226	F226 R26 had an initial investigation completed on 4/4/14 and found event happened 10+ years ago. FM-A was not active POA of finances since admission to facility. A further investigation and OHFC/CEP report was filed on 4/21/14 and was determined by OHFC that no further action was necessary from their office on 4/28/14. R26 was provided support by the Psychologist on 4/23/14. Care Plan was reviewed and updated. All potential vulnerable adult situations is reviewed and reported to the administrator immediately. The interdisciplinary team reviews all occurrence reports and daily communication board to ensure all allegations are brought forward and investigated per policy. Policy and procedure for Vulnerable Adult Reporting was reviewed and is current. Administrator attended "Vulnerable Adults Act" education provided by DHS Policy Specialist on 4/30/14.	

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F 226	Continued From page 5 personal, or other benefit, gain or profit for the perpetrator; or monetary or personal loss by the individual..." The policy identified under Internal Investigative Steps for Reporting: "The facility must investigate and report suspected abuse or neglect which may have occurred prior to a resident's admission...." The policy also directs the person designated to complete the investigation under section I, "Immediately make a report to the State Agency." R26's admission Minimum Data Set(MDS) dated 3/30/14, indicated he was cognitively intact, had no behaviors problems, and was independent with activities of daily living. R26's care plan dated 4/2/14 indicated he has some short term memory loss, but no indication of any long term memory loss. During an interview on 4/15/14 at 9:57a.m. R26 stated he had been abused. He went on to explain a family member (FM)-A stole his money and property, "I had a cabin and [FM-A] sold it and took about $40,000 from me." R26 also stated he had reported this to staff at the facility but was unsure of who he reported this to. R26's progress note dated 4/4/14, included, "Spoke with [FM-A] regarding history of finances. [FM-A] stated that resident has a history of accusing [FM-A]/friends of stealing money from him. This has affected the relationship between them...." When interviewed on 4/18/17, at 7:10a.m.	F 226	Education on the Vulnerable Adult Reporting Policy is being provided to staff on 5/19/14 and is ongoing. Administrator, Clinical Administrator, and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 226	Continued From page 6 household coordinator (HHC)-E, who was the designated social worker, stated she was on vacation when R26 was admitted to the facility. The administrator was covering for her while she was on vacation. HHC-E was informed about R26's allegation of financial exploitation by FM-A, when she had returned. HHC-E stated, "I interviewed the [FM-A] to be thorough." She did not report the incident to the state agency, because she thought her investigation was completed after talking to FM-A, even though the policy directed the facility to contact the state agency and complete a thorough investigation. When interviewed on 4/18/14, at 1:43 p.m. the administrator stated she did the initial social work admission process when R26 was admitted. He had made the allegation against FM-A at that time. The administrator verified this allegation was not reported to the state survey agency as directed by the facility policy. Although R26 informed the administrator on admission about the misappropriation of property and money The facility failed to report this allegation of misappropriation of property/money to the state agency, as directed by the facility policy.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 R21, R42, and R85 have had sleep studies and dietary assessments completed. R47 was relocated to a table by the window on 4/17/15. R16's broda chair was reviewed for functionality. Re-assessments were completed on R47, R85, and R42 for assistance with dining and ADL needs. Care plans and group sheets have been reviewed and updated.	

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 4 of 12 residents (R42, R85, R47, R16) reviewed for dining. In addition, the facility failed to ensure morning cares were provided in a way that enhanced dignity for 3 of 6 residents (R42, R47, R21) reviewed who had activities of daily living completed, and left in bed to finish sleeping. Findings include: DINING R42's significant change Minimum Data Set (MDS) dated 1123114, included severe cognitive impairment, required one person physical assist for eating, recent significant weight loss, and had a diagnosis of dementia, and hospice (end of life) cares had been initiated. The ADL/Functional Rehabilitation Potential Care Area Assessment (CAA) failed to assess if R42 was able to feed herself routinely or not. R42's care plan dated 1126114, included R42 required assist of one person for ADL's (activities of daily living). The nutrition care plan dated 9119113, indicated expected weight loss, but failed to identify if R42 required any type of assistance with eating. The urinary incontinence care plan directed staff to, "Encourage adequate fluid intake w/[with] and between meals daily." R42 was observed on 4/14/14, at 8:37 a.m. being	F 241	The facility initiated an IDT focus group to enhance dining process and resident dignity including rise at will. Policy and procedure for Resident care, dignity and dining room protocol was reviewed and is current. Education on the dignity, resident sleep preferences, and oral care is being provided to staff on 5/19/14 and is ongoing. Dining room and dignity audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits to determine the need for ongoing monitoring. Clinical Administrator and/ or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 241	Continued From page 8 brought into the dining room in her wheel chair and left at the dining room table without any breakfast. She fell asleep at the table at and remained sleeping. At 8:57a.m. dietary aide (DA)-A brought a slice of toast and a glass of juice to R42 but did not awaken her. R42 continued to sleep at the table until 9:20a.m. when nursing assistant (NA)-A attempted to wake her. R42 took one bite of toast, then fell back to sleep and remained sleeping until 9:25a.m. when she was removed from the dining room by NA-A. R42 had slept through breakfast for 43 minutes before being removed from the dining room. When interviewed on 4/18/14, at 10:25 a.m. LPN-A, the clinical coordinator, stated R42 sometimes requires assistance with eating and staff should monitor for this, and provide assistance as needed, if she needs to sleep, staff should lie her down. R85's quarterly MDS dated 2/7/14, included dementia with severe cognitive impairment, required supervision, oversight, encouragement or cueing and set up assist for eating. R85's care plan dated 2/4/14, included a potential nutritional risk due to dysphagia [difficulty swallowing] and variable food intake at meals. Staff were instructed to monitor intake and assist with set up of meal tray. During observation of the morning meal on 4/14/14, at 7:45a.m. R85 was sitting at the dining table sleeping, until she was woken by DA-A and served her meal at 8:39 a.m. DA-A commented R85 was more sleepy than usually, and reported this to licensed practical nurse (LPN)-B. LPN-B did not approach R85. R85	F 241		

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continued to sleep with her breakfast in front of her until 8:57 a.m. when she opened her eyes. She had brown sugar on her hot cereal but no milk. R85 did not attempt to feed herself and at 9:08a.m. DA-A asked RBS how she was feeling, but DA-A did not stay at the table for a response from R85 and left. At 9:08 a.m. RBS started feeding herself, one hour and twenty-three minutes after arriving in the dining room, and twenty-nine minutes after being served the meal. During this time, no one encouraged, cued, or helped set up her cereal, or assisted her to eat.

During observation of the morning meal on 4/17/14, at 7:40a.m. RBS had arrived at the dining room table. R85 looked around the dining room, yelled out at 8:17 a.m. the household coordinator, (HHC)-8 told R85 she would get her breakfast. R85 did not get served her meal until 8:20a.m., 40 minutes after arriving in the dining room.

During observation of the morning meal on 4/18/14, at 7:36a.m. RBS had arrived at the dining room table, she was not served her meal until8:10 a.m., 34 minutes after arriving.

Even though the facility determined R85 was at nutritional risk and required encouragement and cueing to eat, she had to wait 34-56 minutes to be provide with a meal, and 83 minutes to be encouraged to eat.

R47's annual MDS dated 1/17/14, indicated severe cognitive impairment, and that R47 had minimal physical behaviors directed toward others. The MDS also indicated R47's diagnoses included dementia, and functional quadriplegia.

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R47's care plan, revised on 1/26/14, directed staff to remove R47 to a quiet are to eat, and offer feeding assistance when R47 was aggressive and agitated in the dining room.

During observation of the morning meal on 4/1/4/14, at 7:45a.m. R47 was seated by herself at a table facing the wall. R47 banged on the table when she arrived, and an unknown dietary aide obtained her meal for her. R47 did not exhibit any further behaviors.

During observation of the noon meal on 4/14/14, at 12:53 p.m., R47 was seated again alone at a table, facing the wall. R47 was feeding herself and exhibited no aggressive or unusual behaviors during this time.

In an interview on 4/14/14, at 1:17 p.m., DA-A verified that R47 was seated in her wheel chair, alone at the table, and facing the east wall of the dining room and was unsure why.

On 4/15/14 at 8:12a.m., R47 was observed in the North Haven dining room, prior to the breakfast meal service. R47 was again seated in her wheel chair, alone at a table along the east wall, of the dining room, and facing the wall.

During an interview on 4/15/14 at 8:40a.m., NA-B verified that R47 was seated in the North Haven dining room, facilig the wall and was unsure why.

During observation on 4/17/14, at 8:23a.m., R47 was again seated alone at the table, facing the wall. R47 fed herself and did not exhibit any unusual or remarkable behaviors.

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During in interview on 4/17/14, at 12:46 p.m., NA-A stated that R47's spot in the North Haven dining room was at her own table, "facing the wall, and I don't know why." NA-A also said that R47 had been at that table alone, "As long as I can remember." NA-A said there was a time when R47 had unwelcomed behaviors in the dining room, like, "yelling and making noises," but not of lately. NA-A stated R47 should not have to eat facing the wall, alone.

During an interview on 4/18/14, at 10:03 am, LPN-A stated that R47 was not supposed to be facing the wall. LPN-A said there were a, "tot of changes in the dining room" to get the residents to all fit. LPN-A stated it was a matter of "dignity," and that R47, "should be facing the window or other people," but "not the wall" while eating in the dining room.

R16's annual MDS dated 1/31/14, included severe cognitive impairment, and was dependent upon staff for all activities of daily living (ADL's). The MDS listed a diagnosis of Alzheimer's disease. R16's care plan dated 2/7/14, included she was dependent upon staff for wheel chair mobility.

During observations, on 4/14/2014 at 9:19a.m., R16 was pulled backwards in her wheelchair, out of the dining room and then to her room by an unknown nursing assistant.

Review of the facility Dining Room Protocol policy dated 1/21/13, included, "Seat residents at 'resident seating' no more then [sic] 30 minutes before meal service and/or when resident

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F 241	Continued From page 12 desires." "Take resident meal order/request. .All residents should have their meal within 20 minutes after ordering." "Rotate to tables offering encouragement and or assistance where indicated." MORNING CARES R42's significant change MDS dated 1/23/14, included severe cognitive impairment, a diagnosis of dementia, and required extensive assistance with dressing, grooming, and hygiene. R42 was observed on 4/17/14, at 7:12a.m. for morning cares. NA-G entered room, turned on the overhead light and woke R42. NA-G proceeded to wash R42's face, hands, underarms, and provided peri care. During this time, R42 was resistive, yelled out during cares, and atte'mpted to hit and kick NA-G multiple times while NA-G was providing cares. During this, NA-G would talk to R42 and tell her not to do that, and block the hits with her arm, or get out of the way of the kicks. At 7:22a.m. R42's pants were pulled up to her knees and was then covered back up with the bed line, while her pants were around her knees. NA-G stated she had to get assistance to finish getting R42 up with the mechanical lift and left the room. R42 fell asleep and remained to sleep until 9:23a.m. (one hour and 59 minutes after she had been groomed and dressed for the day) when the director of nursing (DON) and NA-W entered the room with a mechanical lift. The DON and NA-W left the room stating R42 was on hospice care, was sleeping, and they would allow her to sleep. R42 slept	F 241		

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until10:54 a.m. when NA-B and NA-G woke her up and assisted her for lunch (3 hours and 42 hours after waking her and providing morning cares).

When interviewed on 4/17/14, at 11:02 a.m. NA-B stated if they cannot get 2 persons to get R42 up right away, she will fall back asleep and they just let her sleep then.

