STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245432	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracepointe Crossing Gables	1601 Riverhills Parkway Northwest Cambridge, MN 55008

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide safe transfers for 1 of 3 residents (R1) who required gait belts (transfer belt) for transfer and ambulation assistance. This resulted in actual harm when R1 was being ambulated without a gaitbelt, fell, and sustained a fracture of the shoulder. The facility implemented corrective action prior to the investigation, so the deficiency was issued at Past Noncompliance. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses of heart failure, acute respiratory failure, and muscle weakness. The MDS indicated she required partial to moderate assistance with transfers and ambulation, and she had a history of falls in the prior 2-6 months to her admission. R1's care plan dated 4/15/25, directed assist of one staff and walker for transfers. R1's care sheet (nursing assistant care guide) directed use of a hemi walker (walker designed for individuals who require support with one arm) in/out of recliner and assist of 1 from wheelchair for toilet transfers. On 6/5/25 at 9:45 p.m., a progress note indicated R1 had a fall while ambulating to the bathroom with her walker and staff assistance. R1 had increased pain in her left arm/shoulder area at the time of the fall. On 6/7/25 an x-ray report indicated R1 had a nondisplaced fracture of the neck of the acromion (shoulder). On 6/24/25, at 11:08 a.m., nursing assistant (NA)-A stated she always used a gait belt to transfer R1. On 6/24/25, at 11:11 a.m., NA-B stated she always used a gait belt to transfer R1. Further, she stated she consistently observed other staff using a gait belt for R1's transfers. On 6/24/25 at 11:35 a.m., R1 stated she did not have a gait belt on when she fell on 6/5/25. The staff use the gait belt about 90% of the time when they assisted her with transfers. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 6/24/25, at 11:55 a.m., R2 was observed receiving ambulate assistance by a nurse aide with a gait belt. On 6/24/25, at 12:05 p.m., NA-C stated a gait belt was always indicated for all assistance of one staff (A1) transfers. During an observation, on 6/24/25, at 12:35 p.m., R3 was observed receiving assistance of A1 ambulating with his four-wheeled walker and a gait belt. On 6/24/25 at 1:30 p.m., NA-D stated she was assisting R1 to the bathroom on 6/5/25 when R1 fell. R1 had her walker, but did not have a gait belt on at the time of the fall. She had not been instructed to use a gait belt for transfers that required one assist. Following R1's fall on 6/5/25 she had been reeducated on the facility ambulation and transfers policy. On 6/24/25 at 1:55 p.m., registered nurse (RN)-A stated the care sheets were populated by the care plans. The care plans did not include direction to use a gait belt for transfers and ambulation, gait belts were expected to be utilized at all times for residents who required assist of 1 for transfers and ambulation. It was the facility's policy to use a gait belt for all transfers that required one assist. On 6/24/25 at 2:33 p.m., the administrator stated using gait belts for resident transfers and ambulation was not included in residents' care plans as it was the facility policy and a standard of care. NA-D was hired 4/18/25. Document review of NA-D's Skills Competency, signed by NA-D on 4/29/25, indicated she demonstrated competency assisting a resident to transfer and ambulate. NA-D's Role Orientation Checklist, dated 5/2/25, indicated she had received education on the use of a gait belt. The facility policy Gait Belts for Transfers and Ambulation dated 12/14, directed gait belts are not used as a restraint, and will be used for all transfers of weight bearing residents who require assistance with transfers and/or ambulation. The Past Noncompliance began on 6/5/25. The deficient practice was corrected by 6/6/25, after the facility implemented a systemic plan that included the following actions: immediate education on facility policy for all NA's and nurses requiring the use of a gait belt for all transfers and ambulation that required assist of one. Interviews with staff, on 6/24/25, confirmed understanding of facility policy requiring the use of gait belts with all assisted transfers. Observation of transfers, on 6/24/25, demonstrated compliance with use utilize gait belts for residents' transfers and ambulation.