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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SRDT

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) **13575 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 **02/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 02/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
02/12/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5615

Electronically Delivered: March 4, 2015

Ms. Wendy Kingbay, Administrator
Gables of Boutwells Landing
13575 - 58th Street
Oak Park Heights, Minnesota 55082

Dear Ms. Kingbay:

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 29, 2015 the above facility is certified for or recommended 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 feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 24, 2015

Ms. Wendy Kingbay, Administrator
Gables of Boutwells Landing
13575 - 58th Street
Oak Park Heights, Minnesota 55082

RE: Project Number S5615007

Dear Ms. Kingbay:

On January 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015. 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 February 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 29, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 9, 2015 and therefore remedies outlined in our letter to you dated January 22, 2015, will not be imposed.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

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	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
GABLES OF BOUTWELLS LANDING	13575 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 F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	02/09/2015	ID Prefix F0166 Reg. # 483.10(f)(2) LSC	02/09/2015	ID Prefix F0243 Reg. # 483.15(c)(1)-(5) LSC	02/09/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		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/AK	02/24/2015	32984	02/18/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/8/2015	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 24, 2015

Ms. Wendy Kingbay, Administrator
Gables of Boutwells Landing
13575 - 58th Street
Oak Park Heights, Minnesota 55082

Re: Reinspection Results - Project Number S5615007

Dear Ms. Kingbay:

On February 18, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 8, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
25613	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **02/09/2015**	ID Prefix **21855** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/09/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/09/2015**
ID Prefix **21915** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/09/2015**	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** SR/AK	**Date:** 02/24/2015	**Signature of Surveyor:** 32984	**Date:** 02/18/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/8/2015	_____	**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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SRDT

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) **13575 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 **01/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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

17. SURVEYOR SIGNATURE Date :
Karen Beskar, HFE NE II 01/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/12/2015 (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

Electronically delivered
January 22, 2015

Ms. Wendy Kingbay, Administrator
Gables Of Boutwells Landing
13575 58th Street
Oak Park Heights, MN 55082

RE: Project Number S5615007

Dear Ms. Kingbay:

On January 8, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be) 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: susanne.reuss@state.mn.us

Phone: (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 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5615s15epoc

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 _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		1/29/15

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

Electronically Signed | 01/29/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not provide adequate privacy related to video monitoring in the resident's room for 1 of 1 resident (R104) reviewed for privacy. Findings include: During random observations on 1/7/15, at 7:30 a.m. a visual and audio video monitor screen, approximately six inches square, rested on a desk in the hallway next to the door of R104's room. The door to R104's room was closed and R104 could be easily seen and heard on the monitor screen from several feet away. R104 was calling, "Is anyone there? Is anyone out there? Is anyone there to help me? Can somebody help me?" There was no staff in the vicinity of this room and monitor. Approximately five minutes later, staff came to the area and entered the resident's room. The monitor was turned off and a medication administration was completed by a trained medication assistant (TMA)-A. R104 was agitated and verbally aggressive during the medication administration. The camera for the video monitoring was placed near the door inside the resident's room and aimed at the resident's bed.	F 164	Resident 104's use of desk video monitor was reviewed by nursing. It was determined that a portable video that a portable video monitor that staff can carry with them would be more effective in protecting resident's privacy. A new physical device was effective in protecting resident's privacy. A discussion was held with the Health Care POA and the POA continues to request video monitoring for the resident. Care plan was reviewed and updated. Residents are assessed for the use of devices such as video monitor with significant change, quarterly and in accordance with the RAI process. The policy and procedure has been reviewed and current. Education will be complete on 2/6/15. Audits on privacy and confidentiality will be completed on 10% of the total number of residents x4 weeks. Reports will be reported to the QA for on going compliance and need for further auditing. The clinical Administrator will be responsible for on going compliance. Date certain for purpose of ongoing compliance is 2/9/15	

