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	06/13/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to assess and determine safety for 1 of 1 residents (R205) reviewed for self-administration of medications (SAM). Findings include: R205's hospital discharge orders printed 6/7/24, included an allergy of onions with a reaction of anaphylaxis (a serious life-threatening reaction usually occurring within a few seconds to minutes when coming in contact to an allergen). R205's order summary report dated 6/11/24, included an allergy to onions. Order summary report failed to include an order for an EpiPen or epinephrine (a medication given to treat anaphylaxis). R205's facility assessment titled Nursing Minnimum Data Set (MDS) dated [DATE], included a section addressing self-administration of medication. Response in that section indicated resident did not wish to self-administer medications. On 6/11/24 at 8:16 a.m., an EpiPen was on R205's movable bedside table. The EpiPen was approximately 6 inches in length, label was bright yellow and white with black lettering. The EpiPen was in a clear plastic container with a yellow top. Other objects on the beside table included a black television remote, a tissue box and a few pieces of paper. The EpiPen did not have a pharmacy label or patient identification. On 6/11/24 at 3:00 p.m., R205 was in his room sitting in his wheelchair with his movable beside table directly in front of him. A staff member brought a mug into R205's room and placed in on the bedside table. R205's EpiPen was visible on the bedside table. On 6/12/24 at 7:30 a.m., R205 was in his room with therapy. Other staff was observed exiting his room. Bedside table was against the wall opposite the door, next to the recliner chair. The EpiPen was visible on the bedside table. During interview on 6/12/24 at 7:15 a.m., trained medical assistant (TMA)-A stated if she found a medication in a resident's room that was not on the medication list or was not supposed to be left in the room, she would report it to the nurse or her supervisor. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/24 at 5:52 p.m., licensed practical nurse (LPN)-A stated resident's who were able to self-administer medication are assessed by a registered nurse (RN). It was entered into each specific medication order and listed on the resident's care plan. During interview on 6/13/24 at 10:04 a.m., TMA-B stated if she noticed a medication in a resident's room, she would try to remove it to bring to a nurse. If the resident refused, she would have notified the nurse because sometimes resident's have medication in their rooms that they are not supposed to have. During interview on 6/12/24 at 12:22 p.m., RN-A stated the facility assessment titled Nursing Minnimum Data Set (MDS) was typically completed in the resident's room. RN-A confirmed R205's MDS indicated the resident did not want to self-administer medications. RN-A confirmed R205 did not have an order for an Epi-Pen nor an self-administration of medications. RN-A proceeded to the R205's room to ask about the EpiPen. R205 had one EpiPen in his T-Shirt pocket with the top visible and one EpiPen in an unlocked drawer of his bedside dresser. R205 gave both medications to RN-A. RN-A confirmed the medication was not properly labeled and had a past expiration date of October 2021. During interview on 6/12/24 at 12:34 p.m., director of nursing (DON) stated an assessment to evaluate cognitive and physical ability would have been completed if a resident wanted to self-administer medications. The resident would have been provided a lock box to store the medication safety. DON confirmed the resident did not have an active order for an EpiPen. She expected the staff to notify nursing if they noticed a medication in a resident's room. DON stated this would be important so the facility knows what the resident was taking and to ensure other residents did not have access to the medication. During an interview on 6/13/24 at 10:17 a.m., R205 stated staff were aware he had an EpiPen in his room. He said it was always sitting on his table within arm's reach and in the open. He stated he also took it with him to every meal and placed it on the table next to his meal. He stated staff have commented on the EpiPen while in his room. Facility document titled Self Administration of Medication Policy dated November 2016 included the facility would conduct a self-administration assessment upon admission, quarterly and with any significant change to determine if a resident was safe to self-administer medications. Any medications left in a resident's room would be secured. The resident's care plan would indicate if the resident was able to self-administer medications. All medications had to be kept in the original container and be properly labeled.