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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XI16

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 **11/21/2016** (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	__ 6. Scope of Services Limit
___ 3. 24 Hour RN	__ 7. Medical Director
___ 4. 7-Day RN (Rural SNF)	__ 8. Patient Room Size
___ 5. Life Safety Code	__ 9. Beds/Room

* 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 :
Susanne Reuss, Unit Supervisor 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 12/07/2016 (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
Posted 12/08/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245615
December 7, 2016

Ms. Julie Thompson, Administrator
Gables of Boutwell's Landing
13575 58th Street
Oak Park Heights, MN 55082

Dear Ms. Thompson:

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 November 15, 2016 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 contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 7, 2016

Ms. Julie Thompson, Administrator
Gables of Boutwell's Landing
13575 58th Street
Oak Park Heights, MN 55082

RE: Project Number S5615009

Dear Ms. Thompson:

On October 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 6, 2016 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 October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 15, 2016 and therefore remedies outlined in our letter to you dated October 18, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245615 Y1	A. Building B. Wing Y2	11/21/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0318	Correction	ID Prefix F0441	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.65	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 12/07/2016	SIGNATURE OF SURVEYOR 16022	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245615	A. Building 01 - THE GABLES OF BOUTWELLS LANDING B. Wing	12/6/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/15/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 12/07/2016	SIGNATURE OF SURVEYOR 12424	DATE 12/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/14/2016	☐ 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: XI16

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 **10/06/2016** (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

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Mary Beth Lacina, HFE NE II — 10/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/14/2016 (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
Posted 11/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 18, 2016

Ms. Julie Thompson, Administrator
Gables of Boutwells Landing
13575 - 58th Street
Oak Park Heights, MN 55082

RE: Project Number S5615009

Dear Ms. Thompson:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, 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 January 6, 2017 (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 April 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING _____ B. WING _____	10/06/2016

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		11/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2016

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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	245615	A. BUILDING _____ B. WING _____	10/06/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not develop a plan of care for ordered range of motion services for 1 of 1 resident (R89) reviewed for range of motion. Findings include: During stage one staff interview R89 was identified as having a contracture with no range of motion or splint in place. During observation of morning care by nursing assistant (NA)-A on 10/5/16, no splint was placed and no range of motion (ROM) was done with R89. Document review revealed an order on 6/22/16, from nurse practitioner (NP)-A that read, "PT eval & treat Assess for ROM program as resident refuses walking program." The record also contained a Therapy to Nursing Functional Maintenance Program form, dated 6/24/16, that directed discontinuation of the resident's walking program and to start range of motion to both lower extremities, with a handout of directions for the range of motion. Document review revealed a care plan that did not contain any direction for range of motion or splint application for R89. The form that directed nursing assistant care, titled Communication Sheet, contained no direction for range of motion services or splint application. On 10/05/16, at 2:02 p.m. the director of nursing stated that the nurse on duty on 6/24/16 must	F 279	THIS PLAN AND RESPONSE TO THESE SURVEY FINDINGS IS WRITTEN SOLELY TO MAINTAIN CERTIFICATION IN THE MEDICARE PROGRAM. THESE WRITTEN RESPONSES DO NO CONSTITUTE AND ADMISSION OF NONCOMPLIANCE WITH ANY REQUIREMENT NOR AN AGREEMENT WITH ANY FINDINGS. WE WISH TO PRESERVE OUR RIGHT TO DISPUTE THESE FINDINGS IN THEIR ENTIRETY AT ANY TIME AND IN ANY LEGAL ACTION. WE MAY SUBMIT A SEPARATE REQUEST FOR INFORMAL DISPUTE RESOLUTION FOR CERTAIN FINDINGS AND DETERMINIATIONS. Resident #89 was evaluated by Physical Therapist on 10/5/16 and evaluation showed that resident had not declined in lower extremity function since last evaluation of 6/24/16. On 10/5/16 a functional maintenance program was given to nursing directing that range of motion program be started for resident #89. Resident #89 care plan was reviewed and revised with current ROM program interventions and NAR care sheets revised with current interventions. All FMP's are reviewed as part of the daily IDT process for changes and updates. All care plans are reviewed and updated in conjunction with the RAI process and	