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F 164	Continued From page 2 When observed on 1/7/15, at 12 p.m. R104 was not in her room. The video monitor was turned off. During observation on 1/8/15, at 8:36 a.m. R104 was sitting in a wheelchair in her room. The door to her room was open, and the video monitoring screen on the desk was on with the resident easily seen and heard on the monitor when standing several feet away from the desk. Review of the admission record for R104 showed that the 91-year-old resident had been admitted 10/23/14, and had diagnoses that included anxiety, dementia with behavior disturbances, a healing leg fracture, muscle weakness, and a fall. The Brief Interview for Mental Status done with R104 during the 10/30/14 Minimum Data Set was scored at 8-moderate cognitive impairment. Record review revealed a focus for fall risk on page 2 of the current care plan, dated 11/12/14, that contained an intervention reading, "I have a video monitoring system on when in room. Turn off with cares. Close my door @ noc [night]." This intervention was dated 11/30/14. During interview on 1/8/15, at 11:00 a.m. licensed practical nurse (LPN)-A was asked the reason for the video monitoring of R104. LPN-A explained that R104 liked her door closed and yelled when staff opened the door to check on her. The monitor was to be turned off when staff was in R104's room with her or if she had visitors, otherwise the video monitor should be turned on throughout the day and night. LPN-A stated that this is the way that staff can monitor R104 for safety without upsetting the resident.	F 164		

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F 164	Continued From page 3	F 164		

When interviewed on 1/8/15, at 11:04 a.m. registered nurse (RN)-A, the nurse manager of R104's unit, was asked the same question and replied, R104 varied day to day in her reaction to being checked for safety. Most days R104 would be very upset if staff opened her door to check on her. RN-A was asked if if there had been any less intrusive interventions tried by staff to provide safety monitoring for R104, prior to implementing video monitoring. RN-A responded that she was not sure. RN-A then relayed a story that R104's family member had suggested to facility staff that video monitoring had worked well for R104 at the resident's previous facility. This family member had asked facility staff if video monitoring was possible at this facility and the staff responded that it was possible. The surveyor then requested any assessments done prior to implementing the video monitoring and any consents related to the video monitoring.

On 1/8/15, at 11:40 a.m., the director of nursing provided a Physical Device Evaluation for R104, dated 11/30/14, that addressed the video monitoring in the resident's room. The director of nursing stated that the family had power of attorney and gave verbal consent for the video monitoring, and staff reviewed the privacy aspect of this device at the time of this assessment and decided that the video monitoring screen at the desk in the hallway was not very visible to anyone walking by, only if sitting at the desk.

On 1/8/15, at 11:50 a.m. the director of nursing stated that the facility had made the decision to go out and buy small, portable video monitoring screens that facility staff can carry in their pockets when monitoring R104 and protect R104's privacy. She stated that this change would be

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F 164	Continued From page 4 implemented by the end of the day. The director of nursing was asked if the resident was aware of the video monitoring and the director of nursing stated that she did not believe that the resident would be aware of the video monitoring because of the resident's impaired cognitive function.	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to resolve issues brought forth from resident and family for 3 of 3 residents (R6, R71, R228) related to odors and noise level. Findings include: When interviewed on 1/5/15, at 4:04 p.m. family (F)-A expressed concern about the odor in the bedroom and bathroom. F-A said the facility was informed on numerous occasions and at care conferences, the family concerns regarding the strong smell of urine. F-A mentioned R6 wears a brief but has been known to urinate in various areas of the bedroom and bathroom. When the environmental tour was completed on 1/7/15, at 1:50 p.m. urine odors were detected in R6's room. The odors were confirmed by engineers (E)-A and B, and housekeeping (H)-A. When reviewed, the e-mail correspondence to	F 166	Resident 6 room carpet was deep cleaned on 1/5/15. Boutwells team has decided to replace carpet, carpet is in the process of being replaced. Resident 71 grievance is resolved by staff crushing medication in the medication room and changing the time of medication dispensation. Automatic pill crushers were ordered on 1/8/15 to address this issue further for future cases. Staff began using new crushers on 1/21/15. Resident 228 grievance was resolved by motor replacement, it was replaced 1/9/15. The grievance policy and procedure has been in review and is current. Audits which will include interview of random residents in regards to grievances will be completed weekly for 4 weeks on 10% of residents. Environmental rounds of the residents living spaces will be	1/29/15

