DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0VP6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245018**

2.STATE VENDOR OR MEDICAID NO.
(L2) **935840400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/21/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **122** (L18)

13.Total Certified Beds **122** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek,Health Program Rep Senior 01/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/11/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/10/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On September 3, 2015 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of F.

On October 27, 2015 a PCR was completed and two deficiencies were reissued. As a result of this visit and that the facility did not achieve substantial compliance. This Department imposed:

Category 1 remedy of State monitoring, effective November 9, 2015.
Mandatory Denial of Payment for New Medicare and Medicaid Admissions (DPNA), and a two year loss of NATCEP, effective December 3, 2015

On 12/21/2015, a Health PCR was completed and substantial compliance was verified. Please refer to the CMS 2567b.

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245018

January 11, 2016

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

Dear Mr. Tobalsky:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 25, 2015 the above facility is certified for:

122 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 122 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

2nd REVISED LETTER

January 14, 2016

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

RE: Project Number S5018027

Dear Mr. Tobalsky:

On November 9, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 9, 2015. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 3, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 9, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 3, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on September 3, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 27, 2015. The most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required.

On December 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 3, 2015, as of November 25, 2015. As a result of the revisit findings, the Department is discontining the Category 1 remedy of state monitoring effective December 21, 2015.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 9, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 3, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 3, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 3, 2015, is to be rescinded.

In our letter of November 9, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 3, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 25, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	12/21/2015

Name of Facility	Street Address, City, State, Zip Code
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**12/21/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**12/21/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/kfd	01/11/2016	30923	12/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0VP6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245018**

2.STATE VENDOR OR MEDICAID NO.
(L2) **935840400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

4. TYPE OF ACTION: **7** (L8)

1. Initial — 2. Recertification
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/27/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited — 1 TJC
2 AOA — 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **122** (L18)

13.Total Certified Beds **122** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Mary Bruess, HFE NEII — 11/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/29/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/10/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On October 27, 2015, the Minnesota Department of Health and on October 12, 2015, the Minnesota Department of Public Safety completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on the facilitys plan of correction that they had corrected the deficiencies as of October 13, 2015. Based on our visit, we have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on September 3, 2015. The deficiencies not corrected are as follows:

- F0164 - S/S: E - 483.10(e), 483.75(l)(4) - Personal Privacy/confidentiality Of Records
- F0241 - S/S: D - 483.15(a) - Dignity And Respect Of Individuality

The most serious deficiencies in the facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E).

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective November 9, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the Protecting, maintaining and improving the health of all Minnesotans last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 3, 2015. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 3, 2015. Post Certification Revisit (PCR) to follow.

Refer to the CMS 2567 along with the facilitys plan of correction, CMS 2567b for both health and life safety code.

Minnesota Department of Health

Certified Mail # 7015 0640 0003 5695 5026

November 9, 2015

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, Minnesota 55421

RE: Project Number S5018027

Dear Mr. Tobalsky:

On September 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 3, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 27, 2015, the Minnesota Department of Health and on October 12, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on September 3, 2015. The deficiencies not corrected are as follows:

F0164 - S/S: E - 483.10(e), 483.75(l)(4) - Personal Privacy/confidentiality Of Records
F0241 - S/S: D - 483.15(a) - Dignity And Respect Of Individuality

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective November 9, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the

last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 3, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 3, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 3, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 3, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than

sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on October 27, 2015, to determine compliance with Federal deficiencies issued during a recertification survey exited on September 3, 2015. During this visit the following regulations were determined to be not corrected.	{F 000}	**F000** It is the policy of Crest View Lutheran Home to follow all federal, state, and local guidelines, laws, regulations, and statues. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
{F 164} SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	{F 164}		

POC accepted kt 11/13/15

Received kt 11/16/15 POC

RECEIVED
NOV 16 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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

