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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 59TB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/6/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **122** (L18)
13.Total Certified Beds **122** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Barbara White, HFE NE II 11/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/20/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/19/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245018

November 17, 2017

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

Dear Mr. Tobalsky:

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

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

Effective June 20, 2017 the above facility is certified for:

122 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245018

October 12, 2017
By e-POC Only

Crest View Lutheran Home
Attn: Administrator
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

Dear Administrator:

SUBJECT: SURVEY FINDINGS AND IMPOSITION/DISPOSITION OF REMEDIES
Cycle Start Date: May 11, 2017

SURVEY RESULTS
On May 10, 2017 and May 11, 2017, Life Safety Code (LSC) Surveys and Health Surveys were completed at Crest View Lutheran Home by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level G, cited as follows:

- F311 -- S/S: G -- 483.24(a)(1) -- Treatment/Services to Improve/Maintain ADLs
- F314 -- S/S: G -- 483.25(b)(1) -- Treatment/Svcs to Prevent/Heal Pressure Sores
- F318 -- S/S: G -- 483.25(c)(2)(3) -- Increase/Prevent Decrease in Range of Motion

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on May 26, 2017, of the imposition of the following remedy:

- State Monitoring effective May 31, 2017

Based on the survey findings, the MDH notified you they were recommending that the CMS impose additional remedies, as follows:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 11, 2017
- Federal Civil Money Penalty

The authority for the imposition of remedies is contained in §1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The MDH conducted a revisit at your facility on July 6, 2017, and found that your facility was in substantial compliance as of June 20, 2017. As a result, the following remedies will not go into effect:

- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective August 11, 2017, will not be imposed
- Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective November 11, 2017, will not be imposed

However, based on the period of time your facility was not in substantial compliance, the following remedies have gone into effect:

- State Monitoring, which was effective May 31, 2017, is discontinued effective June 20, 2017
- Federal Civil Money Penalty, see below

CIVIL MONEY PENALTY
On September 6, 2016, the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation Civil Money Penalty (CMP) amounts authorized under the Social Security Act. See 81 Fed. Reg. 61538 (Sept. 6, 2016); see also 45 CFR Part 102. The CMP imposed in this letter reflects the adjusted amounts. In determining the amount of the CMP that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. **Additionally, on July 7, 2017, CMS revised its CMP policies in S&C Memorandum 17-37-NH, effective July 17, 201**7. We are imposing the following CMPs in accordance with these revisions:

- Federal Civil Money Penalty of $6,988.00 per instance for the instance of noncompliance at F311 (S/S: G) identified in the CMS-2567 survey ending May 11, 2017.
- Federal Civil Money Penalty of $6,988.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 survey ending May 11, 2017.
- Federal Civil Money Penalty of $6,988.00 per instance for the instance of noncompliance at F318 (S/S: G) identified in the CMS-2567 survey ending May 11, 2017.

The total CMP amount imposed is $20,964.00. If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Mrs. Charlotte A. Hodder at Charlotte.Hodder@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged

- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification at RO5LTCHearingWaivers@cms.hhs.gov. **Please include your CCN and the Cycle Start Date in the subject line of your email. The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

CMP CASE NUMBER

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245018.
- The start date for this cycle is May 11, 2017.

CMP PAYMENT

When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago Regional Office. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR §488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10.125%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

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 $10,483.00; 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.

As indicated above, a CMP which to date has accrued in the amount of $10,483.00 or more, is being imposed against Crest View Lutheran Home. If you fail to request a hearing, in writing, within 60 calendar days from receipt of this letter; or if you submit a written waiver of your right to a hearing, which results in the CMP being reduced to an amount that is still $10,314 or more; or if you timely request a hearing and there is a final administrative decision upholding the CMP in the amount of $10,483.00 or more, your facility is subject to a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) prohibition for two years. The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $10,483.00 or more. This prohibition is not subject to appeal. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed the following remedy:

- Federal Civil Money Penalty

If you disagree with the findings of noncompliance which resulted in this imposition, 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 Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at

OSDABImmediateOffice@hhs.gov.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, 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. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Health Insurance Specialist, at (312) 353-5169.

Sincerely,

Jan Suzuki

Jan Suzuki
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health
U.S. Department of Justice, District of Minnesota

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 59TB

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Facility ID: 00005

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(L1) **245018**
2.STATE VENDOR OR MEDICAID NO.
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(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **122** (L18)
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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
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* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 06/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/19/2017 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
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(L27)

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A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/19/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 26, 2017

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

RE: Project Number S5018029

Dear Mr. Tobalsky:

On May 11, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716 Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 31, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F311. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiencies cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiencies cited at F318. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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, Licensing and Certification Program 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 11, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 11, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

c

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	05/11/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On May 11, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure of 2 of 2 residents (R67, R142) reviewed for	F 246	F246 It is the policy of Crest View Lutheran	6/20/17

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

Electronically Signed | 06/05/2017

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F 246	Continued From page 1 environmental observations, had call lights within reach. Findings include: R67 was observed seated on her wheelchair on 5/9/17, at 1:58 p.m., and the call light was on the floor by the head of the bed. When asked if she was able to reach it, R67 stated "no." R67 also indicated she had poor eyesight so the call light was supposed to be pinned on her bedding for easy access. At 2:02 p.m. nursing assistant (NA)-F verified R67's call light was not within reach and picked it up from the floor and pinned it to R67's bedding. When asked whether R67 was able to use call light NA-F stated, "Yes, she uses it to call for assistance." A Care Area Assessment (CAA) related to falls, dated 5/30/16, identified R67 had balance deficits and visual impairment, and staff assisted resident with all transitions. R67's care plan dated 5/16, indicated R67 had a potential/actual alteration in safety, falls related to weakness, balance impairment (needs assist with all transitions), vision impairment, incontinence and rheumatoid arthritis. The care plan directed staff to keep the call light within reach and to remind resident when/how to use the call light to ask for assistance. On 5/11/17, at 2:11 p.m. the director of nursing (DON) stated she expected call lights to be within reach for residents who were able to use them. R142's quarterly Minimum Data Set (MDS) dated 3/9/17, indicated R142 was mildly cognitively impaired and had fallen two or more times since the previous MDS dated 12/16/16. R142's	F 246	Home that all residents have the right be treated with respect and dignity and receive services with reasonable accommodation of needs. These accommodations include having call lights in bedrooms kept within reach through staff intervention. Resident R67□s call light was checked to ensure it was placed in a proper location that could be accessed by her while in her bedroom. Resident R142 was discharged to the hospital on 5/24/17, and therefore was unable to have her call light placement reviewed. For all other residents that this alleged deficient practice may have affected, a whole-house audit on call lights was completed to ensure all lights were in proper working order, as well as kept within reach for resident use. The Call Light Placement Policy was reviewed by an interdisciplinary team on 6/5/17. This policy describes the procedure for keeping resident call lights within reach, in order for residents to quickly make their need of assistance known. Staff members are to check call light placement while in resident rooms, in order to ensure they are always within reach. All staff will be reeducated on this policy and procedure by 6/16/2017. Call light placement audits will be completed twice weekly for four weeks, weekly for four weeks, and then	

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F 246	Continued From page 2 Admission Record dated 5/11/17, indicated R142 had diagnoses including emphysema (chronic lung disease) and depression. On 5/8/17, at 1:18 p.m. R142 was lying in bed. R142's call light was on the floor next to R142's bed. When asked if she could reach the call light, R142 attempted to reach the call light but was unable and R142 acknowledged she could not reach it. On 5/8/17, at 1:20 p.m. nursing assistant (NA)-J verified R142's call light was on the floor. NA-J stated R142 was able to use call light but did not always use it. NA-J then reattached the call light to R142's blanket. During interview on 5/8/17, at 3:52 p.m. NA-K said, "She [R142] can use the call light." A Care Area Assessment (CAA) related to falls, dated 12/13/16, indicated R142 was at risk for falls related to weakness and R142 had difficulty maintaining balance when sitting or changing positions. The care plan dated 12/16, indicated R142 had the potential for falls. The plan instructed staff: "Keep call light within reach. Remind resident when /how to use. Remind to ask for assistance." On 5/11/17, at 2:22 p.m. the director of nurses stated, "I expect call lights will be in reach of all residents." The facility's Call Lights policy revised 3/14, directed when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light.	F 246	scheduled no fewer than bi-weekly by the Director of Nursing, based on audit findings. Outcomes and results from these audits will be brought to the facility□s next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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F 246	Continued From page 3 Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand.	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a significant change Minimum Data Set (MDS) for 1 of 1 resident (R142) reviewed for a decline in health status. Findings include: R142's admission MDS dated 12/9/16, indicated R142 was moderately cognitively impaired, needed extensive assistance with locomotion on and off the unit, required limited assistance for transfers, dressing and personal hygiene, and was independent with eating. The MDS also indicated R142 was occasionally incontinent of urine, and was at risk for developing pressure ulcers but currently did not have any.	F 274	F274 It is the policy of Crest View Lutheran Home to complete a significant change Minimum Data Set after comprehensively assessing a resident, and determining that a significant change in mental or physical condition has occurred. For resident R142, a comprehensive assessment and significant change Minimum Data Set was not able to be completed, as she discharged to the hospital on 5/24/2017. For all other residents that this alleged deficient practice may have affected, a whole-house audit was completed to	6/20/17