During observation of morning cares on 4/18/14, at 7:30 a.m. NA-N provided hygiene and dressing for R42. R42 had been awoken and was yelling out during the cares NA-N was providing. NA-N pulled R42's pants up to her knees and then left her in bed with her pants around her knees and stated she needed to get assistance with the mechanical lift. R42 fell asleep and remained sleeping and was not assisted into her wheel chair until 10:30 a.m., three hours after she received morning cares.

When interviewed on 4/18/14, at 8:00a.m. NA-N stated they often get R42 dressed and ready for the day, but have to wait for help with the mechanical lift. R42 will go back to sleep and won't get up until much later. NA-N stated that R42 is often combative with cares in the morning and it is better when she is allowed to sleep and wake up naturally on her own schedule.

During interview on 4/18/14, at 2:00p.m. licensed practical nurse (LPN)-B stated R42 should be allowed to sleep until she wakes up naturally and not woken, dressed and then left in bed.

When interviewed on 4/18/14, at 10:25 a.m. LPN-A (the clinical coordinator) stated R42 is uncooperative if she is sleepy and should be

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F 241	Continued From page 14 allowed to sleep until she wakes up. If she falls back to sleep after being dressed for the day, before staff can help her up, staff should allow her to sleep until she wakes up. R47's annual MDS dated 1/17/14, indicated severe cognitive impairment, and R47 required extensive assistance with bed mobility, transferring, locomotion, toileting, ADLs, including personal oral hygiene. R47's care plan, updated 1/26/14, indicated "I require 1 staff [sic] participation with personal hygiene and oral care." During observation on 4/17/14, at 7:26a.m. NA-B knocked on R47's door, entered the room, and asked R47 if she wanted to get up. R47 was not awake. NA-B began gathering supplies for morning cares, pulled out a shirt, then asked R47 if she liked the outfit. R47 was now awake and responded, "gaah." NA-B changed R47's incontinent brief, and completed morning cares, including washing R47's face, chest, underarms and combing hair. After applying deodorant, NA-B dressed R47, then covered R47 with the blanket, returned the bed to low position and placed the call light within R47's reach. Oral care was not offered R47 at this time. R47 fell back asleep by 7:50a.m. At 8:17a.m., NA-A and NA-B entered R47's room, and assisted R47 into her wheel chair with use of a Hoyer (a mechanical lift). NA-A shaved R47's facial hairs, and NA-B combed R47's hair. Oral care was not provided R47 at this time. During an interview of 4/17/14 at 9:37a.m., NA-B verified that R47's oral care was not done this	F 241		

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morning. NA-B stated that if there are usually only three (aides) on the unit, and the "little things" like oral care for residents, often "get missed." NA-B stated, for the residents who use a lift, the, "Hoyer's" we awaken them, get them cleaned and dressed, then leave them in bed until we can get back to them later. NA-A stated we do this routinely for, "aiLthe Hoyer's", otherwise we "couldn't get our assignments done." NA-B stated with all the residents who require use of a "Hoyer" we can't get them "up and ready," and up to breakfast on time. NA-B also stated range of motion (ROM) for residents "rarely" gets done in the morning.

R21's quarterly MDS, dated 1/24/14, indicated he did not walk, used a wheelchair for all mobility, and that R47 required extensive assistance with all ADL's. The MDS also indicated R47 had dementia, without any associated behaviors.

During observation on 4/17/14, at 9:44a.m., R21 was lying in bed in his room, ahd was covered with a blanket, exposing only R21's face. NA-C entered R21's room with a mechanical lift, and began talking to R21, letting him know it was time to get up and go to breakfast. NA-C positioned the lift by R21's bed, then NA-C uncovered R21 who was noted to be fully dressed. NA-C assisted R21 to sit up on the bed, and positioned the lift sling around R21. NA-B and NA-C utilized the lift, and transferred R21 from the bed to the wheel chair. NA-C shaved R21's face, while NA-B combed R21's hair. Then, NA-C then pushed R21 out of the room and into the dining room.

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In an interview on 4/17/2014 at 9:50a.m., NA-G stated she had washed and dressed R21, "about half an hour ago." NA-G stated she routinely awakened residents, then cleaned and dressed them, including R21, and then had the residents go back to sleep, "before breakfast." NA-C verified that R21 had not yet eaten this morning, and stated, "it was late" for R21 to be getting breakfast now.

During an interview on 4/17/14 at 10:03 a.m., licensed practical nurse (LPN)-A said when staff are assisting residents in the morning, they should be "doing everything" and "get them up." LPN-A stated that some residents may not want to get up, it "depends on" who it is, but that routinely, residents should "stay up," and not be put right back to sleep in the morning.

A facility policy regarding dignity, updated 10/04, included, "...that residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life." Further, the facility "...is committed to an atmosphere that humanizes and individualizes each resident and their experiences."

The Resident Care policy dated 9/3/10, included, general morning and bedtime cares. The policy did not include leaving the resident in bed until further help arrives, after morning cares are completed.

F246	483.15(e)(1) REASONABLE ACCOMMODATION	F246		

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F 246 SS=D	Continued From page 17 OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were within reach for 1 of 35 residents (R24) observed who were in the stage 1 sample. Findings include: R24's quarterly Minimum Data Set (MDS), dated 1/31/14, included moderate cognitive impairment, had a stroke with hemplegia/hemiparesis (paralysis/weakness on one side of body), and had functional iri1pairment of upper and lower extremity on one side of the body. She required extensive assistance with activities of daily living. R24's care plan dated 2/10/14, directed staff to assure resident's call light was within reach at all times. Also, the care plan directed staff to encourage the resident to use the call light as necessary. During observations, on 4/15/14, at 4:01 p.m.	F 246	**F246** R24 care plan and group sheet has been reviewed and updated to include proper placement of the call light. All resident care plans were reviewed related to call light use. Call light policy and procedure was reviewed and is current. Education on call light placement is being provided to staff on 5/19/14 and is ongoing. Call light placement audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits to determine the need for ongoing monitoring. Clinical Administrator and/ or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 246	Continued From page 18 R24 yelled for water and stated her room was too hot. R24's call light was in her paralyzed left hand. When the call light was given to R24 in her right hand, she pushed the call light button which activated the call system. During observations, on 4/16/14, at 7:14p.m. R24 yelled out, "Chap stick, chap stick." The resident's call light was noted to be on her left side between her arm and torso on top of the bed linens. R24 was instructed to put on her call light. R24 stated she did not have one. The call light was given to R24 in her right hand and she pushed the call light button activating the call light system for assistance. During inte!View on 4/18/14, at 9:20a.m. nursing assistant (NA)-A stated R24 communicates her needs by using the call light in her room. NA-A stated she places the call light on R24's chest and clips it to her clothing. NA-A verified that their group sheet does not direct staff where to place the call light she R24 could reach it easily with her non-affected hand. During interview on 4/18/14, at 10:33 a.m. licensed practical nurse (LPN)-A stated she would expect the nursing assistants and staff to place the call light in R24's right hand. LPN-A stated the care plan did not direct staff to place the call light in the resident's right hand, even though her left hand was paralyzed.	F 246		
F 248 SS=D	483.15(1)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F248	Continued From page 19 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as eVidenced by: Based on observation, interview, and document review the facility failed to ensure that 2 of 3 residents (R46 and R16) reviewed for activities, were provided with activities to meet their individualpreferences related to a comprehensive resident assessment. Findings include: R46's annual Minimum Data Set (MDS) dated 1/31/14, included she was cognitively intact, was dependent upon staff for transfers, bed mobility, dressing, and hygiene. In addition the MDS identified activity preferences that were very important to R46 included books, newspapers., and magazines to read; to listen to preferred music; to do things with groups of people; to do favorite activities; and to go outside to get fresh air when the weather is good. R46's Diagnosis Report, dated 4/18/14, had diagnoses including generalized muscle weakness, generalized pain, and functional quadriplegia. R46's Therapeutic/Psychosocial Assessment, dated 1/31/14, identified R46, "Likes reading, trivia, watching TV programs (fishing shows /	F 248	F248 R46 and R16 have had new therapeutic/psychosocial assessments completed on 5/12/14. Care plans and group sheets have been reviewed and updated. Activity needs/wants have been reviewed at resident council and at the monthly calendar committee meeting. The May resident recreation calendar has been reviewed and updated. All residents care plans related to activity preferences were reviewed and updated as needed by 5/28/14. All residents will have psychosocial assessments completed in conjunction with the RAI process base on resident interest with care plan and group sheets updated. Education on resident activity preferences and psychosocial assessments is being provided to staff on 5/19/14 and is ongoing. Psychosocial audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits to determine the need for ongoing monitoring. Administrator, Household Coordinator, Activity Director and/or designee will be responsible for ongoing compliance.	

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F 248	Continued From page 20 hunting programs) resident likes watching American Idol, cooking programs, baseball, football." The program plan indicated R46 actively participated, liked group activities, and to socialize with other residents. In addition, the assessment identified R46 was able to pursue own activities of interest. R46's care plan dated 2r1/14, included, "I am able to pursue my own activity interests." The goal for R46 was, "I will choose my own activities." Staff were instructed to, "Continue to provide me with information in regards to activities offered. Resident likes bingo, trivia, chatting, music, cooking, and reading. Provide me with supplies to pursue my activity interests." When interviewed on 4/15/14, at 1:19 p.m. R46 stated he would like activities that were more challenging than what the facility has offered. A group does play Scrabble, which he enjoys, however, staff only a lot one hour for the game, and the game can not be finished in that time frame. He would enjoy other board games, but these are not offered/available for him to use. He continued to state, staff used to help with Cribbage on the weekend, but this is no longer available either. R46 stated, "You get lumped together in the institution." A review of the facility monthly April 2014 Recreation Calendar, included Scrabble and Cribbage every other week. No other board games were identified. During interview on 4/18/14, at 12:32 p.m. the Recreation Director (RD-A), stated R46 likes	F 248	Date certain for purposes of ongoing compliance is 5/28/2014.	

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bingo, men's group, and he is in the activity group. RD-A verified the care plan did not reflect R46's current interests and the goal was not specific to him. RD-A was not aware R46 had concerns over the lack of challenging activities being offered in the facility.

R16's annual MDS dated 1/31/14, included severe cognitive impairment with a diagnosis of Alzheimer's disease, and was dependent upon staff for all ADL's. The staff assessment of daily and activity preferences included listening to music. The activities Care Area Assessment dated 2/5/14, included, health issues which resulted in reduced activity participation, hand indicated care planning would occur to maintain her current level of function.

R16's Therapeutic/Psychosocial Assessment, dated 1/30/14, identified "The resident's eyes are always closed, loves listening to music and to scriptures," and, "seems to be ok with family visits." The program plan was for 1:1(one on one) visits and pastoral care. In addition, the assessment's participation identified R46, "Usually sleeps throughout the day and only gets up during meals," and "sleeps most of the time." The summary/analysis of the assessment identified the, "Resident is on hospice care and usually sleeps most of the time. The resident's eyes are always closed."

R16's activities care plan, not updated since 11/12/12, included, "I am unable to participate in activities due to progressive dementia with

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behavioral disturbances and Alzheimer's disease. I am on the 1:1 visit list." The goal date was 5/2014 and listed, "Resident will display pleasure during one-to-one visits evidenced by calm, no yelling out, no visible anxiety, through next review date." Staff were instructed, "I need 1 to 1 visits and activities if unable to attend out of room events." "Resident likes hand massage, soft music in resident's room and also likes listening to somebody read for her." The undated hospice care plan did not include any type of activity or volunteer provided by hospice.

Review of R16's One-One Activity log, dated 10/31/13-4/3/14, identified that R16 had only six days with an individual one-on-one activity sessions during this time frame. A ten minute hand massage activity session occurred on 10/31/13, 11/14/13, 1/17/14, 3/19/14, and 4/3/14 and a twenty minute reading session occurred on 2/24/14. There were no other activities recorded for R16 in these 127 days.

