



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2026

Administrator

CREST VIEW LUTHERAN HOME

4444 RESERVOIR BOULEVARD NORTHEAST

COLUMBIA HEIGHTS, MN 55421

RE: CCN: 245018

Cycle Start Date: August 13, 2026

Dear Administrator:

On August 13, 2026, a 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 isolated deficiencies that constituted immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On August 11, 2026, the situation of immediate jeopardy to potential health and safety cited at K781 was removed.

On August 11, 2026, the situation of immediate jeopardy to potential health and safety cited at K920 was removed.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 18, 2026. This prohibition is not subject to appeal. 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.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 February 13, 2027 (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.

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.

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:

tamika.brown@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
202-795-7490

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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245018		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST , COLUMBIA HEIGHTS, Minnesota, 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
E0000	Initial Comments On (8/10/26 through 8/13/26), a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was in compliance.			E0000			09/17/2026
F0000	INITIAL COMMENTS On 8/10/26 to 8/13/26, a standard recertification survey was conducted at your facility. (S5018043) A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H50183648C (iQIES #3122290) H50183649C (iQIES #3093911) H50183650C (iQIES #3017123) H50183651C (iQIES #3011471) H50183652C (iQIES #3009663) H50183653C (iQIES #2990395) H50183656C (iQIES #2979013) H50183654C (iQIES #2743690) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an			F0000			09/17/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	Continued from page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			09/17/2026	
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a physician-ordered ultrasound was obtained, and the results were communicated to the provider timely for 1 of 1 resident (R2) reviewed for diagnostic testing follow up and provider notification. The delay from the initiation of the ultrasound order on 7/29/26 until the provider received the results resulted in delayed evaluation and treatment of R2's continued left groin pain and swelling. R2 was subsequently transferred to the emergency department (ED), hospitalized, treated with intravenous (IV) antibiotics, and underwent surgical exploration and drainage of a scrotal abscess. Further, the facility failed to clarify discharge orders from the hospital for blood glucose monitoring for 1 of 1 resident (R6) who received insulin. Findings included: R2 R2's quarterly Minimum Data Set (MDS), dated 6/4/26, identified R2 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R2's diagnoses included chronic pain (persistent or recurring pain). R2's physician progress note, dated 7/29/26 at 10:59 a.m., indicated R2 was evaluated for left groin pain after nursing staff reported swelling. The physician identified left groin swelling and tenderness and ordered laboratory testing to rule out infection and a Doppler ultrasound of the left groin.		F0684	Immediate Correction Action: R2 was sent to the hospital on 8/11/26 for further evaluation and treatment. R2 returned to the facility on 8/16/26 with new orders. R6 has discharged from the facility as of 8/24/2026. Corrective Action as it applies to others: All other residents with ultrasound orders and/or orders for insulin could be affected by this practice. A full house audit was completed to ensure that any other resident with an ordered ultrasound was completed, and results were communicated to the provider. No like residents were identified to have a current order for an ultrasound. A full-house audit was completed to identify any resident with an insulin order to ensure blood sugar checks are being completed as ordered. Any resident who received insulin and did not have a blood sugar check order was reviewed with the provider and orders updated as needed. The notification to provider and medication and treatment order policies were reviewed, and no changes were made at this time. Education was provided to all nurses regarding updating the provider if diagnostics that are ordered cannot be completed timely and ensuring that all residents that are receiving insulin are also receiving blood sugar checks. Reoccurrence will be prevented by DON or designee completing weekly audits x 2 months of ultrasound and x-ray orders to ensure that the diagnostic was completed timely and the provider was updated regarding any delay. DON or designee will audit 5 residents receiving insulin weekly x 2 weeks to ensure that they are having blood sugar checks completed, then 5 residents monthly x 2 months, until determined by QAPI to decrease frequency of audits.		09/17/2026	

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F0684 SS = G	Continued from page 2 R2’s progress note, dated 7/31/26 at 3:32 p.m., indicated Trident Care, the diagnostic imaging provider, was contacted regarding the ultrasound and reported a technician would be sent when available. R2’s progress note, dated 8/3/26 at 2:34 p.m., indicated the ultrasound was expected to be completed the following day. R2’s physician progress note, dated 8/3/26 at 5:06 p.m., indicated R2's left groin swelling had been present since 7/29/26. Examination identified a reducible, non-strangulated left inguinal hernia. R2 continued to have bowel movements. R2’s progress note, dated 8/4/26 at 2:13 p.m., indicated Trident Care was contacted regarding the outstanding ultrasound and reported a technician would be sent, with the date to be communicated to the facility. R2’s progress note, dated 8/6/26 at 3:09 p.m., indicated the ultrasound had been completed and the results were pending. The ultrasound was completed eight days after it was ordered. R2’s ultrasound report, dated 8/6/26 at 2:35 p.m., identified a probable large bowel-containing hernia extending into the scrotum and indicated a computed tomography (CT) scan was warranted for confirmation. R2’s ultrasound report indicated the results were faxed to the facility on 8/7/26 at 8:39 p.m. R2’s physician progress note, dated 8/7/26 at 10:30 p.m., indicated the ultrasound results had not been received by the physician. R2 continued to report left groin pain. The physician identified a reducible, non-strangulated left inguinal hernia. R2’s physician progress note, dated 8/11/26 at 2:26 p.m., indicated the physician had received the ultrasound results, which identified a large bowel-containing scrotal hernia. R2 was sent to the ED for further evaluation. R2’s ED note, dated 8/11/26, indicated R2 presented with left groin pain. A CT scan of the abdomen and pelvis identified diffuse scrotal wall edema and a 3.8-centimeter rim-enhancing fluid collection near the left testicle concerning for an abscess. A scrotal ultrasound identified an approximately 4-centimeter fluid collection in the left inferior hemiscrotum suspicious for an abscess and findings consistent			F0684			09/17/2026