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F 166	Continued From page 5 engineering, dating back to 6/30/14, revealed 11 requests were submitted for carpet cleaning due to odors. The email to engineering on 6/30/14, indicated the family had voiced concerns about the odor in the room and the carpet was badly in need of cleaning. In the email, nursing staff voiced concerns that the odor was an ongoing issue and requested bi-weekly or tri-weekly cleaning. All information and concerns about the room was requested and nothing more was provided. No information was provided that an increase in cleaning was done. Interview with director of nursing (DON) and administrator on 1/8/15, at 8:40 a.m. revealed the urine odors have been an ongoing issue and replacing the carpet and the flooring in the bathroom would be needed. A preventative maintenance policy and procedure was requested and engineering provided a past preventative maintenance form titled, Work Order, which included room inspections, completed on 10/26/14. No further policy and procedures for room inspections was provided. R71, when interviewed on 1/5/15 at 5:30 p.m., indicated there was pounding going on above the room around 5:00 in the morning which caused R71 to be awakened. R71 stated, "I want to know what it is." R71 indicated it had been reported to someone but nothing had been done. When the environmental tour was completed on 1/7/15, at 2:15 p.m. the noise concern from R71 was mentioned. (E)-A and B, and (H)-A were not aware of the noise but would follow up on the issue. When (H)-A spoke to the household coordinator (HC)-A it was confirmed that staff	F 166	completed with quarterly care conferences minimally and as needed. Reports will be reported to QA for on going compliance and will determine need for furthering auditing. Clinical or household Coordinators or their designee will be responsible for on going compliance. Date certain for purpose of on going compliance is 2/9/15	

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F 166	Continued From page 6	F 166		

knew about the noise. It was the mechanical crushing of the medications in the room next door for a resident who received early medications.

On 1/8/15 at 8:45 a.m. the interview with the DON and the administrator confirmed the noise heard by R71 was indeed the mechanical pill crusher used by the staff. The facility had now ordered silent electric pill crushers and in the meantime pills would be crushed outside of the room on the medication cart.

R228 reported loud rattling noises in the room which made sleeping difficult. She said, "I've just gotten use to it." R228 indicated staff was aware and nothing had been done.

When the environmental tour was completed on 1/7/15, at 2:25 p.m. a rattling noise was detected in R228's room. The noise was confirmed by engineers (E)-A and B. R228's room was located above the laundry area and engineering confirmed the noises were from the clothes dryers. E-A confirmed he had made adjustments to the dryers in the laundry. During the environmental tour, R228 confirmed the noise was better however it had not been alleviated. E-A believed the noise was from the clothes dryers motors and that new motors would need to be ordered.

All information was requested from engineering regarding the noise concerns and what had been done to alleviate the noise. Email correspondence to engineering was reviewed for 12/4/14 and 12/24/14, which confirmed the noise in the room. The work order from 12/4/14 indicated, the noise was from the laundry room below and the noise had been taken care of.

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F 166	Continued From page 7 When interviewed on 1/08/15 at 2:06 p.m. the health unit coordinator (HUC)-A confirmed sending both work orders. HUC-A indicated the noise was reported to engineering each time the nursing assistants heard concerns from the residents, however the noise had been going on for about a year. E-A could not confirm how long the noise had been going on, as E-A had only been employed for a short period of time. E-B was not aware how long the noise had been going on. Preventative maintenance reports were requested from the laundry room and were not provided. The untitled/undated policy and procedure, under the section, Resident/Family/Staff Concern Form Guidelines, indicated when a resident or family receives a complaint the complainant deserves full attention from the staff. Staff should complete the Resident/Family/Staff Quality Concern Form. If the staff member can solve the concern immediately it should be solved and an explanation written of the form. A copy is then sent to the administrator and the supervisor. If the concern cannot be taken care of immediately, the concern form should be routed to the supervisor or department head and the complaint is addressed within 5 days. Once the follow up is completed the form is sent off to the administrator for review. During stage one interview on 1/6/15, at 11:27 a.m. there was a loud rattling noise in the room of R228. R228 stated that the loud rattling noise comes and goes, and she has heard it so often that she has somewhat adjusted to it. She also stated that she did have trouble resting and sleeping in the facility and was not sure if the	F 166		

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F 166	Continued From page 8 noise was contributing to that problem. When interviewed on 1/6/15, at 11:50 a.m., registered nurse (RN)-B, the clinical coordinator of this unit, stated that she was not aware of a current problem with a rattling noise in the room of R228, but she believed that she had placed a work order for a noise in that room in the past. During observation on 1/8/15, at 1:33 p.m., R228 had been discharged and facility staff was cleaning this resident's room. A loud rattling noise could be heard coming from that room when standing ten feet away from the door of the room.	F 166		
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to invite and make arrangements for residents on 2 of 3 floors (1st and 3rd) to attend resident council held each month on second floor.	F 243	Resident 48 and all other Boutwells residents will receive invitations to monthly council meetings on long term care households and resident council meeting information will be added to the	1/29/15

