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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RUAY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 25613

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245615**

2.STATE VENDOR OR MEDICAID NO.
(L2) **378150100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GABLES OF BOUTWELLS LANDING**
(L4) **13574 58TH STREET**
(L5) **OAK PARK HEIGHTS, MN** (L6) **55082**

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)

6. DATE OF SURVEY **01/22/2014** (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 **108** (L18)

13.Total Certified Beds **108** (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
	108			
(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):

CCN-245615
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 January 31, 2014, the facility is certified for 108 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Mary Beth Lacina, HFE NE II — 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/07/2014 (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
03/04/2009
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245615

February 7, 2014

Ms. Laura Cognetta, Administrator
Gables Of Boutwells Landing
13574 58th Street
Oak Park Heights, MN 55082

Dear Ms. Cognetta:

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 January 31, 2014, the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 6110

February 7, 2014

Ms. Laura Cognetta, Administrator
Gables Of Boutwell's Landing
13574 58th Street
Oak Park Heights, Minnesota 55082

RE: Project Number S5615006

Dear Ms. Cognetta:

On December 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 5, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 6, 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 December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, effective January 31, 2014 and therefore remedies outlined in our letter to you dated December 19, 2013, 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
245615	A. Building B. Wing	1/22/2014

Name of Facility	Street Address, City, State, Zip Code
GABLES OF BOUTWELLS LANDING	13574 58TH STREET OAK PARK HEIGHTS, MN 55082

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 F0309 Reg. # 483.25 LSC	01/22/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	01/22/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	02/07/2014	30921	1/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/5/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245615	A. Building B. Wing 01 - THE GABLES OF BOUTWELLS LANDING	2/6/2014

Name of Facility	Street Address, City, State, Zip Code
GABLES OF BOUTWELLS LANDING	13574 58TH STREET OAK PARK HEIGHTS, MN 55082

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 K0025	Correction Completed **01/31/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **01/31/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	2/7/2014	12424	2/6/2014
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
12/4/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RUAY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 25613

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245615**

2.STATE VENDOR OR MEDICAID NO.
(L2) **378150100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GABLES OF BOUTWELLS LANDING**
(L4) **13574 58TH STREET**
(L5) **OAK PARK HEIGHTS, MN** (L6) **55082**

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)

6. DATE OF SURVEY **12/05/2013** (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 **108** (L18)

13.Total Certified Beds **108** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(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 :
Karen Beskar, HFE NE II — 01/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/03/2014 (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
03/04/2009
(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.
00320
(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

CCN-245615

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7130

December 19, 2013

Ms. Laura Cognetta, Administrator
Gables of Boutwells Landing
13574 - 58th Street
Oak Park Heights, Minnesota 55082

RE: Project Number S5615006

Dear Ms. Cognetta:

On December 5, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 January 14, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 March 5, 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 June 5, 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 12/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13574 58TH STREET OAK PARK HEIGHTS, MN 55082

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 309 D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement interventions to prevent/minimize wounds from developing, failed to determine the underlying causal factors for the wounds and failed to ensure ongoing consistent monitoring of foot/ankle wounds for 1 of 1 resident (R16) who developed wounds.	F 309 1/15/14 SER	Resident 16 was comprehensively assessed by nursing for skin risk. A new braden and risk risk data collection tool was completed on 12/23/13. Cause of existing wounds and type of wounds were clarified. Diagnosis list now includes PVD. A weekly measurement and monitoring of wounds of existing wounds is currently being conducted. Care plan was reviewed and updated. Residents are assessed for skin risk on admission, with significant change and quarterly in accordance with RAI processes.	1/6/14

