DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 5, 2024

Administrator
The Gables Of Boutwells Landing
13575 58th Street North
Oak Park Heights, MN 55082

RE: CCN: 245615
Cycle Start Date: July 10, 2024

Dear Administrator:

On August 30, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

September 5, 2024

Administrator
The Gables Of Boutwells Landing
13575 58th Street North
Oak Park Heights, MN 55082

Re: Reinspection Results
Event ID: YXXP12

Dear Administrator:

On August 19, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 17, 2024

Administrator
The Gables Of Boutwells Landing
13575 58th Street North
Oak Park Heights, MN 55082

RE: CCN: 245615
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 10, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 October 10, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by January 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES OF BOUTWELLS LANDING	13575 58TH STREET NORTH 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
E 000	Initial Comments On 7/8/24-7/10/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/8/24-7/10/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		8/19/24

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

Electronically Signed | 07/22/2024

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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F 756	Continued From page 1 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 756	This Plan of Correction constitutes our	

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F 756	Continued From page 2 review, the facility failed to ensure the provider documented a clear clinical rationale for actions taken or not taken; including risks and benefits to justify the continued use of medications identified to put the resident at risk for falls and adverse effects for 1 of 1 resident (R83) reviewed for requests for clinical rationale. Findings include: R83's admission Minimum Data Set (MDS) dated 2/13/24, identified a fall occurred in the past two to six months prior to admission. No behaviors or rejection of care occurred, and the mood interview indicated no depression. R83's corresponding Care Area Assessments (CAA), undated, identified falls was triggered related to history of falls, impaired mobility, cognition, hearing, pain, incontinence, anticipated decline, and medication side effects and care planning was in place to minimize risks and provide symptom relief or palliative measures. Additionally, psychotropic medication use was triggered related to high risk drugs taken (antipsychotic and antidepressant). Care planning was in place to minimize risks and provide symptom relief or palliative measures. R83's quarterly MDS dated 5/13/24, identified intact cognition, and no behaviors or rejection of care. The mood interview identified minimal depression. Diagnoses included metabolic encephalopathy (brain dysfunction), Alzheimer's disease, depression, and anxiety. No falls had occurred since the prior admission assessment. Impairments to upper or lower extremities were present, and a wheelchair was used for mobility. Hospice services were in place. High risk drugs	F 756	written allegation of compliance for the deficiencies cited to maintain certification in the Medicare and Medicaid programs and constitutes a credible allegation of compliance. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of The Gables Care Center of Boutwells Landing to comply with F756. To assure continued compliance, the following plan has been put into place: 1) Regarding cited residents, R83 is on hospice and has exhibited no negative impacts from the observations documented. R83 is noted to be at their functional, cognitive, and psychosocial baseline. R83 medications reviewed by hospice and onsite provider and no adjustments made at this time and staff will continue to follow current plan of care. 2) Measures put in place to ensure deficient practice does not recur: The Radius Pharmacy: Long-term Care Policy & Procedure Manual was reviewed and remains current. Our facility providers will be re-educated regarding the importance of appropriate documentation on the pharmacy consultant recommendation communication forms for the care of all our residents. 3) Actions taken to identify other potential residents having similar occurrences: All like residents' pharmacy	

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F 756	Continued From page 3 used included antipsychotic, antianxiety, antidepressant, and opioid; and a gradual dosage reduction had not been attempted nor documented by a physician as clinically contraindicated. R83's anticonvulsant care plan dated 2/7/24, identified brain activity could be affected. Interventions to administer medications as ordered, monitor for side effects, inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. R83's pain care plan dated 2/7/24, identified a risk for pain related to impaired mobility and cognition, history of falls, skin impairments and anticipated decline. Interventions included pain would be assessed, medications would be administered as ordered, non-pharmacological interventions as needed, and hospice consulted as needed. R83's antipsychotic care plan dated 2/8/24, identified diagnoses of delirium, agitation, anxiety and hospice care. Interventions to administer medications as ordered, monitor for side effects, inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. R83's mood and behavioral care plan dated 5/21/24, identified diagnosis of depression and anxiety. Interventions included provide encouragement to participate in activities and demonstrate effective coping skills. Non-pharmacological interventions included: tell	F 756	consultant communication forms have reviewed to ensure they are up to date and documented correctly with the provider. 4) Effective implementation of actions will be monitored by: Clinical managers will audit 100% of our next pharmacy consultant recommendations to physician for August 2024 and September 2024 to ensure our facility is maintaining compliance. Results will be reviewed by the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance. 5) The Director of Nursing is responsible for ongoing compliance. 6) Date of Correction: 8/19/24.	