During observation on 4/14/14, at 9:19a.m. R16 was sleeping in a wheelchair. At 3:55p.m. R16 was in bed sleeping on her back, no music was playing in her room.

When observed on 4/15/14, at 8:14a.m. R16 was sleeping in bed on her back. No music was playing in her room and at 8:36a.m. R16 was assisted by nursing assistant (NA)-C eating breakfast in the dining room.

During observations on 4/16/14, at 7:01 p.m. R16, was in bed, no music was playing in her

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F 248	Continued From page 23 room. During observation on 4/17/14, at 7:02a.m. R16 was in bed positioned on her back, no music was playing in her room. At 7:52a.m. NA-C assisted R16 with morning cares. At 11:12 a.m. R16's hospice music therapist (HMT)- G, was in the room and played guitar and sang the hymn, How Great Thou Art. R16 had her eyes closed and seemed relaxed during HMT-G visit. During interview on 4/14/14, at 10:41 a.m. licensed practical nurse (LPN)-A stated that a hospice volunteer comes, reads, and visits regularly with R16. When interviewed, on 4/14/14 at 10:54 a.m., the Household Coordinator (HHC)-8 stated R16 is on hospice and likes music and people reading to her. He did not know if R16 had a music player in her room or not. During interview on 4/18/14, at 9:34a.m., NA-A stated R16 is up for meals and that a volunteer that comes to read to her, but not sure where the volunteer comes from. NA-A stated the only time the radio is turned on is when her family visits every week. During interview on 4/18014, at 12:41 p.m. the Recreation Director (RD)-A reviewed and stated the current assessment and care plan were not acceptable for R16. In addition, she stated that R16 should have a 1:1 program with sensory	F 248		

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F 248	Continued From page 24 stimulation, even with R16's eyes closed she could benefit from such a program. A policy was requested, but not provided by the facility.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure furnishings within the dining area were conducive to eating for 2 of 2 residents (R8 and R56) who were assigned to a table that wobbled. Findings include: R8's quarterly Minimum Data Set (MDS), dated 2/7/14, indicated RB was cognitively intact. R8's eye exam from Retina Center of Minnesota, dated 1/17/14, indicated that this resident has macular degeneration in her left eye, as well as, "floaters in both," with associated eye pain of the left eye. When interviewed on 4/15/14, at 8:56a.m. R8 stated the table in the main dining room, where she eat her meals was lop-sided, wiggled back and forth, which makes it difficult to eat. R8 states she had reported the wobbly table, but staff just stuff paper under the table leg and it does not	F 253	F253 R8 and R56 table was replaced on 4/17/14. Education on reporting malfunctioning equipment is being provided to staff on 5/19/14 and is ongoing. Observations and reporting of tables will be made during rounds for two months. The facility QA&A committee will review reports to determine the need for ongoing monitoring. Environmental Services Director, Administrator, and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 253	Continued From page 25 fix the table's problem.	F 253		

R8's table in the dining room was observed on 4/17/14, at 8:00a.m. One of the four legs had two pieces of cardboard under it.

An environmental tour was completed on 4/17/14, at 1:00 p.m. with the housekeeping/laundry director (HLD) and the environmental services director (ED). The HLD and ED observed R8's table in the main dining room with the cardboard under one leg. Neither were aware of this concern, HLD and ED repaired the table by placing the table leg stabilizer into the correct position. At 1:50 p.m., both the HLD and ED stated the staff are to contact them, either by phone or email, when a facility repair was needed. At 2:30 p.m. the ED stated he looked at his repair logs and he had not been informed of the table leg concern.

During meal observations, on 4/18/14 at 8:00 a.m., in the main dining room, R8 and R56 were eating breakfast at the same table which was repaired on 4/17/2014. The same table leg was again stabilized with four powder creamer packets.

During interview with both R8 and R56, on 4/18/14 at 8:05a.m., they stated the table is always being propped with something, when it wobbles. Both residents further stated that they mention it frequently to staff and "All they [staff] ever do is wedge things down there." R8 and R56 both indicated that due to their declining vision, when the table wobbles, it can be difficult to eat.

During observation and interview on 04/18/14 at

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F 253	Continued From page 26 8:30a.m., the HLD again observed the table leg being propped with the four powder creamer packets. The HLD stated that she was not notified of this concern and would have the table replaced after the current residents had finished their breakfast. When interviewed, on 04/18/14 at 1:30 p.m., the facility administrator (ADM) stated she was unaware of this table's concern and the housekeeping and dietary staff should be alerting enviromental services to repairs being needed.	F 253		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that resident room temperature concerns were addressed for 1 of 3 residents (R8) who complained their room was cold. Findings include: R8's quarterly Minimum Data Set (MDS), dated 2/7/2014, indicated that R8 had a Brief Interview for Mental Status (SIMS) score of 15. The score indicated R8 was alert, oriented and had no cognition problems.	F 257	**F257** R8 has a thermometer placed in her room. Temperature has been conducive to resident's needs. R8 was offered a room change to a non-window side room, resident declined. Ongoing monitoring of resident's comfort will be reviewed weekly by Household Coordinator and/or designee. Work order policy was reviewed and updated. Education on work order process is being provided to staff on 5/19/14 and is ongoing. Room temperature audits will be completed on 10% of resident rooms weekly for two months. The facility QA&A committee will review audits and determine the need for ongoing monitoring. Environmental Services Director, Administrator, and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 257	Continued From page 27	F 257		

During interview, on 4/15/2014 at 8:56a.m., RB stated she has been cold in her room, especially this winter. RB stated that her daughter told her it was probably because she wasn't the closest room to the heat source.

During environmental tour on 4/17/14 at 1:30 p.m., with the Housekeeping/Laundry Director (HLD) and the Environmental Services Director (ED), noted that R8's bed was located against the exterior wall of her room and a window was located at the foot of her bed. The window was loosely covered by a sheet of clear plastic. The plastic moved with the breeze from the outside the window. The ED felt around the edge of the window and noted there was a cool breeze coming from under the window ledge, which had not been covered with plastic. Neither the HLD nor the ED knew who had covered the window or when this has happened. RB who was in the room at this time stated she remembered she had mentioned the cold room to the facility before Christmas by her and her family, but did not remember if the facility or her family covered the window with plastic to decrease the cool breeze in the room. RB further stated that during the winter months, there was a strong breeze even with the plastic on the window. Now, since the weather was getting warmer the breeze was still there but not as cold. The thermostat, located by the exit door of RB's room, at the opposite end of the room not close to the window read 74 degrees Fahrenheit.

During interview on 04/17/14 at 1:50 p.m., both the HLD and ED stated staff are to contact them, either by phone or email, when a facility repair was needed. Later the same day at 2:30p.m., the ED stated he looked at his log, and there was no

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F 257	Continued From page 28 information from the previous ED about the issue or who had hung the plastic over the window for R8. During interview on 4/18/14 at 4:30p.m., the facility administrator (ADM) stated they did not have a written policy for reporting facility repairs. The ADM stated that staff have been educated to either email or call environmental services.	F 257	F282 R42 has had an oral, dietary, toileting, repositioning, and sleep study completed. Care plan and groups sheet was reviewed and updated. R85 has had an oral assessment and a sleep study completed. Functional maintenance program was reviewed and is current. Care plan and group sheets were reviewed and updated.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal cares as directed by the care plan for 3 of 8 residents (R42, R85 and R47) who needed assistance with activities of daily living. Findings include: R42's significant change Minimum Data Set (MDS) dated 1/23/14, included severe cognitive impairment, a diagnosis of dementia, required extensive assistance with dressing, grooming, hygiene, and one person physical assist with eating. R42's care plan dated 1/26/14, included to brush	F 282	R85 facial hair was removed upon identification. R47 has had an oral assessment completed. Care plan was reviewed and is current. All functional maintenance programs were reviewed for appropriateness. All residents are provided oral care daily with AM cares unless otherwise noted on their care sheets. Residents rounds occur on each household each shift to ensure resident care needs are being met. All residents are reviewed quarterly and with significant change in conjunction with the RAI process. Care plan and group sheets updated. Policy and procedure for care plan, AM/PM cares, skin, and range of motion were reviewed and is current.	

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F 282	Continued From page 29 teeth with morning and bedtime cares with one assistant. The nutrition care plan dated 9/19/13 indicated expected weight loss, but failed to identify if R42 required any type of assistance with eating. The bowel and bladder care plan dated 1126114, directed staff, "Toileting/Repo [reposition] schedule: AM/PM -Q2H [every two hours] as will allow; NOC [night] 1 time prior to 0500 [5:00 a.m.]. " The Impaired mobility care plan dated 1126114, included, "Bed mobility: I require staff assistance for bed mobility. I am able to make changes in body position once properly aligned in bed. A1 [assist of one] staff unless combative then A2." R42 was observed on 4/17/14, at 7:12a.m. during personal cares provided by NA-C. R42 was on her back, and after cares was positioned on her left side. R42 continued to be on her left side until 8:30a.m. at which time she was on her right side and remained on her right side from 8:30 a.m. until 10:54 a.m. (2 hours and 24 minutes) when NA-C and NA-B assisted R42 into a wheel chair. Oral hygiene was not provided during this time with either staff encounter. When interviewed on 4/17/14, at 11:02 a.m. NA-B stated oral cares should be provided at bedtime, and not in the morning. NA-B verified R42 should be turned and repositioned every 2 hours, but had not been completed. R42 was observed during personal cares on 4118/14, at 7:05a.m. by NA-N, who had not provided any oral hygiene for R42. When interviewed at 8:00 a.m. NA-N stated R42 gets her mouth care provided in the evening, and not in the morning.	F 282	Education on providing restorative nursing, dignity, and oral care is being provided to staff on 5/16/14 and is ongoing. ROM/ADL audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits and determine the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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When interviewed on 4/18/14, at 2:00p.m. licensed practical nurse (LPN)-B stated the nurse aides should provide oral hygiene during the morning and at bedtime.

When interviewed on 4/18/14, at 10:25 a.m. LPN-A (who was the clinical coordinator) stated the nursing assistants should be providing oral hygiene with morning and evening cares and repositioning R42 every two hours, as directed by the care plan.

R85's quarterly MDS dated 2/7/14, included severe cognitive impairment with a diagnosis of dementia. The MDS indicated she required supervision, oversight, encouragement, or cueing and set up for eating. R85 also required extensive assistance with personal hygiene and ambulation and was not on a restorative ambulation program.

R85's care plan dated 2/4/14, included_a potential nutritional risk due to dysphagia (difficulty swallowing) and variable food intake a meals. Staff were instructed to monitor intake and assist with set up of meal tray. The mobility care plan identified limited mobility and instructed staff to ambulate to and from meals with one assist, a rolling walker and gait belt. TheADL (activities of daily living) care plan dated 11/19/13, directed staff to assist with personal hygiene and oral cares. R85's Therapy to Nursing Functional Maintenance Program dated 2/7/14, directed nursing staff to ambulate R85 to and from all meals and as needed for behaviors.

R85's physician orders dated 4/1/14, included an order, "Denture adhesive to be applied to

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dentures before meals." R85's medication administration record (MAR) identified an order to apply denture adhesive before meals, but was not signed that it had been provided for February, March, orApril2014 MAR's.