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F 279	Continued From page 2 have neglected to implement the directions of the therapy department to begin range of motion services for R89.	F 279	as needed with any change of condition. The care plan policy has been reviewed and is current. Education was provided for staff responsible for updating resident care plans related to the timeliness of care plan reviews. Random audits will be conducted on minimally 5% of residents for completion of care plan weekly and results reviewed with the facility QA committee to ensure ongoing compliance. Resident #89 will be included in random audits. The Clinical Administrator is responsible for ongoing compliance. Date certain for the purpose of ongoing compliance is 11/15/16.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility did not provide ordered range of motion services for 1 of 1 resident (R89) reviewed for range of motion. Findings include: During stage one staff interview, R89 was	F 318	Resident #89 was evaluated by Physical Therapist on 10/5/16 and evaluation showed that resident had not declined in lower extremity function since last evaluation of 6/24/16. On 10/5/16 a functional maintenance program was given to nursing directing that range of motion be started for resident #89.	11/15/16

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F 318	Continued From page 3 identified as having a contracture with no range of motion or splint in place. During observation of morning care by nursing assistant (NA)-A on 10/5/16, no splint was placed and no range of motion (ROM) was done with R89. Record review revealed an order on 6/22/16, from nurse practitioner (NP)-A that read, "PT eval & treat Assess for ROM program as resident refuses walking program." The record also contained a Therapy to Nursing Functional Maintenance Program form, dated 6/24/16, that directed discontinuation of the resident's walking program and to start range of motion to both lower extremities, with a handout of directions for the range of motion. Record review revealed a care plan that did not contain any direction for range of motion or splint application for R89. The form that directed nursing assistant care, titled Communication Sheet, contained no direction for range of motion services or splint application. When interviewed on 10/05/16, at 10:28 a.m., registered nurse (RN)-A stated that she was not aware of R89 currently receiving any range of motion. During interview on 10/05/16, at 1:20 p.m. NA-A stated that she did not provide any range of motion services for R89 and range of motion was not listed on the sheets that gave nursing assistants direction for care. On 10/05/16, at 2:02 p.m. the director of nursing stated that the nurse on duty on 6/24/16 must	F 318	Resident #89 care plan was reviewed and revised with current ROM program interventions and NAR care sheets revised with current interventions. The restorative nursing and functional maintenance policy has been reviewed and is current. A system was put in place so that there will be three checks and balances to make sure everything on the functional maintenance programs gets transcribed and care planned appropriately. All new FMP's are reviewed as part of the daily ITD process. Education was provided for staff responsible for initiating range of motion programs and functional maintenance programs. Random audits will be conducted on minimally 5% of residents for completion of range of motion programs and initiation of functional maintenance programs weekly and results reviewed with the facility QA committee to ensure ongoing compliance. Resident #89 will be included in the random audits. The Clinical Administrator is responsible for ongoing compliance. Date certain for the purpose of ongoing compliance is 11/15/16.	

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F 318	Continued From page 4 have neglected to implement the directions of the therapy department to begin range of motion services for R89. On 10/05/16, a surveyor requested that the therapy department evaluate R89 for any decline in lower extremity function. On 10/05/16, at 3:05 p.m. physical therapist (PT)-A stated that he had just completed an evaluation of R89 and provided the Physical Therapy Plan of Care (Evaluation Only) form documenting this evaluation and showing that R89 had not declined in lower extremity function since her last evaluation on 6/24/16. PT-A also provided a Therapy to Nursing Functional Maintenance Program form, dated 10/05/16, directing nursing to "Please do Range of Motion 5-10 reps 1 x day," with an attached handout of directions for this range of motion service.	F 318		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		11/15/16