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F 756	Continued From page 4	F 756		

resident to take a breath, ask resident if she was in pain, talk to me about the North Shore, turn on TV (likes Greys Anatomy,
music channel), encourage resident to be out of her room (tends to self-isolate). Target behaviors included: sadness or crying, anxiety related to where family members were, decreased appetite, self-isolation and paranoia.

R83's pain ratings dated 2/7/24 through 6/27/24, identified consistent pain ratings of zero.

R83's behavior tracking dated 5/11/24 through 7/10/24, identified no behaviors or mood concerns occurred.

R83's Order Summary Report dated 7/10/24, identified the following active medications:

1. Start date 2/7/24, methocarbamol (central muscle relaxant) give 500 milligrams (mg) by mouth two times a day for muscle spasms.

2. Start date 2/7/24, tramadol (opioid agonist produces similar pain relief effects as morphine and other opioids) give 100 mg by mouth three times a day for pain.

3. Start date 2/7/24, C-morphine (opioid) give 5 mg sublingually every one hour as needed (PRN) for pain or dyspnea (difficulty breathing).

4. Start date 2/7/24 gabapentin (anticonvulsant) give 300 mg by mouth three times a day for nerve pain.

5. Start date 2/13/24, Seroquel (an antipsychotic) give 12.5 mg by mouth at bedtime for delirium, agitation, anxiety.

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F 756	Continued From page 5 6. Start date 2/16/24, venlafaxine (Effexor, an antidepressant) give 37.5 mg by mouth one time a day for depression take in addition to the 150 mg tablet for a total daily dose of 187.5 mg. 7. Start date 2/16/24, Effexor give 150 mg by mouth one time a day for depression take in addition with 37.5 tablet for a total dose of 187.5 mg. 8. Start date 7/2/24, lorazepam (benzodiazepine) give 0.5 mg by mouth every 2 hours as needed for Anxiety for 14 days (renewed). R83's Medication Administration Records (MAR) dated 5/1/24 through 7/10/24, identified PRN morphine was never given. PRN lorazepam was given once, on 5/12/24 and marked as effective. All other medications listed above were taken routinely since their start date. R83's Consultant Pharmacist (CP) Communication to Physician dated 3/30/24, identified since a recent fall occurred, the resident was at risk for falls, and the above medications (1 through 7, specifically) might increase the risk of falls; an assessment for ongoing use was requested. Additionally, methocarbamol was "strongly urged to avoid use in the elderly - strong correlation with falls". Also, the new guidelines from American Geriatric Society (AGS) Beers list (criteria for potentially inappropriate medications) "strongly" recommended avoiding three or more central nervous system (CNS)-active drugs as they can increase the risk of falls. CNS-active drugs included antidepressants, antipsychotics, benzodiazepines, and opioids. Lastly, a	F 756		

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F 756	Continued From page 6 combination of some CNS medications could cause serotonin syndrome and the risk of QT prolongation (heart rhythm disorder which can be life threatening), as well as additional sedative, CNS and/or respiratory-depressant effects. The CP requested an assessment by the provider of the above medications to determine appropriateness of reducing the dose or frequency. Options provided were: - Discontinue (DC). - Reduce. - No changes because the medications are necessary, benefits outweigh the potential risks, and are required to maintain functional status. - Other. The box for "other" was checked and "hospice" was written next to it. The form was signed by nurse practitioner (NP)-A on 4/2/24. The form lacked documentation from the provider of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. R83's provider progress notes dated 3/20/24 and 6/17/24, lacked documentation of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. During an observation and interview on 7/8/24 at 5:13 p.m., R83 was in her wheelchair, self-propelling around her room, well-groomed and conversational. She stated she had no pain at the time, had good support and was happy with her hospice services. R83 stated her doctor and hospice managed her medications and she would go along with what they decided to do. During an interview on 7/10/24 at 9:55 a.m.,	F 756		

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F 756	Continued From page 7	F 756		

nursing assistant (NA)-A stated she worked at the facility for over one year and R83 was alert with intermittent confusion, and she had not noticed any recent behaviors.

During an interview on 7/10/24 at 9:57 a.m., NA-B stated she had worked routinely with R83 for about one month and mood was very stable, no delusions, agitation. R83 attended activities and could self-propel after being set up.