R85 was observed on 4/14/14, at 7:45a.m. in the dining room, sleeping at the dining table. R85 continued to sleep at the table even after her meal was served to her at 8:39 a.m. Dietary aide (DA)-A reported that R85 was more sleepy than usual to licensed practical nurse (LPN)-8 at 8:39 a.m. LPN-B did not approach R85. R85 opened her eyes and looked around at 8:57 a.m. but made no attempt to feed herself. DA-A asked R85 how she was feeling at 9:05_ a.m., but did not stay at the table for a response, or encourage her to eat. R85 started feeding herself at 9:08a.m., one hour and 23 minutes after being seated at the table. When R85 spoke, her upper denture bobbed down slightly. She had multiple long hairs on her chin. No one had encouraged or assisted R85 to eat, even though NA-A, NA-B, and household coordinator (HHC)-B was in the dining room assisting other residents. R85 was removed from the dining room in her wheel chair by DA-A at 9:25 a.m. She did not ambulate or assist R85 with removing the chin hair as directed by the care plan.

R85 was observed for morning cares on 4/17/14, at 6:50a.m. NA-G and NA-B assisted her to ambulate to the bathroom with two hand held assist (not the rolling walker), assisted her with her washing up and dressing, and then placed her in the wheel chair. Oral hygiene had not been provided, and denture adhesive had not been applied to her dentures. R85 propelled her own wheel chair to the dining room at 7:35 a.m. She

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F 282	Continued From page 32 had not been assisted to ambulate there. Denture adhesive had not been applied prior to the morning meal. Her chin hairs had not been removed as directed by the care plan. When inte!Viewed on 4/17/14, at 10:15 a.m. LPN-A stated R85 should be assisted to ambulate to and from meals, should have oral hygiene performed and denture adhesive placed prior to meals. Staff should have attempted to wake her, encourage or assist her with eating as needed and should shaVe all women if needed with morning cares. R85 was observed for morning cares on 4/18/14, at 7:09a.m. NA-H assisted her to the bathroom in her wheel chair. R85 was washed and dressed and placed back in her wheel chair. Oral hygiene and denture adhesive was not provided. R85's chin hairs had not been removed. R85 propelled her own wheel chair to the dining room at 7:36 a.m. NA-H assisted R85 back to her room in her wheel chair at 9:05 a.m. Staff did not assist her with ambulation to or from the meal. When interviewed on 4/18/14, at 9:05a.m. NA-H stated R85 only ambulates if she is restless and asking to be walked. They usually shave the women in the morning if needed, she had not done this for R85 today. NA-H stated R85 sleeps with her dentures in, and the afternoon shift would provide oral hygiene at bedtime. She would only apply denture adhesive if there was a problem. When interviewed on 4/18/14, at 1:00 p.m. LPN-8 verified nurses were not signing the denture adhesive was being applied prior to meals. She stated the nurses do not apply the denture	F 282		

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adhesive, the nurse assistants do, which should be completed prior to each meal. LPN-S was unsure if the nursing assistants were doing this or not.

The Dining Room Protocol policy dated 1/21/13, included, "Seat residents at "resident seating" no more than [sic] 30 minutes before meal service and/or when resident desires." "Take resident meal order/request...All residents should have their meal within 20 minutes after ordering." "Rotate to tables offering encouragement and or assistance where indicated."

R47's annual MDS dated 1/17/14, indicated severe cognitive impairment, and R47 required extensive assistance with bed mobility, transferring, locomotion, toileting, ADLs, including personal oral hygiene. R47's care plan, updated 1/26/14, indicated "I require 1 staff [sic] participation with personal hygiene and oral care."

During observation on 4/17/14, at 7:26a.m. NA-B began routine morning cares for R47. Oral care was not offered or provided R47 at this time. R47 remained in her bed, and fell back asleep by 7:50 a.m. At 8:17a.m., NA-A and NA-B entered R47's room, and assisted R47 into her wheel chair. NA-A shaved R47's facial hairs, and NA-B combed R47's hair. Oral care was neither offered or provided R47 at this time.

During an interview on 4/17/14 at 9:37a.m., NA-B verified that oral care was not completed for R47 this morning. NA-B stated that if there are usually only three [aides} on the unit, and the "little things" like oral cares for residents, often "get missed."

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F 282	Continued From page 34 NA-B said oral care should be provided "two times everyday," in the morning and when the residents go to bed. In an interview on 4/17/14 at 12:26 p.m., LPN-B stated she would expect routine resident cares "be provided to residents." During on interview on 4/18/14 at 1:38 p.m., the director of nursing (DON) stated she would "expect the aides" to tell the nurses or care coordinators if ROM, grooming or hygiene was "not getting done and why," and to ask of the nurses what help was needed to "make sure the tasks get done."	F 282	**F312** R42 has had oral, dietary, toileting, repositioning, functional maintenance program, dining process and sleep study completed. Care plan and group sheet was reviewed and updated. R85 has had oral assessment, functional maintenance program reviewed and a sleep study completed. Care plan and group sheet was reviewed and updated to reflect use of dental adhesive. R47 has had an oral assessment completed. Care plan was reviewed and is current. All functional maintenance programs were reviewed for appropriateness. All residents are provided oral care daily with AM cares unless otherwise noted on their care sheets. Residents rounds occur on each household each shift to ensure resident care needs are being met. All residents are assessed for ADL's, mobility, skin risk, and toileting minimally quarterly and with significant change in conjunction with the RAI process.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 5 residents (R42, R85 and R47) reviewed for activities of daily living (ADL's) received the necessary assistance with eating, grooming, and/or ambulation as had been determined as needed. Findings include:	F 312		

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R42's significant change Minimum Data Set (MDS) dated 1/23/14, included severe cognitive impairment, a diagnosis of dementia, required extensive assistance with dressing, grooming, hygiene, and one person physical assist with eating. R42 had suffered significant weight loss since the previous assessment. R42's dental Care Area Assessment (CAA) dated 1/24/14, included natural teeth, unable to physically understand need for teeth/oral hygiene. "Resident cannot remember how to brush her teeth or follow commands/demonstration on this." The dental CAA indicated care planning would be reviewed.

R42's care plan dated 1/26/14, included to brush teeth with morning and bedtime cares. The nutrition care plan dated 9/19/13 indicated expected weight loss, but failed to identify if R42 required any type of assistance with eating.

R42 was observed on 4/14/14, at 8:37a.m. being brought into the dining room in her wheel chair. R42 had not received her food and was sleeping at the table at 8:45 a.m. R42 was brought a piece of toast and a glass of juice at 8:57 a.m. by dietary aide (DA)-A. DA-A did not wake her up. R42 continued to sleep at the table until 9:20 a.m. when nursing assistant (NA)-A attempted to wake her. R42 took one bite of toast, then fell back to sleep. R42 remained sleeping until 9:25a.m. when she was removed from the dining room by NA-A. R42 had slept through breakfast for 43 minutes, only encouraged by staff once to eat/drink, and was removed from the dining room after only one bite of food.

R42 was observed on 4/17/14, at 7:12a.m. for morning cares, being provided by nursing

F 312

An IDT focus group has been established to evaluate the dining process to meet residents needs.

Oral hygiene, skin, repositioning, toileting, and FMP policies were reviewed and is current.

Education on ADL's, FMP, oral care and staff resources for assistance is being provided to staff on 5/19/14 and is ongoing.

ROM/ADL audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits and determine the need for ongoing monitoring.

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

Date certain for purposes of ongoing compliance is 5/28/2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING ________ B. WING	04/18/2014

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

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS$-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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assistant (NA)-C. R42 was washed up and dressed, and then covered back up and left in bed until10:54 a.m. when NA-B and NA-G assisted her up into the wheel chair. Oral hygiene had not been provided with either encounter.

When inteiViewed on 4/17/14, at 11:02 a.m. NA-B stated oral cares should be provided by the aide at bedtime, not in the morning.

R42 was obse!Ved for morning cares on 4/18/14, at 7:05 a.m. provided by NA-N. R42 was washed and dressed, however oral hygiene had not been provided prior to R42 going to breakfast.

When inteiViewed on 4/18/14, at 8:00a.m. NA-N stated R42 gets her mouth care provided in the evening, not in the morning.

When inteiViewed on 4/18/14, at 2:00p.m. licensed practical nurse (LPN)-B stated the nurse aides should provide oral hygiene morning and at bedtime and provide assistance in the dining room if she is not eating.

When interviewed on 4/18/14, at 10:25 a.m. LPN-A (the clinical coordinator) stated R42 sometimes requires assistance with eating and staff should monitor for this, and provide assistance as needed. The nurse aides should be providing oral hygiene with morning cares.

R85's quarterly MDS dated 2f1/14, included severe cognitive impairment with a diagnosis of dementia. she required supeiVision, oversight, encouragement, or cueing and set up for eating. R85 also required extensive assistance with

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personal hygiene and ambulation and was not on a restorative ambulation program.

R85's care plan dated 2/4/14, included a potential nutritional risk due to dysphagia (difficulty swallowing) and variable food intake at meals. Staff were instructed to monitor intake and assist with set up of meal tray. The mobility care plan identified limited mobility and instructed staff to ambulate to and from meals with one assist, a rolling walker and gait belt. The ADL (activities of daily living) care plan dated 11/19/13, directed staff to assist with personal hygiene and oral cares.

R85's physician orders dated 4/1/14, included an order, "Denture adhesive to be applied to dentures before meals."

R85's medication administration record identified the order to apply denture adhesive before meals, but was not signed out as being provided by nursing for February, March, or April 2014.

R85's Therapy to Nursing Functional Maintenance Program dated 2n/14, directed nursing staff to ambulate R85 to and from all meals and as needed for behaviors.

R85 was observed on 4/14/14, at 7:45a.m. in the dining room, sleeping at the dining table. R85 continued to sleep at the table even after her meal was served to her at 8:39a.m. Dietary aide (DA)-A reported that R85 was more sleepy than usual to licensed practical nurse (LPN)-B at 8:39 a.m. LPN-B did not approach R85. R85 opened her eyes and looked around at 8:57 a.m. but made no attempt to feed herself. DA-A asked R85 how she was feeling at 9:05a.m., but did not

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stay at the table for a response, or encourage her to eat. R85 started feeding herself at 9:08 a.m., one hour and 23 minutes after being seated at the table. When R85 spoke, her upper denture bobbed down lightly. She had multiple long hairs on her chin. No one had encouraged or assisted R85 to eat, even though NA-A, NA-B, and household coordinator (HHC)-B was in the dining room assisting other residents. R85 was removed from the dining room in her wheel chair by DA-A at 9:25 a.m. She did not ambulate her as directed by the care plan.

R85 was observed for morning cares on 4/17/14, at 6:50 a.m. NA-C and NA-B assisted her to ambulate to the bathroom with two hand held assist (not the rolling walker), assisted her with her washing up and dressing, and then placed her in the wheel chair. Oral hygiene had not been provided, and denture adhesive had not been applied to her dentures. R85 propelled her own wheel chair to the dining room at 7:35 a.m. She had not been assisted to ambulate there. Denture adhesive had not been applied prior to the morning meal. Her chin hairs had not been removed.

When interviewed on 4/17/14, at 10:15 a.m. LPN-A stated R85 should be assisted to ambulate to and from meals, should have oral hygiene perfonned and denture adhesive placed prior to meals. Staff should have attempted to wake her, encourage or assist her with eating as needed. Staff should shave all women if needed with morning cares.

R85 was observed for morning cares on 4/18/14, at 7:09a.m. NA-H assisted her to the bathroom in her wheel chair. R85 was washed and dressed

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and placed back in her wheel chair. Oral hygiene and denture adhesive was not provided. R85's chin hairs had not been removed. R85 propelled her own wheel chair to the dining room at 7:36 a.m. NA-H assisted R85 back to her room in her wheel chair at 9:05 a.m. Staff did not assist her with ambulation to or from the meal.