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

Kathy Quill, LNHA Administrator 1/3/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days olio he 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 1 Findings include: R16's admission Comprehensive Skin Risk Data Collection form dated 7/17/13, identified R16 as having a very mild risk of developing skin breakdown. The form indicated R16 had blanchable redness to both "feet knuckles" and blanchable redness to the right malleolus (ankle), and no other wounds or lesions to the feet. Resident assistants to do skin checks daily with cares and licensed nurse to do skin checks weekly with bath. A body audit form dated 8/12/13, identified no skin issues for R16 and indicated, "Skin intact." R16's admission Minimum Data Set (MDS) dated 7/24/13, and the quarterly MDS dated 10/24/13, listed the active diagnoses for R16 as heart failure, hypertension, dementia, CVA, and Parkinson's disease. Peripheral vascular disease and peripheral arterial disease were not identified on the form. The MDS indicated R16 was at risk for developing pressure ulcers and identified R16 had no peripheral ulcers, vascular ulcers, or any other wounds. Wound Assessment Flow Sheets, dated 9/14/13, 10/19/13 and 11/21/13, identified wounds on R16's feet/ankles described as blood blisters, scabs, wounds from injury, scratches and open areas. The forms lacked identification of the type of wounds such as if the wounds were from pressure, arterial problems, venous problems, laceration, or stasis ulcers. The assessment summary identified R16's diagnoses and limited mobility contributing to the wounds, and interventions included appropriate footwear to prevent further skin issues particularly on right and left foot and proceed to care plan. "Skin tolerance in chair and bed is deferred as it does not relate to the current skin condition." A Skin Risk Assessment form dated 9/14/13,	F 309	The policy and procedure has been reviewed and is current. Education on staff will be completed on 12/31/13. Audits on skin risk will be conducted on 10% of the total number of residents x 4 weeks. Reports will be reported to QA for ongoing compliance and will determine need for further auditing. The clinical administrator will be responsible for ongoing compliance. Date of certain for purpose of ongoing compliance is 1/6/14	

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F 309	Continued From page 2 identified R16 had changed to moderate risk for skin breakdown. Following the identification of R16's wounds, the clinical record lacked evidence of ongoing measurement, monitoring for healing of the wounds and/or staging of the wounds. A physician's Order dated 9/18/13, stated "1) Pt [patient] needs new shoes with wide toe box. 2) Present Blisters/inflammation ..." A 10/19/13 Skin Assessment identified potential risk factors for skin breakdown as the need for assist with activities of daily living and resident is chairfast at this time. Open areas/blood blisters to toes have scabbed over, daily monitoring until resolved in place. No other areas of concern. Positioning aides and strategies used include pressure reduction mattress, wheelchair cushion, pillows, grab bars, repositioning schedule, and continue to monitor. A Resident/Visitor Occurrence Report dated 11/20/13, indicated, "[R16] has o/a (open area) on L (left) ankle bony prominence. It is round in shape with peeling skin around and pink skin around. Some bleeding noted ...Analysis as to cause of Occurrence: possibly from shoes rubbing, or resident rubbing feet on bed while in bed? Action to Minimize Reoccurrence: AM shift to check shoes to see if rubbing. Get OOB (out of bed) if restless. Keep L outer ankle cushioned with Kerlix for now ...Not VA reportable - vascular in nature." An entry in Progress Notes dated 11/20/13, indicated, "Writer notified of an o/a on residents L outer ankle. The area seemed to have cracked open on the bottom. The area is reddened and has peeling skin around it. No pain associated with the area. Will have a.m. shift check to see if shoes rub on the area. He moves in bed frequently so likely not from inactivity. He likely	F 309		

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F 309	Continued From page 3 opened the area up from sheering his skin across the sheets. Will have nurse contact the MD to eval the most likely cause of it and tx [treatment] options ...Intervention: keep area cushioned for now with Kerlix. Keep pillows under area when turned in bed. Work order placed for possible air mattress. Get pt (patient) OOB when restless." Although the analysis of cause from the Resident/Visitor Occurrence Report and the Progress Note dated 11/20/13, identified the resident's shoes as rubbing on skin or the resident rubbing his feet on his bed as possible causes of the wounds, the conclusion indicated the wounds were vascular in nature. The clinical record lacked evidence of regular, ongoing monitoring of the wound sizes or staging of the wounds. A provider note dated 11/22/13, written by nurse practitioner (NP)-A, indicated, "Staff are also concerned about an open area on [R16's] right ankle (thought to be caused by his bumping his ankle on his w/c and compounded by his PVD). He has atrial fib and heart failure and is on ASA (aspirin) 325 mg (milligrams) for anticoagulation since he is a fall risk ...left ankle open area of 1 cm with eschar in base of wound. Edges of wound are sharp, pulses are lacking. Skin surrounding open area is dry and flaking. Mottled coloring of LE with diminished pulses (DP and PT). There is a 1.2 cm stage II open area on the base of the left great toe. Wound bed is granulating without slough in wound bed. Ankle ulcer Comment: with eschar in wound bed. n [sic] Appears to be arterial in nature. Plan: Change dressing to Santyl and Flagyl powder daily. Protect LE (lower extremity)." A provider note dated 12/3/13, completed by NP-A indicated, R16 has severe CAD. He developed blood blisters on his feet and a	F 309		