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F 243	Continued From page 9 Findings include: The resident council president (R41) was interviewed on 1/6/15, at 10:20 a.m. and indicated council meetings were held monthly on the second floor. When asked whether the other floors were involved he indicated he did not know. R48, who resides on 3rd floor, was interviewed on 1/5/15 at 7:10 p.m. and when asked about resident council meetings indicated, she didn't know anything about those council meetings. The household coordinator (HC)-A was in charge of the council on 2nd floor. When interviewed on 1/6/15, at 11:00 a.m., HC-A stated, "I've never been asked to connect with the residents on 3rd or 1st floors." She thought 3rd floor and transitional care unit (TCU) on 1st had their own councils. When asked how residents are made aware of the council meetings she indicated, it was put on the activity calendar each month. When the activity calendars were reviewed the council meeting appeared on the October calendar for 2nd floor and did not appear on any other calendars for November, December or January for 2nd or 3rd floor. HC-B from 3rd floor was interviewed on 1/6/15, at 1:32 p.m. and confirmed there was no notice on the activity calendar about council meetings, and there was no council held on 3rd floor. When asked as to whether or not the residents were invited to the 2nd floor council meetings she indicated, residents were invited, however she could provide no documentation regarding residents acceptance or refusal to go. 1/08/15, at 1:15 p.m. social worker (SW)-A was interviewed and indicated there was no council on TCU due to short term stay. She indicated, for those staying longer, residents have access to the activity calendar for the whole house and the	F 243	informational binder for TCU residents. New recreation therapist re-educated to include council meetings on the activity calendar to help make residents aware of council meetings. Household coordinators educated on council guidelines, invitations and follow up. The guidelines for resident council have been reviewed and are current. Audits will be conducted on resident council compliance in regards to invitations, guidelines, and being printed on the activity calendar on 10% of residents monthly for three months. Reports will be reported to QA for on going compliance and will determine need for further auditing. The Administrator or designee will be responsible for ongoing compliance. date certain for purpose of ongoing compliance is 2/9/15.	

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F 243	Continued From page 10 council meetings are listed on the calendars. The activity calendar was the only means by which residents on TCU find out about the council. The leaders of the council do not come down and personally invite residents. SW-A indicated she was not involved in the resident council at all. On 1/08/2015 at 2:31 p.m., the administrator was interviewed about the resident council. The administrator was not aware of any resident council concerns and was not aware that residents had concerns about getting to the council. The administrator stated, the staff in charge of the councils, "are not pulling it together well." A policy and procedure about resident council was requested however the information provided, Resident Council Guidelines, did not address invitations and arrangements for other residents to attend.	F 243		

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	245615	A. BUILDING **01 - THE GABLES OF BOUTWELLS LANDING** B. WING _____	**01/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Gables of Boutwells Landing was found 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. 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 104 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 22, 2015

Ms. Wendy Kingbay, Administrator
Gables Of Boutwells Landing
13575 58th Street
Oak Park Heights, Minnesota 55082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5615007

Dear Ms. Kingbay:

The above facility was surveyed on January 5, 2015 through January 8, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793, or email: susanne.reuss@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25613	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 5, 6, 7, and 8, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: MN. Statute 144.A.04, Subd.4 Based on document review and interview, the facility failed to maintain a comprehensive tuberculosis infection control program regarding tuberculosis medical review for 1 of 5 new	21426	Corrected	1/29/15

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21426	Continued From page 3 employees (E1) who required a chest X-ray for tuberculosis screening. Findings include: Review of tuberculosis screening records on 1/7/15, showed that documentation of physician evaluation for E1 was not present. The record of E1 contained documentation of a blood test, Quantiferon TB Gold in Tube, where the assay is intended for use as an aid in the diagnosis of TB [tuberculosis] infection. E1 had an abnormal positive blood test result completed on 11/20/14. Following the abnormal positive blood test results, the records of E1 contained a chest X-ray for tuberculosis screening, dated 11/21/14. The findings documented by the physician for the test read "no radiographic evidence of active TB." There was no documentation of a corresponding physical examination following the chest X-ray. The facility form titled, Employee Health Nurse Screen Notes, indicated E1 had a history of BCG vaccine and the skin test reacted positively but further read, "I was tested for TB Mantoux and it was negative". There was no further documented clarifying data available. When interviewed on 1/7/14, at 2:00 p.m. the director of nursing (DON) did not have any further documentation to explain if the employee was a new conversion or why the statement indicated a prior Mantoux was negative. Page 10 of Regulations for Tuberculosis Control in Minnesota Health Care Settings-July 2013 read, "Baseline TB screening is required for all HCWs [health care workers] (Table 3.1).	21426		