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F 274	Continued From page 4 R142's quarterly MDS dated 3/9/17, indicated changes to R142's physical abilities. R142 was identified to have declined in transfers, dressing and personal hygiene, all areas where the resident had decreased from limited to extensive assistance. In addition, the resident had deteriorated from occasional incontinence to always incontinent. The 3/9/17, MDS indicated R142 was moderately cognitively impaired, and needed extensive assistance with transfers, walking in corridor, dressing, eating and personal hygiene. In addition, the MDS indicated R142 required limited assistance with locomotion on and off the unit, and required supervision while walking in room. The MDS further indicated R142 was always incontinent of urine and had a current stage 1 pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.). On 5/11/17, at 2:13 p.m. MDS registered nurse (RN)-D verified the information from the admission and quarterly MDS. In addition, RN-D stated, "It looks to me like some areas got worse and some got better." RN-D further indicated the team "probably decided" the charges were not significant. RN-D stated there was no documentation about that decision and was unsure why there was no note. RN-D stated there was an MDS policy and the facility followed the Resident Assessment Instrument (RAI) manual. The Resident Assessment Instrument manual dated 10/16, included the definition of a significant change as a decline or improvement in a resident's status that::	F 274	ensure all residents that have recently experienced a change in condition are being assessed for a significant change Minimum Data Set. The procedures in the Resident Assessment Instrument manual were reviewed by an interdisciplinary team on 6/5/2017. The procedure defines a significant change as a decline or improvement in a resident's status that 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting. 2. Impacts more than one area of the residents' health status; and 3. Requires interdisciplinary review and/or revision of the care plan. The STOP AND WATCH policy was reviewed by an interdisciplinary team on 6/5/2017. The policy defines the procedure for quickly identifying and reporting any changes in resident condition to the unit nurse in charge of the residents' care. The next step after the STOP AND WATCH forms are received by the unit nurse, an assessment or evaluation will occur for the identified changes, and will be communicated to the primary physician for possible orders to treat. All STOP AND WATCH forms will be communicated to the nurse supervisor to include on the shift report that is reviewed by an interdisciplinary team. The interdisciplinary team, with the direction of the MDS Coordinator, will review if any significant change assessments need to be completed for a possible significant	

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F 274	Continued From page 5 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary (IDT) review and/or revision of the care plan. The manual further directed when the IDT determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.	F 274	change Minimum Data Set to be initiated. All staff will be reeducated on this procedure by 6/16/2017. An audit of STOP AND WATCH forms and possible significant changes will be completed twice weekly for four weeks, weekly for four weeks, and then scheduled no fewer than bi-weekly by the Director of Nursing, based on audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a	F 279		6/20/17

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F 279	Continued From page 6 comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 279		

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F 279	Continued From page 7 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for the use of side rails for 2 of 6 residents (R147, R91) recently admitted to the facility. Findings include: R147's diagnoses included: diabetes mellitus, retention of urine, and right below the knee amputation, according to the quarterly Minimum Data Set (MDS) dated 3/8/17. A care area assessment (CAA) for falls, dated 11/8/16, indicated R147 was at risk for falls related to requiring extensive assistance with cares, and used psychotropic medications. The CAA further indicated R147 required staff assistance with transfers. The resident's care plan dated 2/17, indicated R147 had potential/actual alteration in safety. The care plan did not indicate R147 had side rails attached to the bed. On 5/11/17, at 10:10 a.m. a maintenance staff was observed in R147's room, and stated he'd checked the resident's siderails and they were tight. At that time R147 was asked about the use of siderails on the bed, and whether the risk and benefits had been reviewed with the resident. R147 acknowledged use of the siderails, but was not aware of any risk/benefit review. R91's 30 day MDS dated 4/6/17, indicated the	F 279	F279 It is the policy of Crest View Lutheran Home to develop and implement a comprehensive person-centered care plan for each resident. These care plans will include, but are not limited to, the services that are furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being. This includes the use of side rails or other assistive devices for bed mobility. Resident R147 has discharged from Crest View Lutheran Home to a home in the community, and therefore was unable to be assessed for appropriate assistive devices for bed mobility. Resident R91 was assessed for the use of assistive devices for bed mobility, and completed assessments determined it was determined that he did not need to use any devices for bed mobility. His devices were removed from the bed, and his Care Plan and CNA Team Sheet were updated with the necessary changes. For all other residents that this alleged deficient practice may have affected, a whole-house audit was completed for assistive devices for bed mobility. Each	

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F 279	Continued From page 8 resident had diagnoses including: hypertension and femur fracture, and had intact cognition. A CAA for falls, dated 3/16/17, indicated R91 was at risk for falls related to unsteady gait with a recent femur fracture. The CAA indicated staff directions to assist with transfers and ambulation. R91's care plan dated March 2017, indicated R91 had potential/actual alteration in safety, falls related to weakness, pain, incontinence, and femur fracture sustained 3/17. R91's care plan did not address the resident's use of side rail's. On 5/8/17, at 1:22 p.m. during the room tour and interview, two siderails were observed affixed to R91's bed. Both siderails were observed to be loose with a give of approximately four inches. R91 then stated he had been at the facility for seven weeks. On 5/11/17, at 10:05 a.m. maintenance staff and licensed practical nurse (LPN)-D went to R91's room to check the siderails. The maintenance staff indicated the siderails had come with the bed and were properly affixed. When R91 was asked, the resident stated he did not use the siderails. On 5/11/17, at 10:23 a.m. the unit coordinator, LPN-D, reviewed the medical records for both residents. LPN-D verified neither R91 or R147's care plans addressed the use of side rails. LPN-D further acknowledged that despite the siderails having come with the beds, no attempts had been made to remove the siderails for residents who did not use them. On 5/11/17, at 2:11 p.m. the director of nursing (DON) stated they were working on a new physical device assessment and further stated	F 279	resident was comprehensively assessed for the use of assistive devices for bed mobility, and if bed side rail use was indicated, non-side rail alternatives were used. If bed side rails were indicated for use through the assessment, and other alternatives were trialed and not appropriate, or the resident's preference was to use a bed side rail, a risk a benefit consent form was completed with the resident and their representative. Risks associated with bed side rail use were discussed using the FDA "A Guide To Bed Safety". This federal guide highlights the risks and benefits of bed side rails. Once the comprehensive assessment for assistive devices for bed mobility were completed, all care plans and team sheets were updated to accurately reflect the devices used. The policy and procedure for assessing residents for assistive devices for bed mobility was reviewed and updated by an interdisciplinary team on 6/5/2017. The policy defines the process for assessing, trialing possible alternatives to bed side rails, issuing risk and benefits consents for bed side rails, and care planning assistive devices for bed mobility. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for assistive bed mobility devices will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings.	

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F 279	Continued From page 9 she would have expected the care plans to identify the physical safety devices used. The DON stated the care plan was supposed to be developed to include appropriate use of a device. The facility's Physical Devices policy revised 4/17, directed: The unit nurse or designee will complete the physical device evaluation on admission, re-admission, significant change of condition and annually. The unit nurse or designee will request physical devices based on the evaluation. The unit nurse or designee is responsible for updating the care plan and team sheet.	F 279	Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her 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. (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	F 280		6/20/17

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F 280	Continued From page 10 of care. (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. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 280		

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F 280	Continued From page 11 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a plan of care was updated for 2 of 3 residents (R69, R35) reviewed for activities of daily living (ADL's); in addition, the facility failed to ensure a plan of care was updated for 1 of 1 resident (R142) who was reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Findings include: R69 care plan for falls dated 9/16/16, indicated keep a clutter free environment, observe for changes in gait and balance and ensure appropriate footwear; the alteration in mobility care plan dated 9/16/16, had an undated "declined" written into ambulation. Team sheets lacked any mention of a wheelchair or positioning for R69.	F 280	F280 It is the policy of Crest View Lutheran Home to create person-centered plans of care based on comprehensive assessments of resident needs and preferences. This includes creating the plan of care related to mobility devices, such as wheelchairs and walkers, as well as for avoiding or limiting skin breakdown. Residents R69 and R35 were comprehensively assessed by an occupational therapist for the proper use of mobility devices. Both plans of care include personalized wheelchairs and cushions for appropriate positioning and safety. Their care plans and team sheets were updated to include these personalized changes. Resident 142 discharged to the hospital on 5/24/2017, and was unable to have her	

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F 280	Continued From page 12 On 5/8/17, at 4:00 p.m. R69 was observed sitting in her wheelchair in the doorway of her room, her feet were crossed and tucked under her chair. At 6:30 p.m. R69 was observed self-propelling toward her room, pulling herself forward with her slippered toes. On 5/9/17, at 8:21 a.m. R69 was observed self-propelling down the hallway, her toes barely touching the floor. She had trouble making forward motion and threw her upper body forward to get movement or pulled herself along the hand rail to get started. She was then able to self-propel with her toes. At 2:44 p.m. R69 was observed in the dayroom, with her toes resting on the floor. On 5/10/17, at 7:53 a.m. R69 self-propelled to the dayroom and then into the dining room, using her toes, and throwing her upper body forward. At 8:22 a.m. R69 completed breakfast and left the dining room, wandering up and down the hallway, continuing to use her slippered toes to self-propel. At 9:10 a.m. continued to self-propel the wheelchair with her toes, wandering up and down the hallway. On 5/11/17, at 9:17 a.m. the director of Physical Therapy (DPT) stated therapy had not seen R69 since the initial therapy in 9/16, but he would get R69 a smaller wheelchair so her feet touched the ground. The DPT further stated whenever therapy saw a new evaluation [patient], they talked to the nursing assistants (NA's) because they see the patient the most. The DPT further stated he depended on NA's to give him information about residents, got referrals from nursing and went to the interdisciplinary team meeting twice a week	F 280	care plan updated to include appropriate interventions to avoid or limit skin breakdown. For all residents that this alleged deficient practice may have affected, a whole-house audit was completed by a physical and occupational therapist team by 6/5/2017 for wheelchair positioning and appropriate use of wheelchair cushions, foot rests, and other necessary wheelchair devices. Care Plans and team sheets were updated to accurately reflect the personalized plan of care for mobility devices. CNA team sheets were updated to match resident care plans. In addition, a whole-house skin audit was completed for every resident to identify all current skin issues and to ensure an appropriate plan of care is in place, and that CNA team sheets accurately reflect the resident care plans. The policies and procedures for care planning, wheelchair fitting, and skin integrity were all updated and reviewed by an interdisciplinary team on 6/5/2017. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for mobility devices will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings.	