Campus Administrator 11/12/15

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
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 164}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy for 9 of 9 residents (R185, R134, R202 R14, R58, R24, R42, R203, R204) whose privacy was observed disrespected. Findings include: R185 stated in an interview on 10/27/15, at 8:06 a.m. "Staff will knock on my door and enter my room before I give permission. It bothers me because I might not be fully clothed." R134's room was entered by a nursing assistant (NA)-A on 10/27/15, at 8:12 a.m. without knocking or introducing herself, and waiting for permission to enter. R202's room was exited at 9:09 a.m. by NA-A, and then a minute later NA-A entered R202's room without knocking, announcing who was at the door and waiting for permission to enter. R14's and R58's doors were knocked on lightly and without pause were entered on 10/27/15, at 8:15 a.m. by NA-B. NA-B did not announce her name or ask permission to enter. R24's room was entered at 8:21 a.m. by NA-B after NA-B called out "knock knock" and entered without announcing her name or asking permission to enter. R42's room was then entered at approximately 8:30 by by NA-B after the NA knocked softly, called R42's name, and then entered without	{F 164}	**F164** It is the policy of Crest View Lutheran Home that every resident has the right to personal privacy and confidentiality. Residents R185, R134, R202, R14, R58, R24, R42, and R204 were all affected by this deficient practice. All residents have the potential to be affected by this deficient practice. Education will be provided to all staff regarding the policy and procedure for resident privacy and dignity; specifically, for knocking and announcing one's self before entering a room. All staff will be educated by 11/18/2015. Audits concerning resident privacy, specifically for knocking and announcing one's self before entering a resident room will completed weekly for four weeks, bi-weekly for 2 months, and then randomly thereafter at the discretion of the Director of Nursing (DON).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 164}	Continued From page 2 pause. R203's door was entered on 10/27/15, at 9:10 a.m. by a physical therapist (PT)-A who knocked and announced, "therapy" and without waiting for a response entered R203's room. R204's room was entered at 10:54 a.m. by a licensed practical nurse (LPN)-A who knocked and called the resident's name, but did not announce who she was nor asked for permission to enter. During an interview on 10/27/15, at 3:12 p.m. the director of nursing (DON) and the administrator explained an ins-service training had been held for all staff on 10/6/15, 10/7/15, and 10/8/15. All cited deficiencies were discussed and facility/staff brainstormed ideas as to how to provide privacy for residents. Both the administrator and DON verified the expectation relating to privacy was that all staff were to knock, announce who they were, and wait for a response before entering resident rooms. A review of the facility's plan of correction related to privacy dated 10/2/15, indicated "Education will be provided to all staff regarding P & P [policy and procedures] of residents privacy on 10/6,10/7,10/8/2015...Audits regarding residents privacy--knocking on door, pulling curtains will be 2x's [twice] per week on different shifts. A Privacy Audit dated 10/15/15, indicated NA-A was observed by the DON that day not knocking nor waiting for a response prior to entering a resident's room. NA-A educated immediately by the DON.	{F 164}	The reports of these audits will be reported to the QAPI committee for review and further recommendations. The DON/Designee will be responsible for compliance by 11/25/2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 164}	Continued From page 3 A list of employees working at the facility was provided to the surveyor on 10/27/15, at approximately 1:00 p.m.; the facility employed approximately 242 workers. An Education Sign In Sheet for the following days 10/6,10/7,10/8/2015 indicated 87 employee signed off that they had attended one of the three days of education relating to privacy of residents. A follow-up interview with the DON on 10/27/15, at approximately 2:45 p.m. the DON verified not all employees who worked at the facility had attended one of the three in-service training session. Although NA-A was working on the unit, the NA had not attended the in-service on privacy. The DON verified she did not have a system to track employees who did not attend the education/in-service, nor was any staff removed from the schedule due to the lack of education nor was make up information provided prior to working with residents. The administrator stated on 10/27/15, at 3:36 p.m. he expected all staff would have been trained in the facility's policy and procedures and plan of correction related to deficiencies cited. "I understand we did not do this. If staff did not complete the re-education/training they should have been taken off the schedule." A 10/15 Quality Of Life-Dignity policy directed staff as follows: Resident's privacy and property shall be respected at all times. Staff will knock and request permission before entering resident's room. If there is no response, staff will re-attempt knocking. If there is no response after two attempts, staff will slowly open door and announce themselves."	{F 164}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified interaction was provided to 2 of 3 residents (R3, R134) reviewed for dignity. Findings include: R134 was heard calling from her room "help me, help me" while her call light was activated on 10/27/15, at 8:12 a.m. As the surveyor approached R134's room a nursing assistant (NA)-A was walking down the hallway towards R134's room speaking in a loud, frustrated tone of voice that could easily be heard, "Oh, not again [R134's name]!" NA-A walked passed the surveyor and entered R134's room without knocking, announcing who she was or waiting for permission to enter. As NA-A entered the room she loudly asked R134, "What do you need? I was just in your room and I told you a nurse would be in to see you!" During an interview at 1:01 p.m. with R134 and R134's family member (FM)-A. R134 stated she did not recall being spoken to by NA-A that morning. FM-A explained R134 had short term memory impairment and would not have been able to recall the event. FM-A stated, however, "MY mother deserved to be treated with respect	{F 241}	**F241** It is the policy of Crest View Lutheran Home to promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents R3 and R134 were affected by this deficient practice. Employee NA-A, who was observed by MDH Surveyors providing care in an undignified and disrespectful manner has been terminated by Crest View Lutheran Home. Education will be provided to all staff regarding the policy and procedure for resident dignity and respect. All staff will be educated by 11/18/2015. Audits concerning resident dignity and respect will be completed weekly for four weeks, bi-weekly for two months, and randomly thereafter at the discretion of the Director of Nursing (DON). The reports of these audits will be reported to the QAPI committee for review and further recommendations. The DON/Designee will be responsible for compliance by 11/25/2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 241}	Continued From page 5 and dignity." Following the interview FM-A told the surveyor, "Thank you for what you did, and what you do." R134's quarterly Minimum Data Set (MDS) dated 10/10/15, indicated R134 had no refusal of cares nor exhibited any physical, verbal or psychotic behaviors. R134 required extensive assistance of two staff with bed mobility. R134's care plan dated 10/15, indicated R134 had potential alteration in mood due to cognitive impairment and depression. R134's goal was to be safe in her environment. Approaches from staff included offering support, reassurance and encouragement as needed, validating the resident's feelings and providing a safe environment. R3 was wheeling herself up and down the hallway barefoot and with both of her shoes on her lap at 8:17 a.m. She self-propelled herself towards NA-A and asked NA-A, "Can you help me get my shoe on?" NA-A looked directly at R3 and with a harsh loud tone that could be easily heard stated, "Yes, but don't you rush me!" R3 began to wheel away from NA-A as she asked, "Are you ok today?" to which NA-A replied, "Yes." NA-A then left the area and returned five minutes later and assisted R3 to her room. R3 was then interviewed at 9:33 a.m. R3 recalled asking NA-A for help with her shoes, but says she was told by NA-A, "'I don't have time to help you' and not to rush her." When asked how that made her feel R3 replied, "It hurt my feelings. Some days I need help with my shoes. I can't do it by myself." When asked why she asked NA-A if she "okay" she explained it was because of "the way she talked to me, and the harsh tone in her voice	{F 241}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 241}	Continued From page 6 made me feel something was wrong with her." R3 added, "I should be treated with respect and dignity." R3's quarterly MDS dated 8/17/15, indicated the resident was cognitively intact, had no refusal of cares nor exhibited any physical, verbal or psychotic behaviors. R3 required staff assistance to provide maneuvering of limbs during dressing. R3's care plan dated 5/15, indicated the resident had schizophrenia, delusional disorder and anxiety. The goal was for the resident to be clean, well groomed staff was to anticipate and provide all the resident's needs. At 10/27/15, at approximately 9:45 a.m. an interview was conducted with the administrator and director of nursing (DON) regarding the manner in which R3 and R134 had been spoken to by NA-A. Both the administrator and DON verified the expectation was that no resident should have been spoken to in a harsh tone of voice from staff nor treated in a undignified manner. During an interview at 12:22 p.m. NA-A explained she was trying to hurry through her day when everything started to stack up and residents were all needing help all at the same time. NA-A verified her tone of voice was harsh when she spoke to R134 and R3. NA-A explained "I never meant it to be harsh speaking. It has not been a good day, and I was just in her room [R134]--they need to give me time." During an interview on 10/27/15, at 3:12 p.m. the director of nursing (DON) and the administrator explained an ins-service training had been held for all staff on 10/6/15, 10/7/15, and 10/8/15. All	{F 241}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	R 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
{F 241}	Continued From page 7 cited deficiencies were discussed and facility/staff brainstormed ideas as to how to promote the dignity of residents. A list of employees working at the facility was provided to the surveyor on 10/27/15, at approximately 1:00 p.m.; the facility employed approximately 242 workers. An Education Sign In Sheet for the following days 10/6,10/7,10/8/2015 indicated 87 employee signed off that they had attended one of the three days of education relating to privacy of residents. A follow-up interview with the DON on 10/27/15, at approximately 2:45 p.m. the DON verified not all employees who worked at the facility had attended one of the three in-service training session. Although NA-A was working on the unit, the NA had not attended the in-service on dignity. The DON verified she did not have a system to track employees who did not attend the education/in-service, nor was any staff removed from the schedule due to the lack of education nor was make up information provided prior to working with residents. The administrator stated on 10/27/15, at 3:36 p.m. he expected all staff would have been trained in the facility's policy and procedures and plan of correction related to deficiencies cited. "I understand we did not do this. If staff did not complete the re-education/training they should have been taken off the schedule."	{F 241}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **10/13/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **10/27/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/27/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/27/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **10/27/2015**	ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **10/27/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/27/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GL/mm	**Date:** 11/04/2015	**Signature of Surveyor:** 33043	**Date:** 10/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building 01 - MAIN BUILDING 01 B. Wing	10/12/2015

Name of Facility	Street Address, City, State, Zip Code
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 10/09/2015	ID Prefix Reg. # NFPA 101 LSC K0103	Correction Completed 10/09/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TL/mm	Date: 11/04/2015	Signature of Surveyor: 28120	Date: 10/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/3/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MDH
Minnesota
Department
of Health

December 29, 2015

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, Minnesota 55421

RE: Project Number S5018027

Dear Mr. Tobalsky:

On October 27, 2015, a Post Certification Revisit was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

We will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

cc: Licensing and Certification File

POCA HEALTH PCR.ORC

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0VP6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245018**
2.STATE VENDOR OR MEDICAID NO.
(L2) **935840400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **122** (L18)

13.Total Certified Beds **122** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, Health Program Rep Senior 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/10/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3025

September 21, 2015

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, Minnesota 55421

RE: Project Number S5018027

Dear Mr. Tobalsky:

On September 3, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 13, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 3, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by March 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5018104 was completed at the time of the recertification survey. The complaint was unsubstantiated.	F 000	**F000** It is the policy of Crest View Lutheran Home to follow all federal, state, and local guidelines, laws, regulations, and statues. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care	F 164	POC accepted 10/2/15 SJ Fan Ho F164 It is the policy of Crest View Lutheran Home to provide Privacy for all residents in a manner that promotes And enhances quality of life, dignity, respect and Individuality- Staff will knock and request permission Before entering residents rooms, staff will promote, Maintain, and protect resident privacy, including bodily privacy during assistance with personal cares and during treatment procedures.	