When interviewed on 4/18/14, at 9:05a.m. NA-H stated R85 only ambulates if she is restless and asking to be walked. They usually shave the women in the morning if needed, she had not done this for R85 today. NA-H stated R85 sleeps with her dentures in, and the afternoon shift would provide oral hygiene at bedtime. She would only apply denture adhesive if there was a problem.

When interviewed on 4/18/14, at 1:00 p.m. LPN-B verified nurses were not signing out the denture adhesive to be applied prior to meals, she stated the nurses do not apply the denture adhesive, the nurse aides do. This should be done prior to each meaL LPN-B had no way of knowing if the nurse aides were doing this or not.

R47's annual MDS dated 1/17/14, indicated severe cognitive impairment, and R47 required extensive assistance with bed mobility, transferring, locomotion, toileting, ADLs, including personal oral hygiene. R47's care plan, updated 1/26/14, indicated "I require 1 staff [sic] participation with personal hygiene and oral care."

During observation on 4/17/14, at 7:26a.m. NA-B began routine morning cares for R47. NA-B changed R47's incontinent brief, washed R47's face, chest, underarms, combed her hair, and

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applied deodorant. NA-B dressed R47, then covered R47 with the blanket, returned the bed to low position and placed the call light within R47's reach. Oral care was not offered R47 at this time. R47 fell back asleep by 7:50a.m. At 8:17 a.m., NA-A and NA-B entered R47's room, and assisted R47 into her wheel chair. NA-A shaved R47's facial hairs, and NA-B combed R47's hair. Oral care was not provided R47 at this time-.

During an interview on 4/17/14, at 9:37a.m., NA-B verified that oral care was not completed for R47 this morning. NA-B stated that if there are usually only three [aides] on the unit, and the "little things" like oral cares for residents, often "get missed." NA-B said oral care should be provided "two times everyday," in the morning and when the residents go to bed.

In an interview on 4/17/14 at 12:26 p.m., licensed practical nurse (LPN)-B stated she would expect routine resident cares "be provided to residents."

During on interview on 4/18/14 at 1:38 p.m., the director of nursing (DON) stated she would "expect the aides" to tell the nurses or care coordinators if range of motion, grooming or hygiene was "not getting done and why," and to ask the nurses what help was needed to "make sure the tasks get done."

The Oral Hygiene policy dated 8/03, included, a purpose of: to cleanse mouth, teeth, and dentures, to prevent infection and irritation, to moisten the mucous membrane, and to promote

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F 312	Continued From page 41 personal hygiene. The policy provided instructions on performing oral hygiene, and included a note: "Offer oral hygiene before breakfast and at bedtime." The Resident Care policy dated 9/3/09, included, to assist with oral care according to cares plan, and to shave residents in a.m.	F 312	F314 R42 was re-assessed related to skin risk and repositioning and a sleep study completed. Care plan and group sheet was reviewed and updated. Skin Risk Policy has been reviewed and is current.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care was provided as determined as needed to prevent pressure ulcers for 1 of 2 residents (R42) reviewed who was at risk for pressure ulcers. Findings include: R42's significant change Minimum Data Set (MDS) dated 1/23/14, included severe cognitive impairment, a diagnosis of dementia, hospice care had been initiated, was at risk for pressure ulcers, and required extensive assistance with	F 314	All residents who require assistance with repositioning had their care plan reviewed and updated as needed. Resident rounds occur daily on each shift to ensure resident repositioning needs are being met. All residents are assessed for skin risk and repositioning needs minimally quarterly and with significant change and in conjunction with RAI process and care plan updated. Education on the need for repositioning is being provided to staff on 5/16/14 and is ongoing. Repositioning audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review audits and determine the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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bed mobility, transfers, and mobility. The pressure ulcer Care Area Assessment (CAA) dated 1/26/14, included R42 was at risk for pressure ulcers, "Resident is a 92 year old female with significant decline in mobility and cognition. Resident now a transfer mechanically with A2 [assist of two] staff, unable to communicate needs consistently. Resident is still able to make major changes in body position while in qed just not safe with transfers/ambulation (multiple falls) any longer (was independent with mobility not long ago.) Resident skin intact. Is incontinent of bowel and bladder always, requires assist to properly align body in bed, does slide around on the bed. Resident spends majority of time in bed or w/c [wheelchair] now. Poor nutritional intake with recent significant weight loss. Admitted to hospice 1/14/14 for dx [diagnosis] terminal dementia with failure to thrive." The CAA indicated care planning would occur to minimize-risks.

R42's care plan dated 1/26/14, included under bowel and bladder incontinence, directed staff to, "Toileting/Repo [reposition] schedule: AM/PM -Q2H [every two hours] as will allow; NOC [night] 1 time prior to 0500 [5:00a.m.]." The Impaired mobility care plan dated 1/26/14, included, "Bed mobility: I require staff assistance for bed mobility. I am able to make changes in body position once properly aligned in bed. A1 [assist of one] staff unless combative then A2." R42's potential for impaired skin care plan dated 1/26/14, included to provide adequate fluids with and between meals, and to turn and reposition per elimination care plan.

R42's Comprehensive Skin Risk Data Collection

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dated 1/21/14, included risk factors involving problems with sensory perception, moisture, activity, nutrition, and friction/shearing. The form concluded a two hour day time repositioning schedule was appropriate.

R42 was obse!Ved on 4/14/14, from 8:37 a.m. until 9:25 a.m. sleeping at the breakfast table. Nursing assistant (NA)-A attempted to wake her up at 9:20a.m. but was unable to and removed R42 from the dining room at 9:25a.m. NA-A never encouraged R42 to drink her beverages as was directed in the care plan.

R42 was observed on 4/17/14, at 7:12a.m. during personal cares provided by NA-C. R42 had been on her back, and positioned on her left side when cares were completed. R42 continued to be on her left side until8:30 a.m. at which time she was on her right side. R42 remained on her right side until10:54 a.m. (2 hours and 24 minutes) when NA-C and NA-B assisted her into a wheel chair.

When interviewed on 4/17/14, at 10:45 a.m. NA-G stated R42 should be repositioned every two hours because she was unable to reposition herself any more. NA-G verified R42 had not been repositioned since before 8:30a.m. NA-G stated R42 was unable to to move herself around, and some days she still could, but she was not able to changes herself from side to side any more.

When interviewed on 4/18/14, at 2:00p.m. licensed practical nurse (LPN)-B stated R42 should be assisted to reposition every two hours, especially when she was more fatigued as her ability to reposition herself varies from day to day.

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F 314	Continued From page 44 When interviewed on 4/18/14, at 10:25 a.m. LPN-A (the clinical coordinator) stated R42 has been declining in her ability and some days she can move herself around- better than other days. LPN-A verified R42 was at risk for the development of pressure ulcer and needed to be repositioned every two hours. The Skin Risk Policy dated 8/13, included, each residents risk factor and potential causes should be reviewed individually, addressed in the analysis and interventions implemented.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rails exceeded the recommended spacing in zone 1 as recommended in the current U.S. Department of Health and Human Services Food and Drug Administration (FDA) guidelines for Bed System Dimensional and Assessment Guidance to Reduce Entrapment, issued 3/10/06 for 1 of 3 residents (R62) who currently utilized side rails. Findings include:	F 323	**F323** R62 grab bar was removed on 4/17/14. Physical device assessment was reviewed and updated. Care plan and group sheet was reviewed and updated. Physical Device Policy has been reviewed and is current. A physical device audit was completed on all grab bars of residents in the facility on 4/17/14 and is ongoing. All residents are assessed for proper use of positioning devices minimally quarterly and with significant change of condition in conjunction with the RAI process and care plan and group sheets updated. Education on the FDA guidelines for grab bars is being provided to staff on 5/16/14 and is ongoing. Education was provided to Hospice on 5/19/14.	

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F 323	Continued From page 45 R62's quarterly Minimum Data Set (MDS) dated 3/20/14 identified diagnoses of cerebral vascular accident (CVA)- with paralysis on non dominant side, muscle weakness, and paralysis agitans (Parkinson's disease). R62 also had moderate cognitive impairment and needed extensive assistance for bed mobility and was totally dependent for transferring out of bed. The activities of daily living care area assessment (CAA) dated 7127113 indicated R62 had physical limitations such as weakness, limited range of motion, poor coordination, poor balance and visual impairments. R62's care plan updated 11/29/13 indicated problems of self care performance deficit, limited mobility, confusion, impaired balance and cognitive impairment. During observation on 4/17/14 from 7:00a.m. to 8:30a.m. R62 was lying on his left side in bed with his knees slightly bent and lower legs crossed. His bed was pushed against the wall and an assist rail was noted on the left side or exit side of the bed. The assist rail was attached to the frame of the bed. There was a large space noted between bars of the rail causing a potential entrapment hazard. R62 was observed on 4/17/14 from 8:42a.m. in bed, sleeping, would awaken and move his left leg and place it over the edge of the bed. He would then fall asleep, and when he awoken would again place his leg over the edge of the bed. He continued to do this same process until 9:12a.m. when he was gotten up for the day. Review of the Physical Device Data Collection Tool dated 10/1/13 indicated "resident supplied with a different transfer/grab bar on 9/30/13.	F 323	Physical device audits will be completed weekly on 5% of residents for two months. The facility QA&A committee will review the audits and determine the need for ongoing monitoring. Clinical Administrator, Environmental Services Director and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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Resident able to demonstrate proper use of grab/transfer bar with turning in the bed." The assessment did not identify if R62 was safe to use the assist rail even though there was a large gap between the bars of the assist rail.

On 4/17/14 at 1:25 p.m. the maintenance personnel (M)-A measured the assist rail in the up position. The openings between the bars of the rail (zone 1) measured 20.67 inches wide by 15.35 inches high. The M-A agreed the gap was a potential entrapment hazard for R62. The FDA guidelines for Bed System Dimensional and Assessment Guidance identified zone 1 was to be less than 4 3/4 inches wide, to prevent possible entrapment hazards.

During interview on 4/17/14 1:27 p.m. with registered nurse (RN)-A and nursing assistant (NA)-K about the assist rail. RN-A stated, "We consider that [assist rail] a grab transfer bar provided by hospice to assist with positioning in bed and cares." NA-K stated, "He doesn't really grab it now, he used to, and is a little stiff up top now."

During an interview with RN-A and NA-D at 1:45 p.m. NA-D confirmed R62 was capable of moving himself around in bed and could potentially get caught within the large opening of the assist rail. RN-A stated, "Hospice supplied the bed and rail to us." She confirmed they had not completed an assessment to determine if the large gaps were appropriate for R62.

The facility policy ntitled Physical Device policy, last modified January 2010, under procedure number 8 indicated "All side rails on the resident bed will meet the FDA guidelines for safety."