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F 280	Continued From page 13 for any PT concerns. At 9:22 a.m. the DPT stated he would get R69 a small [wheel]chair cushion, so her feet can reach the floor. She really wanted to keep that chair. R69's care plan lacked information that R69 was wheelchair bound. The nursing assistant care plan did not address positioning or wheelchair use. R35 did not have the care plan updated with changes in wheelchair positioning devices. The facility failed to update the care plan and Team Sheet with wheelchair seating changes. On 5/8/17, at 1:51 p.m. R35 was slouched down in the wheelchair, able to self-propel forward , but at risk of sliding out of wheelchair. R35 was self-propelling at a fast pace to the dining room. On 5/8/17, at 7:21 p.m. R35 was taken to the bathroom by NA-G, who noticed she was slouched down in the chair. NA-G had her sit upright and push back in the w/c while NA-G pulled on her pajama pants to move her back but it was unsuccessful. R35 was taken to the bathroom and had a wet pummel cushion and pad. There was a thin non-slip blue pad under the pummel cushion. On 5/9/17, at 8:35 a.m. R35 had just gotten out of bed into the w/c and was in a slouched position, even though she was assisted to the dining room. On 5/9/17, at 9:40 a.m. a positioning note by therapy. "Assessed patient w/c [wheelchair] positioning following staffing report of patient sliding out of chair. Noted missing R arm pad, maintenance request placed to replace arm pad.	F 280	Audits for skin integrity will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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F 280	Continued From page 14	F 280		

Noted patient sitting forward on chair, not sitting back completely, likely causing sliding out of chair. Measurements of patient w/c size needed taken, 18x16 continues to be appropriate. Patient heel to knee 15", current chair with pummel is 18" and patient is not using leg rests to compensate for change in height. Replaced pummel with very low profile gel pad to increase ability to reach floor for self propelling. Patient appears to maintain body back in chair and presents with increased upright posture. Will monitor for fit and comfort. Educated nurse and TMA re: concerns and changes made, they will also monitor patient's w/c positioning and report any concerns to therapy."

On 5/9/17, at 2:49 p.m. R35 was observed sitting slightly more upright than before, but continued to slouch.

On 5/10/17, at 9:12 a.m. R35 was observed coming down the hallway, with assist of NA-C and sitting on the pummel cushion.

On 5/11/17, at 8:29 a.m. R35 was sitting on low profile gel cushion, still slightly slouched, pummel cushion on the wheelchair. At 8:33 a.m. licensed practical nurse (LPN)-B stated that the cushion was changed yesterday, he thinks PT came and did it. Staff noticed she was being watched [by MDH].

On 5/11/17, at 9:12 a.m. the DPT stated the assessment had been done by occupational therapist (OT)-A and the care plan should have been changed when the positioning change was made. The DPT stated the process was to forward information to the director of nursing (DON) and she changed the plan of care. The

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F 280	Continued From page 15	F 280		

DPT further stated when the positioning assessment was made, the OT would have left the gel cushion in place and staff should have been using it.

On 5/11/17, at 9:33 a.m. RN-A stated changes would be typed in the supervisor report for every shift, which goes to all department heads, and they meet every morning with the DON, administrator and department heads. RN-A stated it should have been changed on the NA Team Sheet and the care plan. RN-A would check into the breakdown in communication. RN-A further stated they print new Team Sheets every day, but because the office was being remodeled, they currently did not have printer access and had not been able to print updates.

On 5/11/17, at 1:51 p.m. the director of nursing (DON) was interviewed and stated she would expect the plan of care to be updated and then the Team sheets should be updated.

The Care Plan Policy and Procedure dated 3/17, indicated: the care plan is to be changed and updated as the care changes for the resident and as the resident changes in condition are identified. It is to be current at all times. Any updates made on resident care plans will be reflected on the resident Team sheets if updates are necessary for direct care staff.

R142's quarterly Minimum Data Set (MDS) dated 3/9/17, indicated R142 was mildly cognitively impaired and required Extensive assistance with all activities of daily living (ADL'S) except for propelling wheelchair on and off the unit which was limited assistance and walking in room which

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F 280	Continued From page 16	F 280		

R142 required supervision. R142's MDS indicated R142 was frequently incontinent of bowel and always incontinent of urine and had a stage one pressure ulcer (Intact skin with a localized area of non-blanchable erythema). R142's Admission Record dated 5/11/17, indicated R142 had diagnosis of metabolic encephalopathy (temporary or permanent damage to the brain due to many possible causes), emphysema (chronic lung disease) and depression.

R142's pressure ulcer Care Area Assessment (CAA) Worksheet dated 12/13/16, indicated R142 was at risk for developing pressure ulcers related to incontinence and need for assistance with bed mobility and instructed staff to assist as needed and monitor for changes.

Alteration in skin integrity care plan dated 12/16, indicated there was potential problems because of decreased mobility and incontinence. Care plan instructed staff to reposition per tissue tolerance assessment foam cushion in wheelchair, provide pericare after incontinent episodes, monitor skin with cares, treatments per doctors orders notify dietary with any open area or skin changes and nutritional supplements as ordered. Care plan did not reflect ongoing treatment of reddened skin on buttock since 3/14/17. Care plan did not reflect history of stage one pressure ulcers. Care plan was updated 5/10/17, after concern brought to director of nurses attention to indicate five small stage II pressure areas located on bottom, coccyx area.

During interview on 5/10/17, at 2:06 p.m. the director of nurses (DON) verified there was no care plan in in the chart for wounds on R142's bottom. DON said, "We have a separate care

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F 280	Continued From page 17 plan that the wound nurse would put if she had seen a wound. If she is not here than I will put the care plan in if I know about it." The DON stated nurses are able to update a care plan and they are suppose to. I have the wound nurse write on the care plan when a wound is healed and yellow the problem out. On 5/10/17 at 3:11 p.m. R142 was lying in bed. The director of nurses (DON) asked R142 if she had a sore on her bottom and R142 said, "Yes." The DON measured 5 wounds. The DON said, "I would call them all Stage II pressure ulcers." Skin Integrity care plan dated 5/10/17, was initiated after surveyor and director of nurses observed R142's bottom. Skin Integrity care plan indicated R142 had five stage two pressure areas and instructed staff to turn and reposition resident every two hours, instructed staff to address friction and shear concerns, to perform daily monitoring and weekly wound progress observations and to do treatment as ordered.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care	F 282	F282	6/20/17

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F 282	Continued From page 18 planned interventions to reduce the risk for worsening of contractures and a decline in ability to ambulate for 1 of 5 residents (R150) reviewed for activities of daily living (ADL's); in addition, the facility failed to implement care planned interventions to reduce the risk for falls for 1 of 4 residents (R39) reviewed for accidents. Findings include: R150's 30 day Minimum Data Set (MDS) dated 2/9/17, indicated she was severely cognitively impaired and required extensive assist of one staff for transfers, dressing and personal hygiene. R150's quarterly MDS dated 4/19/17, indicated she required extensive assist of two staff to complete transfers, dressing and personal hygiene, identifying a need for greater assistance. R150's care plan dated April 2017, identified an alteration in mobility related to Alzheimer's dementia, contractures, muscle weakness and limited range of motion (ROM). The care plan directed staff to perform upper extremity range of motion daily and apply palm protectors to both hands. A facility document titled Willow Team 2, undated directed staff to apply hand splints at bedtime and remove in the morning. During an observation on 5/10/17 at 7:44 a.m., R150 was lying in bed. On the bedside stand were 2 hand splints/palm protectors. One splint was on an upper shelf, the other splint was on a lower shelf behind a jug of water. R150 was not wearing any hand splints. During an additional observation on 5/11/17 at 8:59 a.m., the hand splints remained in the same location as the previous observation, and the	F 282	It is the policy of Crest View Lutheran Home to implement all services or care interventions per the written personalized plan of care for each resident. Resident R150 was reviewed for the risk for worsening contractures and decline in ability to ambulate, and their personalized care plan and CNA team sheet were updated to accurately reflect the updated plan of care. Resident R39 was comprehensively assessed for the risk of falls, and the appropriate use of interventions to limit or reduce falls. Their personalized care plan and CNA team sheet were updated to accurately reflect the updated plan of care. Resident R39 was also screened by an occupational and physical therapist team for proper wheelchair positioning and adaptive equipment. Her personalized care plan and CNA team sheet were updated to accurately reflect the recommendations made. For all residents that this alleged deficient practice may have affected, a whole-house audit for all assistive devices was completed, as well as a review of every resident on a restorative walking program by 6/5/2017. In addition, a whole-house audit was completed for all resident fall interventions added to the plans of care, post-fall. Personalized care plans and resident team sheets were updated, as needed, to	

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F 282	Continued From page 19 resident was not wearing any hand splints. During an interview on 5/11/17 at 9:17 a.m., NA-I and NA-H stated they regularly took care of R150. NA-I stated the nursing staff on the unit did not perform any range of motion or ambulation services for R150. They stated therapy staff come and take R150 upstairs for range of motion and ambulation. NA-I also stated R150's palm protectors were supposed to be off at night and put back on in the morning. (The oppositite of the directions on the facility document titled Willow Team 2). During interview on 5/11/17 at 9:33 a.m., R150 stated she has only had hand splints on once, "but then they disappeared." During an interview on 5/11/17 at 10:28 a.m., the director of rehabilitation services (DOR) stated R150 was not currently receiving services from therapy. The DOR stated nursing staff should be assisting the resident with her ROM program. During an interview on 5/11/17 at 10:39 a.m., licensed practical nurse (LPN)-B stated he was not aware R150 had hand splints. During interview on 5/11/17 at 1:12 p.m., the director of nursing (DON) stated when an ambulation and/or ROM program is set up, the referral will specifically state if nursing is to complete it. She further stated the NA's should know when they are responsible for the program. R39's quarterly Minimum Data Set (MDS) dated 1/28/17, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living. R39's care plan dated	F 282	accurately reflect recommended fall interventions. The policies and procedures for care planning and implementing care interventions were updated and reviewed by an interdisciplinary team on 6/5/2017. All staff will be reeducated on these policies and procedures by 6/16/2017. Audits for assistive devices, including those for contractures, will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Audits for fall interventions will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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4/17, indicated a potential for alteration in safety related to weakness, balance impairment and cognitive deficits. The care plan directed staff to ensure foot pedals were on when in wheel chair and use Dycem in wheel chair.