Scanned JT POC 10/5/15

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Campus Administrator | (X6) DATE: 10/2/15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 164	Continued From page 1 institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to provide privacy 2 of 2 (R121, R76) residents who reported concerns about privacy. Findings include: R121 was observed on 9/2/15, from 8:03 to 9:05 a.m. At 8:14 a registered nurse (RN)-A knocked and entered R121's room without waiting for a response from the resident. No conversation was heard between R121 and RN-A, and she left the room within a minute's time. At 8:51 an unidentified maintenance staff knocked on R121's door and stated, "Hello maintenance" and entered without waiting for a response. Following the observations on 9/2/15, at 9:58 a.m. the maintenance director said the maintenance worker was on an assignment and unavailable for an interview. R121 was interviewed on 9/22/15, at 2:34 p.m. and was asked how she felt when the maintenance staff person knocked and then walked in her room. R121 responded, "He just knocked but did not wait. I might not have been	F 164	Residents R121 and R76 privacy was affected by this deficient practice. All Residents have potential to be affected by this deficient practice. Education will be provided to all staff regarding P&P of Residents privacy on 10/6,10/7, 10/8/2015. Audits regarding residents privacy- knocking on doors, pulling Curtain will be 2x's per week on different shifts x's 1 month , then 1x per month thereafter. The reports of these audits will be reported to QA&A committee For review and further recommendation. DON/Designee will be responsible for compliance By October 13th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 164	Continued From page 2 dressed or might have been in the bathroom. All the staff do it. They will just walk in or they will knock as they enter...My privacy is very important to me." R121's admission Minimum Data Set (MDS) dated 7/22/15, indicated R121 was cognitively intact, her hearing was intact and she was able to communicate her needs. The resident care plan dated 7/15, noted an alteration in self-care, and staff was instructed staff to "provide privacy." R76 was interviewed on 8/31/15, at 7:07 p.m. and when asked about personal privacy during cares responded, "I don't think they are able to do that." People come and go. There may be 4-5 people who enter my room while they are doing cares. R76 reported that the practice bothered him. During continuous observation on 9/2/15, from 7:10 to 9:49 a.m. several staff entered R76's room. At 8:30 a housekeeper entered without knocking. A 8:53 NA-B entered R76's room without knocking. An and unidentified maintenance man knocked, said "hello." He did not wait for a response, but entered and went into R76's bathroom, then left the room. At 8:57 NA-B knocked on the door and entered R76's room without waiting for a response, and again at 9:01 entered without knocking and informed R76, "I will be right back." NA-B returned two minutes later and entered the room without knocking. At 9:05 R76 gave permission for the surveyor to observe his morning cares. NA-B closed the door, but opened the privacy curtain at the foot of the bed. R76 requested NA-B not open the curtain so far. Clothing was selected and NA-B pulled the privacy curtain part way back, leaving an opening of approximately 2 1/2 feet. At 9:24	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 164	Continued From page 3 a.m. licensed practical nurse (LPN)-B knocked on R76's door, opened it a crack, but then entered after no response was given by R76 or NA-B. LPN-B then pulled the curtain closed, but left an approximate 18 inch opening, and proceeded to provide a treatment to R76's inner groin. NA-B left the room and then re-entered without knocking, carrying bed linens. NA-B activated the call light to summon assistance with R76's cares. When asked about the length of time it would usually take to get assistance NA-B responded, "I can never find someone. They are busy you know." Five minutes later the staffing coordinator pushed the door open without knocking and told NA-B to turn R76's light off. NA-B informed the staffing coordinator she needed assistance. A minute later the staffing coordinator knocked and walked into R76's room without waiting for a response and informed NA-B that NA-D would be right there. Two minutes later NA-D knocked, and when no response was given by R76 or NA-B, entered the room. R76's annual MDS dated 5/21/15 indicated the resident was cognitively intact, and was dependent on staff for dressing, personal hygiene, toileting, and transfers. A care plan dated 5/15 noted an alteration in self-care, with an approach dated 8/15 as, "provide privacy." LPN-B stated on 9/2/15, at 10:08 a.m. regarding knocking and not waiting for a response, "A lot of time they [residents] are still asleep so I will say good morning and things." During a follow up interview with R76 on 9/2/15, at 10:26 a.m. R76 stated, "As I told you yesterday I am very hard of hearing. I wish the curtain could be pulled to . There is a mirror that he can	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 164	Continued From page 4 see me in. That is why I asked [NA-B] to pull the curtain. I don't want them to cover my pictures, but I wish they could fix the other curtain so it closed." NA-B stated on 9/2/15 at 10:28 a.m. that the curtain did not go all the way around R76's bed. "I think it got it stuck. I think he likes the other curtain tied up to look at his daughter" (referring to her picture). NA-B stated, "I tell them [residents] I am going to be coming in and out. I knock or say this is [NA-B], but do not always say." During an interview on 9/2/15, at 10:57 a.m. the staffing coordinator stated, "I always knock. I don't know if I knocked too lightly." The coordinator then demonstrated how she knocked on resident doors, and stated she knocked, cracked the door, and then saw NA-B so told her to turn off the call light. LPN-B said on 9/2/15, at 1:31 p.m. "I observe the staff and provide reminders to knock on doors, but they do not always do so. I provide reminders to pull the curtains." During an interview on 9/3/15, at 10:08 a.m. the director of nursing (DON) stated, "I just told my expectation to the nurses and nursing assistants at their meetings. You knock, hear no response, you knock again and wait for response. Slowly open the door. I don't want to hear about 'knock knock and walk in' you wait for response." The DON also stated her expectation was for staff to provide privacy during cares. An Agenda for Nurses meeting held 8/6/15, instructed staff:"...Knocking on Residents	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 164	Continued From page 5 door-YOU MUST KNOCK FIRST and WAIT for a response before entering room. (Demonstration given) Proper way and incorrect way..." A 9/13 Quality of Life--Dignity policy instructed staff: "It is the policy of Crest View Senior Communities to care for each resident in a manner that promotes and enhances quality of life, dignity, respect and individuality...Resident's private space and property shall be respected at all times...Staff will knock and request permission before entering residents' rooms...Staff will promote, maintain and protect resident privacy, including bodily privacy during assistance with personal cares and during treatment procedures."	F 164		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document report the facility failed to provide training on abuse prevention prior to working with residents for 6 of 6 (E1, E2, E3, E4, E5, E6) employees reviewed for abuse prohibition. Findings include: The facility's 9/14, Abuse Prohibition Policy was provided on 9/1/15. Page 1 of the policy indicated, "All facility staff will be in-serviced upon	F 226	F226 It is the policy of Crest View Lutheran Home To provide education on Abuse Prohibition Upon first day of employment and annually Thereafter regarding resident rights, including Freedom from mistreatment, neglect, or abuse Including injuries of unknown source, and misappropriation of property. Employees E1,E2,E3,E$,E5,E6 did not have Training on abuse prohibition prior to Working with residents. This deficient practice could affect all employees and residents. Education on Abuse Prohibition will be given to Employees E1,E2,E3,E4,E5,E6. All staff Education On Abuse Prohibition will be given on 10/6,10/7, and 10/8/2015. All new employees will be given training on Abuse Prohibition on first day of orientation prior to working with residents and then annually thereafter. The reports of compliance will be reported to QA&A Committee for review and further recommendation. DON/Designee will be responsible for compliance By October 13th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 226	Continued From page 6 first employment, and at least annually thereafter, regarding Resident Rights, including freedom from mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property...Staff will be in-serviced on resident mistreatment, neglect, and abuse including injuries of unknown source, and misappropriation of property upon first employment and annually thereafter...." Employee files were reviewed and revealed the following: (Where discrepancies were noted in hire dates, Paycom Online Payroll System print out of Employee--Name, Department and Hire--Date provided by facility 9/2/15, was used as hire date.) E1's date of hire was 5/5/15. E1's first day of work was 5/6/15, and first day working alone was 5/27/15. E1 signed a Nursing Safety Employee Orientation Checklist 5/6/15, however, the Abuse Prevention and Identification Training was not signed until 6/25/15. E2's date of hire was 8/4/15. E2's first day of work was 8/4/15, and first day working alone was 8/8/15. E2 signed a Nursing Safety Employee Orientation Checklist 8/5/15, however, the Abuse Prevention and Identification Training was not signed until 8/19/15. E3's date of hire was 6/8/15. E3's first day of work was requested but was not provided. Individual In-Service Tracking indicated a date of hire as 6/20/15. Abuse Prevention and Identification Training was not signed on 6/23/15. E4's date of hire was 8/12/15. E4's first day of work was 8/31/15. E4 signed a Nursing Safety	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 226	Continued From page 7 Employee Orientation Checklist 8/31/15. No documentation was available showing abuse training was provided. E5's date of hire was 6/19/15. E5's first day of work was 6/19/15, and last day worked was 7/11/15. No documentation was provided to show E5 had ever been trained in abuse prevention, nor was proof of job orientation provided. E6's date of hire was 6/8/15. E6's first day of work was 6/8/15. E6 signed a Nursing Safety Employee Orientation Checklist pm 6/8/15, however, the Abuse Prevention and Identification Training was not signed until 6/23/15. During interview on 9/3/15, at 9:30 a.m. a registered nurse (RN)-A stated, "I do train new employees on definitions of abuse on the first day, but it does not say it here" (referring to the Nursing Safety Employee Orientation Checklist). RN-A stated the material covered "reporting injuries--including change in status to the nurse and how to do that." RN-A said training was not in depth, but employees, "I tell them what abuse looks like and that they have to report it. I do not use the word mandatory." RN-A confirmed E4 had not received abuse in-service training yet, and E5 no longer was employed by the facility, but had also not received the training. During an interview on 9/03/15, at 9:38 a.m. the dietary manager verified E-5 was currently employed at the facility. The director of nursing (DON) described what was covered with employees on their first day 9/3/15, at 10:08 a.m. The DON covered a Nursing Safety Employee Orientation Checklist	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 226	Continued From page 8 that included reporting falls, skin tears bruises, and resident disclosure of unknown falls injury. The DON verified the Nursing Safety Employee Orientation Checklist did not indicate abuse reporting was covered. The DON stated she was given the packet of information on 6/8/15, that was covered on 6/23/15, at the group in-service. The DON was unsure if all employees were provided the packet on their first day, but acknowledged, "Most likely did not read it when handed it." The DON's expectation was that staff receive orientation including abuse prior to working with residents on the floor. Although she may have expected persons just finishing school to know about abuse, she would not have expected maintenance, dietary, or housekeeping staff to know about abuse prior to being hired. "How would they know that? It would be employers job to teach that." During interview on 9/3/15, at 2:27 p.m. the administrator stated, "I expect them to be trained on abuse immediately at orientation. My expectation is everyone we have on the floor would have an understanding of the vulnerable adult act, including maintenance and dietary." The administrator verified abuse was not listed on the Nursing Safety Employee Orientation Checklist, but would have expected it to have been. The administrator added that abuse and maltreatment was covered in the handbook which employees were provided at the time of hire. "They do not sign anything at that time regarding the handbook."