

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Gracepointe Crossing Gables		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure the minimum data set (MDS) assessment was correctly coded for 1 of 5 residents (R4) in the sample reviewed for unnecessary medications. Findings Include: R4's PointClickCare (PCC) (electronic medical record) diagnosis listing documented resident had the diagnoses of type 2 diabetes, morbid obesity due to excess calories and intestinal bypass. R4's last comprehensive minimum data set (MDS) assessment dated [DATE], indicated resident moderately cognitively impaired and was independent with activities of daily living (ADLS). A review of R4's PCC Physician Orders, last updated 9/4/25, R4 was prescribed the following medication: Trulicity Subcutaneous Solution Auto-injector 1.5MG/0.5ML (Dulaglutide) Inject 1.5 mg subcutaneously in the evening every Tue related to TYPE 2DIABETES MELLITUS WITH DIABETIC CHRONICKIDNEY DISEASE (E11. 22) Prescription date of 6/24/25 This medication is a GLP-1 (glucagon-like peptide-1), a hormone naturally produced in the intestines that plays a crucial role in regulating blood sugar levels. A review of the last two MDS assessments, both coded as Comprehensive MDS assessment, dated 7/15/25 and 9/3/25 were noted to have incorrect coding in Section N (Medications). It was noted in Section N of both assessments, R4 was marked as have received 1 injection of insulin. However, in review of the [NAME] Lilly and Company medication instruction sheet (last revised 9/2018 and found online at www.trulicity.com), informed the consumers Trulicity was not an insulin (used by diabetics to control blood sugar levels), but rather a medication used as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. In review of the medication reference guide, entitled Drugs.com, indicated the following: No, Trulicity is not a form of insulin. Trulicity mimics the effects of GLP-1 a naturally occurring hormone that stimulates insulin secretion. Trulicity is only suitable for people with type 2 diabetes who still have functioning insulin-producing cells in their pancreas. Trulicity is given by subcutaneous injection, once a week. In review of another medication reference guide, PDR (Physician's Drug Reference), which can be found at pdr.net, indicated the following: GLP-1 is an important, gut-derived, glucose homeostasis regulator that is released after the oral ingestion of carbohydrates or fats. In patients with type 2 diabetes, GLP-1 concentrations are decreased in response to an oral glucose load. GLP-1 enhances insulin secretion; it increases glucose-dependent insulin synthesis and in [NAME] secretion of insulin from pancreatic beta cells in the presence of elevated glucose. During interview on 9/4/25 at 10:15 a.m., the director of nursing (DON) and a Corporate registered nurse ((RN)-Corp stated that the corporation data inputs and completed all resident MDS assessments offsite. The unit managers for each unit completed individual resident nursing assessment which aided the offsite nurses to complete the MDS assessment. If the offsite nurses have a question the facility is emailed for clarification. The onsite MDS coordinator main role was to monitor MDS scheduling for all the units and to ensure the assessments are completed in required time frames. DON further stated the interdisciplinary team also gets together and reviews each resident prior to the completion and submission of the current MDS being assessed for. Both staff members indicated training may be at hand when it came to GLP-1 medication. In review of a facility policy, entitled: Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission (last modified March 2025) indicated the following: 3. c. An accurate assessment requires collecting data and information from multiple sources. These sources must include the resident, and direct care staff on all shifts, and should also include the resident's clinical record, physician, and family, guardian or significant other as appropriate or acceptable. Documentation in clinical record must support the items coded on the MDS.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interview, the facility failed to provide a palatable diet by serving cold food at a temperature over 40 degrees. This had the potential to affect 17 residents who resided in the memory care unit. Findings include: During observation on 9/3/25 at 12:10 p.m., the dietary aid (DA)-A on the first floor kitchen had started to serve the assisted living facility (ALF). The nursing home residents were scheduled to be served starting at 12:30 p.m. The ALF and nursing home (NH) hot food was in the steam table, and the dessert for the ALF and NH was a fruit salad served in individual bowls on trays on top of the counter. Facility's temperature log indicated the fruit salad's temperature was 38 degrees at 11:50 am. During observation on 9/3/25 at 12:47 p.m., DA-A started to serve lunch to the nursing home residents on the 1st floor. The dessert served in bowls were on top of the counter. During observation and interview on 9/3/25 at 1:21 p.m., after all the residents were served a food tray which included the fruit salad, testing