Review of a facility document titled Fall, dated 4/13/17, indicated R39 fell after sliding out of her wheel chair. A Crest View Lutheran Home Progress Noted dated 4/14/17, indicated R39 had a history of falls and attempting unsafe transfers. Resident had foot pedals to be placed on wheel chair to prevent resident from sliding out of chair.

On 5/9/17, at 2:26 p.m., R39 was seated in a standard wheel chair. R39 was seated with her hips at the front edge of the seat with the backrest of the wheelchair even with the top of her shoulders. There were no foot pedals on R39's chair. On 5/10/17, at 9:58 a.m., R39 was seated in her wheelchair. There were no foot pedals on the chair, and R39's legs were dangling approximately 6 inches above the floor. At 12:48 p.m., she sat in the dayroom in the chair with no foot pedals. At 1:14 p.m., staff escorted R39 from her room in her wheel chair. There were no foot pedals on the chair. On 5/11/17, at 8:04 a.m., R39's wheel chair was observed in her room. The chair did not have Dycem and no foot pedals were visible in the room. At 8:55 a.m., R39 was again observed in her wheel chair with no foot pedals and her feet dangling.

On 5/10/17, at 1:35 p.m., nursing assistant (NA-J) stated R39 had not fallen in about six months, but stated she stated she did slide out of her wheel chair. NA-J stated she was unsure what R39's fall interventions were.

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F 282	Continued From page 21 On 5/11/17, at 10:40 a.m., licensed practical nurse (LPN)-B stated R39 has had falls. He stated when she is up in her wheel chair staff keep an eye on her and if she is sleepy, staff lay her down. On 5/11/17, at 10:43 a.m., NA- B stated she was not aware R39 was supposed to have foot pedals on at all times. On 5/11/17, the director of nursing stated the interdisciplinary team (IDT) reviews all falls and implements interventions on the plan of care. She stated she expected the staff to follow the interventions put in place by the IDT. Facility policies related to following the plan of care was requested, but none was provided.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309		6/20/17

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F 309	Continued From page 22 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper wheelchair positioning for 2 of 3 residents (R69, R35) reviewed for positioning; and failed to ensure adequate management of unsafe behaviors for 1 for 2 residents (R10) reviewed for behavior management. Findings include: R69 R69 was admitted to the facility on 9/7/16, with diagnoses of dementia, anxiety, chronic heart failure and low back pain with lumbar compression fracture. R69 had moderate cognitive loss and disorganized thinking, with minimal depression. R96 rejected cares and had wandering behaviors in the wheelchair. R69 requried extensive assistance of 2 staff for bed mobility, transfers and toilet use. The care plan	F 309	F309 It is the policy of Crest View Lutheran Home to provide residents with care and services that establish and maintain the highest level of well-being. This includes developing personalized plans of care related to appropriate mobility devices as well as ensuring adequate management of unsafe behaviors. Residents R69 and R35 were comprehensively assessed by an occupational therapist for the proper use of mobility devices. Both plans of care include personalized wheelchairs and cushions for appropriate positioning and safety. Their care plans and team sheets were updated to include these personalized changes.	

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F 309	Continued From page 23 and team sheets lacked any mention of wheelchair or positioning for R69. On 5/8/17, at 4:00 p.m. R69 was observed sitting in her wheelchair in the doorway of her room, her feet were crossed and tucked under her chair. -at 6:30 p.m. R69 was observed self-propelling towards her room, pulling herself forward on using her slippered toes. On 5/9/17, at 8:21 a.m. R69 was observed self-propelling down the hallway, her toes barely touch the floor and she had trouble making forward motion and so threw her upperbody forward to get movement or pulled herself along the rail to get started, and was then able to self-propel with her toes. -At 2:44 p.m. observed in the dayroom, her toes are resting on the floor. On 5/10/17, at 7:53 a.m. R69 had self-propelled to the dayroom and then into the diningroom, using her toes, and throwing her upperbody forward to get started, then is able to self-propell in wheelchair. -At 8:22 a.m. R69 had completed breakfast and left the diningroom, wandering up and down the hallway, continuing to use her slippered toes to self-propel. -At 8:47 a.m. self-propelled to the dayroom. -At 8:38 a.m. self-propelled into the dining room for another cup of coffee. -At 9:10 a.m. continued to self-propel, wandering up and down the hallway. On 5/11/17, at 9:17 a.m. the director of Physical Therapy (DPT) stated therapy had not seen R69 since the intial therapy in September 2016, he would get R69 a smaller wheelchair so her feet touch the ground. DPT further stated whenever	F 309	A comprehensive, interdisciplinary review for Resident R10 was conducted to identify new approaches and recommendations in order to manage unsafe behaviors. This review was comprised of impressions from both Crest View team members, and community partners including licensed clinical psychology social workers and resident R10's nurse practitioner. Changes to the plan of care in order to manage unsafe behaviors was updated on the CNA team sheet, and educated to direct care givers. For all residents that this alleged deficient practice may have affected, a whole-house audit was completed by a physical and occupational therapist team by 6/5/2017 for wheelchair positioning and appropriate use of wheelchair cushions, foot rests, and other necessary wheelchair devices. Care Plans and team sheets were updated to accurately reflect the personalized plan of care for mobility devices. CNA team sheets were updated to match resident care plans. In addition, a whole-house review was conducted by 6/6/2017 for the behavior management of all residents identified to be exhibiting unsafe behaviors. For all residents identified to be exhibiting unsafe behaviors, educations are to be provided to front-line care givers to understand resident triggers for said behaviors, and approaches that can be used to mitigate them. Policies and procedures for care planning	

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F 309	Continued From page 24 therapy goes to see a new evaluation [patient], they talk to the nursing assistants (NA's) becuase they see the paient the most, DPT stated depend on NA's to give him information about the other residents, also get referalls from nursing and goes to IDT twice a week for any PT concerns. -At 9:22 a.m. DPT stated he will get her a small [wheel]chair cushion, so R69's feet can reach the floor, because she really wants to keep that chair. -At 9:24 a.m. trained medication aide (TMA)-C, stated if they see something unusal in residents walking or self propelling, they would say something to charge nurse. -At 9:25 a.m. NA-I stated staff would notify chanrge nurse, if saw anything unusal in walking or self-propelling. A review of therapy notes dated 9/7-8/16, initial assessment for gait training, lower extremity strenghting, transfer bed/mbolity training/ balance excersies. -Last day of therapy note on 9/30/17, maximum asssit with bed mobility and ransfers. refusing ambulation. no longer actively participating in therapy.no further skilled therapeutic intervetion in indicated at this time. R35 R35 was admitted on 4/13/16, with diagnoses of denemtia, repated falls, fracture of the right humerous, and comfort care. R35 had verbal and physical behaviors directed towards others, and rejected care daily. R35 required assist of two staff for bed mobility and toileting and assist of one staff for transfers. R69 required assistance with all cares, and wandered on the unit in the wheelchair. The care plan indicated pummel cushion in wheelchair, wanders aimlessly	F 309	and behavior management were updated and reviewed by an interdisciplinary team on 6/5/2017. All staff will be reeducated on these policies and procedures by 6/16/2017. Audits for mobility devices will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Audits for the on-going effectiveness of behavior management programs will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Social Services, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing and Director of Social Services will be responsible for compliance. Compliance date: 6/20/2017	

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F 309	Continued From page 25	F 309		

thoughout the facility, unaware of whereabouts or concerns, well fitting non-skid footwear. The Team Sheet indicated R69 was a fall risk, monitor for safety, observe for discomfort, and ambulates per self.

On 5/8/17, at 1:51 p.m. R35 was slouched down in the wheelchair, able to self-propel forward , but at risk of sliding out of wheechair. Self-propelling at a fast pace to the diningroom.
-At 7:21 p.m. R35 was taken to the bathroom by NA-G, who noticed she was slouched down in the chair, NA-G had her sit upright and then push back in the w/c while NA-G pulled on her pajama pants to move her back (unsuccessful). R35 was then taken when taken to the bathroom she had a wet cushion, (pummel cushion), and pad. there was a thin nonslip blue pad under the pummel cushion.

On 5/9/17, at 8:35 a.m. R35 had just gotten out of bed into w/c and was in slouching position, even though she was assisted to the dining room.