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21426	Continued From page 4 Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST [tuberculin skin test] or single IGRA [interferon gamma release assay]." Page 11 of Regulations for Tuberculosis Control in Minnesota Health Care Settings-July 2013 read, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." Page 13 of Regulations for Tuberculosis Control in Minnesota Health Care Settings-July 2013 read, "HCW with a written documentation of a previous positive TST or IGRA...4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done...HCW with a verbal (undocumented) history of a previous positive TST or IGRA These HCWs should undergo the same screening procedures as HCWs without previous results. Results of the screening should be documented in the HCW's record." SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could review the TB policies and procedures to ensure all required information is included. Appropriate staff could be educated regarding requirements. Audits could be conducted and the results reviewed at the quality committee	21426		

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21426	Continued From page 5 meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not provide adequate privacy related to video monitoring in the resident's room for 1 of 1 resident (R104) reviewed for privacy. Findings include: During random observations on 1/7/15, at 7:30 a.m. a visual and audio video monitor screen, approximately six inches square, rested on a desk in the hallway next to the door of R104's room. The door to R104's room was closed and R104 could be easily seen and heard on the monitor screen from several feet away. R104 was calling, "Is anyone there? Is anyone out there? Is anyone there to help me? Can	21855	Corrected	1/29/15

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21855	Continued From page 6 somebody help me?" There was no staff in the vicinity of this room and monitor. Approximately five minutes later, staff came to the area and entered the resident's room. The monitor was turned off and a medication administration was completed by a trained medication assistant (TMA)-A. R104 was agitated and verbally aggressive during the medication administration. The camera for the video monitoring was placed near the door inside the resident's room and aimed at the resident's bed. When observed on 1/7/15, at 12 p.m. R104 was not in her room. The video monitor was turned off. During observation on 1/8/15, at 8:36 a.m. R104 was sitting in a wheelchair in her room. The door to her room was open, and the video monitoring screen on the desk was on with the resident easily seen and heard on the monitor when standing several feet away from the desk. Review of the admission record for R104 showed that the 91-year-old resident had been admitted 10/23/14, and had diagnoses that included anxiety, dementia with behavior disturbances, a healing leg fracture, muscle weakness, and a fall. The Brief Interview for Mental Status done with R104 during the 10/30/14 Minimum Data Set was scored at 8-moderate cognitive impairment. Record review revealed a focus for fall risk on page 2 of the current care plan, dated 11/12/14, that contained an intervention reading, "I have a video monitoring system on when in room. Turn off with cares. Close my door @ noc [night]." This intervention was dated 11/30/14. During interview on 1/8/15, at 11:00 a.m. licensed	21855		

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21855	Continued From page 7	21855		

practical nurse (LPN)-A was asked the reason for the video monitoring of R104. LPN-A explained that R104 liked her door closed and yelled when staff opened the door to check on her. The monitor was to be turned off when staff was in R104's room with her or if she had visitors, otherwise the video monitor should be turned on throughout the day and night. LPN-A stated that this is the way that staff can monitor R104 for safety without upsetting the resident.

When interviewed on 1/8/15, at 11:04 a.m. registered nurse (RN)-A, the nurse manager of R104's unit, was asked the same question and replied, R104 varied day to day in her reaction to being checked for safety. Most days R104 would be very upset if staff opened her door to check on her. RN-A was asked if if there had been any less intrusive interventions tried by staff to provide safety monitoring for R104, prior to implementing video monitoring. RN-A responded that she was not sure. RN-A then relayed a story that R104's family member had suggested to facility staff that video monitoring had worked well for R104 at the resident's previous facility. This family member had asked facility staff if video monitoring was possible at this facility and the staff responded that it was possible. The surveyor then requested any assessments done prior to implementing the video monitoring and any consents related to the video monitoring.