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F0684 SS = G	Continued from page 3 with left epididymoorchitis (inflammation of the epididymis and testicle). The ultrasound also identified right epididymitis (inflammation of the epididymis) with a small right hydrocele (fluid collection around the testicle). R2's ED documentation indicated urology was consulted and recommended antibiotic treatment. R2 was started on IV Zosyn, an antibiotic used to treat bacterial infections, and aspirin was held pending surgical evaluation. R2's hospital documentation, dated 8/12/26, indicated R2 was scheduled for exploratory surgery and IV antibiotics were continued. R2's hospital documentation, dated 8/13/26, indicated R2 underwent left scrotal exploration and drainage of a scrotal abscess. R2 remained under the care of the urology team and was documented as doing better without current pain. During an interview on 8/13/26 at 12:25 p.m., licensed practical nurse care coordinator (LPN)-A stated when a provider ordered a diagnostic test, such as an ultrasound, staff contacted Trident to arrange for the test to be completed at the facility. LPN-A stated the test should generally have been completed within one or two days. LPN-A confirmed R2's ultrasound was ordered on 7/29/26 and was not completed until 8/6/26. LPN-A stated Trident had reported being short staffed. LPN-A reviewed the ultrasound report and confirmed the ultrasound was completed on 8/6/26 and faxed to the facility on 8/7/26. LPN-A stated the report recommended a CT scan for confirmation, and she was unable to locate documentation that the nurse practitioner (NP) was notified of the results before 8/11/26, when R2 was sent to the ED. During an interview on 8/13/26 at 1:19 p.m., Trident Care representative (Rep)-A stated Trident received the facility's telephone order for R2's ultrasound on 7/30/26 and ultrasounds were considered scheduled procedures. Rep-A stated Trident's communication log identified attempts to contact the facility on 7/31/26; however, the calls went unanswered and a message could not be left because the facility's voicemail box was full. Rep-A stated additional attempts were made later that afternoon. Rep-A stated Trident made several additional attempts to contact the facility on 8/1/26, but the calls went unanswered and messages could not be left. Rep-A stated the facility contacted Trident on 8/4/26, at which time the ultrasound was scheduled. The ultrasound was completed on 8/6/26, and the			F0684			09/17/2026

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F0684 SS = G	Continued from page 4 results were faxed to the facility on 8/7/26. During an interview on 8/13/26 at 2:14 p.m., the NP stated R2 had groin swelling and she ordered an ultrasound. The NP stated she was “frustrated and upset” regarding the delay in obtaining the ultrasound. The NP stated she spoke with nursing staff on 8/7/26 regarding R2 and was informed a physician had evaluated R2 and identified a hernia. The NP stated R2 continued to experience pain during visits on 8/3/26 and 8/7/26, although the pain was stabilized. The NP stated facility staff had not updated her regarding the delay in obtaining the ultrasound. The NP stated that after she received the ultrasound results, she sent R2 to the ED for further evaluation. The NP stated if she had received the ultrasound results sooner, she would have sent R2 to the ED sooner. The NP stated the lapse was inappropriate and could have caused harm. During an interview on 8/13/26 at 2:31 p.m., the director of nursing (DON) stated she expected nursing staff to follow up with Trident sooner regarding the delay and document the communication. The DON stated the NP should have been notified and kept informed regarding efforts to obtain the ultrasound. The DON stated the length of time from when the ultrasound was ordered until the NP received the results was not acceptable and the delay could have worsened R2’s condition and potentially caused harm. The facility policy, Notification of Changes, dated 11/25, indicated changes in a resident’s condition or treatment were to be shared with the resident and/or resident representative, according to their authority, and reported to the attending physician or designee. The policy indicated its objective was to ensure staff made appropriate notification to the physician or delegated non-physician practitioner and the resident and/or resident representative when a change in condition or an accident occurred that could require physician intervention. The policy indicated its intent was to provide appropriate and timely information regarding changes in a resident's condition to the parties responsible for making decisions regarding the resident’s care, treatment, and preferences. R6 R6’s quarterly Minimum Data Set (MDS) dated 7/29/26 indicated R6 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs). R6’s diagnoses included			F0684			09/17/2026

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F0684 SS = G	Continued from page 5 vascular dementia, diabetes, atherosclerosis native arteries, and hypertension. R6’s Order Summary Report dated 8/13/26, indicated R6 had an order for Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes with a start date of 5/16/2026. Review of R6’s electronic medical record (EMR) failed to identify an order to check R6’s blood sugar readings to monitor R’6 blood glucose levels to ensure they were meeting blood glucose target levels. Review of R6’s progress notes indicated R6 was sent to the hospital on 5/13/26. R6 returned to the facility 5/15/26. Review of R6’s discharge orders dated 5/15/26, indicated R6’s metformin (oral medication used to treat diabetes) was discontinued. R6 continued on insulin, however, the discharge orders did not identify a blood glucose monitoring order. When interviewed on 8/13/26 at 9:14 a.m. licensed practical nurse (LPN)-A care coordinator stated they were not sure why R6 did not have blood glucose checks. LPN -A reviewed R6’s EMR and stated R6 had blood glucose checks twice daily before they were hospitalized. LPN-A stated when R6 was readmitted a call should have been placed to the provider to clarify if blood glucose checks should be done due to R6 received insulin. When interviewed on 8/13/26 at 12:43 p.m. director of nursing (DON) stated R6’s orders should have been reviewed when they were readmitted from the hospital. DON stated the expectation was when R6’s orders were put into the computer the person that entered the orders should have noted they were on insulin which should have triggered a call to the provider to clarify the orders. DON stated blood glucose checks for a person on insulin was important to ensure the level was not going too low. DON reviewed R6’s EMR, verified there was no order to check R6’s blood glucose. Facility provided Medication and Treatment Orders policy dated 1/5/26, however, the policy failed to address clarification of orders.			F0684			09/17/2026
F0553 SS = E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her			F0553	Immediate corrective action taken: R4, R5, and R91 are scheduled for care conferences prior to 9/15 per resident and family preference. R17 had a care conference completed on 8/24/26.		09/17/2026

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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST , COLUMBIA HEIGHTS, Minnesota, 55421	
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F0553 SS = E	Continued from page 6 person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide timely care conferences for 4 of 4 residents (R4, R5, R17 and R91) reviewed for care planning. Findings included: R4 R4's quarterly Minimum Data Set (MDS), dated /29/26, identified R4 had intact cognition and was independent with activities of daily living (ADLs). R4's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease that causes difficulty breathing) and coronary artery	F0553	Continued from page 6 Corrective action as it applies to others: A full house audit was completed to ensure that all residents have a scheduled care conference within the last 90 days. Any resident who was identified to be out of the 90-day window was scheduled a care conference to be completed according to resident and family schedule preference and availability. Care conference regulations were reviewed and remain current. Social service personnel were provided with education regarding scheduling and timing of care conferences. Reoccurrence will be prevented by Social Service director or designee will complete an audit 2 times per week x 2 weeks to ensure that all residents within their ARD have a care conference scheduled to be completed, then once weekly x 2 weeks, until determined by QAPI to decrease frequency of audits.	09/17/2026