During an interview on 7/10/24 at 10:07 a.m., registered nurse (RN)-C stated she had observed R83 transfer this morning with the NA and her transfer was steady. RN-C stated R83's mood and behavior and health were stable for the past couple of months.

During an interview on 7/10/24 at 12:17 p.m., hospice RN-D stated they had not received a request to review R83's CNS-active medications for ongoing use, and that would typically be reviewed by the facility primary care providers. RN-D reviewed R83's hospice chart and stated it appeared she had been stable.

Interviews with NP-A were attempted on 7/10/24 at 11:43 a.m., and 1:02 p.m. NP-A was out of the office and unable to provide information on the response to the CP communication form.

During an interview on 7/10/24 at 12:45 p.m., the CP stated unless otherwise identified on the form, a response was expected by the next primary care provider visit, or about two months. The CP stated he would expect if the provider wanted no changes then to document the benefits outweighed the risk, and the medications were the least restrictive measures. The CP stated the

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THE GABLES OF BOUTWELLS LANDING	13575 58TH STREET NORTH OAK PARK HEIGHTS, MN 55082

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F 756	Continued From page 8 4/2/24, response of "hospice" on R83's communication form was not a clear rationale nor assessment of risks and benefits of ongoing use. During an interview on 7/10/24 at 1:49 p.m., the director of nursing (DON) stated if the CP requested an assessment on an identified medication irregularity for R83, it would be deferred to the facility primary care providers. The DON stated she thought "hospice" was an adequate rationale. The DON stated unless they saw a negative impact she would not expect further documentation from the provider. The facility's undated policy titled CP Reports identified recommendations would be acted upon and documented by the facility staff and/or the prescriber. If the prescriber had not responded the medical director would be contacted.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.41% with 2 errors out of 27 opportunities for errors involving 2 of 7 residents (R25 and R34) who were observed during the medication pass. Findings Include:	F 759	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited to maintain certification in the Medicare and Medicaid programs and constitutes a credible allegation of compliance. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is	8/19/24

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 _____	07/10/2024

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F 759	Continued From page 9 R25 R25's quarterly minimum data set (MDS) dated 5/1/24, identified R25 was cognitively intact and required staff assistance with most activities of daily living. The MDS indicated R25 had diabetes mellitus (DM) and received insulin daily in the 7-day lookback period. R25's care plan revised 5/14/24, identified a risk for alteration in blood glucose levels related to the diagnosis of diabetes and tasked staff with providing medications per orders. R25's provider order dated 6/28/24 indicated, "HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject as per sliding scale: if 141-180 = 2 units give before meals, anything above 400 gives 14 units. May sub Admelog, or Novolog based on insurance.; 181 - 220 = 4 units, 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 340 = 10 units; 341 - 400 = 12 units; 401 - 999 = 14 units, subcutaneously before meals for T2 DM give before meals, anything above 400 give 14 units." R25's July 2024 Medication Administration Record (MAR), indicated R25 received Humalog three times a day. During observation on 7/9/24 at 11:58 a.m., registered nurse (RN)-A obtained R25's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe and applied a sterile needle. The pen was dialed to the ordered dose, 4 units. RN-A had not primed the needle prior to administering the medication to R25.	F 759	submitted to meet requirements established by State and Federal law. It is the policy of The Gables Care Center of Boutwells Landing to comply with F759. To assure continued compliance, the following plan has been put into place: 1) Regarding cited residents R25 and R34, they have exhibited no negative impacts from the observations documented. Both residents noted remain at their functional, cognitive and psychosocial baselines. RN-A received a coaching for the medication errors and not following the medication administration policy. 2) Measures put in place to ensure deficient practice does not recur: Review of the Insulin Pen Management Policy has taken place and has been reviewed and remains current. All nursing staff are being re-educated regarding the importance of following the policy for the care of all of our diabetic residents. 3) Actions taken to identify other potential residents having similar occurrences: All like residents' diabetic orders were reviewed and are up to date, and additionally remain at their baselines. 4) Effective implementation of actions will be monitored by: The clinical managers will audit 10% of all diabetic resident's care weekly x4 weeks and then monthly x2 months to ensure facility maintains compliance with the medication administration policy. Results of these audits will be reviewed by the facility	