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate was less than 5%, for 3 of 7 residents (R34, R69, RB) observed during medication administration. The facility medication error rate was 16%. Findings include: A facility policy Medication Administration Error Policy revived 1/10 indicated a medication error occurs when the medication is administered at the wrong time, route, dose and person. R34 medication set up was observed on 4/17/14, at 10:10 a.m. with licensed practical nurse (LPN)-E. LPN-E dispensed the medication ursodiol (a bile acid that decreases the amount of cholesterol produced by the liver and absorbed by the intestines) 300mg (milligram) and exelon (improve the function of nerve cells in the brain) 4.5 mg. LPN-E then proceeded to give R34 his medications. Review of the physician orders dated 4/17/14, indicated ursodiol 300 mg take one capsule oral and exelon 4.5mg one capsule orally were both to "take with meals". During interview 4/17/14, at 10:20 a.m. LPN-E stated she should have given R34 his	F 332	F332 R34 and R8 had medication error reports completed and MD updated. Nurses involved in medication administration were re-educated upon identification of error. Education on medication pass guidelines is being provided to nurses/TMA's on 5/16/14 and is ongoing. Medication pass survey audits will be completed on each nurse/trained medication assistant. Medication pass survey audits will be completed randomly on 5% of nurses/TMA's weekly for two months. The facility QA&A committee will review the audits and determine the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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F 332	Continued From page 48 medications at 8:00a.m. with his breakfast but an emergency had come up and she was unable to give his medications at that time. RB was observed during a medication pass on 4/17/14, at 1:02 p.m. by LPN-E. LPN-E removed RB's prednisolone ophthalmic (eye) solution 1% from the medication cart. The label read, install one drop into each eye. LPN-E then placed a pair of gloves in her pocket and entered R8's room. LPN-E put the gloves on and squeezed the eye drop bottle twice and install two drops of the eye solution into each eye. R8 had the prednisone white solution running down her cheek from the eye drops. The physician orders dated 4/17/14, indicated prednisolone ophthalmic solution 1% install one drop into each eye four times a day, not two drops as observed on 4/17/14 at 1:02 p.m. During interview 4/17/14, at 1:10 p.m. LPN-E stated the medication order indicates to give one drop into each eye and that she installed "one big drop" into each eye. R69's medications were observed being administered on 4/18/14, at 7:23 a.m. by LPN-B. R69 medications were in a bubble packet. LPN-8 pushed the medication through the foil paper of the bubble pack into the medication cup. After setting up several medications LPN-B attempted to remove the mediCation atenolol (medication used for high blood pressure) 25 mg then placed the medication bubble pack on the side of the medication cart. The atenolol was not placed in the medication cup and had fallen out of the bubble pack onto the floor next to the medication cart. LPN-8 then proceeded to pour water and was getting ready to give R69 her medications. The surveyor stopped LPN-8 and asked her if the atenolol was in the medication cup, she stated "yes". LPN-B was showed.the atenolol which was	F 332		

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F 332	Continued From page 49 on the floor. LPN-B picked up the atenolol off the floor and dispensed another atenolol from the bubble pack and administered the medications to R69. During interview 4/18/14, at 9:00a.m. the director of nursing (DON) was informed of the 16% medication error rate per the above observations. The DON stated R34 should have received his medications with his breakfast and the nurses were nervous when being watched which is probably why the errors occurred. During interview 4/18/14, at 9:32a.m. the consultant pharmacist stated that R34's medications are to be given with meals to help reduce gastric-intestinal upset and R8 should have received one drop into each eye and did not feel these errors were significant.	F 332		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353	**F353** R42, R85, R47, and R16 meal times have been reviewed and adjusted meal times accordingly. Sleep studies and dietary assessments were completed on R21, R42, and R85. Oral assessments were completed on R47, R85, and R42. Care plans have been reviewed and updated. An oral, toileting, and repositioning assessments were completed on R42. Care plan was reviewed and updated. R85 has had an oral assessment completed. Care plan was reviewed and updated.	

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section, the_facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance for 4 of 12 residents (R42, R85, R47, R16) reviewed for dining assistance, and 3 of 6 residents (R42, R47, R21) reviewed for activity of daily living assistance. In addition, for 7 of 21 residents (R50, R109, R46, R8, R18, R20, and R28) interviewed, and 5 of 8 (NA-B, NA-G, NA-P, DA-A and LPN-B) staff interviewed complained of not being able to get their job duties completed due to inffficient staffing.

Findings include:

There were 4 of 12 residents (R42, R85, R47, R16) that had to wait extensive periods of time to be assisted with meals and 3 of 6 residents (R42, R47, R21) who were woken, assisted with activities of daily living and left in bed for extensive periods of time after they had been awaken by staff to wait for additional help. Refer to F241 for additional information.

There were 2 of 5 residents (R42, R85 and R47) that did not receive assistance with activities of daily living (ADL) assistance due to lack of staffing. Refer to F312 for additional information.

Resident interviews:

Provider's Plan of Correction (F 353):

R47 has had an oral assessment completed. Care plan was reviewed and is current.

R50, R109, R46, R8, R18, R20, and R28 were interviewed and concerns addressed. Plan was initiated and residents were educated/informed of plan in place. Follow up interviews with residents will be conducted weekly and ongoing as needed to ensure residents' needs are being met.

An IDT focus group has been established to evaluate dining process, resident care needs, current staff assignments, and resident desires to re-evaluate staff schedules and support needs.

Dining hours adjusted to allow for resident wake at will, residents choice, and resident needs to be met.

PIPP Grant and recruiting efforts are being reviewed and is ongoing

Staff have been reallocated to adequately meet resident's dining needs.

Root cause analysis along with staff input was completed to determine proper placement of staff throughout facility to ensure residents needs are being met in an appropriate and timely manner.

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F 353	Continued From page 51 RSO's quarterly Minimum Data Set (MDS) dated 3/14/14, indicated she was cognitively intact. R50 was interviewed on 4/15/14, at 9:20a.m. and stated the facility does not have enough staff in the morning which makes her have to wait a long time to be assisted with morning cares. R50 stated that on 4/14/14, she had to wait over an hour for help, which was not unusual, by that time her bladder was so uncomfortable, she could "have cried." R109's quarterly MDS dated 2/3/14, included she was cognitively intact. R109 was interviewed on 4/17/14, at 1:05 p.m. and stated she often does not feel well after lunch because of gastrointestinal problems. It was normal for her to have to wait 45 minutes to over one hour to lie down which increases her abdominal discomfort and make her uncomfortable. R46's annual MDS dated 1/31/14, indicated R46 was cognitively intact, but dependent upon staff for transfers, bed mobility, dressing, and personal hygiene. During an interview on 4/15/14, at 1:19 p.m. R46 stated that he and another resident waited in the dining room about 45 minutes to an hour before they were served their meal because there was are not enough staff. In addition, R46 stated that last Saturday, 4/12/14, at 9:20a.m. he waited until10:45 a.m. for his breakfast. "They are short of *staff*. Not enough people to go around. There are a number of office people trained but they aren't here Saturday and Sunday so you just have to wait. There aren't enough staff."	F 353	Education/communication continues to be provided through all staff, stand ups and survey correction meetings and is ongoing. Adequate staffing audits will be completed randomly on 10% of residents weekly for two months. The facility QA&A committee will review the audits and determine the need for ongoing monitoring. Discussion of resident satisfaction and call light response will be reviewed at resident council meetings. Administrator, Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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R8's quarterly MDS dated 217/14, identified R8 had was cognitively intact.
During interview on 4/15/14 at 9:05a.m. R8 stated, "Sometimes you have to wait along time for someone to come and wait on you. This morning they must have been short. We had to wait for our breakfast and there was just one helping." R8 also stated she uses her wheelchair for long distance and does propel herself, however her shoulders and arms get tired. If I call for help, she still has to wait a half hour to 45 minutes for any assistance.

R18's quarterly Minimum Data Set (MDS) dated 3/7/14, indicated intact cognition, and that she required extensive assistance with toileting, bed mobility and tra-nsferring. During an interview on 4/15/14 at 10:40 a.m., R18 stated "sometimes there is not enough staff," and that it seemed the worst between when the "day shift leaves and the afternoon staff comes in." R18 stated she had incidents of soiling herself because "staff has not responded to my needs."

R20's quarterly MDS, dated 4/4/14, indicated that she was cognitively intact, and that she was totally dependent upon staff for transferring, and required extensive assistance for toileting. In an interview on 4/15/2014 at 2:44 p.m.,R20 stated "we wait for everything." R20 said that while it has not happened daily, "I have soiled myself because of the waiting. R20 said "I'd like to burn" the call light, because "nobody ever comes."

R28's quarterly MDS, dated 1/10/14, indicated she had intact cognition and required extensive

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assistance for bed mobility, transferring, dressing and toileting. During an interview on 4/14/14 at 4:27p.m., R28 stated that during the morning and evening meals, and then when staff are putting residents to bed, are when "it's usual" to have to wait as much as 45 minutes to get help.

STAFF INTERVIEWS

During an interview of 4/17/14 at 9:37a.m., NA-B stated they only have three nurse aides to get everyone up, the, "little things," like oral cares for residents often, "gets missed." NA-B stated for residents who require a mechanical lift, they are expected to get them washed and dressed for the day, and then cover them back up until they can find additional help to get them in their chairs with the mechanical lifts. NA-B stated a good number of residents are late for breakfast because they do not have .enough help to get them there on time and help feed those who need to be fed. In addition, if they are expected to perform range of motion on residents, they do not have time to do this.

During an interview on 4/17/14, at 9:50a.m. NA-G stated she routinely awakened residents, then clean and dress them and then had the residents go back to sleep "before breakfast." NA-C stated residents were often late for breakfast.

During an interview on 4/17/14, at 1:48 p.m. NA-P stated there were a lot of residents who required

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use of some kind of mechanical lift NA-P stated, "I think about 20 of the 29 residents" used a lift on the unit. NA-P stated that there were recently more staff hired, but that because of the staff's age, could not operate a lift by themselves, and often that required, "extra wait time," for the resident as the staff searched for another staff to assist with the transfer. NA-P stated that on occasion "I have skipped oral cares, and range of motion (ROM)" because of "time" issues. NA-P said she thought work of toileting and repositioning of the residents, "gets done, but maybe not timely." NA-P also said she did not have any additional "time" to talk and visit with the residents when they may be feeling "down" and just needed a few more minutes during cares. NA-P said she had little or no quality time with residents because "so many residents" required "much assistance."

During an interview on 4/14/14, at 9:49a.m. dietary assistant (DA)-A stated "we get behind" serving meals because so many of the residents on this end require lifts, and don't get to the dining room on time. DA-A said often the residents come to the dining room, and are left to themselves, and have to wait a long time before they can eat, because the aides still must get others up and dressed, and often, "I'm here alone with the residents." DA-A said that breakfast is to start at eight, but if there are not enough staff available, at the begin of the meal service, "how can the residents all get fed near the same time?" The DA-A also said the steam table is to come down "around 9 a.m.," but after that time, "I'm not able to offer choices for the residents, especially if they require a "mechanical or altered diet." The DA-A also said, that if residents eat breakfast so

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F 353	Continued From page 55 late, "they're not going to want to eat at noon." DA-A stated "we could use more help," especially to assist "feeding the residents." In an interview on 4/17/14 at 12:26 p.m., licensed practical nurse (LPN)-B stated she would "expect" routine resident cares, and range of motion be provided to residents, and "expected" aides to let her know if those things were not done. LPN-B also said there were "twenty or twenty-one" residents who required some kind of lift for transfers on the north side, and said, frankly, that some cares such as "ROM and other care areas" are missed because of "short staff." LPN-B also said the aides who are not of age, those 16 and 17 years old, can do all tasks, "except be the main operator of the lifts." LPN-B said, not being able to operate the lifts, puts pressure on "all the other staff," and "we all get behind on our work." LPN-8 said that it "would be nice" to get the residents up and dressed without "having to put them back to bed," and added that it "was not really possible now" as there were too many residents requiring "lift assistance." LPN-B also stated that the "care managers" have assisted the aides on the floor "a lot," and also have had to come in on weekends "if we are short." During on interview on 4/18/14 at 1:38 p.m., the director of nursing (DON) stated the staffing ratio is a combination of the census and case mix or the acuity of the residents' needs, and that the acuity varies "from day to day." The DON said that, presently, the facility was not full to capacity. The DON said the resident assistant minors (RAMs) have been educated and can *do* "everything" except run the rhechanicallifts. The	F 353		

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F 353	Cantinued From page 56 DON stated the nursing assistant position "is difficult to fill" and that "we have been trying" to improve staffing he e. The DON said "we compete" with the metro area, and that was a "big detriment" to finding staff. The DON also said she would "expect the aides" to tell the nurses or care coordinators if ROM, grooming or hygiene was "not getting done and why," and to ask of the nurses "what was needed to help to "make sure the tasks get done." The DON also said the ancillary staff often "assisted" daily to help the aides, and that the supervisory staff has also "come in on the weekends" to help out. A facility policy regarding staffing policies, undated, indicated, that "Schedules will be developed with the intent of meeting the needs of residents."	F353		
F 373 SS=E	483.35(h) FEEDING ASST-TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work urider the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call	F 373	F373 R3, R6, R39, R24, and R1 have had dietary assessments completed. Care plans were reviewed and updated. PHS Feeding Residents policy was reviewed and is current. It is the position of GracePointe Crossing Gables East that paid feeding assistants are no longer utilized. All residents are assessed for ADL need including feeding assistance minimally quarterly and with any related change in condition in conjunction with RAI process and care plan and group sheets updated.	