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 241	Continued From page 9 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review facility failed to investigate further when 1 of 1 resident (R121) reported undignified treatment during therapy sessions. Findings include: R121 reported when interviewed on 8/31/15, at 3:20 p.m. she was not treated appropriately by a registered physical therapist (RPT)-A. She stated she informed staff of the problem at her care conference and was given permission to fire RPT-A as her therapist. When she greeted people in the therapy room, she said the RPT-A would "ignore" her, and wouldn't have anything to do with her. It was the first time anyone spoke to me that way. She said she had gone to the gym to use the machines when she knew the individual was not working. R121's admission Minimum Data Set (MDS) dated 7/22/15, revealed the resident was cognitively intact and was able to communicate her needs. In addition, the MDS noted diagnoses included anxiety, major depression, and post-traumatic stress disorder (PTSD), with some mood indicators present, however, behavioral symptoms were absent. A care plan dated 7/15/15, identified the resident had depression and problems with adjustment to the nursing home, anxiety and depression, as	F 241	F241 It is the policy of Crest View Lutheran Home to care for each resident in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents will be treated with dignity and respect at all times. Resident R 121- When resident was interviewed on 8/31/15 by the state health department, resident stated she was not treated appropriately by the Registered physical therapist during therapy sessions. The facility failed to investigate allegation further after resident complained of (RPT-A) during a care conference. Facility immediately reported the resident complaints to MDH portal and (RPT-A) was immediately suspended pending investigation. After investigation completed the outcome was unsubstantiated. All residents would have the potential to be affected by this deficient practice. Education on P&P of Dignity will be given on 10/6, 10/7, 10/8/2015. To include that complaints from Resident's will be investigated further to promote resident's dignity and respect for his/or her individuality. Complaint form to be utilized for resident complaints and follow up to be discussed with IDT for resolution. The reports of compliance will be reported to QA&A Committee for review and further recommendation. DON/Designee will be responsible for compliance By October 13th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 241	Continued From page 10 well as PTSD, and evidenced by negative statements and self-deprecation. Staff was directed to encourage the resident to express her feelings, frustrations, and concerns, and to offer support, encouragement, 1:1 visits, and a psychological consult if indicated. The resident required assistance with transferring and wheelchair mobility, and physical therapy was ordered. Staff was to discuss any resident or family concerns about mobility loss, and discuss any self-image issues. During interview on 8/31/15 at 8:10 p.m. a licensed social worker (LSW)-A explained R121 had had an initial care conference since her admission. At that time, R121 expressed some concerns about her diet, laboratory work, a medication she was taking, and her progress in therapy. LSW-A stated R121 reported feeling "'a little bit rushed,'" and brought up a concern regarding one of the RPT's pushing her too hard. At that time, it was decided a physical therapy aide (PTA) would work with R121, however, there was no additional follow up as to how the plan was working, as R121 was only in therapy for an additional week. RPT-A who treated R121 was interviewed on 9/1/15, at 8:23 a.m. RPT-A explained initially R121 did well in therapy with a lot of encouragement. R121's goals were not met when she discharged from therapy. She was currently on a walking program and used equipment on her own. RPT-A stated R121 did request RPT-A not attend her care conference, and instead, the PTA and OTR attended. After the conference RPT was informed R121 no longer wanted to work with RPT-A. RPT-A explained there had been a meeting when R121	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 241	Continued From page 11 was admitted and reported it had been an issues at a previous facility with therapy, and she requested the RPT push R121 during therapy sessions. PTA-A reported attending a follow up care conference when interviewed on 9/1/15, at 8:42 a.m. Concerns had been brought up at that time that the resident felt unhappy and did not like the way RPT-A spoke to her during therapy session and felt it was "verbally abusive." PTA-A said it seemed RPT-A was encouraging the resident to work to her potential, but it never seemed verbally abusive in PTA-A's opinion. PTA-A said they tried to give residents a week's notice prior to therapy ending, and if they were showing a plateau, they needed to inform residents they needed to show progress in order to continue in therapy. PTA-A stated, "I have worked with [RPT-A] for seven or eight years. I have never heard [RPT-A] be abusive to a resident." OTR-A stated during an interview on 9/1/15, at 8:59 a.m. R121 was cognitively intact. OTR-A stated it seemed R121 was very concerned at the care conference regarding her interactions with RPT-A and feeling she was being pushed too hard. RPT-A was wanting R121 to primarily use the walker, but R121 wished to instead primarily use the wheelchair. A plan was worked out where PTA-A would work with the resident for the next week. Although R121 was safe with the walker, she had acknowledged she was scared. PTA-A said RPT-A called her a "'baby'" but no one had witnessed this. OTR-A said RPT-A definitely pushed people in therapy, but in six months time had never heard the RPT be verbally abusive to anyone. OTR-A reported feeling R121 was actually motivated, as she'd be early to therapy,	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 241	Continued From page 12 but thought she may have been afraid to use the walker due to previous falls. During interview on 9/1/15 at 9:15 a.m. with a certified occupational therapy assistant (COTA)-A it was reported R121 needed a lot of encouragement. COTA-A described R121 as lacking confidence and very sensitive. A laid back style worked best and if pushed to hard, she would get agitated. COTA-A had never witnessed any verbal abuse by RPT-A. During an interview on 9/2/15, at 2:12 p.m. a trained medication aide (TMA)-A stated R121 never reported anything negative related to therapy session, and felt she in fact liked therapy. TMA-A said R121 never reported anything about RPT-A. A licensed practical nurse stated on 9/2/15, at 2:12 p.m. R121 never reported any problems with therapy or RPT-A. A 9/13, Quality of Life--Dignity Facility policy that instructs staff: "It is the policy of Crest View Senior Communities to care for each resident in a manner that promotes and enhances quality of life, dignity, respect and individuality...Residents will be treated with dignity and respect at all times...Being 'treated with dignity' means the resident will be assisted in maintaining and enhancing their self-esteem and self-worth...Resident 's private space and property shall be respected at all times."	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 246	Continued From page 13 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathroom mirrors were at an appropriate height to accommodate needs for 1 of 8 residents (R96) who utilized a wheelchair and was reviewed for environmental concerns. Findings include: R96's room was observed on 8/31/15, at 1:51 p.m. The mirror in R96's was mounted to the wall at a height which would not have allowed the resident to view himself from wheelchair height. R96 accessed his bathroom by wheelchair. On 9/1/15, at 12:53 p.m. R96 stated that the bathroom mirror was too high for him to view himself. R96 explained he utilized a wheelchair and was unable to stand on his own due to a stroke. R96's significant change Minimum Data Set (MDS) dated 7/14/15, indicated he required extensive assistance with one person physical assist with transferring and locomotion on/off the unit, toilet use and personal hygiene. The MDS also indicated that R96 utilized a wheelchair and had a physical impairment on one side of the body.	F 246	F246 It is the policy of Crest View Lutheran Home To provide reasonable accommodation of Needs/preferences, except when the health of the individual or other resident's would be endangered. Resident R 96 did not receive reasonable accommodation as evidenced by resident's bathroom mirror was not at reasonable height to view himself from wheel chair. All residents have potential to be affected by this deficient practice. Resident R96 will be provided portable mirror to view self while in bathroom. All mirrors will be checked by Environmental services for appropriate height for residents. Portable mirrors will be given to residents who require or request mirror. Education provided to all staff on P&P to provide reasonable accommodation of needs and preferences. 10/6, 10/7, 10/8/2015. Compliance will be reported to QA&A Committee for review and further recommendation. DON/Designee will be responsible for compliance By October 13th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 246	Continued From page 14 R96's care plan dated 7/15 identified alteration in mobility related to hemiplegia/hemiparesis paralysis on one side of the body), poor balance, muscle weakness and limited range of motion (ROM). Interventions included addressing any self-image issues with the resident and assist with wheelchair as needed. An environmental tour was conducted on 9/2/15, at 9:21 a.m. with the maintenance manager (MM) and the administrator. The administrator stated they had not received any complaints about the height of bathroom mirrors, or "We would have taken care of that already". The administrator stated that the mirrors in the bathroom "meet the federal requirements, but if a resident can't see, this will be a quick fix". A policy was requested but none was provided.	