On 5/9/17, at 9:40 a.m. positioning note by therapy. " Assessed patient w/c [wheelchair] positiong following staffing report of patient sliding out of chair. Noted missing R arm pad, maintenance request placed to replace arm pad. Noted patient sitting forward on chair, not sitting back completely, likely causing sliding out of chair. Measurements of patient w/c size needed taken, 18x16 continues to be appropriate. Patient heel to knee 15", current chair with pummel is 18" and patient is not using leg rests to compensate for change in height. Replaced pummel with very low profile gel pad to increase ability to reach floor for self propelling. Patient appears to maintain body back in chair and presents with

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F 309	Continued From page 26 increased upright posture. Will monitor for fit and comfort. Educated nurse and TMA re: concerns and changes made, they will also monitor patient's w/c positioning and report any concerns to therapy. -At 2:49 p.m. R35 was observed sitting slighly more upright than before, but continued to slouch. On 5/10/17, at 9:12 a.m. R35 observed coming down the hallway, with assist of NA-C. sitting on the pummel cushion. On 5/11/17, at 8:29 a.m. R35 sitting on low profile gel cushion this morning, still slighly slouched pummel cushion on the wheelchair. -At 8:29 a.m. NA-H and NA-I had gotten R35 up and put her on the gel cushion. -At 8:33 licensed practical nurse (LPN)-B stated that the cushion was changed yesterday, he thinks PT came and did it. Staff had noticed she was being watched [by MDH]. -At 9:12 a.m. DPT stated the assessment had been done by occupational therapist (OT)-A and the care plan should have been changed when the positioning change was made. DPT stated the process is information forwarded to DON (director of nursing) and she changes the plan of care. DPT further stated when positioning assessment was made the OT would have left the gel cushion in place and staff should have been using it. -At 1:51 p.m. the director of nursing (DON) was interviewed and stated she would expect the plan of care to be updated and then the Team sheets should be updated with changes. The facility failed to follow the OT directions for positioning from 5/9/17 on Tuesday and Wednesday, and failed to update the care plan and Team Sheet with wheelchair seating	F 309		

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F 309	Continued From page 27 changes. R10's Admission Record Information sheet indicated a diagnoses of schizoaffective disorder, bipolar disorder single manic episode, unspecified, and major depressive disorder. A quarterly Minimum Data Set (MDS) dated 2/2/17, indicated R10 was moderately cognitively impaired and displayed symptoms of minimal depression. R10's MDS indicated R10 had displayed continuous disorganized thinking with physical symptoms directed toward others one to three days in the last seven days. In addition, the MDS indicated R10 experienced verbal behaviors directed towards others and behaviors not directed towards others on a daily basis. During continuous observation on 5/10/17, from 6:58 a.m. to 8:02 a.m. observations revealed: At 6:58 a.m. R10 observed to be in bed, fully dressed lying on her back with knees flexed. Bright overhead lights were on. Call light observed to be at the foot of bed. R10 asked surveyor to "get that f****** thing for me". Surveyor informed nursing assistant (NA)-A that R10 needed her call light, NA-A went into room. At 7:02 a.m. R10 repetitively said, "I want to get up." This verbalization continued for approximately two minutes, during which three staff walked by the room. licensed practical nurse (LPN)-A entered room and said, "Annie will be here today". R10 resting quietly in bed. At 7:05 a.m. R10 repetitively saying, "I want to get up". NA-A entered room and stated that someone would help R10 in a few minutes. R10 stated she wanted help now. NA-A left room. R10 then repetitively stated "I want to get up" for approximately two minutes.	F 309		

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F 309	Continued From page 28 At 7:13 a.m. NA-A and trained medication aide (TMA)-B assisted R10 out of bed, standing R10 next to the bed. NA-A and TMA-B were positioned on each side of R10, supporting R10 by holding under upper arms. NA-A washed R10's face. R 10 said three times, "Stop it, you stupid b****." NA-A quickly washed R10's front and back of torso, abdomen and groin with washcloth and soap. NA-A did not rinse areas. R10 spit at NA-A's face. NA-A stated not to spit at staff. R10 said, "Get out of here. Stop it." At 7:15 a.m. R10 spit at TMA-B's face and said to TMA-B, "Stop it you stupid b****." NA-A and TMA-B continued to hold R10 up and applied adult brief. At 7:16 a.m. R10 spit at TMA-B's face. At 7:16:a.m. R10 looked at TMA-B and said, "Go to h***." TMA-B said to R10, "I'll go there when I leave here." At 7:17 a.m. R10 attempted to scratch TMA-B with right hand. R10 yelled three times, "Look out." TMA-B and NA-A pulled up pants, then seated R10 on the side of the bed. At 7:19 a.m. R10 attempted to scratch TMA-B while TMA-B attempted to apply clothing protector. NA-A asked R10 if she was mad at staff. R10 did not reply. NA-A asked R10 if she wanted to brush her teeth. R10 said, "No G** **** it." At 7:21 a.m. NA-A asked R10 if she wanted clothing protector on, R10 said, "Ok." R10 threw toast at NA-A, and half a piece of toast at surveyor. At 7:30 a.m. TMA-A entered R10's room and asked her if she would take to take her medications. R10 stated, "No, I don't want them G**d*** it. Get out of here." TMA-A stated that this was his second attempt to give R10's medications.	F 309		

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F 309	Continued From page 29 At 7:33 a.m. R10 repetitively said, "Get this out of here." TMA-A entered room, asked R10 if she was done with her breakfast tray, then TMA-A repeated the question twice more. R10 stated, "Go to h***." TMA-A left R10 seated on the edge of the bed. R10 had eaten a quarter of a piece of toast and a six ounce glass of orange. At 7:41 a.m. LPN-A offered R10 multiple books. R10 refused all. LPN-A offered R10 a blanket, R10 refused. LPN-A gave R10 the call light, and left a book on the bed. At 7:52, a.m. R10 said, "I want to sit up." repetitively. LPN-A went into room, R10 now quiet. At 7:54 a.m R10 said, "I want to sit up" LPN-A went into room. LPN-A did not assist R10 to sit up. At 7:58 a.m. R10 said five times, "My back hurts." At 8:00 a.m. R10 said, "I can't read this." NA-A walked by room, At 8:01 a.m. TMA-A entered room with cup of medications. TMA-A stated that overheard heard her say her back hurts. TMA-A said twice, "Do you want to take your medications?" TMA-A said, "Do you want them or not?" R10 did not answer. TMA-A said, "Call me when you want them." On 5/10/17, at 9:43 a.m. TMA-A stated that R10 refused the antipsychotic Abilify about four times a week. TMA-A stated that he would make multiple attempts at administering Abilify before he charted a refusal. TMA-A stated R10 often spits medications back at him. On 5/10/17, at 1:18 p.m. NA-A stated you have to know R10's happy times and crabby times. NA-A said she says "This is (name), I want to take care of you. Why are you so mad." NA-A stated that R10 scratches staff with her nails. NA-A showed	F 309		

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surveyor scarring on the back of right hand resultant of an injury R10 had done "maybe 2 weeks ago". Scars are two linear areas two to three inches long and one-half inch wide. NA-A stated she sometimes waits then returns later. NA-A stated she teaches the new aides how to take care of R10.

On 5/10/17, at 2:01 p.m. LPN-A stated that the aides come to her, saying that R10 won't let them change brief. LPN-A stated sometimes her coming in to room helps. LPN-A stated she is not aware of staff sharing behavior management techniques with each other or with her. LPN-A stated there were no list of behavioral techniques. LPN-A stated that staff have learned preferences and keep trying techniques. LPN-A stated she tries to do a skin assessment when the staff are changing R10's brief, but is not always able to conduct an assessment.

On 5/10/17, at 3:15 p.m. a consulting Social Worker (SW)-A stated she last saw R10 in January of 2017. She stated mental health provider for Associated Clinic of Psychology (ACP). saw R10 in March. SW-A stated R10's cognition had declined, R10 "used to tell jokes". SW-A stated had not assessed R10's cognitive changes. SW-A stated she utilizes informal observation to assess R10's status. SW-A stated in the past she had success offering R10 Juicy Fruit gum or popcorn. SW-A stated had seen staff complete some of R10's physical cares. SW-A stated R10 has not had formal psychiatric care "in a while". SW-A stated social service staff (SS)-A "lets me know if things are working". SW-A stated she meets with SS-A once a week. SW-A said, "SS-A hasn't mentioned medication refusals." SW-A stated when seeing R10, she

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models "continued compassion" for the staff to use. SW-A stated SS-A has "been less available."

On 5/11/17, at 8:09 a.m. SS-A stated the behavioral specialist "comes every Wednesday". SS-A stated she meets with the behavioral specialist and checks in on residents we should see and "why they should be seen". SS-A stated when SW-A comes in, she meets with us and goes to floor staff and get more information. SS-A stated that she prints Treatment Administration Record (TAR) and highlight the behaviors so SW-A can see that. SS-A stated facility had contracted psychiatric services with ACP and did not offer any other counseling services. SS-A stated changes in resident health are discussed in the morning meeting. She stated that there "haven't been any changes with R10".SS-A stated that "we review progress in Friday behavior (Interdisciplinary Team) IDT meeting If (staff) education needed, we place it in binders and have it on team sheet.

On 5/11/17, at 8:23 a.m. SS-A stated that R10 is "becoming more quiet, more inward. The progression of her illness I believe". SS-A stated that R10 "needs more assistance getting up, needs help walking". SS-A that R10 is talking and responding less than she used to. SS-A stated that she is "frozen" in her bed and chair, says she needs help and then swears at you when offer help." If R10 swears or yells at you "not really about you" SS-A stated that the behavior plan included "just kind of ignoring it" and going on with your tasks. Ignoring is a not structured plan and does not have time intervals. She stated that she believed these programs reduced her hitting by 50%. SS-A stated that she tries to meet with R10 "two to three times per week" and does a

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narrative summary. SS-A stated that she had noted that R10's hair was greasy and had dandruff. SS-A stated that she was not aware of the frequency Abilify was being refused "I'll have to double check on that": and that she "expects floor staff to report medications aren't being given". SS-A stated that she does not see the Certified Nurse Practitioner (CNP) a lot" .