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F0553 SS = E	Continued from page 7 disease (CAD, narrowing or blockage of the blood vessels that supply the heart). R4’s care plan, printed 8/12/26, identified R4 would have an appropriate discharge plan and R4 and/or R4’s family would make safe and appropriate decisions regarding discharge. Interventions directed staff to invite R4 and R4’s family to care conferences quarterly or as needed and to discuss discharge planning options as needed. R4’s electronic health record (EHR) identified the most recent documented care conference was conducted on 2/3/26. The EHR lacked evidence subsequent quarterly care conferences were conducted. R5 R5’s significant change MDS, dated 6/17/26, identified R5 had moderate cognition impairment and required assistance with ADLs. R5’s diagnoses included type 2 diabetes mellitus with hyperglycemia (a condition that causes elevated blood sugar levels) and a pressure ulcer of the right heel (an area of skin and underlying tissue damage caused by prolonged pressure). R5’s care plan, printed 8/2/26, identified R5 would be content with long-term care placement and R5 and/or R5’s family would make safe and appropriate decisions regarding discharge. Interventions directed staff to invite R5 and R5’s family to care conferences quarterly or as needed and to discuss discharge planning options as needed. R5’s EHR identified the most recent documented care conference was conducted on 2/19/26 in conjunction with R5’s re-admission assessment. The EHR lacked evidence subsequent quarterly care conferences were conducted. R17’s annual MDS, dated 8/5/26, identified R17 had intact cognition and required assistance with ADLs. R17’s diagnoses included acute and chronic respiratory failure with hypercapnia (a condition in which breathing is impaired and carbon dioxide levels in the blood are elevated), heart failure (a condition in which the heart is unable to pump blood effectively), and hemiplegia (paralysis affecting one side of the body). R17’s care plan, printed 8/12/26, lacked evidence care conferences were addressed or that an intervention was developed to invite R17 and/or R17’s representative to participate in quarterly care			F0553			09/17/2026

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F0553 SS = E	Continued from page 8 conferences. R17's EHR identified the most recent documented care conference was conducted on 8/19/25. The EHR lacked evidence subsequent care conferences were conducted in November 2025, February 2026, and May 2026. During an interview on 8/12/26 at 3:29 p.m., social worker (SW)-B stated care conferences should have been completed quarterly. SW-B confirmed R4's last care conference was conducted on 2/3/26 and subsequent quarterly care conferences should have been conducted in April 2026 and July 2026. SW-B confirmed R5's last care conference was conducted on 2/19/26 in conjunction with R5's admission assessment, a quarterly care conference should have been conducted in March 2026, and a care conference should have been conducted following R5's significant change in June 2026. SW-B confirmed R17's last care conference was conducted on 8/19/25 and subsequent quarterly care conferences should have been conducted in November 2025, February 2026, and May 2026. SW-B confirmed the identified care conferences for R4, R5, and R17 had not been conducted. R91 R91's quarterly Minimum Data Set (MDS) dated 4/16/26, indicated R91 was admitted on 3/5/18, was cognitively intact, and had the following diagnoses: anemia, hypertension (high blood pressure), renal insufficiency, arthritis and depression. R91's care plan dated 7/28/26, indicated a focus on an alteration in psychosocial well-being related to major depressive disorder, and had the following intervention: -facility will invite resident and their family to care conferences quarterly. This intervention was initiated on 1/19/26. R91's most recent Care Conference Summary was completed on 10/16/25. R91's medical record lacked any evidence a care conference had been conducted since 10/16/25. On 8/11/26 at 12:45 p.m., the regional social work consultant (RSW) confirmed a care conference had not been conducted since October of 2025, for R91. RSW stated the social worker was typically responsible for organizing and conducting the care conferences. However, they did not have one on			F0553			09/17/2026

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F0553 SS = E	Continued from page 9 staff for a long time to guide and direct the department. The care conference for R91 and others had fallen behind and not been completed. RSW stated the expectation was for the care conferences to be completed upon admit, annually, quarterly, and with any significant changes. On 8/11/26 at 12:09 p.m., the director of nursing (DON) confirmed R91's care conferences had not been completed for F91 since October 25', and their expectation was for them to be completed upon admit, annually, quarterly and with a significant change, Furthermore the Don stated the importance of completing care conferences to ensure the residents are included and have a say in their care and treatment plans. A care conference policy for the facility was requested, and none were provided.	F0553		09/17/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584	Immediate corrective action taken: R23's fall mat was immediately removed and replaced with a clean fall mat. The stained fall mat was removed and disposed of in the trash. R37's air mattress was removed and replaced with a different air mattress on 8/11/26. R37's current air mattress is functioning properly. Corrective action as it applies to others: All residents who utilize a fall mat or an air mattress have the ability to be affected by this practice. A full-house audit was conducted on all residents who have a fall mat to ensure the mat is clean and in good working order. All residents who utilize an air mattress were audited to ensure the air mattress is in good condition and fits the bed frame appropriately. Any mattresses that were found to be not functioning properly were removed and replaced. Education was provided to all staff regarding fall mat cleaning and air mattresses. Staff were educated to update housekeeping if a fall mat was identified to be soiled and housekeeping staff were educated to notify nursing leadership if a new fall mat was needed. Staff were educated to update maintenance if a non-functioning air mattress is identified and/or if the mattress is not fitting the bed frame appropriately. Reoccurrence will be prevented by DON or designee completing an audit weekly on all fall mats to ensure cleanliness x 2 weeks, then monthly x 2 months. DON or designee will complete an audit of all air	09/17/2026