On 1/8/15, at 11:40 a.m., the director of nursing provided a Physical Device Evaluation for R104, dated 11/30/14, that addressed the video monitoring in the resident's room. The director of nursing stated that the family had power of attorney and gave verbal consent for the video monitoring, and staff reviewed the privacy aspect of this device at the time of this assessment and

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21855	Continued From page 8 decided that the video monitoring screen at the desk in the hallway was not very visible to anyone walking by, only if sitting at the desk. On 1/8/15, at 11:50 a.m. the director of nursing stated that the facility had made the decision to go out and buy small, portable video monitoring screens that facility staff can carry in their pockets when monitoring R104 and protect R104's privacy. She stated that this change would be implemented by the end of the day. The director of nursing was asked if the resident was aware of the video monitoring and the director of nursing stated that she did not believe that the resident would be aware of the video monitoring because of the resident's impaired cognitive function. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies relating to the privacy and confidentiality provided to all residents and provide inservice for all staff regarding privacy and confidentiality. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and	21880		1/29/15

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21880	Continued From page 9 residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by:	21880		

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21880	Continued From page 10 Based on observation, interview and document review the facility failed to resolve issues brought forth from resident and family for 3 of 3 residents (R6, R71, R228) related to odors and noise level. Findings include: When interviewed on 1/5/15, at 4:04 p.m. family (F)-A expressed concern about the odor in the bedroom and bathroom. F-A said the facility was informed on numerous occasions and at care conferences, the family concerns regarding the strong smell of urine. F-A mentioned R6 wears a brief but has been known to urinate in various areas of the bedroom and bathroom. When the environmental tour was completed on 1/7/15, at 1:50 p.m. urine odors were detected in R6's room. The odors were confirmed by engineers (E)-A and B, and housekeeping (H)-A. When reviewed, the e-mail correspondence to engineering, dating back to 6/30/14, revealed 11 requests were submitted for carpet cleaning due to odors. The email to engineering on 6/30/14, indicated the family had voiced concerns about the odor in the room and the carpet was badly in need of cleaning. In the email, nursing staff voiced concerns that the odor was an ongoing issue and requested bi-weekly or tri-weekly cleaning. All information and concerns about the room was requested and nothing more was provided. No information was provided that an increase in cleaning was done. Interview with director of nursing (DON) and administrator on 1/8/15, at 8:40 a.m. revealed the urine odors have been an ongoing issue and replacing the carpet and the flooring in the bathroom would be needed.	21880	corrected	

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21880	Continued From page 11 A preventative maintenance policy and procedure was requested and engineering provided a past preventative maintenance form titled, Work Order, which included room inspections, completed on 10/26/14. No further policy and procedures for room inspections was provided. R71, when interviewed on 1/5/15 at 5:30 p.m., indicated there was pounding going on above the room around 5:00 in the morning which caused R71 to be awakened. R71 stated, "I want to know what it is." R71 indicated it had been reported to someone but nothing had been done. When the environmental tour was completed on 1/7/15, at 2:15 p.m. the noise concern from R71 was mentioned. (E)-A and B, and (H)-A were not aware of the noise but would follow up on the issue. When (H)-A spoke to the household coordinator (HC)-A it was confirmed that staff knew about the noise. It was the mechanical crushing of the medications in the room next door for a resident who received early medications. On 1/8/15 at 8:45 a.m. the interview with the DON and the administrator confirmed the noise heard by R71 was indeed the mechanical pill crusher used by the staff. The facility had now ordered silent electric pill crushers and in the meantime pills would be crushed outside of the room on the medication cart. R228 reported loud rattling noises in the room which made sleeping difficult. She said, "I've just gotten use to it." R228 indicated staff was aware and nothing had been done. When the environmental tour was completed on 1/7/15, at 2:25 p.m. a rattling noise was detected in R228's room. The noise was confirmed by	21880		

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	25613	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES OF BOUTWELLS LANDING	13575 58TH STREET OAK PARK HEIGHTS, MN 55082