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F 441	Continued From page 5 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate hand hygiene was completed to reduce the risk of contamination for 2 of 7 residents (R16 and R73) observed for personal cares. Findings include: R16's quarterly Minimum Data Set (MDS), dated 6/29/16, indicated the resident needed extensive assist with dressing and transfers. During observation on 10/5/16, at 9:14 a.m. nursing assistant (NA)-D had R16 sitting at edge of bed and had just changed the foley bag to a	F 441	Staff involved in providing care to Residents #16 and #73 were immediately re-educated on hand hygiene and glove use. Residents #16 and #73 will be included in random audits for infection control. The policy and procedure related to proper hand washing, glove use and proper cleaning of shared equipment has been reviewed and is current. All staff are educated on hand hygiene and glove use and proper cleaning of equipment upon hire and minimally annually. Nursing staff have completed in-services on proper hand washing, glove use and	

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F 441	Continued From page 6 leg bag. NA-D, while wearing gloves, took the foley bag that contained urine into the bathroom, emptied it into a graduate and then proceeded to flush the foley bag with water. NA-D used a large syringe stored in the bathroom to flush the bag and empty into the toilet. The bag was recapped and placed in shower area to dry. NA-D emptied the graduate into the toilet, rinsed with water and emptied into the toilet. The graduate was stored in the bathroom with the large syringe. NA-D then removed gloves and tossed into the wastebasket in the bathroom. NA-D then left the bathroom. The nursing assistant did not wash hands or use hand sanitizer after changing or the cleanings of the foley bag. At 9:17 a.m. NA-D was stopped and asked to wash hands after removing the soiled gloves. NA-D stated she had forgot to wash her hands after removing the gloves. On 10/5/16, at 11:00 a.m. the registered nurse (RN)-C verified the nursing assistant should be washing hands after the removal of gloves when doing personal cares. On 10/6/16, at 2:30 p.m. the clinical administrator verified nursing assistants should be washing hands after the removal of gloves when providing cares and indicated the subject had just been addressed with staff. Facility's Hand Hygiene policy dated 2015 revealed: "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents,	F 441	proper cleaning of shared equipment. The Clinical Administrator or designee will audit for infection control compliance. Random audits will be conducted on 10% of residents weekly. Audit results will be reported to the QA committee and action plans developed as needed. Date certain for the purpose of ongoing compliance is 11/15/16.	

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personnel, equipment and/or the environment. Specific examples include but are not limited to: 2. When hands are visibly soiled. 3. Before and after direct resident care... 11. Before and after assisting a resident with personal cares (peri-care, bathing, oral cares). 12. Before and after handling peripheral vascular catheters and other invasive devices... 24. After touching any item or surface that may have been contaminated with blood or body fluids, excretions or secretions (e.g. measuring graduate, commode)."

R73's quarterly MDS dated 9/8/16, indicated R73 required total two person assist with transfers and extensive two person assist with toileting and dressing.

Care plan dated 9/15/16, indicated R73 required assistance with ambulation, transfers, mobility, locomotion, and needed two assist with bed mobility and one assist with wheelchair. Care plan indicated R73 had risk for impaired skin integrity and to monitor, document, report to physician as needed changes in skin status, appearance, color, wounds.

On 10/5/16, at 8:11 a.m. nursing assistant (NA)-B and NA-C were observed providing cares for R73. NARs entered room with lift equipment, washed hands and applied gloves. NARs explained cares to R73. NA-B cleansed R73's peri-area, removed soiled pad, tossed it in the garbage, removed gloves and tossed them in the garbage. NA-B applied clean gloves, sprinkled powder on abdomen, placed and fastened clean pad on R73. NA-B placed pants on R73's feet and pulled them up while directing R73 to roll and turn. NA-B then placed lift sling underneath R73. NA-B and NA-C secured sling and informed R73