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F0584 SS = E	Continued from page 10 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide a safe, clean and comfortable environment for 2 of 2 clients (R23, R37) reviewed for environment. Findings include: Findings included: R23's quarterly Minimum Data Set (MDS) dated 8/5/26 indicated R23 had moderate cognitive impairment and required staff assistance with activities of daily living (ADLs). R23's diagnoses included Alzheimers disease, iron deficiency anemia, protein-calorie malnutrition, hypertension, chronic kidney disease, hypothyroidism, neuromuscular dysfunction of bladder, vitamin D deficiency, glaucoma, insomnia, muscle weakness, cerebrovascular disease, and history of falling. R23's care plan dated 8/7/26 indicated R23 had an actual alteration in safety related to history of falls, impaired cognition, had decreased safety awareness and history of self-transfers. Interventions directed staff to ensure wheelchair and bed brakes were locked during transfers, do not leave R23 alone in her room when in wheelchair, ensure call light was in reach and have night light on in room at night. On 8/12/26 at 8:05 a.m. observed a grey foam fall mat next to R23's bed, there was a reddish-brown stain that measured two feet by two feet on the fall mat, around the edges of the fall mat there were			F0584	Continued from page 10 mattresses weekly x 2 weeks, then monthly x 2 months to ensure the air mattress is in working order and fits the bed frame appropriately. Audits will be reviewed during QAPI to determine if audits need to continue, decrease in frequency, or can be resolved.		09/17/2026

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F0584 SS = E	Continued from page 11 several areas of foam missing. On 8/12/26 at 2:45 p.m. nursing assistant (NA)-A stated she was not sure who was responsible for cleaning the fall mats, NA-A observed the fall mat, stated she was not sure what was on the fall mat. On 8/13/26 at 9:00 a.m. the fall mat continued to have the reddish-brown stain. When interviewed on 8/13/26 at 9:08 a.m. registered nurse (RN)-A stated she was not aware R23's fall mat was dirty and was not aware of who cleaned the fall mats. When interviewed on 8/13/26 at 9:14 a.m. licensed practical nurse (LPN)-A care coordinator observed R23's fall mat, stated she was not sure what was on the floor mat, stated someone should have cleaned or replaced the fall mat for infection control reasons but was not sure who was responsible for cleaning of fall mats. When interviewed on 8/13/26 at 12:43 p.m. director of nursing stated she expected fall mats to be cleaned when a deep clean of the rooms was done and when staff noticed that the mat as dirty for infection control purposes. Facility provided Deep Cleaning Procedures policy undated and Daily Cleaning Procedures policy undated, however, neither policy addressed cleaning of fall mats. R37 On 8/10/26 at 6:43 p.m. R37's air mattress appeared flat and shifted down exposing the top portion of the bedframe. The bed was in a seated position. On 8/11/26 at 11:23 a.m. R37's air mattress continued to be in shifted down and exposing the bedframe. On 8/11/26 at 1:08 p.m. R37 was resting with head of bed elevated to sitting position. Air mattress continued to be shifted down exposing the top portion of the bedframe.			F0584			09/17/2026

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F0584 SS = E	Continued from page 12 On 8/11/26 at 1:15 p.m. nursing assistant (NA)-A stated she had been in R37's room several times, but R37 was not ready yet. R37 was own person and she directed her own cares. NA-A entered room and stated the bedframe had not been exposed earlier in the day. On 8/11/26 at 1:30 p.m. registered nurse (RN)-A stated NA-A had just reported the exposed bedframe to him. His process would be to check the resident to assure safety and call maintenance. RN-A stated the exposed bedframe had not been reported to him prior. On 8/11/26 at 1:35 p.m. R37 stated she'd been having issues with her mattress. It had been fixed a while back and was good for about 2 weeks. However, she'd been having issues the last few days and no staff had attended to the issue. On 8/11/26 at 1:40 p.m. maintenance director stated he had fixed R37's mattress a few weeks back but was not aware of the current issue. On 8/12/26 at 1:18 p.m. Director of Nursing (DON) stated her expectation was staff would report anytime a bedframe was exposed or if a mattress appeared to not be functioning properly. She expected the resident would be assessed for safety, and the mattress would be evaluated and replaced immediately if necessary. A facility policy was requested, however, none provided.			F0584			09/17/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents with medications accessible at the bedside were assessed to determine whether they could safely self-administer medications and were authorized to self-administer medications for 2 of 2 residents (R4 and R17) reviewed for self-administration of medications.			F0554	Immediate corrective action taken: R4 and R17 were reviewed for self-administration. R17 was determined to be unable to self-administer medications, and all OTC medications were removed from the resident room. R4 was assessed to be able to self-administer his Ventolin inhaler, and an order was obtained from the provider. R4's orders and care plan were updated to reflect resident's ability to self-administer. Corrective action as it applies to others: All residents who desire to self-administer medications have the ability to be affected by this practice. A full-house audit was completed on all residents who choose to self-administer to ensure that a self-administration assessment was completed and resident had a proper physician's order. Any resident who did not have an assessment completed		09/17/2026

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F0554 SS = D	Continued from page 13 Findings included: R4 R4's quarterly Minimum Data Set (MDS) assessment, dated 7/29/26, identified R4 had intact cognition and was independent with activities of daily living (ADLs). R4's diagnoses included chronic obstructive pulmonary disease (COPD) (a chronic lung condition that causes difficulty breathing) and coronary artery disease (CAD) (a condition in which the blood vessels that supply the heart become narrowed or blocked). During an observation on 8/10/26 at 2:00 p.m., a Ventolin inhaler (a medication used to open the airways and improve breathing) was observed on R4's over-the-bed table and was accessible to R4. During a subsequent observation on 8/11/26 at 4:13 p.m., the Ventolin inhaler remained on R4's over-the-bed table and accessible to R4. R4's electronic health record (EHR) lacked evidence a self-administration of medications (SAM) assessment had been completed to determine whether R4 could safely self-administer medications. R4's physician orders lacked an order authorizing self-administration of medications, and R4's care plan lacked documentation addressing self-administration of medications. R17 R17's annual MDS assessment, dated 8/5/26, identified R17 had intact cognition and required assistance with ADLs. R17's diagnoses included acute and chronic respiratory failure with hypercapnia (a condition in which breathing is impaired and carbon dioxide levels in the blood are elevated), heart failure (a condition in which the heart is unable to pump blood effectively), and hemiplegia (paralysis affecting one side of the body). During an observation on 8/10/26 at 1:50 p.m., three bottles of oral medications, including ibuprofen 200 milligram (mg) tablets (a medication used to relieve pain and inflammation), a stool softener (a medication used to prevent or relieve constipation), and TUMS (an antacid used to relieve heartburn and indigestion), along with a bottle of dry eye relief eye drops, were observed on R17's over-the-bed table and accessible to R17. R17 stated she took the medications whenever she needed them and when she was unable to get ahold of staff, which she			F0554	Continued from page 13 or an MD/NP order was completed and obtained. The self-administration of medications policy was reviewed and remains current. All nursing staff were educated that a self-administration assessment must be completed prior to a resident self-administering medications and an order must be received from the MD/NP. Nurse leadership was educated that self-administration must be included in the resident's care plan. Reoccurrence will be prevented by DON or designee will complete audits on 3 residents who choose to self-administer weekly x 2 weeks, then 5 residents monthly x 2 months, to ensure a self-administration assessment is completed, MD/NP order obtained, and care plan updated to reflect self-administration. Audits will be reviewed during QAPI to determine if audits need to continue, decrease in frequency, or can be resolved.		09/17/2026