was conducted on one tray with the culinary director assistant (CAD). The CAD used a facility's food thermometer to check the temperature of the foods. The fruit salad's temperature was 62 degrees Fahrenheit. The CAD stated the fruit salad was plated at 11:45 a.m., and they were not put in the refrigerator. CAD stated, I would like cold foods to be served at 38 to 40 degrees, 60 degrees is too high for the fruit salad. During interview on 9/4/25 at 7:35 a.m., the CAD stated the fruit salad was prepared at the facility. The recipe included the following ingredients, canned fruit cocktail, marshmallow, whipped topping, maraschino cherries, and vanilla pudding. During interview on 9/4/25 at 9:03 a.m., DA-A stated yesterday, she placed the individual bowls of fruit salad on the counter. DA-A stated the fruit salad was a cool item and it was not refrigerated. During interview on 9/4/25 at 9:08 a.m., the culinary director (CD) stated the fruit salad was a cold item. CD stated the fruit salad at 60 degrees could cause foodborne illnesses. During interview on 9/4/25 at 12:51 p.m., the director of nursing (DON) stated her expectation for cold food was not to sit on the counter for an extended period because the food will warm up. DON stated the concern about serving the cold food at a temperature over 40 or 41 degrees had the potential to cause foodborne illnesses. The Nutrition and Culinary Services Department, Menu item: Fruit Salad recipe indicated should be stored in the refrigerator at 41 degrees or lower. The Time/Temperature Control for Safety Food dated 2/15/23 indicated, the temperature danger zone was 41 and 135 degrees. This document also indicated maintaining cold food at 41 degrees or below.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure glucometers (a device used to monitor blood sugar levels) were appropriately disinfected between uses, for 1 of 4 residents (R85) in the sample who had a blood sugar check by a unit glucose meter. This had the potential to affect all four residents on 2nd Floor North unit who received scheduled blood sugar checks. In addition, the facility failed ensure personal protective equipment (PPE) was worn by staff while assisting 1 of 1 resident (R79) on contact precautions. Findings include:</p> <p>R85</p> <p>R85's PointClickCare (PCC) (electronic medical record) diagnosis page documented resident had the following diagnoses: type 2 diabetes mellitus with unspecified complications, mild non-proliferative diabetic retinopathy without macular edema and morbid obesity due to excess calories. R85's Comprehensive Minimum Data Set (MDS), dated [DATE], indicated resident was moderately cognitively impaired and required partial to maximal assistance from staff to complete her activities of daily living (ADLS).</p> <p>In review of R85's PCC order summary report, resident had the following physician orders:</p> <ol style="list-style-type: none"> 1. Insulin Glargine Subcutaneous Solution 100 UNIT/ML(milliliter) (Insulin Glargine) Inject 20 units subcutaneously in the morning 2. NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject 8 units subcutaneously one time a day for Hold insulin for BG &lt; (less than) 120 or if not eating 3. Accu check before meals. Call if BS (blood sugar) less than 70 or greater than 450 three times a day for Diabetic Monitoring AM Is fasting check <p>During observation on 9/3/25 at 1:01 p.m., licensed practical nurse (LPN)-A prepared to check R85's blood sugar before she received her noon meal in her room. LPN-A gathered the required supplies of the Accu-Check meter, a test strip, an prepackaged alcohol pad and needle lancet. LPN-A performed hand hygiene using alcohol hand gel and donned disposable gloves. Upon entering R85's room, LPN-A informed resident she was here to check her blood sugar level, prior to the noon meal and insulin injection. R85 indicated which finger she wished to be used and LPN-A prepped the finger, cleansing it with the alcohol pad. Once air dried, LPN-A used the lancet (device used to puncture the skin), obtained a droplet of blood and captured it on the Accu-Check test strip. A tissue was provided to R85 for her finger while the test calculated. R85's blood sugar level was 267. R85 stated she had just had some candy and it will go down shortly. Seeing the meal tray being delivered, LPN-A gave R85 her insulin. LPN-A Then left R85's room, returning to the medication cart and placed the glucometer on the medication cart, doffed her gloves and applied alcohol gel to her hands. LPN-A then open the medication cart, removed two more alcohol pads and wiped down the glucometer, placing it back into the medication cart.</p> <p>During interview on 9/3/25 at 1:24 p.m., LPN-A stated this unit only has one glucometer and is shared among all the diabetics on the unit. LPN-A stated they clean the device by wiping it down with alcohol pads and allow it to air dry between resident uses.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/3/25 at 1:33 p.m., LPN-B stated that each unit has bleach wipes which glucose meters are to be cleaned with before using with another resident.