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system.

A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:
o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
Feeding techniques.
Assistance with feeding and hydration.
Communication and interpersonal skills.
Appropriate responses to resident behavior.
Safety and emergency procedures, including the Heimlich maneuver.
Infection control.
Resident rights.
Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course

F 373

The Dining process has been reviewed by IDT and assignments reviewed to allow for additional dining support by nursing staff and adjusted culinary server hours and staff to allow for resident needs

The dining room protocol was reviewed and updated.

Communication of this practice has occurred and will be evaluated ongoing.

Audits of the dining room process will be completed weekly and discussed at resident council monthly. The facility QA&A committed will review audits to determine the need for ongoing monitoring.

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

Date certain for purposes of ongoing compliance is 5/28/2014.

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for paid feeding assistants.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure 5 of 5 residents (R3, R6, R39, R24, R1) reviewed for assistance with eating, were comprehensively assessed to be safely fed by a paid feeding assistant (PFA) (non-nursing trained person used to assist resident with eating).

Findings include:

The facility provided an undated list entitled "Residents appropriate for trained feeding assistants." The list identified 11 residents, that were appropriate to be fed by a paid feeding assist (PFA), which included R3, R6, R39, R24 and R1. The director of nursing (DON) stated on 4/14/14, at 11:18 a.m. these residents were the ones typically fed by the facility's PFA.

R3's quarterly Minimum Data Set (MDS) dated 2/21/14, included severe cognitive impairment with a diagnosis of dementia, required extensive assistance with eating, and was on a mechanically altered diet.

R3's care plan dated 1/2/14, included, "I am at potential risk for aspiration, dehydration, skin breakdown & [and] wt. [weight] loss." Staff were instructed to: "Provide, seJVe diet as ordered...I require meal setup & may need minimal assist

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observe for need. Encourage my independence." "Observe and report to MD [medical doctor] PRN [as needed] for slsx [signs and symptoms] of dysphagia [difficulty swallowing]: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing."

R3 was observed being assisted with the morning meal by paid feeding assistant (PFA)-C, on 4114/14, from 8:35a.m. until9:25 a.m. R3's food was pureed, and her liquids at nectar thick consistency without a straw in them. R3 was talking nearly constantly, even when she had her mouth full of food. When she would talk with her mouth full, she would start coughing, then sounded congested. PFA-C had placed a straw in R3's juice at 8:51 a.m. Licensed practical nurse (LPN)-A came to the table at 8:53a.m. and instructed the straw be removed. PFA-C did remove the straw. R3 continued to talk with her mouth full and cough, PFA-C reminded R3 not to talk with her mouth full several times. LPN-A told PFA-C she would assist R3 at 8:57a.m., which she did. R3 continued to talk with her mouth full and cough, despite being reminded by LPN-A not to do so.

R3 was observed on 4116114, from 12:09 p.m. until12:55 p.m. for the noon meal, being assisted by nursing assistant (NA)-A. R3 talked nearly constantly, especially when NA-A gave any attention to different resident at the table. NA-A had to remind R3 to swallow and not talk with her mouth full at least a dozen times, R3 would only stop talking for a few seconds. R3 did not have a straw in her liquids. R3 would occasionally start coughing and then would sound congested as

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F 373	Continued From page 60 she continued to talk with her mouth full. R3's physician order report dated 2/7/14, included she had Alzheimer's disease and "dysphagia-oropharyngeal phase," and an order for a, "Diet: Dysphagia L-1 [pureed], low lactose, nectar thick liquids-uSe straw with nectar thick liquids and encourage to take small sips as tolerated." R3's Geriatric Services of Minnesota Progress Note by the physician dated 12/18/13, included, "h/o [history of] dysphagia." R3's dietary assessments dated 11/26/13, and 2/11/14, included she had chewing and swallowing difficulty, and was on a level 1 diet with nectar thickened liquids. R3's Hydration Risk Assessment dated 2/16/14, included, "Swallowing problems and/or is on thickened liquids." R3's North Haven Assignment Sheet, dated 4/17/14, included, "Diet: L1-pureed, Nectar thick liq. [liquids] cue to not talk while eating/swallowing_." When interviewed on 4/14/14, at 12:40 a.m. nursing assistant (NA)-A stated R3 yells out when she is eating, which causes her to cough. A few weeks ago R3 had, "choked and coughed so hard her face turned red." NA-A stated R3 needs constant reminders not to talk while eating, take small bites, and take a deep breath if she is coughing on the food she had in her mouth when she starts talking. NA-A reported the, "choked and coughed," episode to a nurse at the time it	F 373		

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occurred.

R3's progress notes dated 3118/14 through 4115114, included 10 notes indicating R3 had been talking during meill times. A progress note dated 2/20114, included, "Resident yelling out during breakfast this a.m., talking/yelltng with food in her mouth. Staff remind resident to eat what's in her mouth without yelling to avoid choking. Redirection effective for short period." There was no indication that R3 has been assessed to determine if she could be safely fed by a PFA even though she had problems with choking and coughing while being fed.

R3's General Order dated 4/14114, included, "Ok for speech eval and treat." The SLP [speech language pathologist] Evaluation dated 4115/14, indicated R3's swallow ability was within functional limits and no recommendations were made on this form. However, a progress note dated 4115/14, included, "SLP [speech/language pathologist] eval [evaluation] completed. Evaluation only. Refer to POC [plan of care] for details. New FMP [functional maintenance program] put in place," which was signed by the SLP. The FMP was not provided by the facility.

When interviewed on 4/14/14, at 12:45 p.m. LPN-8 stated R3 had one episode of choking when a family member had given her regular thin liquids, other than that, she was not aware of any choking or swallowing problems with R3. LPN-8 stated she is always available during meal times, if any were to have problems with eating, they could call out to her.

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When interviewed on 4/14/14, at 1:05 p.m. PFA-C stated he checks with the nurses on who needs assistance with eating each day, assisting residents one to three times per week. He would only feed residents who do not have problems with choking, including R3, R6, R39, R24, R1 . R3 had never choked, she just coughs when she talks with her mouth full of food, whih happens routinely with each meal.

When interviewed on 4/14/14, at 4:30p.m. the facility's consultant nurse stated R3's eating problems are behavior related, R3 has not choked or aspirated, and she would not consider her as having complicated feeding problems, even though R3 talks while eating which causes her to cough.

Even though R3 had been fed by a PFA, she had complicated feeding problems related to behavior of talking while her mouth was full of food, which caused her to cough. R3 was not provided with a straw that had been ordered, and had a known diagnosis of dysphagia. The facility had not assessed these risk factors as part of a determination if a PFA could assist R3 to eat.

R6's quarterly MDS dated 2/28/14, included a diagnosis of a stroke, required extensive assistance to eat, and was on a mechanically altered diet. The nutritional CAAdated 5/31/13, included, "Res is at risk for altered nutrition status d/t is obese per BMI and requires the use of mech [mechanical] altered and therapeutic diet d/t dysphagia and to help control weight."

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R6 was observed on 4/14/14, as he arrived in the dining room at 9:10a.m. and was placed in the corner of the room, with a tray table. R6 was served a pureed diet with thickened liquids and had a two handled covered cup. R6 would talk, but his speech was not understandable, and sounded congested when he spoke. R6 drank liquids independently and at 9:25a.m. NA-B fed him the remainder of his meal. He did not talk after being assisted to eat his morning meal.

R6's care plan dated 2/26/14, included, "I am at risk for altered nutritional status d/t morbid obesity, dementia with dysphagia which requires the use of mech [mechanically] altered diet,...I require the use of adaptive equipment r/t eating too fast and require partial to total assist at meals with eating and drinking." Staff were instructed to, "Observe and report to MD [medical doctor] PRN [as needed] for s/sx [signs/symptoms] of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing."

R6's Physician Order Report dated 2/24/14, included a diagnosis of chronic bronchitis, and a diet of L-1 honey thick liquids via two handled cups with spout lids. Small portions, ok regular portions of meat and fruit. Baby spoons to assist with taking smaller bites of food."

R6's Geriatric Services of Minnesota Progress Note dated 2/24/14, he had been treated for pneumonia in January 2013, and, "h/o [history of]

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CVA [stroke] with L [left] sided hemiplegia [weakness], aphasia [unable to speak] and dysphagia [difficult swallowing]-At risk for aspiration. Appropriate diet in place." There was no indication in the resident record that R6 had been assessed to determine if she was safe to be fed by a PFA, even though R6 had dysphagia and was at risk for aspiration.

When interviewed on 4/14/14, at 12:40 p.m. NA-A stated R6 will cough at times when eating, and is on thickened liquids. He will often say, "I can't breath, I can't breath," and sounds congested, while talking but he doesn't seem to be having problems with swallowing.

Although R6, had dysphagia and was at risk for aspiration he was being fed by a PFA, despite the facility not assessing if R6 was safe to be fed by a PFA.

R39's significant change MDS dated 4/3/14, included diagnoses of dementia and Parkinson's disease, he was independent with eating, but received nutrition via a feeding tube. R39's nutritional Care Area Assessment (CAA) dated 4/3/14, included, "Res [resident] does have dx [diagnosis] of dysphagia, however this has resolved and staff reports res tolerates current diet without swallowing difficulty."

R39's Physician Order Report dated 1/28/14, included a diagnosis of dysphagia and an order for a diabetic diet. An order to flush G-tube [a

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tube inserted through the abdominal wall and into the stom·ach], with 8 ounces of ginger ale once a day two days a week was dated 12/12/13.

R39's care plan dated 12/29/13, included, "I have a G-tube. I do not use this at this time for any nutritional or hydration purposes. I have this just in case I decline as I have a hx [history] of poor nutritional intake previously and required external feedings." "I have nutritional problem or potential nutritional problem r/t [related to] res [resident] requires use of therapeutic CCHO [diabetic] diet d/t [due to] DX [diagnosis] of hyponatremia, HX of dysphagia with Ox of Parkinson's (resolved at this time), and potential difficulty feeding self d/t tremors." R39's goal included, "I will show no signs/symptoms of aspiration/choking through review date."

R39's Geriatric Services of Minnesota Progress Note dated 2/25/14, included, a diagnosis of "Advanced Parkinsonism with dysphagia, maintaining wts [weights] on oral feeds." There was no indication in the record that R39 had been assessed to be safely fed by a PFA even though he had diagnosis of dysphagia. There was no indication in the resident record that R39 had been assessed to detennine if she was safe to be fed by a PFA, even though R36 had dysphagia.

R39 was observed for the breakfast and noon meal on 4/17/14, at 9:00a.m. and 12:00 p.m feeding himself independently, and did not have any difficulty swallowing.