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F0554 SS = D	Continued from page 14 stated occurred often. During a subsequent observation on 8/11/26 at 12:11 p.m., the same medications remained on R17's over-the-bed table and accessible to R17. During an observation on 8/12/26 at 7:43 a.m., the same medications remained on R17's over-the-bed table and accessible to R17. R17's EHR identified the most recent SAM assessment had been completed in August 2025 and determined R17 was not able to safely self-administer medications. The EHR lacked evidence a subsequent SAM assessment had been completed. R17's physician orders lacked an order authorizing self-administration of medications, and R17's care plan lacked documentation addressing self-administration of medications. During an interview on 8/12/26 at 8:02 a.m., trained medication aide (TMA)-A stated a nurse assessed residents to determine whether they could safely self-administer medications. TMA-A stated that if a resident was approved to self-administer medications, authorization would be documented in the resident's physician orders. TMA-A reviewed R4's and R17's physician orders and confirmed neither resident had an order authorizing self-administration of medications. TMA-A accompanied the surveyor to both residents' rooms and confirmed the Ventolin inhaler was on R4's over-the-bed table and the oral medications and eye drops were on R17's over-the-bed table. During an interview on 8/12/26 at 8:07 a.m., registered nurse (RN)-D stated residents were required to be assessed to determine whether they could safely self-administer medications. RN-D stated that when a resident was determined capable of safely self-administering medications, a physician's order was obtained and entered into the resident's orders. RN-D accompanied the surveyor to R4's and R17's rooms and confirmed the medications remained on the residents' over-the-bed tables. RN-D stated the medications should not have been left in the residents' rooms and stated she would remove the medications and initiate the process to address self-administration of medications. During an interview on 8/12/26 at 8:15 a.m., the director of nursing (DON) stated that when a resident wished to self-administer medications, an assessment was completed to determine whether the resident could safely do so. If the resident was			F0554			09/17/2026

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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST , COLUMBIA HEIGHTS, Minnesota, 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
F0554 SS = D	Continued from page 15 determined capable of safely self-administering medications, the facility obtained a physician's order and updated the resident's care plan. The DON stated that when staff found medications in a resident's room, staff were expected to speak with the resident, explain the self-administration process, provide education, and remove the medications until an assessment was completed and a physician's order was obtained. During a subsequent interview on 8/12/26 at 8:51 a.m., the DON confirmed R4 did not have a SAM assessment completed. The DON confirmed R17's most recent SAM assessment had been completed in August 2025 and stated SAM assessments should have been completed quarterly to ensure residents remained safe and able to self-administer medications. The DON reviewed R17's August 2025 SAM assessment and confirmed the assessment determined R17 was not able to safely self-administer medications. The facility policy, Self-Administration of Medications, dated 2/24, indicated residents had the right to self-administer medications when the interdisciplinary team (IDT) determined self-administration was clinically appropriate and safe. As part of the comprehensive assessment, the IDT assessed each resident's cognitive and physical abilities to determine whether self-administration was safe and clinically appropriate. When self-administration was determined to be safe and appropriate, the determination was documented in the resident's medical record and care plan and was reassessed periodically based on changes in the resident's medical and/or decision-making status. If the IDT determined a resident could not safely self-administer medications, nursing staff administered the resident's medications. The policy further directed that medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party.			F0554			09/17/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			F0761	Immediate corrective action taken: All controlled medication boxes were affixed to the refrigerator in all medication rooms. The medications in the unlabeled medication cup were disposed of properly as the resident had refused to take them. Corrective action as it applies to others: A full-house audit was completed of medication rooms and medication carts. No other narcotic boxes were identified to be unfixed from the refrigerator and no additional unlabeled medication cups were identified.		09/17/2026

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F0761 SS = D	Continued from page 16 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 and interview, the facility failed to maintain separately locked and permanently affixed compartments for storage of controlled medications in the medication room refrigerator for 3 of 3 medication rooms reviewed for medications storage. Further, the facility failed to ensure medications were properly labeled when an unlabeled medication cup containing medications was stored in a medication cart. Findings include: On 8/13/26 at 9:25 a.m., during observation of the medication room on the 1st floor, licensed practical nurse (LPN)-B opened the refrigerator and removed the unaffixed narcotic lock box from the refrigerator. LPN-B stated the box was always locked but currently was not. It had never been affixed to the refrigerator. On 8/13/26 at 9:58 a.m. director of nursing (DON) accompanied writer to all other medication rooms in the building, 3 total, and confirmed the narcotic lock boxes were not affixed to the refrigerators in any of the medication rooms. DON stated their expectation was for the narcotic lock boxes to be locked and affixed to the refrigerator. A policy was a requested for medication storage and none was provided.			F0761	Continued from page 16 All nurses were educated on the importance of having the controlled substance boxes affixed to the refrigerators and the disposal of medications when a resident refuses to take them. Nurses were educated that no unlabeled medication cups can be stored on the medication cart and when a resident refuses, medications must be disposed of properly. Reoccurrence will be prevented by DON or designee will complete audits of all medication refrigerators weekly x 2 weeks to ensure that the controlled substance boxes remain affixed to the refrigerator and then monthly x 2 months. Medication carts will be audited 2 times per week x 2 weeks, then once weekly x 2 months to ensure that no unlabeled medication cups are found in the medication cart and that all refused medications are disposed of properly. Audits will be reviewed during QAPI to determine if audits need to continue, decrease in frequency, or can be resolved.		09/17/2026