On 5/11/17, at 9:39 a.m. registered nurse (RN)-A stated [R10] is "a little more aggressive" and "does resist cares". RN-A stated R10 "has favorites, certain people will let do things" RN-A stated that "her favorites include me, she loves me dearly". RN-A stated that R10 appears to enjoy when RN-A comes into her room and "dances to her music." RN-A stated that LPN-E, the night nurse is R10's "most bestest friend. If your having troubles with R10, distract her. Tell R10 that LPN-E will be here tonight. Sometimes I use that leverage a little bit." LPN-E stated that R10 uses racial slurs to staff. LPN-E stated that "it's getting harder and harder to communicate". R10 repeats things "over and over". LPN-E stated that the "team sheet" has the behavior plan and "also has a care plan" LPN-E stated that she us aware that R10 is seeing psychologist. LPN-E stated that they tell R10 that "they are her friends". RN-A stated that "changes are expressed in shift reports, in typed reports or defer to chart. RN-A stated that she expected staff to "get through the shift report" and "read the changes".They "let us know" if things are working or having troubles. RN-A stated that behavior planning "starts with social services" for getting changes and recommendations from outside sources i.e. psych." RN-A stated that, regarding her medications"she does sometimes refuse them" RN-A stated that is when medications are

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refused,staff administering medications should let the supervisor know. She stated that the CNP should be contacted if there is a "a consistent pattern". RN-A stated that sometimes"R10 refuses everything", will not allow oral cares or incontinence cares. We with R10 the best we can and re-approach when R10 is scratching and pinching". RN-A stated that "spitting is monitored every shift and tracked with TAR (treatment administration record)." RN-A stated that social services looks at the behavior portion of R10's cares. RN-A stated, "re-approach is main intervention we use." RN-A stated that she is"not sure if ever tried having volunteers sit with her." RN-A stated that"you do what you can" with assessment after a fall or incident" and that R10 usually does not allow having assessment done.

A Certified Nurse Practitioner (CNP) note dated 5/1/17, mentions high risk of fall due to dementia and mental illness. The note further indicated nursing staff had stated R10 often refused care, there were no current concerns, however, assessment is difficult.

Medication Administration Records from February 1, 2017 through May 10, 2017, were reviewed. Documentation indicated R10 had received 62 doses of the antipsychotic Ability 10 mg daily, but had refused 38 doses.

Consulting Social Worker note of 1/18/17 recommended having a volunteer read to R10 outside of her room. A note dated 2/8/17, recommended that if R10 gets agitated, staff could encourage her to take a walk. A note dated 3/8/17, recommended that staff continue a patient and accepting approach with R10.

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F 309	Continued From page 34 Psychology notes from 1/11/17 indicated a suggestion of having a volunteer read to R10 outside of her room, because being outside of her room for periods of time may provide her with relief. Further notes indicated nursing had difficulty at times with administering R10's medications and checking vital signs due to behaviors and combativeness. Progress Notes dated from February 1, 2017, through May 10, 2017, note numerous episodes during which R10 refused physical care, assessments, vital signs and obtaining laboratory values. R10's Care Plan updated 5/2017, directed staff to explain cares before initating, if resistive, leave safe and return. Approaches are documented to include medications as ordered and monitor for changes in weight.	F 309		
F 310 SS=D	483.24(a)(b) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: (1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, …	F 310		6/20/17

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F 310	Continued From page 35 (b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: (1) Hygiene -bathing, dressing, grooming, and oral care, (2) Mobility-transfer and ambulation, including walking, (3) Elimination-toileting, (4) Dining-eating, including meals and snacks, (5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a decline in residents transfer ability for 1 of 1 resident (R96), was identified and reported to ensure an assessment could be completed. In addition, declines noted on the MDS were not updated on the care plan or the nursing assistant care sheet. Findings Include: R96 was admitted to the facility 1/30/15, with admission diagnoses of dementia, a history of falling, fatigue, and major depression. R96 had severe cognitive loss, disorganized thinking,	F 310	F310 It is the policy of Crest View Lutheran Home that all residents are given appropriate treatment and services to improve or maintain the highest level of physical and mental functioning. This includes limiting or avoiding resident declines in activities of daily living. For resident R96, a physical therapy screening was completed to ensure proper transfer technique was being utilized. Resident R96 was evaluated to	

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F 310	Continued From page 36 required assist of two staff for bed mobility and transfers and was totally dependent on staff for all cares and personal hygiene. R96's care plan dated 1/2017, directed staff to use assist of 1-2 staff (2 if resistive) to use EZ stand with assist of 2 and always assist to sit up. Observe for changes in abilities, maintain a clutter free environment, ensure resident is wearing proper footwear during transfers/ambulation. Check and change every 2 hours. The undated nursing Team Sheet directed staff to use the EZ stand with assist of 2. "confused and forgetful, difficult following directions. Staff to anticipate needs. Encourage her to propel herself in wheelchair. NO FOOT PEDALS ON WHEELCHAIR" On 5/9/17, at 2:51 p.m. R96 was sitting in wheelchair in the dayroom, in front of the TV. R96 had eyes closed, and feet hanging down with the toes pointed toward the floor. (feet were not supported). On 5/10/17, at 7:12 a.m. nursing assistant (NA)-C woke R96, who opened eyes briefly. NA-C reviewed the Team Sheet for R96. At 7:15 a.m. NA-C again woke R96 to offer a choice of clothing, little to no response was observed from R96. NA-C warmed water to provide cares to R96, and again took out the Team Sheet to review directions. NA-C obtained assistance from NA-D to roll and dress R96. NA-C and NA-D sat R96 on the side of the bed, NA-C had to support the weight of R96 to keep her upright on the side of the bed, NA-C used one hand to hook the EZ sling around. R96 was able to hold onto the	F 310	be appropriate for a mechanical lift (Hoyer lift) with an assist of two staff members. Her care plan and CNA team sheet were updated to accurately reflect the plan of care regarding transfer ability. For all other residents that this alleged deficient practice may have affected, a whole-house audit was completed by a physical and occupational therapist team for every resident that was identified to need EZ stand assist with transfers. These residents were observed and audited to ensure they were able to bear adequate weight in order to use the EZ Stand lift. If they were determined to need a higher level of transfer assistance, their care plan and CNA team sheets were updated to accurately reflect their plan of care. The policy and procedure for care planning was updated and reviewed by an interdisciplinary team on 6/5/2017. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for resident transfer assistance will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations.	

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F 310	Continued From page 37 handles after several manipulations by the NA's to get her hands onto the handles. R96 was then lifted to a partial stand with legs splayed and knees bent out. R96 was placed in the wheelchair (it was unclear how R96 was bearing weight.). NA-C again reviewed the Team Sheet Angela read the NA sheet again, which directed no foot pedals, encourage to self-propel, NA-C stated in a low tone, "no foot pedals". R96's feet were hanging straight down with the toes pointed toward the floor, only the very tips of her toes touched the floor in her gripper socks. -At 7:43 NA-C completed cares and took R96 to the breakfast, and ensured the breakfast aide NA-B was aware R96 had been brought in. NA-B gathered food and started to feed R96. R96 had minimal soft spoken interaction with NA-B and smiled once, otherwise her eyes were closed. -At 8:22 a.m. R96 was asleep at the breakfast table. -At 8:26 a.m. NA-B returned to the breakfast table and attempted to get R96 to eat more. R96 had eaten approximately ¼ of blueberry muffin, 1 bite of oatmeal, one drink of apple juice (no "straw with beverages" as directed on the care plan). -At 8:35 a.m. was taken to the day room and placed in front of the TV, no sound was on, R96 continued to have closed eyes. Her feet were hanging down. -At 8:47 a.m. remained in front of TV. -At 8:53 a.m. remained in front of TV, starting to lean towards the left. -At 8:54 a.m. licensed practical nurse (LPN)-B added foot pedals to wheelchair and said "how's that" R96 did not respond. Left foot was partially on the foot rest, but left knee remained cocked out to the left side. -At 9:11 a.m. remained in day room, asleep in front of TV, with no sound on.	F 310	The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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-At 9:19 a.m. R96 had been up in chair for 2 hours.
- At 9:21 a.m. NA-C verified she had to bear weight of Resident #96 to use the EZ stand, and she wandered if that was the right lift, but maybe she has good days and bad days. She did verify her NA care sheet had no foot pedals on the directions, and she wandered about that because R96's feet were hanging down and only toes touching the ground. [pedals had been in the room, next to the bed stand].
-At 9:28 a.m. NA-C and NA-B took R96 to room and used the EZ stand to lay her down in bed. During the transfer R96's right foot was correctly placed, but the left foot was in the center, between the designated foot areas, and left foot was turned out with left knee canted out (it was unclear how R96 was bearing weight.). NA-C verified that that the left foot was not in the correct position, and after laying her in bed stated the left knee was stiff. NA-B said "sometimes R96 was more awake and then her leg goes straight".