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the lift would pull her up. NARs transferred R73 from bed to sitting position in wheelchair. NARs then removed sling from R73. NAR's proceeded to place R73's arms in shirt sleeves, put shirt on, and boosted R73 up in wheelchair. They began to apply hand splints on R73's hands and called nurse to assist. Registered nurse (RN)-A came into room, washed hands, applied gloves and continued with splint application. NA-B removed gloves, washed hands and held R73's hand during splint application process. RN-A completed splint application, washed hands and left room. NA-C bagged garbage, washed hands and made bed with clean linens. NA-B rolled up towels, placed them next to R73 on each side of seat in wheelchair and moved R73 to bathroom. NA-B washed hands and left room to get clean towels. NA-B applied clean gloves upon return to bathroom. NA-B cleansed R73's face with warm washcloth, observed R73's chin to be bleeding and asked RN-A to return. RN-A came into room, measured chin injury indicating R73 may have nicked her chin with edge of hand splints and indicated would add that to skin monitoring. NA-C completed making bed, removed gloves, washed hands, left room with bagged linens and lift and plugged lift into hallway wall outlet. NA-C brought bagged linens to utility room and washed hands. NA-B washed hands, put eyeglasses on R73 and wheeled resident to breakfast table.

On 10/5/16, at 10:27 a.m. when asked NA-C about R73's sling and lift, NA-C indicated sling was for use on R73 and was kept in room. NA-C stated she did not disinfect wipe the lift or use it on another resident. NA-C stated she just plugged lift in to recharge, did not clean it, as that had "slipped her mind."

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On 10/5/16, at 10:55 A.M. when asked, NA-B stated R73 had small amount bowel movement in pad this morning when providing peri-cares and would chart that. When asked if NA-B had washed her hands after removing pad, NA-B stated she just removed gloves and continued providing cares for R73.

On 10/6/16, at 11:40 a.m. director of nursing (DON) stated if staff came in contact with bodily fluids they should wear gloves. DON further stated after and in-between peri-cares staff should change gloves and wash hands for 20 seconds. If staff need to re-glove they could do so at that time.

On 10/6/16, at 11:41 a.m. DON stated if resident lift equipment was visibly soiled staff should wipe it down and sanitize it with orange or purple disinfectant wipes.

On 10/6/16, at 1:40 p.m. licensed practical nurse (LPN)-A stated her expectation with gloving during cares was staff should wash hands prior to gloving and change them when soiled. If gloves got soiled in-between, staff should change gloves, wash hands, and put on new pair of gloves.

On 10/6/16, at 1:43 p.m. LPN-A stated every resident has their own sling with lift equipment and indicated slings were washed weekly. LPN-A further stated lift parts that touched residents should be cleaned between patients and staff should clean anything the resident touched.

Facility's Mechanical Lift Cleaning policy dated 12/2009 revealed "2. Nursing staff will clean mechanical lifts as needed between regularly

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F 441	Continued From page 10 scheduled cleaning of the lifts by housekeeping staff." Facility's Resident Care Equipment and Articles for: Handling, Reprocessing, and Transport policy dated 2015 revealed: "To ensure that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately..." "The facility must protect indirect transmission through decontamination (i.e. cleaning, sanitizing, or disinfecting) of an object to render it safe for handling." 2. HCW/service staff will disinfect reusable equipment (see table A) between resident uses or prior to transport using a hospital grade disinfectant."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, sanitary, and comfortable environment for 3 of 35 residents (R2, R24, R26) reviewed for environment. Findings include: On 10/3/16, at 5:19 p.m. during stage one observation, it was noted in R24's room had a large scrape on the closet door. The scrape was nearly the width of the door, and at least 1 inch in	F 465	Specific areas for correction for resident living spaces have been identified and are in process. The resident's involved have been communicated to. Resident #2, Resident #24 and Resident #26 will be included in random audits for safe/functional/sanitary/comfortable environment. The policy and procedure related to water temperature and resident's rights has been reviewed and is current. Work	11/15/16