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F0761 SS = D	Continued from page 17 During observation on 8/13/26 at 8:47 a.m., an unlabeled medication cup containing several unidentified medications was observed in the top right drawer of the medication cart. Licensed practical nurse (LPN)-B identified the medications as belonging to R74 and stated R74 had refused the medications when she attempted to administer them. LPN-B stated she placed the medications in the medication cart drawer and planned to reattempt administration at a later time. R74's medication administration record (MAR), reviewed on 8/13/26 at 9:11 a.m., identified R74's 8:00 a.m. medications for 8/13/26 had been documented as administered. At the time of the review, the medications remained in the unlabeled medication cup in the medication cart. During an interview on 8/13/26 at 9:16 a.m., LPN-B stated when a resident refused medications, she asked the reason for the refusal and reapproached the resident at least three times. LPN-B stated if the resident continued to refuse the medications, the medications were destroyed. LPN-B confirmed R74's medication cup was unlabeled and stated she had not labeled the cup because she was the only nurse who planned to administer R74's medications that morning. LPN-B also confirmed she had documented R74's medications as administered in the MAR even though R74 had not received the medications. LPN-B confirmed the MAR documentation was inaccurate because the medications had not been administered. During an interview on 8/13/26 at 9:30 a.m., the director of nursing (DON) stated she expected nursing staff to discard medications when a resident refused them and document in a progress note that medication administration would be reattempted at a later time. The DON stated medications should not be documented as administered in the MAR until the medications had been administered to the resident. A facility policy related to medication labeling and storage was requested but was not received.			F0761			09/17/2026
F0807 SS = D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides-			F0807	Immediate corrective action taken: R5's orders were updated to ensure that resident was given a full glass of water at the bedside every shift. Current orders to document fluid intake and urine output remained current. Corrective action as it applies to others: All residents who require assistance with food and		09/17/2026

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F0807 SS = D	Continued from page 18 §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fluids were readily available and offered between meals for 1 of 1 resident (R5) reviewed for hydration. Findings included: R5's significant change Minimum Data Set (MDS), dated 6/17/26, identified R5 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R5's diagnoses included neurogenic bladder (difficulty controlling or emptying the bladder due to a problem with the nerves that control bladder function) and a pressure ulcer of the right heel (an area of skin and underlying tissue damage caused by prolonged pressure). The MDS also identified dehydration/fluid maintenance as a triggered area. R5's care plan, printed 8/13/26, identified R5 was at risk for dehydration related to impaired mobility and required assistance with food and fluids. The care plan identified a goal for R5 to remain free from signs and symptoms of dehydration. Interventions directed staff to encourage and offer adequate fluid intake, monitor R5 for signs and symptoms of dehydration, and report suspected signs or symptoms of dehydration to the physician (MD) or physician assistant (PA). R5's August 2026, medication administration record (MAR) included an order for staff to document the amount of fluid provided every shift and notify the provider of concerns related to fluid intake. The MAR documented the following daily fluid intake: 8/1/26: 1,200 milliliters (mL) 8/2/26: 920 mL 8/3/26: 960 mL 8/4/26: 1,150 mL 8/5/26: 820 mL 8/6/26: 900 mL 8/7/26: 1,370 mL			F0807	Continued from page 18 fluids have the ability to be affected by this practice. The facility has implemented a water pass to all residents in the early afternoon. Residents will be provided with a water pitcher daily for hydration and staff will switch out pitchers once daily and refill as needed throughout the day. Education was provided to all culinary and nursing staff regarding the importance of hydration for residents and the implementation of water passes daily and refilling water pitchers as needed throughout the day. Reoccurrence will be prevented by DON or designee will complete audits of 10 residents weekly x 2 weeks and then 10 residents monthly x 2 months to ensure water pass is being completed. Audits will be reviewed during QAPI to determine if audits need to continue, decrease in frequency, or can be resolved.		09/17/2026

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F0807 SS = D	Continued from page 19 8/8/26: 1,460 mL 8/9/26: 600 mL 8/10/26: 1,200 mL 8/11/26: 840 mL 8/12/26: 1,050 mL R5's August 2026 MAR also included an order for staff to monitor urinary catheter output every shift. The MAR documented the following daily urinary output: 8/1/26: 1,400 mL 8/2/26: 1,100 mL 8/3/26: 1,475 mL 8/4/26: 1,700 mL 8/5/26: 1,050 mL 8/6/26: 1,450 mL 8/7/26: 1,725 mL 8/8/26: 750 mL 8/9/26: 400 mL 8/10/26: 300 mL 8/11/26: 1,250 mL 8/12/26: 950 mL During observation on 8/10/26 at 12:54 p.m., no water pitcher, drinking glass, or other fluids were observed in R5's room. During observation on 8/10/26 at 4:13 p.m., R5 appeared confused and fidgeted with items in her room. No fluids were observed in R5's room. R5 had an indwelling urinary catheter and had recently been diagnosed with a urinary tract infection (UTI). During observation on 8/11/26 at 10:21 a.m., R5 sat in her room and fidgeted with items in her nightstand. No fluids were observed in R5's room. During observation on 8/11/26 at 1:37 p.m., R5 sat in her wheelchair in her room. No fluids were			F0807			09/17/2026

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F0807 SS = D	Continued from page 20 observed in R5's room. During observation on 8/12/26 at 7:34 a.m., no fluids were observed in R5's room. During observation on 8/12/26 at 1:37 p.m., R5 lay in bed with her eyes closed. No fluids were observed in R5's room. During observation on 8/13/26 at 11:27 a.m., R5 sat in her room and fidgeted with items in her nightstand. No fluids were observed in R5's room. During an interview on 8/13/26 at 11:30 a.m., nursing assistant (NA)-C stated residents did not have individual water pitchers in their rooms and staff offered fluids at meals. NA-C stated staff should have offered fluids as needed to residents who were unable to independently request fluids. NA-C confirmed that R5 was unable to request fluids. During an interview on 8/13/26 at 12:25 p.m., licensed practical nurse care coordinator (LPN)-A stated staff were expected to offer residents fluids at meals and between meals. During an interview on 8/13/26 at 2:31 p.m., the director of nursing (DON) stated staff were expected to offer fluids at the beginning of each shift and throughout the shift. The DON stated residents who were unable to independently request fluids should have been offered fluids more frequently than at mealtimes. The DON stated that adequate fluid intake was important to prevent dehydration and UTIs. The facility policy regarding hydration, availability of fluids, and offering fluids between meals was requested but was not received for review.			F0807			09/17/2026
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-			F0825	Corrective action as it applies to others: Any resident requiring a specialty or customized wheelchair has the ability to be affected by this practice. A full house audit was completed to identify any resident who was currently waiting for a new wheelchair and/or customizations of their current wheelchair and no like residents were identified at this time. Education was provided to the therapy team regarding timeliness of follow-up when adjustments needed to be made to a residents new and/or current wheelchair. Therapy was educated to inform nursing leadership if any delays in obtaining equipment or adjustments were to happen.		09/17/2026