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F 759	Continued From page 10 R34 R34 admission MDS dated 6/6/24, identified R34 with moderate cognitive impairment and required staff assistance with most activities of daily living. The MDS indicated R34 had DM and received insulin daily in the 7-day lookback period. R34 care plan dated 6/3/24, indicated R34 at risk for alteration in blood glucose levels related to their diagnosis of diabetes and tasked staff with providing medications per orders. R34 provider order dated 7/8/24 indicated, "HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject 5 unit subcutaneously with meals for Type 2 Diabetes." R34's Medication Administration Record printed 7/10/24, indicated R34 received Humalog three times a day. During an observation and interview on 7/9/24 at 12:19 p.m., RN-A obtained R34's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe prior to attaching a sterile needle. The pen was dialed to the ordered dose, 5 units. RN-A had not primed the needle prior to administrating the medication to R34. RN-A stated the needle did not need to be primed unless it was a new pen. During a follow up interview on 7/9/24 at 1:27 p.m., RN-A stated, "I made a mistake, it should be primed." During an interview on 7/10/24 at 10:26 a.m., RN-B stated that insulin pens should be primed prior to administration because it could give a	F 759	Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance. 5) The Director of Nursing is responsible for ongoing compliance. 6) Date of Correction: 8/19/24.	

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F 759	Continued From page 11 lesser dose of insulin. During an interview on 7/10/24 at 11:00 a.m., the director of nursing (DON) stated that insulin KwikPens should be primed prior to administration to ensure the correct dose was given to not cause an error. Manufacturers instructions regarding Humalog Kwikpen dated 8/23, indicated to first dial up to two units to prime the needle, turn pen with needle pointing up, tap pen gently to move air bubbles to the top, push the dose knob until it stops, and ensure insulin is visible at the tip of the needle.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		8/19/24

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F 880	Continued From page 12 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 13 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices were followed when staff failed to utilize enhanced barrier precautions (EBP) and proper hand hygiene for 1 of 1 resident (R20) observed during wound care. Findings include: R20's admission minimum data set (MDS) dated 5/5/24, identified R20 was cognitively intact, required partial to substantial staff assistance in most activities of daily living, and at risk for developing pressure ulcers. Diagnoses included debility (general weakness), chronic obstructive pulmonary disease (COPD), and oxygen therapy. R20's care plan (CP) dated 6/18/24, identified EBP was placed due to a wound. The CP directed staff to follow EBP, in addition to standard precautions, by wearing gown and gloves during high-contact care activities. R20's physician orders dated 6/18/24 indicated wound care to coccyx every shift and as needed for wound integrity. During an observation on 7/8/24 at 1:55 p.m., R20's door had an EBP sign posted and next to the door was an isolation cart inside it contained personal protective equipment (PPE).	F 880	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited to maintain certification in the Medicare and Medicaid programs and constitutes a credible allegation of compliance. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of The Gables Care Center of Boutwells Landing to comply with F880. To assure continued compliance, the following plan has been put into place: 1) Regarding cited resident, R20 was on hospice and passed away on 7/18/24 unrelated to the concerns noted during the survey. RN-C received written corrective action for not following EBP and Hand Hygiene Policies and Procedure. 2) Measures put in place to ensure deficient practice does not recur: Review of the Hand Hygiene Policy and EBP Policy has taken place and has been reviewed and remains current. All nursing and therapy staff are being re-educated regarding the importance of following both policies for the care of all our residents to minimize risk of infection.	

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F 880	Continued From page 14 During an observation on 7/10/24 at 9:49 a.m., registered nurse (RN)-C entered R20's room, completed hand hygiene, donned gloves but not a gown. R20 was sitting on the toilet with the front of the wheelchair facing them. RN-C asked R20 to lean forward, the dressing was removed, gloves were doffed, new gloves donned, but no hand hygiene completed. The area was cleansed and patted dry twice followed by a skin prep solution spray. Gloves were doffed, and a clean set of gloves donned, but no hand hygiene between. A sealed alginate dressing opened, border foam dressing opened and dated, and two were applied to the wound, alginate followed by the foam dressing. Gloves were doffed, and a clean set of gloves donned, but no hand hygiene between. During an interview on 7/10/24 at 10:03 a.m., RN-C identified the EBP sign on R20's door and stated the precautions were in place due to R20's wound. RN-C stated, "that's my fault" for not following the precautions and that hand hygiene should have been completed when changing gloves. During an interview on 7/10/24 at 10:14 a.m., RN-B who stated staff should follow EBP by wearing the gown and gloves, and that hand hygiene was to be completed when changing gloves. During an interview on 7/10/24 at 10:31 a.m., the infection preventionist (IP) stated that EBP were placed for anyone with wounds, including pressure injuries. IP expected staff to gown and glove outside the room and hand hygiene to be performed when changing gloves.	F 880	3) Actions taken to identify other potential residents having similar occurrences: All like residents' on EBP will be reviewed to ensure they are up to date and documented correctly in their care plans. 4) Effective implementation of actions will be monitored by: The clinical managers will audit 10% of all resident's care on EBP weekly x4 weeks and then monthly x2 months to ensure facility maintains compliance with EBP policy and procedure. Also, the clinical managers will perform weekly audits of 10% x4 weeks and then monthly x2 months of resident census to ensure that the facility maintains compliance with infection control practices in regard to hand hygiene. Results of these audits will be reviewed by the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance. 5) The Director of Nursing is responsible for ongoing compliance. 6) Date of Correction: 8/19/24.	