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21880	Continued From page 12 engineers (E)-A and B. R228's room was located above the laundry area and engineering confirmed the noises were from the clothes dryers. E-A confirmed he had made adjustments to the dryers in the laundry. During the environmental tour, R228 confirmed the noise was better however it had not been alleviated. E-A believed the noise was from the clothes dryers motors and that new motors would need to be ordered. All information was requested from engineering regarding the noise concerns and what had been done to alleviate the noise. Email correspondence to engineering was reviewed for 12/4/14 and 12/24/14, which confirmed the noise in the room. The work order from 12/4/14 indicated, the noise was from the laundry room below and the noise had been taken care of. When interviewed on 1/08/15 at 2:06 p.m. the health unit coordinator (HUC)-A confirmed sending both work orders. HUC-A indicated the noise was reported to engineering each time the nursing assistants heard concerns from the residents, however the noise had been going on for about a year. E-A could not confirm how long the noise had been going on, as E-A had only been employed for a short period of time. E-B was not aware how long the noise had been going on. Preventative maintenance reports were requested from the laundry room and were not provided. The untitled/undated policy and procedure, under the section, Resident/Family/Staff Concern Form Guidelines, indicated when a resident or family receives a complaint the complainant deserves full attention from the staff. Staff should complete the Resident/Family/Staff Quality Concern Form.	21880		

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21880	Continued From page 13 If the staff member can solve the concern immediately it should be solved and an explanation written of the form. A copy is then sent to the administrator and the supervisor. If the concern cannot be taken care of immediately, the concern form should be routed to the supervisor or department head and the complaint is addressed within 5 days. Once the follow up is completed the form is sent off to the administrator for review. During stage one interview on 1/6/15, at 11:27 a.m. there was a loud rattling noise in the room of R228. R228 stated that the loud rattling noise comes and goes, and she has heard it so often that she has somewhat adjusted to it. She also stated that she did have trouble resting and sleeping in the facility and was not sure if the noise was contributing to that problem. When interviewed on 1/6/15, at 11:50 a.m., registered nurse (RN)-B, the clinical coordinator of this unit, stated that she was not aware of a current problem with a rattling noise in the room of R228, but she believed that she had placed a work order for a noise in that room in the past. During observation on 1/8/15, at 1:33 p.m., R228 had been discharged and facility staff was cleaning this resident's room. A loud rattling noise could be heard coming from that room when standing ten feet away from the door of the room.	21880		

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21880	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies relating to the residents and/or families concerns and grievances. Inservice's for all employees as to the concern/grievance protocols could be held and auditing of concerns/grievances could be done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to invite and make arrangements for residents on 2 of 3 floors (1st and 3rd) to attend resident council held each month on second floor. Findings include:	21915	Corrected	1/29/15

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21915	Continued From page 15 The resident council president (R41) was interviewed on 1/6/15, at 10:20 a.m. and indicated council meetings were held monthly on the second floor. When asked whether the other floors were involved he indicated he did not know. R48, who resides on 3rd floor, was interviewed on 1/5/15 at 7:10 p.m. and when asked about resident council meetings indicated, she didn't know anything about those council meetings. The household coordinator (HC)-A was in charge of the council on 2nd floor. When interviewed on 1/6/15, at 11:00 a.m., HC-A stated, "I've never been asked to connect with the residents on 3rd or 1st floors." She thought 3rd floor and transitional care unit (TCU) on 1st had their own councils. When asked how residents are made aware of the council meetings she indicated, it was put on the activity calendar each month. When the activity calendars were reviewed the council meeting appeared on the October calendar for 2nd floor and did not appear on any other calendars for November, December or January for 2nd or 3rd floor. HC-B from 3rd floor was interviewed on 1/6/15, at 1:32 p.m. and confirmed there was no notice on the activity calendar about council meetings, and there was no council held on 3rd floor. When asked as to whether or not the residents were invited to the 2nd floor council meetings she indicated, residents were invited, however she could provide no documentation regarding residents acceptance or refusal to go. 1/08/15, at 1:15 p.m. social worker (SW)-A was interviewed and indicated there was no council on TCU due to short term stay. She indicated, for those staying longer, residents have access to the activity calendar for the whole house and the council meetings are listed on the calendars. The activity calendar was the only means by which	21915		

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21915	Continued From page 16 residents on TCU find out about the council. The leaders of the council do not come down and personally invite residents. SW-A indicated she was not involved in the resident council at all. On 1/08/2015 at 2:31 p.m., the administrator was interviewed about the resident council. The administrator was not aware of any resident council concerns and was not aware that residents had concerns about getting to the council. The administrator stated, the staff in charge of the councils, "are not pulling it together well." A policy and procedure about resident council was requested however the information provided, Resident Council Guidelines, did not address invitations and arrangements for other residents to attend. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the procedure and develop methods by which all residents are made aware of and provided the opportunity to be invited and assisted to attend the resident council meetings. The administrator and/or designee could audit the procedure to assure its effectiveness. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		