F 246		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 315	F315 It is the Policy of Crest View Lutheran Home That resident's incontinent of bladder receives Appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident 119 was affected by this deficient Practice when toileting schedule was not followed per resident's plan of care. Care plan reviewed and team card updated to reflect Residents toileting schedule. Comprehensive Bladder assessment will be completed to reflect Resident's individual toileting needs. All resident's have potential to be affected By this deficient practice. Resident's Bowel and Bladder assessments will be reviewed annually,and with significant change, in addition to review toileting schedules/plans with quarterly MDS schedules for continued appropriateness of toileting schedule/plan. Bladder P&P will be reviewed at all staff 10/6, 10/7, And 10/8/2015, in addition to Nurses meeting and Nursing Assistant meetings. The reports of compliance will be reported to QA&A Committee for review and further recommendation. DON/Designee will be responsible for compliance By October 13th 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 315	Continued From page 15 review, the facility failed to ensure toileting was provided for 1 of 1 resident (R119) who was reviewed for activities of daily living (ADL's) and who required assistance from staff. Findings include: R119 was interviewed on 8/31/15, at 5:48 p.m. when a concern from the resident's family member (FM)-A was voiced regarding the lack of assistance with ADL's. FM-A reported R119 was not assisted to the toilet frequently enough, and was often dressed in the same clothing from one day to the next when she visited. R119 appeared unkempt and was dressed in a stained white t-shirt that was halfway un-tucked from his pants. The stain was yellow and ran the length of the bottom of his shirt. When asked if his shirt was wet, R119 felt the shirt and answered, "Yes, it's wet." FM-A then said, "Yes--that's urine on it." FM-A further went on to explain that prior to his admission at the facility, she had taken care of him at home, and had been able to accurately report the need for the toilet, or when he had a urinary accident. FM-A said "I had to change him often because he was wet with urine." During a continuous observation of R119 on 9/2/15, from 8:03 to 11:05 a.m. the following was observed. At 8:03 a.m. a nursing assistant (NA)-A entered R119's room to provide morning cares. NA-A reported the resident's incontinent brief was wet with urine. Pericare was then provided and a clean brief was applied, however, NA-A never asked R119 if he needed to use the toilet to void, nor did she attempt to assist R119 to use the toilet. When asked if NAs carries assignment sheets describing resident cares NA-A responded, "Yes--it's in my pocket." When	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 315	Continued From page 16 R119 cares were completed at 9:02 a.m. NA-A assisted to the dining room where FM-A was waiting. At 9:07 a.m. R119 was assisted to therapy, and at 10:08 R119 was observed participating in therapy using various equipment. At 10:26 a.m. R119 was wheeled back to the unit and assisted to the dining room table for lunch, where FM-A joined the resident. At 10:39 a.m. a licensed practical nurse (LPN)-C wheeled R119 back to his room to obtain a blood glucose test, then returned the resident to the dining room. At 10:52 a.m R119 finished his lunch and was assisted back to his room for a check-up by the physician's assistant. At 10:58 a.m. the surveyor intervened to ask NA-A when R119 was supposed to have been toileted. NA-A produced the NA assignment sheet which read R119 was supposed to have been toileted every two hours. When asked if R119 had been offered the toilet in the previous three hours NA-A replied, "No, he has not been. I did not ask him if he had to use the toilet this morning, because his incontinent pad was already wet." NA-A explained she did not offer R119 to use the toilet during the morning hours, as he was in therapy and then she was busy assisting in the dining room. NA-A said R119 should have been offered to use the toilet, but then just left the unit without then offering toileting assistance to R119. LPN-A was then apprised of the situation at 11:05, and said she would have expected the NAs to follow resident care plans. LPN-A then asked R119 if he needed the toilet and he replied, "No," then was asked if he was wet again he replied "no." R119 agreed to let LPN-A check his incontinent brief while standing beside his bed	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 315	Continued From page 17 with FM-A in the room. When LPN-A checked R119 incontinent pad she verified that the line on the brief had turned yellow, indicating R119's brief was wet with urine. LPN-A explained that the incontinent briefs had a visual line that made it easy for staff to determine if a resident needed changing. FM-A then stated, "See? He doesn't know when he is wet or even if he has to go to the bathroom." R119's 8/21/15, Bowel and Bladder Assessment revealed the resident was continent, but dribbled urine. Under Assessment it was noted the resident required the asistance of one person for cares and transfers, but was continent with occasional inconetinence. However, a plan for promoting continence was not included in the assessment. A Minimum Data Set (MDS) dated 8/24/15, revealed the resident was cognitively intact, required extensive assistance of one staff for dressing and toileting. The resident frequently incontinent (seven times or more a week), but R119's care plan dated 8/15, indicated R119 had limited ability to perform ADL's, and had an alteration in bladder function with incontinence multiple times daily. Staff approaches were to toilet R119 every two to three hours to meet his needs. The resident's Assignment Sheet directed staff to toilet the resident every two hours. A bladder assessment dated 8/21/15, indicated R119 required staff assistance with incontinent products. A related policy was requested, but was not provided.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 323 F 323 SS=D	Continued From page 18 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure interventions were implemented to minimize the risk for falls for 1 of 3 residents (R37) reviewed for accidents. Findings include: R37 reported during an interview with R37 on 9/2/15, at 1:08 p.m. "If I have to go to the bathroom real fast I will put myself on the toilet. I am very careful as I don't want to fall again." R37 also reported she had to be very careful, as she had already fallen twice while at the facility. She said although she used her call light to summon staff's help, the nursing assistants (NAs) were busy and staff was "not fast enough" in getting her to the toilet. R37's 8/14/15, Minimum Data Set (MDS) indicated R37's cognition was moderately impaired, did not reject cares, and had diagnoses including anxiety and constipation. Falls were noted in the two to six months prior to admission. R37 frequently incontinent. R37 needed staff assistance, as she was unable to stabilize herself	F 323 F 323	F 323 It is the policy of Crest View Lutheran Home P&P for Incident, Accident and Fall reporting That All incidents, accidents and unusual Occurrences that involve the residents are documented and investigated for causal factors and prevention of reoccurrence to ensure a safe environment in which the resident may achieve and maintain their highest practical level of physical and psychosocial functioning. The facility failed to provide timely Intervention of placing auto lock brakes on R37 wheelchair as determined by fall review with IDT. Auto lock brakes Were placed on R37 wheel chair 9/2/15. All residents have the potential to be Affected by this deficient practice. The IDT will continue to review fall Reports daily and will provide Interventions that can immediately be put in place to help prevent further falls. If medical equipment is part of intervention such as auto lock brakes The DON or designee will make sure Equipment and service can be provided Immediately and other interventions will be added to assure resident safety. Staff education on P&P of Incidents, Accidents And unusual occurrences will be given 10/6, 10/7,10/8/ 2015. Findings from deficient practice will be Reviewed at QAA x's 3 months. Corrective action will be completed by October 13, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 323	Continued From page 19 when going from from sitting to standing and was "not steady." Subsequently, while in the facility R37 sustained two additional documented falls on 8/23/15, and 8/27/15. A licensed practical nurse (LPN)-C stated on 9/1/15, at 3:43 p.m. that R37 needed one staff assist for transfers to and from the wheelchair (w/c), and had fallen approximately three or four days prior. LPN-C reported R37 had self-transferred herself to the toilet and sometimes "I think she forgets she is not able to transfer herself." The following day at 1:28 p.m. a registered nurse (RN)-B explained that R37 was prescribed a laxative, and was constantly on the toilet and did not like it. Progress notes were as follows: 1) On 8/11/15, it was noted R37 required the assistance of one staff activities of daily living and transferring due to weakness and pain in both legs. On 8/14/15, it was noted R37's cognition was moderately impaired and the resident had been experiencing pain, so had been taking pain medication around the clock that could have been affecting her cognitive status. A note dated 8/23/15, revealed R37 sustained a fall in the bathroom and was found seated by the toilet in her room. The following day it was noted auto lock brakes would be added to her w/c. (No auto lock brakes were observed on the resident's w/c on 9/2/15, at the time of the interview with the resident). Four days later on 8/27/15, R37 again fell when she was attempting to stand from the toilet independently. The note indicated the resident "self-transfers." R37 had not called for help, and instead tried to stand by herself, lost her balance, and fell. No	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 323	Continued From page 20 additional interventions were put into place after the second fall to ensure risk of future falls was minimized. During an interview with RN-B on 9/2/15, at 1:37 p.m. she explained R37 became confused when her ammonia levels were high and she had become dizzy from taking too much Percocet (narcotic pain medication), which was why the medication had been decreased. RN-B verified the nurse practitioner had ordered auto locks for R37's w/c brakes, however, they were not currently on R37's w/c. RN-B further verified no additional interventions had been tried after R37's falls on 8/23/15, and 8/27/15. A few minutes later at 2:14 p.m., a maintenance staff (M)-A stated he was unaware any notification had been provided for the maintenance staff to apply auto locks to R37's w/c. M-A explained there was some kind of protocol that had to be followed. At 2:26 p.m. LPN-D stated she believed there was an order placed to have the auto lock device applied to R37's w/c, but did not think the order had been filled yet. Five minutes later R37 was seated in her w/c in the dining room. R37 reported she had self-transferred herself to the toilet earlier that day. She explained that "some staff say it's okay" for her to do this, while others told her she should have staffs' help. Although undocumented, R37 also reported she had once transferred herself in her room and fell by her bed. She said it had been her "own fault," as she had forgotten to lock her w/c brakes before self-transferring. RN-B then informed the surveyor the maintenance staff	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 323	Continued From page 21 was going to apply the auto lock brakes that day. Same day at 2:44 p.m. M-B explained he received the work order yesterday to put auto lock brakes on R37's wheelchair, but had not found time the previous day, as there were approximately 20-30 work orders a day. At 2:50 p.m. the intern administrative intern reported auto lock brakes was an intervention after one of R37's falls. The administrator then explained that the facility's interdisciplinary team (IDT) met Monday through Friday mornings to discuss falls and fall interventions. On 9/3/15, at 10:28 a.m. R37 was seated in her w/c, and auto lock brakes were observed to have been applied to the w/c. Following the observation, the nurse practitioner (NP)-A explained R37 had been lethargic related to increased ammonia levels, causing her baseline cognition to decline and the resident repeated herself many times in one conversation. In addition, she displayed impaired decision making, judgement, and had poor safety awareness. NP-A reported being informed of R37's falls. At approximately 11:30 a.m. a registered physical therapist (RPT)-A reported R37 was receiving both occupational and physical therapy to work on strength, balance and mobility. The occupational therapist/registered (OTR)-A stated that R37 was to have one staff's assistance for toileting transfers, contact guard assistance when going from sitting to a standing position, and then minimal assist while pivot transferring. OTR-A also stated that therapy was sometimes involved	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 323	Continued From page 22 in resident evaluations for auto lock brakes, but was unaware of this for R37. OTR-A said therapies were not in attendance at the morning team meetings. The 4/12 Incident, Accident, and Fall Reporting policy directed staff as follows: "All incidents, accidents and unusual occurrences that involve the residents are documented and investigated for causal factors and prevention of reoccurrence to ensure a safe environment in which the resident may achieve and maintain their highest practical level of physical and psychosocial functioning...The IDT will review for any other interventions or need for further investigation." The facility's 6/13, Fall Report and Assessment policy was to "provide documentation of each fall, to assist in prevention of further falls and enhance quality of life...The form is filled out completely, including immediate follow-up measures taken to prevent reoccurrence."	