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F 880	Continued From page 15 During an interview on 7/10/24 at 11:00 a.m., the director of nursing (DON) stated that staff should wear gown and gloves in accordance with EBP for high contact care and that it was expected for hand hygiene to be completed between glove changes. A facility policy titled EBP Policy and Procedure dated 4/24, identified the use of gowns and gloves were required for high contact cares for residents at increased risk of multidrug resistant organism (MDRO) acquisition. Therefore, EBP would be implemented for all residents with wounds, even if the resident was not known to be colonized or infected with a MDRO. A facility policy titled Infection Control Standard Precautions Hand Hygiene undated, identified that hand hygiene should be performed before donning and after doffing personal protective equipment.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 17, 2024

Administrator
The Gables Of Boutwells Landing
13575 58th Street North
Oak Park Heights, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: YXXP11

Dear Administrator:

The above facility was surveyed on July 8, 2024 through July 10, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	07/10/2024

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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: On 7/8/24-7/10/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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.	2 000		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		8/19/24

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	25613	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES OF BOUTWELLS LANDING	13575 58TH STREET NORTH 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
21530	Continued From page 3 justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the provider documented a clear clinical rationale for actions taken or not taken; including risks and benefits to justify the continued use of medications identified to put the resident at risk for falls and adverse effects for 1 of 1 resident (R83) reviewed for requests for clinical rationale. Findings include: R83's admission Minimum Data Set (MDS) dated 2/13/24, identified a fall occurred in the past two to six months prior to admission. No behaviors or rejection of care occurred, and the mood interview indicated no depression. R83's corresponding Care Area Assessments (CAA), undated, identified falls was triggered related to history of falls, impaired mobility, cognition, hearing, pain, incontinence, anticipated decline, and medication side effects and care planning was in place to minimize risks and provide symptom relief or palliative measures. Additionally, psychotropic medication use was triggered related to high risk drugs taken (antipsychotic and antidepressant). Care planning was in place to minimize risks and provide	21530	Corrected	

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21530	Continued From page 4 symptom relief or palliative measures. R83's quarterly MDS dated 5/13/24, identified intact cognition, and no behaviors or rejection of care. The mood interview identified minimal depression. Diagnoses included metabolic encephalopathy (brain dysfunction), Alzheimer's disease, depression, and anxiety. No falls had occurred since the prior admission assessment. Impairments to upper or lower extremities were present, and a wheelchair was used for mobility. Hospice services were in place. High risk drugs used included antipsychotic, antianxiety, antidepressant, and opioid; and a gradual dosage reduction had not been attempted nor documented by a physician as clinically contraindicated. R83's anticonvulsant care plan dated 2/7/24, identified brain activity could be affected. Interventions to administer medications as ordered, monitor for side effects, inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. R83's pain care plan dated 2/7/24, identified a risk for pain related to impaired mobility and cognition, history of falls, skin impairments and anticipated decline. Interventions included pain would be assessed, medications would be administered as ordered, non-pharmacological interventions as needed, and hospice consulted as needed. R83's antipsychotic care plan dated 2/8/24, identified diagnoses of delirium, agitation, anxiety and hospice care. Interventions to administer medications as ordered, monitor for side effects,	21530		