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F 465	Continued From page 11 diameter where the paint had been scraped off and had exposed wood like material and splinters. The inside of the bathroom door had a similar long scrape on the door with removed paint and had exposed wood like material and splinters. There were two gouges on the wall near the refrigerator where paint had been removed and white board was exposed. The water in the bathroom did not reach a warm to hot temperature when the water was left running for approximately 2 minutes. During morning cares observation on 10/5/16 at 7:10 a.m., for R26 the bathroom was noted to have two large gouges on the extended interior wall by the sink. The extended corner had paint removed and white board exposed and chipped at both gouges. During the environmental tour on 10/5/16, at 1:45 p.m. the stains on the carpet in the room of R2 remained. R2's trash can also had a large brown streak down the front of it. There were large gouges in the closet door, wall, bathroom door, and door frame of R24's room. The water from R24's bathroom sink faucet was a cool lukewarm temperature that turned slightly warm after running the water for several minutes. The temperature of the water, after running for several minutes, 99-102 degrees Fahrenheit. The bathroom wall of R26 also contained a large gouge. The facility's administrator and the facility's engineer (FE)-A participated in the environmental tour. FE-A stated that the goal for bathroom faucet temperatures in the facility is 105-110 degrees Fahrenheit and he would check into the	F 465	orders were placed during survey to repair issues that were noted for Resident #2, Resident #24 and Resident #26 and corrections completed by 11/11/16. The audit tool that housekeeping uses to document and audit for environmental issues was modified to reflect a more comprehensive audit of the environment. Education was provided to staff related to safe/functional/comfortable environment. The Administrator or designee will audit for compliance. Environmental audits will be conduced by housekeeping quarterly and maintenance will audit random water temperatures weekly and results will be reviewed with the facility QA committee to ensure ongoing compliance and action plans developed as needed. Date certain for the purposes of ongoing compliance is 11/15/16.	

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 _____	10/06/2016

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 465	Continued From page 12 function of the circulating pump of the water system. The administrator stated that the carpet stains and soiled trash can would be cleaned immediately. The administrator explained that resident rooms are audited quarterly for repairs and directed that the gouges in the rooms of R24 and R26 be repaired.	F 465		

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 _____	**10/14/2016**

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
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 Pat.Sheehan@state.mn.us	K 000	EPOC	

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

Electronically Signed | 10/27/2016

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
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K 000	Continued From page 1 or By email to: Angela.Kappenman@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.	K 000		
K 062 SS=C	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 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6,	K 062		11/15/16

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	245615	A. BUILDING **01 - THE GABLES OF BOUTWELLS LANDING** B. WING _____	**10/14/2016**

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K 062	Continued From page 2 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire. Findings include: K-062 On the facility tour between 8:30 am to 12:30 pm on 10-14-2016 observations and staff interview revealed that: 1 The facility did not properly document the quarterly fire sprinkler flow tests. Tests were conducted however there was no documentation of the pressure gauge at the main riser. 2) The gauge on the main riser has not been calibrated or replaced in the last 5 years as required. This deficient condition was verified by the Maintenance Supervisor.	K 062	1. The Automatic Fire Sprinkler system will be tested and documented according to the requirements of NFPA 25 (2011). Documentation of the required tests will be available for inspection in the facility's Life Safety Manual. Environmental Services Director or Designee will be responsible for compliance. Date Certain for this correction is 11/15/16. 2. The Automatic Fire Sprinkler system will be maintained according to the requirements of NFPA 25 (2011). All required maintenance including the five year gauge calibration or replacement will be done at required intervals. Documentation of the maintenance of the fire sprinkler system will be kept available for inspection in the facility's Life Safety Manual. The Environmental Services Director or designee will be responsible for ongoing compliance. The gauge on the main riser will be replaced by 11/15/16.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
October 18, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5615009

Dear Ms. Thompson:

The above facility was surveyed on October 3, 2016 through October 6, 2016 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25613	A. BUILDING: _____ B. WING _____	10/06/2016