</p> <p>During an interview on 9/3/25 at 1:36 p.m., registered nurse (RN)-A, stated we use the alcohol wipes were used to clean the glucometer between residents.</p> <p>During an interview on 9/3/25 at 1:38 p.m., LPN-C stated each diabetic resident on this unit has their own glucometer, we clean them when soiled. Each room had a container of bleach wipes.</p> <p>During an interview on 9/3/25 1:44 PM, LPN-D stated the unit only has one glucometer and they used bleach wipes on the devices between residents.</p> <p>The facility used the Assure Platinum brand of glucose meter, which has the following cleaning / disinfection instructions from the manufacturer:</p> <p>To disinfect an Assure Platinum meter, you must first clean it with soap and water or 70-80% isopropyl alcohol, then disinfect using a lint-free cloth dampened with either a commercially available EPA-registered disinfectant wipe or a 1:10 bleach solution (1 part household bleach to 9 parts water). Always follow the manufacturer's instructions, use proper PPE, and be careful not to get liquid in the test strip or battery ports.</p> <p>Follow These Steps:</p> <ol style="list-style-type: none"> 1. Prepare for a new patient: <ul style="list-style-type: none"> &bull; Wash your hands thoroughly with soap and water. &bull; Put on a new pair of clean gloves. &bull; Use an auto-disabling, single-use lancing device for each patient. 2. Clean the meter: <ul style="list-style-type: none"> &bull; Use a lint-free cloth dampened with a soap and water solution or a 70-80% isopropyl alcohol solution. &bull; Clean the exterior of the meter, wiping off any dirt, blood, or other bodily fluids. 3. Disinfect the meter: <ul style="list-style-type: none"> &bull; Use a different lint-free cloth dampened with either: <ul style="list-style-type: none"> &bull; An EPA-registered disinfectant detergent or germicide. &bull; A solution of 1 part household bleach (5-6% sodium hypochlorite) to 9 parts water (a 1:10 dilution). &bull; Wipe down the meter thoroughly with the disinfectant solution. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/3/25 at 1:34 p.m., NA-B stated R79's was diagnosed with Shingles and was on contact precautions. NA-B stated staff needed to wear gowns and gloves when going into R79's room to do cares. NA-B staff were not to take gowns out of the white laundry basked in the room to wear as they were soiled. NA-B stated staff did not need to wear gown or gloves when just going into pick up trays from previous meals.</p> <p>On 9/3/25 at 1:37 p.m., NA-A stated she took the gown out of the white laundry basket from R79's room and did not know if they were clean or not and then put the gown on to go into R79's room. NA-A stated she should have asked someone if the gowns in the white laundry basket were clean or not. NA-A stated she did not know where to get clean gowns from. NA-A asked another staff to get more clean gowns for R79's bin outside the room.</p> <p>On 9/3/25 at 1:53 p.m., registered nurse (RN)-A stated staff are to wear gowns and gloves when going into a resident's room with contact precautions. RN-A stated staff were to wash their hands or use hand sanitizer before and after going into a resident's room with contact precautions. RN-A stated clean gowns are kept in the bin drawer outside the resident's room, if there were no clean gowns in the bin then staff had to get them from the clean storage room. RN-A stated the white laundry basket in the room was for soiled gowns and staff should not take a gown out of there and wear when entering the residents room. RN-A stated staff should wear a gown and gloves to enter R79's room even when getting meal trays from the counter in the room.</p> <p>On 9/4/25 at 10:17a.m., RN-B stated R79 had shingles and needed contact precautions for staff and visitors. RN-B stated staff were to wash hands before entering or use hand sanitizer, wear gown and gloves when entering R79's room, take off gloves and gown when leaving room and wash hands or use hand sanitizer. RN-B stated staff are to place the soiled gown in the white laundry basket inside the resident room. RN-B stated staff are to get clean gowns from the bin outside of R79's room and not to take the gown from the white laundry basket and wear again as it was soiled. RN-B expected staff to wear gown and gloves whenever they entered R79's room.</p> <p>On 9/4/25 at 1:25 p.m., infection preventionist (IP) stated all staff had been trained on all precautions. IP stated the gowns in the white laundry basket were soiled and staff were not to re-wear them. IP stated the clean gowns were kept in the bin outside the resident's room. IP stated taking a gown from the white laundry basket was not the process of the facility.</p> <p>The facility policy Infection Prevention and Control Manual Transmission-Based Precautions undated, indicated contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment. In addition to standard precautions, contact precautions will be used to prevent the healthcare acquired spread of organisms that can be transmitted by direct resident contact (hand or skin to skin contact that occurs when performing resident cares) or by indirect contact (touching) with environmental surfaces or contaminated resident care equipment.</p>		