| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245432 | A. Building<br>B. Wing | 08/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gracepointe Crossing Gables | 1601 Riverhills Parkway Northwest<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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.

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure care-planned interventions for safety with hot beverages were consistently implemented to reduce the risk of accident and injury for 1 of 1 residents (R1) reviewed who required lids on their hot beverages. This resulted in actual harm for R1 who was served a cup of hot tea without a lid and spilled it onto herself causing multiple second-degree burns. However, the facility had taken multiple corrective action(s) prior to the onsite survey so these findings are issued at past non-compliance. Findings include: A United States (US) National Library of Medicine Burn Classification article, dated 9/2023, identified burns happen with the skin is exposed to heat sources such as flames or hot objects. The article listed definitions and/or types of burns which included a first-degree burn as, . involves the epidermis only. These burns can be pink-to-red, without blistering, are dry and can be moderately painful. The article then listed a section labeled, Partial-Thickness Burns, and recorded them as, A second-degree burn . affects the superficial layer of the dermis. Blisters are common and may still be intact when first evaluated . These burns are painful. Healing typically occurs within 2 to 3 weeks with minimal scarring. A submitted facility-reported incident (FRI), dated 7/22/25, identified an allegation of potential neglect was submitted for R1 by the care center staff. The report outlined R1 was brought into the dining room and was served hot tea in a mug without a lid despite R1 being care-planned to use mugs with a lid for hot beverages. R1 spilled the tea onto herself. R1 was immediately assessed and the provider contacted for treatment orders. The report outlined, The water in the carafe [pitcher] was obtained from the coffee machine which is set at a temp of 170 [F] . Hot beverage policy was followed at the time of the incident. R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment and had no other skin impairments (i.e., burns) present at the time of the review. On 8/8/25 at 9:05 a.m., R1 was observed seated in a high-back wheelchair while in the dining room. R1 was seated at a table with other residents and had a regular plate in front of her on the table which had stacked debris present (i.e., napkins, utensils). R1 had a visible dark-colored, hard plastic coffee cup next to her plate which was turned upside down and underneath of the cup was a white-colored lid. R1 was not served any hot beverages at that time. A white-colored menu slip was placed on the table next to R1's items which outlined R1's name, the date (8/8), and that R1 consumed a regular diet with thin liquids. The slip included a section labeled, Spec [special] Direct [directions], which outlined, HOT BEVERAGES IN MUGS WITH LIDS, ADD ICE TO HOT BEVERAGES IT [sic] REFUSING LIDS, NO STRAWS. Dietary aide (DA)-A was present in the dining room and picked up R1's used cutlery and menu slip from the table. R1 was interviewed and expressed she thought she had eaten pancakes for the breakfast meal but then added aloud, My memory's not that good. R1 stated she didn't have any coffee or tea then added, I got burnt a week ago. R1 recalled the incident and explained a woman was sitting across the table from her whom had spilled her cup which then poured onto her clothes causing a burn. R1 stated, It burnt so bad right into the skin! R1 stated it was painful adding, Oh God yes. R1 was unsure if the person who spilled it was a staff member or another resident responding with, Just a lady in a hurry I guess with her cup. Following this, at 9:12 a.m., DA-A was interviewed and explained the DA staff members are typically the people to make and serve the beverages within the dining room. DA-A stated R1 needed a lid on her coffee cups for hot beverages which was placed at the table for any staff to see and use. DA-A stated R1 had been required to use the lids for a while but was unsure exactly how long adding, Honestly, I don't know. DA-A stated any staff who serve R1 food or beverages should be reading the white-colored menu slip prior to setting the items on the table for her. R1's nutritional care plan, revised 7/28/25, identified R1 had a potential risk for nutritional problems due to requiring additional fluid/nutrition supplement. The care plan outlined R1 was able to eat independently at meals with tray set up and added, . hot beverages in mugs with lids or add ice in hot beverages if she refuses to have a lid. The care plan listed an intervention reading, Assist me with tray set up at meals and provide me with hot beverages in mugs with lids, which had a last revision date listed, 04/09/2025. The care plan listed another intervention which read, Add ice to hot beverages if refusing lids, with a date initiated, 07/28/25.On 8/8/25 at 9:43 a.m., R1's family member (FM)-A was interviewed and verified they were R1's emergency contact. FM-A explained they were aware of R1 having sustained a burn and expressed it had been explained to them that someone got bumped in the dining room which is what caused the hot beverage to spill onto R1. FM-A reiterated they were told the tea was going to someone else and had mistakenly got spilled onto R1 |