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		

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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 10/3/16, 10/4/16, 10/5/16 and 10/6/16, 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not develop a plan of care for ordered range of motion services for 1 of 1 resident (R89) reviewed for range of motion. Findings include: During stage one staff interview R89 was identified as having a contracture with no range of motion or splint in place. During observation of morning care by nursing assistant (NA)-A on 10/5/16, no splint was placed and no range of motion (ROM) was done with R89. Document review revealed an order on 6/22/16,	2 560		

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2 560	Continued From page 3 from nurse practitioner (NP)-A that read, "PT eval & treat Assess for ROM program as resident refuses walking program." The record also contained a Therapy to Nursing Functional Maintenance Program form, dated 6/24/16, that directed discontinuation of the resident's walking program and to start range of motion to both lower extremities, with a handout of directions for the range of motion. Document review revealed a care plan that did not contain any direction for range of motion or splint application for R89. The form that directed nursing assistant care, titled Communication Sheet, contained no direction for range of motion services or splint application. On 10/05/16, at 2:02 p.m. the director of nursing stated that the nurse on duty on 6/24/16 must have neglected to implement the directions of the therapy department to begin range of motion services for R89. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		

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2 895	Continued From page 4 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility did not provide ordered range of motion services for 1 of 1 resident (R89) reviewed for range of motion. Findings include: During stage one staff interview, R89 was identified as having a contracture with no range of motion or splint in place. During observation of morning care by nursing assistant (NA)-A on 10/5/16, no splint was placed and no range of motion (ROM) was done with R89. Record review revealed an order on 6/22/16, from nurse practitioner (NP)-A that read, "PT eval & treat Assess for ROM program as resident refuses walking program." The record also contained a Therapy to Nursing Functional Maintenance Program form, dated 6/24/16, that	2 895		

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2 895	Continued From page 5 directed discontinuation of the resident's walking program and to start range of motion to both lower extremities, with a handout of directions for the range of motion. Record review revealed a care plan that did not contain any direction for range of motion or splint application for R89. The form that directed nursing assistant care, titled Communication Sheet, contained no direction for range of motion services or splint application. When interviewed on 10/05/16, at 10:28 a.m., registered nurse (RN)-A stated that she was not aware of R89 currently receiving any range of motion. During interview on 10/05/16, at 1:20 p.m. NA-A stated that she did not provide any range of motion services for R89 and range of motion was not listed on the sheets that gave nursing assistants direction for care. On 10/05/16, at 2:02 p.m. the director of nursing stated that the nurse on duty on 6/24/16 must have neglected to implement the directions of the therapy department to begin range of motion services for R89. On 10/05/16, a surveyor requested that the therapy department evaluate R89 for any decline in lower extremity function. On 10/05/16, at 3:05 p.m. physical therapist (PT)-A stated that he had just completed an evaluation of R89 and provided the Physical Therapy Plan of Care (Evaluation Only) form documenting this evaluation and showing that R89 had not declined in lower extremity function since her last evaluation on 6/24/16. PT-A also	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 895	Continued From page 6 provided a Therapy to Nursing Functional Maintenance Program form, dated 10/05/16, directing nursing to "Please do Range of Motion 5-10 reps 1 x day," with an attached handout of directions for this range of motion service. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate intervention for range of motion services and documentation to be effective. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 895		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;	21390		

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(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
21390	Continued From page 7 F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate hand hygiene was completed to reduce the risk of contamination for 2 of 7 residents (R16 and R73) observed for personal cares. Findings include: R16's quarterly Minimum Data Set (MDS), dated 6/29/16, indicated the resident needed extensive assist with dressing and transfers. During observation on 10/5/16, at 9:14 a.m. nursing assistant (NA)-D had R16 sitting at edge of bed and had just changed the foley bag to a leg bag. NA-D, while wearing gloves, took the foley bag that contained urine into the bathroom, emptied it into a graduate and then proceeded to flush the foley bag with water. NA-D used a large syringe stored in the bathroom to flush the bag and empty into the toilet. The bag was recapped and placed in shower area to dry. NA-D emptied the graduate into the toilet, rinsed with water and emptied into the toilet. The graduate was stored in the bathroom with the large syringe. NA-D	21390		