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21530	Continued From page 5 inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. R83's mood and behavioral care plan dated 5/21/24, identified diagnosis of depression and anxiety. Interventions included provide encouragement to participate in activities and demonstrate effective coping skills. Non-pharmacological interventions included: tell resident to take a breath, ask resident if she was in pain, talk to me about the North Shore, turn on TV (likes Greys Anatomy, music channel), encourage resident to be out of her room (tends to self-isolate). Target behaviors included: sadness or crying, anxiety related to where family members were, decreased appetite, self-isolation and paranoia. R83's pain ratings dated 2/7/24 through 6/27/24, identified consistent pain ratings of zero. R83's behavior tracking dated 5/11/24 through 7/10/24, identified no behaviors or mood concerns occurred. R83's Order Summary Report dated 7/10/24, identified the following active medications: 1. Start date 2/7/24, methocarbamol (central muscle relaxant) give 500 milligrams (mg) by mouth two times a day for muscle spasms. 2. Start date 2/7/24, tramadol (opioid agonist produces similar pain relief effects as morphine and other opioids) give 100 mg by mouth three times a day for pain. 3. Start date 2/7/24, C-morphine (opioid) give 5	21530		

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21530	Continued From page 6 mg sublingually every one hour as needed (PRN) for pain or dyspnea (difficulty breathing). 4. Start date 2/7/24 gabapentin (anticonvulsant) give 300 mg by mouth three times a day for nerve pain. 5. Start date 2/13/24, Seroquel (an antipsychotic) give 12.5 mg by mouth at bedtime for delirium, agitation, anxiety. 6. Start date 2/16/24, venlafaxine (Effexor, an antidepressant) give 37.5 mg by mouth one time a day for depression take in addition to the 150 mg tablet for a total daily dose of 187.5 mg. 7. Start date 2/16/24, Effexor give 150 mg by mouth one time a day for depression take in addition with 37.5 tablet for a total dose of 187.5 mg. 8. Start date 7/2/24, lorazepam (benzodiazepine) give 0.5 mg by mouth every 2 hours as needed for Anxiety for 14 days (renewed). R83's Medication Administration Records (MAR) dated 5/1/24 through 7/10/24, identified PRN morphine was never given. PRN lorazepam was given once, on 5/12/24 and marked as effective. All other medications listed above were taken routinely since their start date. R83's Consultant Pharmacist (CP) Communication to Physician dated 3/30/24, identified since a recent fall occurred, the resident was at risk for falls, and the above medications (1 through 7, specifically) might increase the risk of falls; an assessment for ongoing use was requested. Additionally, methocarbamol was	21530		

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21530	Continued From page 7 "strongly urged to avoid use in the elderly - strong correlation with falls". Also, the new guidelines from American Geriatric Society (AGS) Beers list (criteria for potentially inappropriate medications) "strongly" recommended avoiding three or more central nervous system (CNS)-active drugs as they can increase the risk of falls. CNS-active drugs included antidepressants, antipsychotics, benzodiazepines, and opioids. Lastly, a combination of some CNS medications could cause serotonin syndrome and the risk of QT prolongation (heart rhythm disorder which can be life threatening), as well as additional sedative, CNS and/or respiratory-depressant effects. The CP requested an assessment by the provider of the above medications to determine appropriateness of reducing the dose or frequency. Options provided were: - Discontinue (DC). - Reduce. - No changes because the medications are necessary, benefits outweigh the potential risks, and are required to maintain functional status. - Other. The box for "other" was checked and "hospice" was written next to it. The form was signed by nurse practitioner (NP)-A on 4/2/24. The form lacked documentation from the provider of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. R83's provider progress notes dated 3/20/24 and 6/17/24, lacked documentation of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. During an observation and interview on 7/8/24 at 5:13 p.m., R83 was in her wheelchair,	21530		

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21530	Continued From page 8 self-propelling around her room, well-groomed and conversational. She stated she had no pain at the time, had good support and was happy with her hospice services. R83 stated her doctor and hospice managed her medications and she would go along with what they decided to do. During an interview on 7/10/24 at 9:55 a.m., nursing assistant (NA)-A stated she worked at the facility for over one year and R83 was alert with intermittent confusion, and she had not noticed any recent behaviors. During an interview on 7/10/24 at 9:57 a.m., NA-B stated she had worked routinely with R83 for about one month and mood was very stable, no delusions, agitation. R83 attended activities and could self-propel after being set up. During an interview on 7/10/24 at 10:07 a.m., registered nurse (RN)-C stated she had observed R83 transfer this morning with the NA and her transfer was steady. RN-C stated R83's mood and behavior and health were stable for the past couple of months. During an interview on 7/10/24 at 12:17 p.m., hospice RN-D stated they had not received a request to review R83's CNS-active medications for ongoing use, and that would typically be reviewed by the facility primary care providers. RN-D reviewed R83's hospice chart and stated it appeared she had been stable. Interviews with NP-A were attempted on 7/10/24 at 11:43 a.m., and 1:02 p.m. NP-A was out of the office and unable to provide information on the response to the CP communication form. During an interview on 7/10/24 at 12:45 p.m., the	21530		