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F 309	Continued From page 4 traumatic ulcer on his left ankle, from hitting his ankle on some object. He has very poor vascular circulation and staff have been caring for his open ankle wound, the blood blisters, have since scabbed over. He is unable to answer any questions about pain or any other symptom pursuit. Family desire the focus of his care to be on comfort only, and do not want any aggressive work up on any existing issues at this time...Plan: Protect lower extremities since he has very poor circulation, no intervention needed for the scabbed lesions. Ankle wound Comment: Arterial in nature. Flagyl powder to open ankle wound and it is without serous drainage and wound bed is clean. Plan: continue current wound care to arterial ulcer on the ankle." On 12/4/13, at 1:30 p.m. the registered nurse (RN)-A was interviewed regarding ongoing monitoring of the wounds. RN-A stated the wounds were monitored for infection and overall healing on the medication administration record (MAR), but were not measured or staged because the wounds "are believed to be arterial in nature." On 12/4/13, at 2:00 p.m. NP-A stated she believed R16 had arterial insufficiency of both lower extremities and the wounds on the feet were a result of this condition. NP-A stated the blood blisters developed because small arterioles clotted off and a blister then appeared at that site on the feet. NP-A stated she believed the malleolus wound originated as a traumatic injury of some type, but could not recall the exact circumstances. NP-A stated after the trauma, R16's ankle had opened up and because of the arterial insufficiency, could not heal properly. On 12/5/13, at 11:00 a.m. R16's family (F)-A was interviewed. When asked if he knew the cause of R16's foot wounds, F-A stated he believed the	F 309		

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F 309	Continued From page 5 resident had hit his toes on the bottom of his bathroom door or got his toes caught under the bathroom door. RN-A was present for part of the interview. When RN-A was asked if she was aware of any concerns mentioned by F-A, RN-A replied she was not aware of these concerns. RN-A further stated R16 now had new shoes with a larger toe box. During observation of wound treatment on 12/5/13, at 8:40 a.m. R16 was lying in bed and was wearing blue foam boots to each foot and cloth socks under the boots. RN-A and the clinical manager, were present for the wound treatment and stated that the scratches near the right malleolus were new on 12/5/13, and most likely occurred because of difficulty applying socks for R16. Later on 12/5/13, R16 was observed to propel himself around his room in his wheelchair. R16 was observed to be wearing dark socks and black sneakers that appeared to have a large toe box, however, there was no padding noted on the resident's lower wheelchair to prevent R16 from hitting his ankle.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	Simply thick thickeners were dated when opened. The policy and procedure has been reviewed and is current. Education on staff will be completed on 12/31/13.	1/6/14

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F 371	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure 7 of 8 containers of Simply Thick were dated when they were opened. This has the potential to effect 5 of 6 residents (R33, R75, R81, R156, R236) in the facility who had physician orders for thickened liquids. Findings include: Observation on 11/4/13, at 10:30 a.m. revealed an open 64 ounce (oz.) bottle of Simply Thick instant food thickener (used to thicken liquids) with a pump dispenser on 3rd floor Trolley kitchenette counter. The container's label indicated on the back of the container: date opened, and then an area to write the date which was blank; use within 90 days once opened. The label had the directions for use and a "best if used by" date, which had a manufacturer's preprinted date. No ingredients were listed. A list of resident's and their diets were located inside the cupboard door. he list indicated R75 was to receive honey thick liquids (liquids thickened to the consistency of honey). On 11/4/13, at 10:40 a.m. on the third floor Zephyr hall, an open and undated 64 oz. container of Simply Thick was observed on the kitchenette counter. On 11/4/13, at 10:45 a.m. on the third floor Summit hall, an open and undated 64 oz. container of Simply Thick was observed on the kitchenette counter. On 11/4/13, at 10:55 a.m. on the second floor Zephyr hall, an open and undated 64 oz.	F 371	Audits on dating of thickeners will be conducted weekly for four weeks. Audits will be reported to QA for ongoing compliance and will determine need for further auditing. The Nutrition and Culinary Director will be responsible for ongoing compliance. Date of certain for purpose of ongoing compliance is 1/6/14	