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	25613	A. BUILDING: _____ B. WING _____	10/06/2016

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21390	Continued From page 8 then removed gloves and tossed into the wastebasket in the bathroom. NA-D then left the bathroom. The nursing assistant did not wash hands or use hand sanitizer after changing or the cleanings of the foley bag. At 9:17 a.m. NA-D was stopped and asked to wash hands after removing the soiled gloves. NA-D stated she had forgot to wash her hands after removing the gloves. On 10/5/16, at 11:00 a.m. the registered nurse (RN)-C verified the nursing assistant should be washing hands after the removal of gloves when doing personal cares. On 10/6/16, at 2:30 p.m. the clinical administrator verified nursing assistants should be washing hands after the removal of gloves when providing cares and indicated the subject had just been addressed with staff. Facility's Hand Hygiene policy dated 2015 revealed: "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment. Specific examples include but are not limited to: 2. When hands are visibly soiled. 3. Before and after direct resident care... 11. Before and after assisting a resident with personal cares (peri-care, bathing, oral cares). 12. Before and after handling peripheral vascular catheters and other invasive devices... 24. After touching any item or surface that may have been contaminated with blood or body fluids, excretions or secretions (e.g. measuring graduate, commode)."	21390		

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21390	Continued From page 9 R73's quarterly MDS dated 9/8/16, indicated R73 required total two person assist with transfers and extensive two person assist with toileting and dressing. Care plan dated 9/15/16, indicated R73 required assistance with ambulation, transfers, mobility, locomotion, and needed two assist with bed mobility and one assist with wheelchair. Care plan indicated R73 had risk for impaired skin integrity and to monitor, document, report to physician as needed changes in skin status, appearance, color, wounds. On 10/5/16, at 8:11 a.m. nursing assistant (NA)-B and NA-C were observed providing cares for R73. NARs entered room with lift equipment, washed hands and applied gloves. NARs explained cares to R73. NA-B cleansed R73's peri-area, removed soiled pad, tossed it in the garbage, removed gloves and tossed them in the garbage. NA-B applied clean gloves, sprinkled powder on abdomen, placed and fastened clean pad on R73. NA-B placed pants on R73's feet and pulled them up while directing R73 to roll and turn. NA-B then placed lift sling underneath R73. NA-B and NA-C secured sling and informed R73 the lift would pull her up. NARs transferred R73 from bed to sitting position in wheelchair. NARs then removed sling from R73. NAR's proceeded to place R73's arms in shirt sleeves, put shirt on, and boosted R73 up in wheelchair. They began to apply hand splints on R73's hands and called nurse to assist. Registered nurse (RN)-A came into room, washed hands, applied gloves and continued with splint application. NA-B removed gloves, washed hands and held R73's hand during splint application process. RN-A completed	21390		

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splint application, washed hands and left room. NA-C bagged garbage, washed hands and made bed with clean linens. NA-B rolled up towels, placed them next to R73 on each side of seat in wheelchair and moved R73 to bathroom. NA-B washed hands and left room to get clean towels. NA-B applied clean gloves upon return to bathroom. NA-B cleansed R73's face with warm washcloth, observed R73's chin to be bleeding and asked RN-A to return. RN-A came into room, measured chin injury indicating R73 may have nicked her chin with edge of hand splints and indicated would add that to skin monitoring. NA-C completed making bed, removed gloves, washed hands, left room with bagged linens and lift and plugged lift into hallway wall outlet. NA-C brought bagged linens to utility room and washed hands. NA-B washed hands, put eyeglasses on R73 and wheeled resident to breakfast table.

On 10/5/16, at 10:27 a.m. when asked NA-C about R73's sling and lift, NA-C indicated sling was for use on R73 and was kept in room. NA-C stated she did not disinfect wipe the lift or use it on another resident. NA-C stated she just plugged lift in to recharge, did not clean it, as that had "slipped her mind."