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Although R39 was identified by the facility as being a candiate to be fed by a PFA, and had dysphagia, the facility had not assessed R39 to determine if he could be safely fed by a PFA despite having dysphagia.

R24's quarterly MDS dated 3/17/14, indicated she required extensive assistance with eating, and a mechanically altered diet. R24's diagnoses, from the MDS, included history of cerebral vascular accident (stroke), with hemiplegia, dysphagia, diabetes, and dementia.

R24 was observed for the morning meal on 4/14/14, from 7:45a.m. until9:25 a.m. R24 was served at 8:45a.m. she fell asleep and at 8:51 a.m. dietary aide (DA)-A woke her up by yelling to her, "sleeping beauty, open your eyes." R24 opened her eyes and started feeding herself. After a few bites, R24 fell asleep again with food in her mouth and her spoon in her hand. R24 slept that way until nursing assistant (NA)-A woke her up at 9:20a.m. R24 took a few more bites and fell asleep. She was removed from the dining room at 9:25a.m.

R24's care plan, dated 2/10/14, indicated "My need for assistance with eating fluctuates with my LOC [level of consciousness] daily and even with each meal. Assist me to the level necessary and document accordingly."

A nutrition assessment, dated 1/28/14, indicated R24 required a regular diet with nectar thick liquids, and used a cup with a spout for drinking. The medical record lacked any additional assessment which indicated R24 could be fed by a paid feeding assistant.

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A hydration risk assessment dated 1/26/14 indicated R24 required assistance with eating and drinking, received Lasix (a water pill) every morning, and had a diet with nectar thick liquids. R24 was assessed as a "hydration risk."

R24's North Haven Assignment Sheet, dated 4/17/14, indicated: Eating: A1 [assist of one], diabetic, Nectar thick liq. [liquids].

A Geriatric Services of Minnesota Progress Note, dated 10/24/2013, indicated "Staff notes [R24] to be sleepy at meals & needs much coaxing to eat. Pt. [patient] denies any problems, pain--though res. [resident] not reliable secondary to dementia." There was no indication in the resident record that R24 had been assessed to determine if she was safe to be fed by a PFA, even though R24 had dysphagia and was on a mechanical altered diet. .

During an interview on 4/14/14 at 9:50a.m., NA-A stated the "nurse" would assign staff to feed residents with any "choking issues or swallowing problems." NA-A said R24 did not "pocket" her foods, and that she has been more "sleepy" and needed encouragement to eat. NA-A also stated she was unaware of any restrictions on who may feed R24, and that [R24] required "thickened liquids" for drinking.

R1's quarterly Minimum Data Set (MDS) dated 3/21/14, included cognition intact, diagnosis' of Multiple Sclerosis, functional quadriplegia, heart failure, diabetes, dysphagia, requires total dependence with eating and on consistent carbohydrate diet.

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R1 was observed being fed by PFA-C on 4/14/14, at 12:55 p.m. LPN-A was informed of concern because R1 had dysphagia diagnosis. LPN-C stated PFA-C has fed R1 a lot oftimes, she is is on a regular diet with regular thin liquids and she felt confident R1 was appropriate to be fed by a PFA.

On 4/15/14 at 9:35 a.m. R1 was observed being fed by nursing assistant (NA)-Q. R1's did not have any problems swallowing his food.

On 4/16/14 at 12:01 p.m. R1 was observed in small dining room at a table being fed by NA-Q without any problems.

R1 care plan dated 3/13/14 identified diagnosis of dysphagia and listed under goals "I will have difficulty chewing/swallowing current diet [sig] with interventions listing texture change as needed. The record did not identify an assessment had been completed to determine if R1 was safe to be fed by a PFA even though he had a diagnosis of dysphagia.

The facility provided a undated "Residents appropriate for trained feeding assistants" list was provided by the director of nursing (DON) on 4/14/14, at 11:18 a.m. The DON stated each PFA would check with a nurse on each day to determine who would be eligible for help on that day. An assessment was not completed in the medical record, and eligibility to be fed by a PFA was not in each resident care plan. The list identified that 11 residents, including, R3, R39, R6, R24, R1, were eligible to be fed by a PFA, and these residents were typically the ones being fed by the PFA's.

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The facility Mealtime Assistant Training, documents dated 4/24/13, were provided by the facility which showed seven non-nursing staff had been trained utilizing the state approved course for paid feeding assistant. PFA-C was included in this training, and had passed the competency testing.

When interviewed on 4/14/14, at 2:50p.m. the DON stated they determine if residents are eligible to be fed by a paid feeding assistant on the basis of if they are alert, and enjoy visiting. The residents are typically the same residents every day, unless something changes in the resident's condition and the selection was not based on complicated feeding problems such as P3's talking while she ate and her choking risk.

A Presbyterian Homes and Services [PHS] Feeding Residents (Family & Volunteers/Non-nursing staff) policy dated 1/2010, included, "It is the policy of PHS to allow a resident's family members and volunteers to assist a resident to eat. The facility reserves the right to withdraw this privilege if it is deemed that the resident's safety is at risk." The policy indicated an non-nursing staff would complete a certified mealtime assistant training program that meets the state approved curriculum. "The facility will assess and determine specific residents that may be safely fed by a volunteer or non-nursing staff trained in feeding assistance." "The volunteers or any trained non nursing staff providing feeding assistance will report to the nurse any concerns that they identify."

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 The nurse involved in providing medications and treatments was re-educated on handwashing, glove use, and infection control practices. R46 had a cover replaced over catheter bag once identified. Infection control standard precautions procedure was reviewed and is current. Catheter care policy was reviewed and is current. All residents are monitored for infection control risk through facility infection control tracking and trending. Reports provided to facility QA&A committee for review. Education on infection control precautions is being provided to staff on 5/16/14 and is ongoing. Infection control audits will be completed on 5% of residents weekly for two months. The facility QA&A committee will review the audits and determine the need for ongoing monitoring. Clinical Administrator and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 5/28/2014.	

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to follow infection control practices for 2 of 2 residents (R8 and R50) during observation of a blood glucose check and instillation of eye drops; for 1 of 1 residents (R46), whose uncovered urinary catheter bag was on the floor; and for 1 of 6 residents (R89) observed during provision of routine cares.

Findings include:

EYE DROPS

During observation on 4/17/14 at 1:02 p.m., licensed practical nurse (LPN)-E prepared to give eye drops for R8. LPN-E removed the prednisolone ophthalmic (eye) solution from the medication cart, then pulled gloves from her pocket and entered RS's room. Without first washing hands, LPN-E donned the gloves retrieved from her pocket, and instilled the eye drop solution into R8's eyes. LPN-E provided R8 with a facial tissue, then removed her gloves and exited R8's room. LPN-E did not wash hands prior to leaving R8's room.

BLOOD GLUCOSE MONITOR

During observation on 4/17/14 at 10:20 a.m., LPN-E retrieved a blood glucometer from the medication cart. LPN-E pulled a pair of gloves out of her pocket and entered R50's room. Without washing her hands, LPN-E put on the gloves and

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proceeded to check R50's blood glucose. After the procedure, LPN-E removed her gloves and exited R50's room. LPN-E did not wash hands prior to leaving R50's room. LPN-E then cleaned the glucometer, and returned it to the medication cart.
During interview 4/18/14 at 9:10a.m., the director of nursing (DON) stated LPN-E should have washed hands before and after giving eye drops and performing the glucometer check. The DON further indicated staff should not be placing gloves in their pockets, and then using the gloves on residents.
A facility Infection Control Standard Precautions Procedure, dated 2013, indicated: "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents; personnel, equipment and/or environment". The procedure further indicated to perform hand hygiene before touching medication or food that is given to a resident.

URINARY CATHETER BAG

R46's annual Minimum Data Set (MDS), dated 1/31/2014, indicated intact cognition, and that R46 was dependent on staff for transfers, bed mobility, dressing, and personal hygiene. The MDS also identified R46 had BPH (benign prostatic hyperplasia), neurogenic bladder and an external catheter. R16's care plan, undated, identified that R16 used a external catheter, and

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	245120	A. BUILDING ____ B. WING	04/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 73	F 441		

that a leg bag was used with the catheter.

During observation on 4/16/14 at 7:09p.m., R46 was sleeping in the recliner in his rooni. R16's catheter drainage bag was uncovered, and the clear side of the bag was in direct contact of the floor. Urine was noted in the bag. There was no barrier between the drainage bag and the floor.

During an interview on 4/18/14 at 12:28 p.m., LPN-A stated the catheter drainage bag should not have been on the floor.

A facility policy, entitled, Catheter, care of Indwelling, modified 09/03, directed staff at step 9: "Don't place the drainage bag on the floor or the bag may become contaminated;" and step 10: "Catheter bag is to be placed in cloth bag when up in wheelchair and when in bed. Cloth bag is to be changed prn [as needed]."

PROVISION OF CARES

R89's physician orders, signed on 4/7/14, identified diagnoses of dementia with behavioral disturbance, depression and dry eyes. R8.9's physician orders identified a pre-scription, ordered 4/3/2014, for Refresh PM (ocular lubricant) ointment to right eye, twice a day for dry eye/ectropion (abnormal turning out of the eyelid). R89's temporary care plan, dated 4/3/14, identified R89 was dependent on staff for all activities of daily living.

During observation on 4/17/2014 at 9:26a.m., nursing assistant (NA)-A and the DON assisted R89 with morning cares. NA-A stated R89's right

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	245120	A. BUILDING ______ B. WING	04/18/2014

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

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F 441	Continued From page 74 eye was mattery, and asked R89 if it hurts. R89 responded "yah." NA-A wiped the mattery right eye and then rinsed the soiled washcloth in the basin of water and laid the soiled cloth on the upper right corner of the bed. The NA-A took a clean wash cloth and placed it in the soiled water and proceeded to wash R89's left eye, face and body. NA-A and DON finished the morning cares at 9:46a.m. During interview, on 4/17/2014 at 9:46a.m., NA-A stated R89 is a new admission and she follows the group sheets that are in a binder at the desk. NA-A also stated that R89 will respond to yes and no questions when R89 is sleeping in his chair staff will lay him down. When interviewed on 4/18/2014 at 2:40p.m., LPN-A stated R89 received Refresh ointment {an eye lubricant}, which isn't an antibiotic, to his right eye, twice a day. LPN-A stated she would need to talk to the nursing assistants about not rinsing the wash cloth used to wash R89's eye in the same water used for washing R89's other body parts.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5120022

PRINTED: 05/08/2014
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245120	A. BUILDING 01 MAIN BUILDING 01 B. WING	04/15/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTIOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEENATIAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, or By email to: Maria-n.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.	K000	POC ok B 5-20-14 RECEIVED MAY 20 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 5-28-14
EXIT: 4-18-14

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: Brandi Barthel, LNHA
TITLE: administrator
(X6) DATE: 5/19/14

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

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	245120	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/15/2014

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K 000	Continued From page 1 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grace Pointe Crossing Gables East was found in not substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Graceponit Crossing Gables East is a 1-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1956 and was determined to be of Type 11(111) construction. In 1982, an addition wwas constructed to the building that was determined to be of Type 11{111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 112 beds and had a census of 101 at the time of the survey.	K000		

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

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	245120	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/15/2014

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K 062	Continued From page 2	K062		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9..2.8.2. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: During the facility tour on 4-15-14 at 9:30AM it was observed that the date indicating the last change of the gage on the complete automatic fire sprinkler system was 6-2009. It was later confirmed by the Director of Maintenance (JB) (via e-mail) that this date on the gage was correct. This deficient practice was confirmed by the Maintenance Director (JB and the Administrator (BB))at the time of exit.	K 062	K062 The gauges have been replaced during the last annual inspection in accordance with NFPA standards on 5/5/14.	