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F 371	Continued From page 7 container of Simply Thick was observed on the kitchenette counter. A resident list inside the cupboard door indicated R156 was to receive pudding thick liquids (liquids thicken to the consistency of pudding). On 11/4/13, at 11:00 a.m. on the second floor Carriage hall, an open and undated 64 oz. container of Simply Thick was observed on the kitchenette counter. A resident list inside the cupboard door indicated R33 and R81 were to receive nectar thick liquids. On 11/4/13, at 11:15 a.m. on the first floor, an open and undated 64 oz. container of Simply Thick was observed in the Dining Room. Review of R236's record indicated he/she was to receive honey thick liquids. On 11/5/13, at 10:00 a.m. the dietary director indicated the policy was the "same as everything else," and stated whomever opened the container was responsible for dating it when opened. Review of the facility policy titled "shelf life for perishable and shelf-stable foods", received 11/5/13, and dated 6/24/2009, indicated "every food or beverage item must by labeled with the date in which it was opened and/or prepared with the following information: - name of product if not on product label or clearly identifiable - date in which it was opened or prepared Manufacturer's information on Simply Thick was requested by the surveyor on 11/4/13, during kitchen tour and was not provided.	F 371		

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

F561500L

PRINTED: 12/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Gables of Boutwells Landing was found not to be in 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 18 New health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101- 5145	K 000	RECEIVED JAN 2 - 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION POC ok TB 1-24-14 RECEIVED JAN 21 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-14-14
Exit: 12-5-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] MHA LNHA

TITLE: Administrator

(X6) DATE: 12/30/13

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

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K 000	Continued From page 1 Pat.Sheehan@state.mn.us or By email to: Barbara.Lundberg@state.mn.us and Marian.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. 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. Gables of Boutwells Landing is a 3-story building with a full basement. The building was constructed in 2008, and was determined to be of Type II(111) construction. The facility is fully fire sprinklered throughout. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 108 beds and had a census of 92 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025	Continued From page 2 Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors within the smoke compartments. Findings include: On facility tour between 09:00 AM and 02:00 PM on 12/04/2013, it was observed that the walls above the smoke barrier doors had penetrations that had not been sealed in an approved manner in the following areas: 1) 3rd floor - Penetrations around conduit above the smoke barrier doors by room 326. 2) 1st floor - Penetrations around conduit above the smoke barrier doors by Activities Room. 3) Lower level - Penetrations around conduit	K 025	Contractors were contacted immediately during tour on 12/4/13 for penetrations in the ceilings/walls so as to begin repairs. Collins Electric came out to the facility on 12/5/13 to begin analysis of repairs and caulking of penetrations noted during tour. Facility engineer director (JA) and Administrator walked through building and reviewed all penetrations throughout with Collins. After walk through of every area, it was determined that other vendors needed to be contacted to patch their penetrations with fire caulking. On 12/17/13, the original contractor met with Administrator and engineer director to make a thorough investigation of all the fire and smoke seals throughout the building in smoke walls and partitions. A plan was made with A&P and Insite Architects to repair thoroughly all penetrations.	

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K 025	Continued From page 3 above the smoke barrier doors by the Auditorium. These deficiencies were verified by Environmental Service Director (JM) and facility Administrator. This deficiency was verified by the facility administrator.	K 025	An audit was conducted on rooms throughout the building to ensure that there were no open holes in ceilings, and to repair as needed with contractors by 1/31/14. The facility will ensure that continued contractors used for facility upgrades and other work in ceilings repair penetrations with fire caulking prior to payment to contractor and exiting building. The Engineering Director and Administrator are responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 1/31/14.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 18.3.6.2. This deficient	K 029	As observed during tour on 12/4/13, there were penetrations in the lower level Electrical Room. The facility engineer director was present for this tour. On 12/5/13, facility engineer repaired the penetrations in this electrical room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING 01 - THE GABLES OF BOUTWELLS LANDING B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13574 58TH STREET OAK PARK HEIGHTS, MN 55082

(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 029	Continued From page 4 practice could affect staff patients and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 12/04/2013, it was observed that the lower level Electrical Room by the auditorium, had penetrations in the corridor wall around conduits This deficiency was verified by Environmental Service Director (JM) and facility Administrator.	K 029	Further audits were conducted by engineer director on 12/5/13 for penetrations. The facility will ensure that continued contractors used for facility upgrades and other work in ceilings repair penetrations with fire caulking prior to payment to contractor and exiting building. The Engineering Director and Administrator are responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 1/31/14.	