On 10/5/16, at 10:55 A.M. when asked, NA-B stated R73 had small amount bowel movement in pad this morning when providing peri-cares and would chart that. When asked if NA-B had washed her hands after removing pad, NA-B stated she just removed gloves and continued providing cares for R73.

On 10/6/16, at 11:40 a.m. director of nursing (DON) stated if staff came in contact with bodily fluids they should wear gloves. DON further stated after and in-between peri-cares staff

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should change gloves and wash hands for 20 seconds. If staff need to re-glove they could do so at that time.

On 10/6/16, at 11:41 a.m. DON stated if resident lift equipment was visibly soiled staff should wipe it down and sanitize it with orange or purple disinfectant wipes.

On 10/6/16, at 1:40 p.m. licensed practical nurse (LPN)-A stated her expectation with gloving during cares was staff should wash hands prior to gloving and change them when soiled. If gloves got soiled in-between, staff should change gloves, wash hands, and put on new pair of gloves.

On 10/6/16, at 1:43 p.m. LPN-A stated every resident has their own sling with lift equipment and indicated slings were washed weekly. LPN-A further stated lift parts that touched residents should be cleaned between patients and staff should clean anything the resident touched.

Facility's Mechanical Lift Cleaning policy dated 12/2009 revealed "2. Nursing staff will clean mechanical lifts as needed between regularly scheduled cleaning of the lifts by housekeeping staff."

Facility's Resident Care Equipment and Articles for: Handling, Reprocessing, and Transport policy dated 2015 revealed: "To ensure that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately..." "The facility must protect indirect transmission through decontamination (i.e. cleaning, sanitizing, or disinfecting) of an object to render it safe for handling." 2. HCW/service staff will disinfect

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21390	Continued From page 12 reusable equipment (see table A) between resident uses or prior to transport using a hospital grade disinfectant." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all handwashing interventions and cleaning of reusable resident equipment The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate handwashing and shared equipmant cleaning/disinfecting services are implemented; to reduce the risk for cross contamination and infection control practices are followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, sanitary, and comfortable environment for 3 of 35 residents (R2, R24, R26) reviewed for environment. Findings include:	21695		

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21695	Continued From page 13 On 10/3/16, at 5:19 p.m. during stage one observation, it was noted in R24's room had a large scrape on the closet door. The scrape was nearly the width of the door, and at least 1 inch in diameter where the paint had been scraped off and had exposed wood like material and splinters. The inside of the bathroom door had a similar long scrape on the door with removed paint and had exposed wood like material and splinters. There were two gouges on the wall near the refrigerator where paint had been removed and white board was exposed. The water in the bathroom did not reach a warm to hot temperature when the water was left running for approximately 2 minutes. During morning cares observation on 10/5/16 at 7:10 a.m., for R26 the bathroom was noted to have two large gouges on the extended interior wall by the sink. The extended corner had paint removed and white board exposed and chipped at both gouges. During the environmental tour on 10/5/16, at 1:45 p.m. the stains on the carpet in the room of R2 remained. R2's trash can also had a large brown streak down the front of it. There were large gouges in the closet door, wall, bathroom door, and door frame of R24's room. The water from R24's bathroom sink faucet was a cool lukewarm temperature that turned slightly warm after running the water for several minutes. The temperature of the water, after running for several minutes, 99-102 degrees Fahrenheit. The bathroom wall of R26 also contained a large gouge. The facility's administrator and the facility's	21695		

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21695	Continued From page 14 engineer (FE)-A participated in the environmental tour. FE-A stated that the goal for bathroom faucet temperatures in the facility is 105-110 degrees Fahrenheit and he would check into the function of the circulating pump of the water system. The administrator stated that the carpet stains and soiled trash can would be cleaned immediately. The administrator explained that resident rooms are audited quarterly for repairs and directed that the gouges in the rooms of R24 and R26 be repaired. SUGGESTED METHOD OF CORRECTION: The administrator, and the Director of Maintenance will be responsible to ensure a safe, clean, functional and homelike environment. The administrator and director of maintenance, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		