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F0825 SS = D	Continued from page 21 §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure timely follow-up and completion of necessary wheelchair modifications for 1 of 1 resident (R36) reviewed for rehabilitative services, resulting in a delay in providing R36 with a new wheelchair. Findings included: R36's quarterly Minimum Data Set (MDS), dated 7/15/26, identified R36 had intact cognition and required assistance with activities of daily living (ADLs). R36's diagnoses included fractures (broken bones that could affect mobility and physical functioning), Parkinson's disease (a progressive neurological condition that could affect movement, balance, and coordination), and malnutrition (inadequate nutrition that could contribute to weakness and decreased physical functioning). R36's Occupational Therapy (OT) note, dated 7/1/26, indicated R36's new high-back reclining wheelchair had arrived at the facility. R36 fit adequately in the wheelchair; however, his bilateral lower extremities did not adequately reach the floor for self-propulsion. The note identified a plan to complete an adjustment to the right wheelchair brake. R36's OT note, dated 7/2/26, indicated the wheelchair modifications remained incomplete due to difficulty adjusting the right wheelchair brake. A work order had been placed requesting assistance from maintenance. R36 sat in the new wheelchair for 20 minutes and reported the wheelchair was comfortable and that he liked the new style. The note indicated R36 continued to use his existing wheelchair until the modifications were completed. R36's OT note, dated 7/13/26, indicated the director of rehabilitation (DOR) remained unable to adjust the wheelchair brake and was awaiting assistance from			F0825	Continued from page 21 Reoccurrence will be prevented by DON or designee will audit 10 residents weekly x 2 weeks to ensure that they are in their proper wheelchair and that any adjustments that are needed have been made timely, then 10 residents monthly x 2 months. Audits will be reviewed during QAPI to determine if audits need to continue, decrease in frequency, or can be resolved.		09/17/2026

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F0825 SS = D	Continued from page 22 maintenance. R36's OT note, dated 7/15/26, indicated R36's power of attorney (POA) was shown R36's new high-back reclining wheelchair. The note indicated the wheelchair continued to await maintenance assistance with the brakes before it could be issued to R36. R36's OT note, dated 7/16/26, indicated the director of therapy (DOT) reported the right wheelchair brake was positioned too close to the armrest, which was identified as a barrier to R36's use of the reclining-back wheelchair with the dumped-seat configuration. R36's OT note, dated 7/20/26, indicated R36 tolerated sitting in the new wheelchair during a therapy session. An attempt to adjust the right wheelchair brake was unsuccessful, and the note indicated maintenance assistance continued to be awaited. R36 continued to use his standard facility-issued wheelchair. During an interview on 8/11/26 at 12:29 p.m., R36's POA stated R36 had an appointment scheduled in June 2026; however, therapy did not allow transportation to be arranged because R36 was not safe using his existing wheelchair. The POA stated therapy indicated they would work on obtaining a new wheelchair for R36 and requested approximately two weeks to do so. The POA stated approximately four weeks later, she followed up and was informed the new wheelchair would be available for R36 to use for his appointment on 8/11/26. The POA stated R36 attended the 8/11/26 appointment using his existing wheelchair rather than the new wheelchair. During the appointment, the existing wheelchair broke and required repair with a screwdriver obtained from the clinic before R36 could return to the facility. The POA stated when R36 returned to the facility following the appointment, the new wheelchair was present in his room. During an interview on 8/13/26 at 10:05 a.m., the DOR stated she had worked with R36 since his admission, primarily to address functional transfers and wheelchair safety. The DOR stated R36 was evaluated on 6/24/26 with a goal of obtaining a new wheelchair and acknowledged she was aware R36 had appointments canceled because his existing wheelchair was not safe for transportation. The DOR stated R36's new high-back reclining wheelchair arrived at the facility on 7/1/26 but required modification to the brakes before it could be issued. The DOR stated she requested maintenance			F0825			09/17/2026

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F0825 SS = D	Continued from page 23 assistance with the brake but ultimately adjusted the brake herself on 8/11/26. The DOR stated the wheelchair was issued to R36 on 8/12/26. During an interview on 8/13/26 at 1:53 p.m., licensed practical nurse (LPN)-C stated a resident should receive a new wheelchair within one or two days after it arrived at the facility. After reviewing the timeline for R36's wheelchair, LPN-C stated it was not appropriate for R36 to have waited that length of time to receive the wheelchair. During an interview on 8/13/26 at 2:31 p.m., the director of nursing (DON) stated she expected staff to follow up on the status of a wheelchair when the process exceeded one or two weeks. The DON stated therapy generally evaluated wheelchairs before they were provided to residents; however, she expected the evaluation process to take no more than one or two days. The DON stated it was not appropriate for R36 to have waited approximately one and one-half months to receive the new wheelchair, particularly because the wheelchair had been at the facility since 7/1/26. A facility policy related to rehabilitative services and follow-up for adaptive equipment was requested but was not received.			F0825			09/17/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 11, 2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Crest View Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			09/09/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245018		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/11/2026	
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST , COLUMBIA HEIGHTS, Minnesota, 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
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1.A detailed description of the corrective action taken or planned to correct the deficiency. 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4.Identify who is responsible for the corrective actions and monitoring of compliance. 5.The actual or proposed date for completion of the remedy. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with additions in 1968 and 2007 and was determined to be built of Type II (111) construction. The building is fully protected throughout by an automatic fire sprinkler system and has a 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 capacity of 106 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			09/09/2026
K0781 SS = J Bldg. 01	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a space heater policy per NFPA 101 (2012 edition), Life			K0781	"Past Noncompliance - no plan of correction required"		08/11/2026