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353	**F 353** It is the policy of Crest View Lutheran Home to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 23 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staffing for 7 of 7 residents (R60, R57, R37, R23, R76, R89, R121) who expressed concerns regarding staffing, and having the potential to affect all residents residing in the facility. Findings include: R60 expressed concern there was insufficient staff to meet resident needs, when interviewed on 8/31/15, at 2:52 p.m. R60 stated, "When I put my call light on I have to wait up to one hour sometimes." R60's family member (FM)-A was present and said she had witnessed it taking up to 45 minutes for R60's call light to be answered, even when she was present in the room. R60 then stated, "I have soiled myself over 100 times waiting for help." R60 also reported that instead of helping her to the toilet, night shift staff had told her just to urinate in her incontinent pad and then staff would change her. R60's quarterly MDS dated 8/18/15, indicated R60's cognition was intact, was was frequently incontinent of urine, and required extensive staff assistance with toileting.	F 353	The nursing schedule was reviewed, and staffing ratios were noted to be well within industry standards. This was evidenced by a 4-star rating (out of a possible 5 stars) on the Minnesota Nursing Home Report Card. The plan includes the designation of a "charge nurse" on each shift and RN coverage in the building 24 hours a day. The Director of Nursing or designee will review average case mix levels daily to ensure adequate staffing is scheduled to meet resident needs as of 10/5/2015. Per Resident Council conversations, the PM shift was noted to have longer wait times for call-light responses. The Staffing Coordinator and Nursing Supervisors were re-educated that the nursing assistants on the floor that are scheduled from 3:00p – 9:00p will now be scheduled until 11:00p if they are needed for additional HS cares. Also, the TMAs scheduled on the PM shift from 4:00p – 8:00p will now be scheduled to 11:00p if they are needed for additional PRN medication distribution. The Nursing Supervisor on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 24 R57 stated on 8/31/15, at 4:32 p.m. she did not think there was sufficient staffing to meet her toileting needs. R57 stated when she put on her call light she had to wait a long time for staff to respond, and sometimes she became incontinent of bladder due to waiting for help. R57's annual MDS dated 8/4/15, indicated R57's cognition was severely impaired (although previous MDS dated 2/6/15, indicated the resident was cognitively intact and survey screening questions were answered appropriately). She required extensive staff assistance with toileting. R37 at 6:50 p.m. stated that she has had waits of long times when she puts her call light on and wets herself a lot of the time because of having to wait so long for help. R37's admission MDS dated 8/4/15, indicated R37's cognition was moderately impaired and she required extensive staff assistance with toileting. She was frequently incontinent of bladder and always incontinent of bowel. R37's MDS dated 8/4/15, also indicated that R37 was frequently incontinent of urine and always incontinent of bowel. R23 reported on 8/31/15, at 6:38 p.m. stated that mornings and evenings were worse to have to wait for staff and that she has had an accidents in her pants while waiting for assistance. R23's admission Minimum Data Set (MDS) dated 5/28/15, indicated R23's cognition was moderately impaired. She required extensive assistance with ADLs. She was continent of bowel and bladder, but had experienced a urinary tract infection within the last 30 days. R76 stated on 8/31/15, at 7:04 p.m. "Staff is pretty scarce some days here" and said he believed there was too much staff turnover at the	F 353	the shift will be responsible for making that determination. In addition, Crest View Lutheran Home is be adding additional supervisory staff to the PM shift in order to better manage call-light response time and customer service. This additional position and its hours were approved and posted for on 9/29/2015. For other residents who may be affected by this practice the daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing levels, designation of charge nurse, to ensure an RN is on the schedule, and/or to ensure adequate staffing is present. Staffing pattern audits will be completed weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. Resident council meeting minutes will be audited monthly at the end of each month to ensure old news is followed up on in an appropriate manner. Call light audits remain ongoing. The results will be reported to the QA/QI Committee for review and further recommendation. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 10/13/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 25 facility. R76 reported the shortage had been for the past month or two. He said he had a hard time getting staff to help him. For example, he had requested the pain medication Tylenol "the other day" and the staff on that shift never came back with the medication. R76's annual MDS dated 5/21/15, indicated his cognition was intact, and he was dependent on staff for ADLs. Although in the year prior R76 was only frequently incontinent of bowel and bladder, from 11/23/14 he was scored as always of both bowel and bladder. R76 was prescribed both routine and as needed pain medication. R121 reported on 8/31/15, there was not enough staff available to help when needed. R121's admission MDS dated 7/22/15, indicated the resident was cognitively intact. R121's MDS also indicated the need for extensive staff assistance with ADLs, but was always continent. R89 stated on 9/1/15, at 2:24 p.m. "Evergreen is a hard unit, so it is hard to keep myself dry. I go in my pad." R89 also stated she would use her call light if she thought staff would answer it. She said she had to remain in a wet incontinence brief unit after 7:00 a.m. R89 further stated, "I don't like being wet. I am uncomfortable and I don't feel clean when I am wet." R89's MDS dated 6/30/15, noted she was cognitively intact. MDS assessments showed fluctuations in her bladder status from one assessment to another over time as occasional, frequent, and always incontinent in the past year, but currently was noted as frequently incontinent. R76 was continuously observed on 9/2/15, from 7:10 a.m. to 9:49 a.m. During the observation of R76's cares at approximately 9:35 a.m. a nursing	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 26 assistant (NA)-B activated the call light to get assistance from another staff. While waiting for several minutes NA-B was asked if it sometimes took a long time to get help and responded, "...Ya, I guess so. I can never find someone. They are busy you know." While waiting for assistance, the staffing coordinator opened R76's room door and instructed NA-B to turn off R76's call light. NA-B informed the staffing coordinator she needed assistance. On 9/2/15, continuous observations were conducted by another surveyor during the morning hours from 7:00 until approximately 10:30 a.m. on the Evergreen unit. During the observations residents' call lights were sounding constantly. Residents could be heard calling out, "Get me up!" and "I need help" as well as, "I need help! Get me out to the dining room." NAs were assisting residents in getting up and dressed and groomed for the day, and with toileting and bathing. A registered nurse (RN)-C was interviewed on 9/3/15, at 11:00 a.m. She stated she was unable to complete all her work in eight hours when assigned to the Evergreen unit. Although she sometimes had help from her supervisor and sometimes not, as "they are busy." RN-C also stated that more often than not she stayed over eight hours, leaving charting for last. She tried to squeeze in a meal break, but could not always afford to take the full thirty minutes she was allowed. During an interview with licensed practical nurse on 9/3/15, at 1:18 p.m. licensed practical nurse (LPN)-A stated, "Without a TMA [trained medication assistant], I would never be able to	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 27 pass all my residents' medications." NA-D stated on 9/3/15, at 9:25 a.m. sometimes NAs could not complete residents' cares timely on the Evergreen unit, particularly if a resident required the assistance of two staff or if their cares took a longer amount of time. NA-D stated at in-services management told them to answer the resident call lights "ASAP" (as soon as possible) and added, "We had always did that anyways. We try our best." Following the interview with NA-D, NA-E explained that she had worked on all the units in the building. Linden and Evergreen units usually were staffed with four NAs, but not always. Willow and Aspen units always had three NAs. NA-E said when they did not have all four NAs on the unit, the work was disseminated between the three NAs who were working. NA-E said it was challenging when a resident required two staffs' assistance and they could not always help the residents right away with their needs. NA-E further stated she informed residents how long they could expect to wait. If she could not meet that timeline, she returned to tell the resident she was not going to be able to help them in the time she had anticipated. NA-E said many of the residents watched their clocks and would report they had been waiting for 15 minutes. NA-E explained it took a lot longer to toilet residents on the memory care unit (Willow). She tried to take a mid-day meal break, but usually had to take it "later." NA-E stated at NA meetings and in-services timeliness of answering resident call lights had been brought up, but she did not recall hearing this since last December. NA-E also explained that staff who called in could not always be replaced, so "you work with one less NA."	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 28 Some days were harder than others, and on the more difficult days she left the male residents unshaven, as the females tended to be more embarrassed by facial hair than the males. NA-F stated on 9/3/15, that on the previous day she only could take a 15 minute meal break because of all the work that had to be completed in the Willow unit. The director of nursing (DON) was interviewed on 9/3/15, at 1:19 p.m. She stated she had just started as DON three months prior. She used the daily resident census to determine staffing patterns, and only she or the administrator were allowed to add additional staffing. The DON said that day's census was 110. Two residents were being discharged and one resident was returning from the hospital. The DON said the staffing person kept the staffing spots filled, replaced staff, and informed the DON if she could not find replacements. At that point the DON or administrator granted overtime. The administrator stated on 9/3/15, at 1:24 p.m. the new average resident census for 1/15 was 120 residents, 2/15 about 115 in March, 6/15, it was 113, and currently it was 110 residents. If they went over 115, they would add a NA on the transitional care unit (Linden). If they could not replace staff on the Evergreen unit, they tried pulling the TMA to work as a NA to help out the supervisor. The administrator stated he pulled the resident acuity report, but had not started actually utilizing the report, as he had only returned to the facility as administrator 17 days ago, having left last winter. In that timeframe, there had been two interim administrators. Upon returning, the administrator had heard reports from residents on	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 29 the Linden unit about not getting their call lights answered and just two weeks ago, he determined an additional staff person was needed on the day shift. In the past year they had been pulling an NA off the Linden unit when the census was 115, but he found out that the NA on the Linden unit was needed even when the census was 109-110 because of resident complaints. The DON and administrator said they had the acuity reports, but had never actually took that into consideration when determining numbers of staff needed. He had used the resident Case Mix classifications to determine staffing as part of the previous year's citations, and thought it had helped. The administrator and DON said it had been hard to pull data from call light audits, as the audits were lacking information. Call light audits