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21530	Continued From page 9 CP stated unless otherwise identified on the form, a response was expected by the next primary care provider visit, or about two months. The CP stated he would expect if the provider wanted no changes then to document the benefits outweighed the risk, and the medications were the least restrictive measures. The CP stated the 4/2/24, response of "hospice" on R83's communication form was not a clear rationale nor assessment of risks and benefits of ongoing use. During an interview on 7/10/24 at 1:49 p.m., the director of nursing (DON) stated if the CP requested an assessment on an identified medication irregularity for R83, it would be deferred to the facility primary care providers. The DON stated she thought "hospice" was an adequate rationale. The DON stated unless they saw a negative impact she would not expect further documentation from the provider. The facility's undated policy titled CP Reports identified recommendations would be acted upon and documented by the facility staff and/or the prescriber. If the prescriber had not responded the medical director would be contacted. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely, irregularities are being acted upon, and when required the provider documents a clear clinical rationale for actions taken or not taken; including but not limited to risks and benefits to justify the continued use. The quality assurance committee	21530		

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21530	Continued From page 10 could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		8/19/24

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21545	Continued From page 11 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.41% with 2 errors out of 27 opportunities for errors involving 2 of 7 residents (R25 and R34) who were observed during the medication pass. Findings Include: R25 R25's quarterly minimum data set (MDS) dated 5/1/24, identified R25 was cognitively intact and required staff assistance with most activities of daily living. The MDS indicated R25 had diabetes mellitus (DM) and received insulin daily in the 7-day lookback period. R25's care plan revised 5/14/24, identified a risk for alteration in blood glucose levels related to the diagnosis of diabetes and tasked staff with providing medications per orders.	21545	Corrected	

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21545	Continued From page 12 R25's provider order dated 6/28/24 indicated, "HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject as per sliding scale: if 141-180 = 2 units give before meals, anything above 400 gives 14 units. May sub Admelog, or Novolog based on insurance.; 181 - 220 = 4 units, 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 340 = 10 units; 341 - 400 = 12 units; 401 - 999 = 14 units, subcutaneously before meals for T2 DM give before meals, anything above 400 give 14 units." R25's July 2024 Medication Administration Record (MAR), indicated R25 received Humalog three times a day. During observation on 7/9/24 at 11:58 a.m., registered nurse (RN)-A obtained R25's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe and applied a sterile needle. The pen was dialed to the ordered dose, 4 units. RN-A had not primed the needle prior to administering the medication to R25. R34 R34 admission MDS dated 6/6/24, identified R34 with moderate cognitive impairment and required staff assistance with most activities of daily living. The MDS indicated R34 had DM and received insulin daily in the 7-day lookback period. R34 care plan dated 6/3/24, indicated R34 at risk for alteration in blood glucose levels related to their diagnosis of diabetes and tasked staff with providing medications per orders. R34 provider order dated 7/8/24 indicated, "HumaLOG Injection Solution 100 UNIT/ML	21545		

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21545	Continued From page 13 (Insulin Lispro). Inject 5 unit subcutaneously with meals for Type 2 Diabetes." R34's Medication Administration Record printed 7/10/24, indicated R34 received Humalog three times a day. During an observation and interview on 7/9/24 at 12:19 p.m., RN-A obtained R34's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe prior to attaching a sterile needle. The pen was dialed to the ordered dose, 5 units. RN-A had not primed the needle prior to administrating the medication to R34. RN-A stated the needle did not need to be primed unless it was a new pen. During a follow up interview on 7/9/24 at 1:27 p.m., RN-A stated, "I made a mistake, it should be primed." During an interview on 7/10/24 at 10:26 a.m., RN-B stated that insulin pens should be primed prior to administration because it could give a lesser dose of insulin. During an interview on 7/10/24 at 11:00 a.m., the director of nursing (DON) stated that insulin KwikPens should be primed prior to administration to ensure the correct dose was given to not cause an error. Manufacturers instructions regarding Humalog Kwikpen dated 8/23, indicated to first dial up to two units to prime the needle, turn pen with needle pointing up, tap pen gently to move air bubbles to the top, push the dose knob until it stops, and ensure insulin is visible at the tip of the needle.	21545		