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K0781 SS = J Bldg. 01	Continued from page 2 Safety Code, section 19.7.8. This deficient finding could have a isolated impact on the residents within the facility. Findings include: The Immdiate Jeopardy (IJ) began on 08/11/2026 at 09:25 AM, it was revealed by observation that there was a space heater plugged into a power strip in resident room 16B that was plugged into a unapproved powerstrip. The administrator was notified of the IJ at that time. The IJ was then removed on 08/11/2026 at 10:08 AM after it was verified, the facility implemented an acceptable removal plan and was then in compliance. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0781			08/11/2026
K0920 SS = J Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical			K0920	"Past Noncompliance - no plan of correction required"		08/11/2026

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K0920 SS = J Bldg. 01	Continued from page 3 Code, sections 400.8, and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: The Immdiate Jeopardy (IJ) began on 08/11/2026 at 09:25 AM, it was observed in resident room 16B a portable space heater was plugged into a non approved powerstrip with the resident bed and resident air mattress also plugged into the same unapproved powerstrip. The administrator was notified of the IJ at that time. The IJ was then removed on 08/11/2026 at 10:08 AM after it was verified, the facility implemented an acceptable removal plan and was then in compliance. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0920			08/11/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, sections 14.3.1 and 14.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/11/2026 at 09:45 AM, it was revealed by a review of available documentation that the facility had not been completing semiannual fire alarm inspections. An interview with Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0345	Immediate Corrective Action: Facility tested and inspected fire alarm system for semi-annual inspection and in compliance. Corrective Action as applies to others: Fire alarm system testing will be completed every 6 months. This deficit practice has the ability to affect all residents within the facility. Education was completed with Maintenance Team on completing scheduled semi annual fire alarm system testing and maintenance. Reoccurrence will be prevented by Maintenance Director and/or designee to audit Maintenance Testing logs monthly X 6 months. Audits will be reviewed at QAPI to determine if audits will continue, decrease in frequency or can be resolved.		09/17/2026

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K0912 SS = F Bldg. 01	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain electrical outlets per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.2.1, and NFPA 70, (2011 edition), National Electrical Code, section 110.12. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 08/11/2026 between 10:45 AM and 1:00 PM, it was revealed by observation in rooms 5, 16 and 18 that the outlets are in disrepair. Items plugged into these outlets were easily removed when tested. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0912	Immediate Corrective Action: Facility has changed out electrical outlets per NFPA 99 Standards and NFPA 70 in rooms 5, 16, and 18. Corrective Action as it applies to others: Full house facility audit of electrical systems receptacles and changed out to be in compliance. Education was completed with Maintenance Team on deficit practice and ensuring electrical receptables are identified and changed out. Reoccurrence will be prevented by Maintenance Director and/or designee to audit 5 resident rooms' electrical outlets X 4 weeks. Audits will be reviewed at QAPI to determine if audit will continue, decrease in frequency or can be resolved.		09/17/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system			K0921	Immediate Corrective Action: Patient Care Related Electrical Equipment (PCREE) testing was completed throughout facility to ensure it was inspected and maintained. Corrective Action as it applies to others: Full house facility audit of PCREE items and changed out to be in compliance. Has the ability to affect all residents of this deficit practice. Education was completed with Maintenance Team on deficit practice and ensuing PCREE testing is completed. Reoccurrence will be prevented by Maintenance		09/17/2026

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K0921 SS = F Bldg. 01	Continued from page 5 consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/11/2026 at 10:15 AM, it was revealed that the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) such as electric beds for all residents, nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment present at the facility showing that it was inspected and maintained. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0921	Continued from page 5 Director and/or designee to audit 5 PCREE items a week X 4 weeks. Audits will be reviewed at QAPI to determine if audit will continue, decrease in frequency, or can be removed.		09/17/2026
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			K0211	Immediate Corrective Action: Facility has changed out the door handle on the kitchen door to ensure egress doors are per code. Corrective Action as it applies to others: Facility audited all doors in facility and all in compliance with egress door codes. Failure to maintain egress doors per code has the ability to have an isolated impact on the residents within the facility. Education completed with Maintenance team on maintaining egress doors per code.		09/17/2026

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K0211 SS = D Bldg. 01	Continued from page 6 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.5.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/11/2026 at 12:20 PM, it was revealed by observation that the emergency exit from the kitchen has a door handle that is approximately 50 inches from the floor. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0211	Continued from page 6 Reoccurrence will be prevented by Maintenance Director and/or designee to audit 5 egress doors a week X 4 weeks. Audits will be reviewed at QAPI to determine if audit will continue, decrease in frequency, or can be removed.		09/17/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5,			K0353	Immediate Corrective Action: Removed the wires that were zip tied to the sprinkler pipe in the Fire Alarm Panel Room. Corrective Action as it applies to others: Facility audited sprinkler system and removed all other wires that were attached to sprinkler system. This deficit practice has the ability to have a widespread impact on the residents within the facility. Education completed with Maintenance team on maintaining the fire sprinkler system. Reoccurrence will be prevented by Maintenance Director and/or designee to audit sprinkler system monthly X 3 months. Audits will be reviewed at QAPI to determine if audit will continue, decrease in frequency, or can be removed.		09/17/2026

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K0353 SS = D Bldg. 01	Continued from page 7 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/11/2026 at 12:20 PM, it was revealed by observation in the Fire Alarm Panel room there were multiple wires zip tied to the sprinkler pipe. An interview with Regional Manintenance Director and Administrator verified this deficient finding at the time of discovery.			K0353			09/17/2026
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and			K0363			

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K0363 SS = A Bldg. 01	Continued from page 8 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/11/2026 at 09:35 AM, it was revealed by observation that the door for resident room 16 was held open with a wooden wedge which was removed at the time of the survey. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0363			09/17/2026
K0923 SS = A Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.			K0923			09/17/2026

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K0923 SS = A Bldg. 01	Continued from page 9 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/11/2026 at 11:00 AM, it was revealed by observation there were 3 "E" sized oxygen cylinders not secured in a stand or cart in the transfill oxygen room 115. All tanks were secured at the time of the survey. An interview with the Regional Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0923			09/17/2026