had been in response to resident complaints at monthly resident council meetings. The DON said it was her expectation call lights be answered within five minutes and bathroom call lights within three to five minutes. The DON said she thought the root cause of the problem was "old school thinking" where "those residents are not in my group, so I don't need to answer them." The DON said she had already re-educated staff regarding the problem. A resident concern form dated 8/28/15, revealed a resident had her call light on at around 3:00 a.m. and that it had not been answered. The resident then yelled for help, but no one came. Another concern form dated 8/24/15, concern form indicated that on 8/23/15, a resident waited from 8:00 to 9:00 a.m. for assistance, and the next day for 45 minutes. The resident reported she felt she was being "ignored." In addition, monthly resident council minutes from 9/14 to 7/15 revealed resident reports that call lights were	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 353	Continued From page 30 not being answered in a timely manner. The previous three months of daily staff postings revealed the TMA position was left blank. The report also indicated the NA assigned to work as a rehabilitation NA had often been pulled to fill in as a NA on the unit. The postings for 7/15 and 8/15, revealed a fluctuating resident census. Available call light audits from 5/6/15 through 8/31/15, indicated resident call length wait times of six to 20 minutes. On 9/3/15, at 2:20 p.m. administrator stated the facility was getting a new call light system and that would allow better tracking of call light response times. The logs however, did not account for example when help was unavailable, but the staffing coordinator instructed NA-B to turn off the call light off as during care observations for R76 the morning of 9/2/15. A 6/12, Call Light policy indicated the purpose was "To respond promptly to resident's call for assistance...Answer ALL call lights promptly whether or not you are assigned to the resident...Answer all call lights in a prompt, calm, courteous manner." A 9/14, Staffing Plan policy noted, "Staffing is based on and reflects consideration of the needs of the resident population along with case mix in determining the composition of the nursing staff. The Director of Nursing adjusts station staffing according to case mix levels on a regular basis...Director of Nursing will review Daily Case Mix average to ensure adequate staff are present on the floor to meet all resident care needs."	F 353		
F 367	483.35(e) THERAPEUTIC DIET PRESCRIBED	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 367 SS=D	Continued From page 31 BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review facility failed to provide physician ordered therapeutic diet for 1 of 1 resident (R66) served thin water when honey thickened liquids were ordered. Findings include: R66 was observed coughing after consuming a drink of water on 8/31/15, at 4:51 p.m. The resident's tray card listed her diet as pureed with honey thick liquids. A glass of honey thickened milk and re[illegible]quid had been provided for R66, along with a glass of regular consistency water. In addition, a carafe of water was on the table. Just after the observation, a dietary aide (DA)-A brought three glasses of thickened liquid to the table for R66's tablemate, but the glass of thin water was not removed from R66's place setting. A nursing assistant (NA)-C, the dietary manager and the director of nursing (DON) were all at R66's table at some point during the meal, however, the thin liquid was not removed from the resident's place setting. At 5:05 p.m. R66 was observed coughing after a drink of thickened water. R66's care plan dated 11/19/14, indicated "Requires set up for meal assistance. Diet: Regular diet honey consistency Thickened liquids swallowing problem." An additional care plan	F 367	F367 It is the policy of Crest View Lutheran Home Hydration Policy, to identify residents at risk for dehydration. Thickened liquids will be provided for residents requiring thickened liquids. R66 was not adversely affected by this deficient practice. All residents would have potential to be affected by this deficient practice. DON /Designee will give All staff education on P&P of hydration on 10/6, 10/7, and 10/8/2015 and all staff will be educated on importance of following residents diet cards prior to giving liquids to prevent any possible adverse effects such as aspiration. Dining room audits will be done 2x's per Week x's 1 month, then monthly thereafter. Findings from this deficient practice and Audit trends will be reviewed at QAA x's 3 months. Corrective action will be completed by October 13, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 367	Continued From page 32 problem dated 12/14 also noted the resident had difficulty swallowing thin liquids, and staff was directed to provide honey thickened liquids. A Yearly Nutritional Assessment for R66 dated 11/30/14, indicated "Diet order Pureed/honey thick liquids" and noted the resident had diagnoses including dysphagia (swallowing disorder), a history of aspiration pneumonia, and chronic lung disease. R66's Swallowing Assessment Speech therapy discharge note dated 12/18/14,"Primary diagnosis aspiration pneumonia. Treatment diagnosis dysphagia...diet was changed to pureed with honey thickened liquids because she was better able to handle this diet...Still occasional cough...." It was noted education related to the risk and benefit of various diets was provided, and the resident agreed to the diet. R66 quarterly Minimum Data Set (MDS) dated 8/22/15, indicated the resident was cognitively intact. R66 was independent with eating after staff set up. The MDS indicated R66 diagnoses included a history of aspiration pneumonia (caused by inhalation of an object into the lungs, usually food or fluids). R66's Order Summary Report signed 8/24/15, indicated her prescribed diet was "pureed texture honey consistency." NA-C verified on 8/31/15, at 5:26 p.m. R66 had been provided a glass containing thin water. NA-C said someone must have poured it for the resident, and said it potentially could have made the resident choke had she consumed the thin water. The surveyor said the resident had	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 367	Continued From page 33 consumed approximately half a glass of the water and was observed coughing on both thin and later thickened liquids. The DON was interviewed regarding the observations on 8/31/15, at 5:31 p.m. The DON explained, "I would expect staff to take it [glass of thin water] away." The DON further explained that if all residents at a table had thickened liquids, carafes of water were not left on the table, but two residents at the table had regular liquids. The DON stated, "I think they should have put it over here" and moved it to the other side of the table. R66's tablemate then stated, "Someone poured the water to her but I can't say who. It was an aide." The facility's 7/13 Hydration Policy indicated, "Identification of Residents at Risk for Dehydration" and instructed staff to provide carafes of ice water on each table at every meal. "Thickened water will be available on all trays for those residents requiring thickened fluids."	F 367		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 431	Continued From page 34 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired insulin medications for (R31, R103) were not stored for use. This had the potential to affect an additional four residents on the unit who utilized insulin. Findings include: The facility's medication storage system was observed on 8/31/15, at 12:30 p.m. on the Aspen Lane unit. Expired insulin labeled for R31 and R103 was stored at room temperature in the cart. R31's Lantus (glargine) insulin had an open date of 7/14/15 and expiration date of 8/11/15. R103's Novolog insulin (insulin Aspart) was open but had	F 431	F431 It is the policy of Crest View Lutheran Home To ensure that medications and biologicals have expiration date on the label; have not been Retained longer than recommended by Manufacture or supplier guidelines; or have Been contaminated or deteriorated, are stored Separate from other medications until destroyed Or returned to the pharmacy or supplier. Residents R31, and R103 were not adversely affected by this deficient practice. New insulin for these residents were immediately ordered from pharmacy. All residents have potential to be affected by This deficient practice. DON/Designee to educate all Nurses on 10/6, 10/7 10/8/2015 on Policy and Procedure on storage and expiration of medication, biologicals, syringes and needles. Audits for expiration of medication will be done 2x's per week x's 1 month, then monthly there after to assure compliance. Findings from deficient practice and audits will Be reviewed at QAA x's 3 months. Corrective action will be completed by 10/13/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 431	Continued From page 35 no open date. The vial had a 7/14/15 date as the date when it was dispensed from the pharmacy. R31's medical history included a diagnosis of type two diabetes. R31 had a physician order for Lantus solution 100 unit/ml (milliliter) 12 units subcutaneously at bedtime for diabetes. R31's August 2015 Treatment Administration Record (TAR) directed staff to administer 12 units of Lantus insulin by subcutaneous injection daily at hours of sleep. R31's care plan revised on 8/15, identified the potential/actual alteration in health maintenance related to diagnosis of diabetes. Interventions included, monitoring blood sugars as ordered, administering diabetic medications and insulin according to physician orders. R103's medical history included a diagnosis of type two diabetes. R103's physician orders signed on 3/20/15 indicated that resident was prescribed Novolog solution 100 unit/ml. Staff were to inject as per sliding scale (based on blood sugar readings) subcutaneously three times a day and at bedtime for diabetes. R31's August 2015 Treatment Administration Record (TAR) indicated the resident was to receive Novolog solution 100 unit/ml three times a day and at bedtime per sliding scale. R103's care plan revised on 7/15, identified the potential/actual alteration in health maintenance related to diagnosis of diabetes. Interventions included, monitoring blood sugars as ordered, administering diabetic medications and insulin according to physician orders. During an interview on 8/31/15, at 12:31 p.m. a	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
F 431	Continued From page 36 licensed practical nurse (LPN)-C verified that both vials of insulin were expired. LPN-C stated that insulin was good for twenty eight days once it had been opened. She stated, "This was supposed to have been discarded on 8/11/15". LPN-C further confirmed there were no any other insulin vials available for use for both R31 and R103 in the cart or in the medication storage room. LPN-C stated, "We must have been using the expired ones". During an interview on 8/31/15, at 12:38 p.m. a registered nurse (RN)-B also confirmed both vials of insulin were expired. RN-B stated that insulin was good for thirty days once open. She stated that her expectations was that all insulin is dated once opened and discarded once expired. The director of nursing (DON) stated during an interview on 9/2/15, at 9:50 a.m. her expectation was that nurses performed visual checks of medication before administration to check for expiration dates. The DON noted that she did not expect any expired medication in the cart. She explained, "We have been doing weekly audits and I'm surprised that insulin was expired that long. You came in and found it within ten minutes". The facility's Storage and Expiration of medication, Biologicals, Syringes and Needles policy dated 1/1/13 directed that, "Facility should ensure that medications and biologicals: have an expiration date on the label; have not been retained longer than recommended by manufacture or supplier guidelines; or, have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier".	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey Crest View Lutheran Home, Building 1 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	**APPROVED** K 000 *By Gary Schroeder at 3:52 pm, Oct 05, 2015* It is the policy of Crest View Lutheran Home to follow all regulations and statutes as they relate to the Life Safety Code. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance. RECEIVED OCT - 5 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Campus Administrator	10/2/15