-At 1:07 p.m. R96 was again asleep in the day room, foot pedals were on the w/c and feet were in proper alignment.
-At 11:46 a.m. physical therapy assistant (PTA) note indicated "screen patient today for transfers. Witnessed a EZ stand transfer and at this time patient would be more appropriate with the Hoyer for transfer Assist of 2. Patient had difficulty sitting up at the edge of the bed with out assist and during the EZ stand transfer patient toes were on the foot plate of the machine, but patient heels were coming up off the foot plate during the transfer. EZ stand deemed not safe."
-At 1:41 p.m. LPN-B stated physical therapy (PT) had been there and assessed R96 as okay to stand, he also came back and watched the aides

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F 310	Continued From page 39 transfer with the EZ stand and said ok. On 5/11/17 at 9:15 a.m. the director of PT stated that R96 had just been seen by therapy for range of motion and stretching. R96 "could no longer ambulate or self-propel the wheelchair and hadn't for a long time." PT further stated R96 had been changed to a Hoyer lift yesterday, because she was no longer safe to transfer in the EZ stand. -At 9:25 a.m. when asked what they would do if they noticed someone was unsafe in the EZ stand transfer, TMA-C stated they would notify the charge nurse. -At 9:29 a.m. LPN-B stated R96 had been watched by PT who said it was ok, and that he would be back to watch the aides do a transfer, LPN-B stated he never came back to talk to me after that transfer. LPN-B was not aware that R96 had been changed to a Hoyer lift for safety reasons. -At 9:33 a.m. RN-A stated change like a Hoyer lift would be typed in the supervisor report for every shift, which goes to all department heads, and they meet every morning with the DON, administrator and department heads. RN-A stated it should have been changed on the NA Team Sheet and the care plan. RN-A would check into the breakdown in communication. RN-A further stated they print new Team Sheets every day, but because the office was being remodeled, they currently didn't have printer access and had not been able to print updates. -At 9:41 a.m. An additional review of the nursing plan of care showed changes dated 5/10/17 directed Hoyer lift, foot rests on in wheelchair and EZ stand had been yellowed out. However, the NA Team Sheets provided 05/11/2017, at 9:42 a.m. had not been updated and still directed staff	F 310		

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F 310	Continued From page 40 to use the EZ stand. -At 9:43 a.m. PT stated nursing was responsible for updating the care plan, when changes were made based on therapy assessments, an email was sent to the director of nursing (DON) and nursing supervisors, who then updated the care plan. -At 9:46 NA-I stated she had gotten R96 up this morning with the EZ stand, and that was what her Team Sheet said to do. -At 10:44 a.m. LPN-D stated physical therapy assistant (PTA) assessed R96 was able to bear weight at that time, when transfer again call him so he could watch the aides and go from there. -At 10:58 a.m. PTA, had changed R96 to Hoyer lift yesterday because she was bearing weight through toes only and not the heels. -At 10:59 a.m. RN-A stated "I should have updated her care plan". -At 1:51 p.m. DON stated the email had gotten sent out late last night, when told that LPN-B was not aware of the change to Hoyer lift, and it was not changed on the care plan or NA Team Sheet, DON stated "I see where you're going with this". DON stated the process of communicating changes with staff "nursing supervisor get notification by email, they are supposed to make the changes. On 5/11/17, at 1:51 p.m. DON stated it [the email with changes for Hoyer lift] got sent out late last night. DON was informed R96 continued to be gotten up with EZ stand, and that LPN-B was not aware of the change to Hoyer lift for safety. DON stated "I see where you're going with this". DON stated the email was cc'd to her.	F 310		

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F 310	Continued From page 41 R96 was transferred 4 times with the EZ stand, after it was deemed R96 was unsafe to transfer with the EZ stand and a Hoyer lift should be used for safety. The EZ Way stand manufacturer's instructions dated 3/11/09, indicate: The EZ Way stand was designed specifically for toileting and changing briefs of patients. The EZ Way stand can also be used for transferring the patient from chair, wheelchair, toilet or bed, and can be used for ambulation. As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Way stand is suitable for their needs. Patients should be able to bear some weight, have upper body strength (i.e. be able to sit on the side of the bed unattended), and be able to follow simple commands. If a patient does not meet each of these three criteria, the EZ Lift total body lift must be used. The Care Plan Policy and Procedure dated 3/17, indicated: 8. the care plan is to be changed and updated as the care changes for the resident and as the resident changes in condition are identified. Any temporary problems will be added to comprehensive care Plan. It is to be current at all times. 9. Changes may be made by any licensed nurse for any nursing related domains. 10. The care plan will be reviewed and updated regularly and during the quarterly MDS assessment period [Minimum Data Set- which is a comprehensive assessment for long term care patients. All areas are assessed including: Patient care- how much can the patient do for himself and how much assist is needed by staff].	F 310		

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F 310	Continued From page 42 11. Any updated made on resident care plans will be reflected on the resident Team sheets if updates are necessary for direct care staff.	F 310		
F 311 SS=G	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services for 1 of 5 (R150) residents reviewed for activities of daily living. This resulted in actual harm for R150 who declined in her ability to ambulate. Findings include: R150's 30 day Minimum Data Set (MDS) dated 2/9/17, indicated she was severely cognitively impaired and required extensive assist of one staff for transfers, dressing and personal hygiene. R150's quarterly MDS dated 4/19/17, indicated she required extensive assist of two staff to complete transfers, dressing and personal hygiene, identifying a need for greater assistance. R150's care plan dated April 2017, identified an alteration in mobility related to Alzheimer's dementia, muscle weakness and limited range of motion (ROM). The care plan directed staff to assist R150 to ambulate twice daily up to 50 feet. A review of a Resident Referral Interdepartmental Communication dated 2/16/17, directed staff to	F 311	F311 It is the policy of Crest View Lutheran Home to provide appropriate treatment and services to maintain or improve their ability to carry out activities of daily living for all residents. This includes providing ambulation services for all residents identified on an ambulation program. The ambulation program for Resident R150 was reviewed on 5/12/2017 by physical therapy to no longer be solely effective, and was re-started on the physical therapy case load in an effort to improve physical functioning related to ambulation. For all other residents that this alleged deficient practice may have affected, a whole-house audit of all residents currently on an ambulation program was completed on 5/12/2017 by physical therapy in order to determine that the programs are effective and remain appropriate. No other residents had a	6/20/17

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F 311	Continued From page 43 assist R150 to ambulate twice daily with a rolling walker and assist of one staff 10-50 feet, 7 days per week. A facility document titled Therapy Re-Certification/Discharge dated 2/3/17, indicated the following: Discharge summary: Patient's last day of therapy is 2/13/17. Patient is maximum assist with bed mobility and pivot transfers and is able to ambulate up to 30 feet with minimum assist. Patient will be placed on an ambulation program. During observation on 5/11/17 at 8:59 a.m., nursing assistant (NA)-H and NA-I performed morning cares on R150. After completing cares, NA-H and NA-I assisted R150 into her wheel chair using a transfer belt. During the transfer, R150 did not put any of her weight on her feet as the NA's lifted her into the chair using the transfer belt. During an interview on 5/11/17 at 9:17 a.m., NA-I and NA-H stated they regularly took care of R150. NA-I stated the nursing staff on the unit did not perform any range of motion or ambulation services for R150. They stated therapy staff come and take R150 upstairs for range of motion and ambulation. During an interview on 5/11/17 at 10:28 a.m., the director of rehabilitation services (DOR) stated R150 was not currently receiving services from therapy. The DOR stated nursing staff should be assisting the resident with her ambulation program. During an interview on 5/11/17 at 10:39 a.m., licensed practical nurse (LPN)-B stated, "I'm not	F 311	decline in functional ability, and ambulatory programs remain effective. The policy and procedure for providing ambulation services was updated and reviewed by an interdisciplinary team on 6/5/2017. This policy defines an additional means of supervision of the CNAs executing the ambulatory program, completed by floor nurses on their respective units and shifts. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for ambulation services will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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F 311	Continued From page 44 sure I've ever seen her (R150) ambulate with staff." During an observation on 5/11/17, at 1:01 p.m., physical therapist (PT)-A and occupational therapist (OT)-A assisted R150 to ambulate using a walker PT-A had brought with him from the therapy department. It was observed there was no walker in R150's room. PT-A and OT-A assisted R150 to stand. PT-A put R150's right hand on the walker and assisted her to grip the walker however, R150 was unable to open her left hand enough to grasp the walker. R150 walked approximately 5 feet and had to sit down in a chair. PT-A stated there was a decline in R150's ability to walk and stated she used to be able to ambulate 30 feet without resting. During the observation, R150 stated it had been awhile since she'd last walked. On 5/11/17 at 1:51 p.m., PT-A stated restorative and ambulation programs were put in place to prevent avoidable declines. During interview on 5/11/17 at 1:12 p.m., the director of nursing (DON) verified when an ambulation or restorative program is set up, it is supposed to indicate specifically that nursing will complete it. The DON further stated the NA's should know when they are responsible for the program. A facility policy related to ambulation programs was requested, but not received.	F 311		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		6/20/17

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F 314	Continued From page 45 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary treatment and services including assessment, to minimize or prevent pressure ulcer development, (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), for 1 of 1 resident (R142) with identified pressure ulcers. R142 sustained harm related to development of new and/or recurring pressure areas. Findings include: R142's quarterly Minimum Data Set (MDS) dated 3/9/17, indicated R142 was mildly cognitively impaired and required extensive assistance with all activities of daily living (ADL'S) except for propelling wheelchair on and off the unit, which was identified as limited assistance, and R142 required supervision when walking in the room.	F 314	F314 It is the policy of Crest View Lutheran Home to properly treat, actively prevent, and heal pressure-related soles for all residents. Resident 142 discharged to the hospital on 5/24/2017, and is unable to receive additional updates on her care plan and CNA team sheet related to appropriate interventions to avoid or limit skin breakdown. For all other residents that this alleged deficient practice may have affected, a whole-house skin audit was completed for every resident to ensure all current skin issues are identified and treatment is in place. CNA team sheets and care plans were also audited to ensure that they	