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21545	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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	245615	A. BUILDING **01 - THE GABLES OF BOUTWELLS LANDING** B. WING _____	**07/09/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 9, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Gables of Boutwells Landing, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 07/23/2024

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 **01 - THE GABLES OF BOUTWELLS LANDING** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES OF BOUTWELLS LANDING	**13575 58TH STREET NORTH** **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	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Information: 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	K 000		

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K 000	Continued From page 2 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 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=C	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		7/31/24

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K 321	Continued From page 3 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024, between 9:00 AM and 12:00 PM, it was revealed by observation that there were 2 ceiling tiles missing in the storage room located on the Lower Level. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 321	The facility will maintain all required fire walls, to include ceiling tiles are required NFPA 101 (2012) Life Safety Code Sections 8.7.1 or 19.3.5.9. The missing ceiling tile located in the storage room will be replaced immediately. The site engineers' staff will conduct an inspection of all ceiling tile and replace any found missing. The Engineering Service Director will be responsible to any repairs noted above and any additional repairs found to be necessary. These repairs will be complete on or before 7/31/24.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		8/26/24

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K 324	Continued From page 4 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain commercial cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/09/2024, between 9:00 AM and 12:00 PM, it was revealed by observation that the baffel filters within the hood had gaps exceeding 1/8" allowing grease into the duct work. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 324	Cooking equipment will be properly maintained in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. The baffle filters will be immediately spaced properly so gap will not exceed the 1/8” space requirement preventing grease from entering duct. The Culinary Director is responsible to develop training on cleaning the baffle filters with emphasis on maintaining < 1/8” gap between the baffled filters when placed back into the exhaust hood. The Culinary Director is also responsible to add training to the new employee orientation. The Environmental Service Director will assign a monthly task in the equipment management system requiring engineering	

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K 324	Continued From page 5	K 324	staff to inspect and ensure the baffle filters are properly installed verifying the gap between filters does not exceed the 1/8" space requirement. Staff training and preventive maintenance assignment will be completed on or before 8/26/24.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the	K 351	The facility will maintain fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. There will be immediate corrections	8/26/24

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K 351	Continued From page 6 facility. Findings include: On 07/09/2024, between 9:00 AM and 12:00 PM, it was revealed by observation that there were wires in contact with the sprinkler pipe in the following areas: a. 3rd floor above the ceiling at the Activity Room b. 2nd floor, above the ceiling at the Trolly House Sign An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 351	addressing wire in contact with the sprinkler pipe located above the ceiling on the 3rd floor by the Activity room and 2nd floor Trolly House Sign so that no external loads will be in contact with the sprinkler pipe or hangers. The site engineering staff will conduct an inspection of space above ceilings to relocate any wires in contact with sprinkler pipe and hangers using proper methods. The Environmental Services Director will be responsible for the repair noted above and any additional repairs found to be necessary. Permitting process will be used to ensure outside contractors are not using fire sprinkler pipe or hangers to support any components being installed. The ESD will be responsible for ensuring this permitting process is followed. These repairs and permitting corrections will be complete on or before 8/26/24.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		8/26/24

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K 353	Continued From page 7 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 07/09/2024, between 9:00 AM and 12:00 PM, it was revealed by observation that in the following areas, items were being stored within 18" of the automatic sprinkler system. a. All of the linen closets, floors 1 through 3. b. 2nd floor activity closet An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	The vertical distance between sprinkler head and the top of the storage will be maintained per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water- Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. Immediate correction to items found within 18” in the Care Center linen storage rooms and activity closet include removal of top shelve and installing tape to add visual reminder of the 18” distance requirement. Housekeeping and Activity staff will receive education focusing on the purpose of the 18” rule which is to prevent storage or any other obstruction from interfering with the spray of water from the sprinkler head during a fire. The Environmental Service Director will assign a monthly task in the equipment management system requiring engineering staff to inspect storage areas to ensure the minimum vertical distance of 18” is maintained between the sprinkler head and the highest items in storage area. These corrections, education, and task assignment will be complete on or	

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K 353	Continued From page 8	K 353	before 8/26/24.	