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
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction typed is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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 018	Continued From page 2 those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 9:30 AM and 11:00 AM on 09/03/2015, observation revealed that two of the three kitchen doors leading into the corridor were propped open. This deficient practice was verified by the administrator at the time of the inspection.	K 018	**K 018** It is the policy of Crest View Lutheran Home that all doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as, those constructed of 1 ¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Also, these doors are free of impediment to closing. The three kitchen doors that were propped open by dietary staff during the annual review we	
K 103 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 103		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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 103	Continued From page 3 Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has combustible construction materials in the interior walls and partitions not in accordance with Life Safety Code Section 19.1.6.3. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 09/03/2015, observation revealed that there are wood stud walls in Room 114. These walls include the east wall and the plumbing chase surround. This deficient practice was verified by the administrator at the time of the inspection.	K 103	immediately removed of impediment to closing. Staff re-education occurred on 10/2/2015 to ensure that no doors are propped open. To ensure that this deficient practice is corrected, environmental audits of door closure will be completed weekly for 4 weeks, monthly for 2 months, and then randomly thereafter. The Director of Environmental Services or his designee will be responsible for compliance. Date of Correction: ~~10/9/13~~ 10/9/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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 103	Continued From page 3 Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has combustible construction materials in the interior walls and partitions not in accordance with Life Safety Code Section 19.1.6.3. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 09/03/2015, observation revealed that there are wood stud walls in Room 114. These walls include the east wall and the plumbing chase surround. This deficient practice was verified by the administrator at the time of the inspection.	K 103	**K103** It is the policy of Crest View Lutheran Home that interior walls and partitions are constructed with noncombustible or limited combustible materials. The walls and plumbing chase surround located in the medication machine room (listed as room 114) that contained wood studs were removed, and all wood studs were replaced with steel. Construction was completed on 9/15/2015. To ensure that this deficient practice is corrected, upon any demolition, construction, or any opening of walls, if combustible materials are noted, they will be removed and replaced with noncombustible or limited combustible materials. The Director of Environmental Services or his designee will be responsible for compliance. Date of Correction: 9/15/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **02** B. WING _____	**09/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	**4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421**

(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	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey Crest View Lutheran Home, Build 2 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction type is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.