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F 314	Continued From page 46 R142's MDS indicated R142 was frequently incontinent of bowel and always incontinent of urine and had a stage one (an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching).The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) pressure ulcer. R142's Admission Record dated 5/11/17, indicated R142 had diagnoses of metabolic encephalopathy (temporary or permanent damage to the brain due to many possible causes), emphysema (chronic lung disease) and depression. R142's pressure ulcer Care Area Assessment (CAA) Worksheet dated 12/13/16, indicated R142 was at risk for developing pressure ulcers related to incontinence and the need for assistance with bed mobility and instructed staff to assist as needed and monitor for changes. The care plan problem area of alteration in skin integrity dated 12/16, indicated the resident had potential for problems because of decreased mobility and incontinence. Care plan interventions included for staff to reposition per tissue tolerance assessment, to apply a foam cushion in the wheelchair, provide pericare after incontinent episodes, monitor skin with cares, treatments per doctors orders, notify dietary regarding any open areas or skin changes, and to provide nutritional supplements as ordered. The resident's care plan was updated 5/10/17, after concerns were brought to the director of nurse's attention	F 314	accurately reflect the plan of care. The policy and procedure for skin integrity and wound care treatment was reviewed and updated by an interdisciplinary team on 6/5/2017. This procedure includes timeliness of reporting resident skin integrity breakdown and wound care protocols. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for skin integrity and wound care will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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F 314	Continued From page 47 regarding five small stage II (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) pressure areas located on R142's bottom/coccyx area. An alteration in bowel and bladder function care plan dated 12/16, indicated the alteration was related to R142's impaired mobility, history of urinary tract infections, and occasional incontinence. Care plan interventions instructed staff to toilet R142 upon rising, before or after meals, at hour of sleep and during the night. A skin integrity care plan initiated 5/10/17, indicated R142 had five stage two pressure areas and instructed staff to turn and reposition the resident every two hours, instructed staff to address friction and shear concerns, to perform daily monitoring and weekly wound progress observations and to do treatment as ordered. On 5/10/17, during continuous observation from 7:05 a.m. until 10:30 a.m. the following findings were identified: -At 7:05 a.m. R142 was observed lying in bed with the head of the bed elevated to 45 degrees. -At 7:31 a.m. R142 sat up in bed with both feet dangling off the side of the bed for three minutes then laid back in bed. - At 7:42 a.m licensed practical nurse (LPN)-C entered room and observed R142 moving up and down in the bed. LPN-C asked R142 to remain in bed and put R142's call light on before going to work with R142's roommate. - At 7:49 a.m. nursing assistant (NA)-L entered the room and told R142 that she would be back in a little while to get R142 up and asked R142 to stay in bed. - At 8:21 a.m. NA-L returned to help R142 get ready for the morning. NA-L helped R142 wash	F 314		

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face and upper body and put on a sweatshirt. NA-L washed R142's legs and applied lotion then put R142's pants on up to her knees and put anti slip socks on her feet. NA-L removed R142's incontinence product that was wet and had a large smear of brown stool on it. NA-L washed R142 bottom. NA-L verified that there were two open areas approximately dime size each on R142's bottom. the open areas were on either side of R142's coccyx. R142's wounds were round in shape. NA-L verified that the open areas had been there at least couple of days since the previous week. Continence pad put on, call light, gathered linens and trash put them on the floor. Removed gloves washed hands NA-J entered the room and put R142's shoes on and then NA-J and NA-L transferred R142 to the wheelchair and then to the toilet. LPN-C entered the bathroom and applied a white cream to R142's bottom. LPN-C told R142 that her bottom looked better than last week.
-At 8:55 a.m. LPN -C wheeled R142 to the dining room for breakfast.
-At 9:18 a.m. R142 was done with breakfast. R142 had been fed half a cup of yogurt, half a bowl of oatmeal and drank a glass of milk and a glass of tomato juice.
-At 10:19 a.m. the staffing coordinator took R142 to her room.
-At 10:20 a.m NA-M placed R142 on the toilet to have a bowel movement.
-At 10:25 a.m. LPN-C entered the bathroom with a tub of Peri rectal compound cream. NA-M helped R142 to stand and washed R142's bottom. R142 said, "Ow that hurts" NA-M dried R142's bottom. LPN-C measured the wound on the right side of R142 coccyx as 1.8 centimeters (cm) x 0.4 cm. LPN-C measured the wound on R142's left side of the coccyx as 2.4 cm x 0.3 cm.

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LPN-C put white cream on R142's bottom. LPN-C said there was no drainage or slough and no granulation or epithealization tissue.

On 5/10/17 at 3:11 p.m. R142 was lying in bed. The director of nurses (DON) asked R142 if she had a sore on her bottom and R142 said, "Yes." The DON with the help of LPN-C, rolled R142 on her left side and measured the wounds on R142's bottom. The DON identified the first area as right ischial tuberosity. The DON sated it measured 2 cm x 0.8 cm the second wound was described as a long skinny wound closest to the anus measuring 1.5 cm x 0.4 cm. The third area was described as sacrum 0.5 cm x 0.5 cm at the end of the second wound. The fourth wound was described as a lump located on the coccyx measuring 2.2 cm x 0.5 cm. The fifth wound was located below the fourth wound and was on the coccyx measuring 1.2 cm x 0.5 cm. The DON said, "I would call them all Stage II pressure ulcers." The DON stated the wounds were all open over boney prominences and did not have any slough in the wound bed.

Review of Weekly Body Audit- V2 from 12/21/16, through 5/5/17, revealed:
12/21/16, -3/24/17 skin intact.
4/7/17, Bruising right and left hand and forehead.
4/21/17, indicated resident had a pressure wound on bottom, but lacked measurements or stage. Audit did indicate skin was intact.
4/28/17 only addressed bruising on back of left hand and indicated skin was intact.
5/5/17 audit indicated R142 had three wounds. The first wound was right buttock, wound typed "Other", described as redness's, no measurements. The second wound was left buttock, wound typed "Other", described as

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redness's, no measurements. the third wound was sacrum, wound typed "Other" described as redness's no measurements. The Weekly Body Audit indicated skin was intact.

Turning and Reposition-sitting dated 3/5/17, indicated R142 was independent with chair mobility.

Turning and Reposition- Laying form dated 3/11/17, indicated R142 was independent with bed mobility. Comments section indicated, "noted redness at resident buttock away from coccyx area, Res [resident] to used [sic] compound cream for buttock ordered by NP [nurse practioner] res to repositioned Q[every] 2 hrs [hours] and PRN [as needed]".

Dietary Note dated 3/13/17, indicated, "Resident now has O/A [open area] on buttock. Requested change of supplements to Boost Breeze 8 oz. [ounces] BID [twice a day] due to refusal of Ensure plus.

Registered Dietician Update dated 4/26/17, indicated R142 had a significant weight loss for three months and from admit. Weight has stabilized over the past week around 112-113 pounds. Skin intact. Will recommend to increase boost breeze to eight ounces three times a day.

Progress note dated 4/19/17, indicated "Resident bottom checked and noted redness during care. Cream applied and reposition every 2 hours to prevent further skin break down."

Progress note dated 5/7/17 "resident has a sore bottom. appears to be excoriated. applied thick compound cream. nursing aids were requested to

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be gentle when cleaning. resident denied pain. nursing staff will continue to monitor."

Progress note dated 5/8/17 "Situation: NARs reported to writer that res. had increased redness on buttocks and open areas. Writer went to apply res. compound cream and noted that res. had sheering to bilateral buttocks.
Background: Res. is incontinent of bowel and bladder and has redness to bottom, compound cream was prescribed to be applied to buttocks every 3 hours with pad change. Res. has been noted by nursing staff to scoot back in wheelchair independently multiple times per shift.
Assessment: Res. reported pain rated at 8/10 in bottom when sitting in wheelchair and was given PRN Tylenol 650 mg and was assisted to lay down. Res. compound cream was applied with pad changes to prevent further breakdown.
Request: Continue to apply res. compound cream to bottom and reposition res. PRN. Check and change res. and offer to lay res. down in between meals to prevent further breakdown on buttocks."

Progress note dated 5/10/17, "Writer [director of nurses] assessed residents bottom, there was total of 5 small open area noted rating of stage 2, area could be of a shearing or friction but because it is in the area of bony prominence writer is classifying them as pressure. wound bed is pink in color did not note any sloughing tissue. This is the first writer as seen area so unable to determine if they are improving or getting worse. area being treated with Peri-rectal compound cream. Res noted to have some tenderness in the area noted on her coccyx this area was noted to have a fatty tissue present making it protrude out some. There was another are [area] by this one just below it. Then there is one are[area] on

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F 314	Continued From page 52 the rt [right] gluteal [sic] fold and 2 area close to the anus area. Writer did not note any S&Sx [signs and symptoms] if infection. Res discomfort seem to improved after the protective cream was applied. Writer did ask nurse to look at her PRN pain meds and see if she had anything she could have is she continue to c/o of discomfort" During interview on 5/10/17, at 8:58 a.m. LPN-C said, "I applied peri rectal compound cream to her bottom." LPN-C stated R142's skin was intact. When LPN-C was asked about the open areas, LPN-C stated R142 had a couple of areas that were open due to shearing. LPN-C said, "They are very superficial. They look better than a couple days ago when I first saw them." When LPN-C was asked if the areas were measured, LPN-C stated the open areas were not measurable because the skin kept moving. LPN-C said, "We will have to measure them today when we lay her down." During interview on 5/10/17, at 10:00 a.m. R142 said, "I get restless because my back and bottom hurt." During interview on 5/10/17 at 10:32 a.m. LPN-C stated the wounds looked different than Monday. LPN-C said, The wounds are less red and the shearing was different on Monday. It looks like it has opened more today. Monday it looked like a superficial scrape." LPN-C said, "Monday she did not have an open area that you can measure." LPN-C stated there were only two wounds located on the left and right gluteal folds. LPN-C said, "I think the cause is being on her bottom. We had seen the redness before. She keeps trying to scoot back in her chair even if she is all the way back."	F 314		

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	245018	A. BUILDING _____ B. WING _____	05/11/2017

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F 314	Continued From page 53 During interview on 5/10/17 at 12:53 p.m. dietician said, "My understanding is she has a new open area. Two small scabs on the left shin." Dietician stated unaware of any other skin breakdown but R142 was at high risk for skin break down During interview on 5/10/17 at 1:45 p.m. LPN-D, care coordinator, verified Weekly Body Audit-V2 for 5/5/17, indicated right buttock redness, left buttock redness, Sacrum redness but that there were no measurements nor was a risk management form completed 5/5/17. LPN-D said, "From what I know there should be more documentation. The doctor was notified on 5/8/17 but should have been notified Friday morning." LPN-D said, "I was going to email therapy for a different cushion." During interview on 5/10/17, at 2:06 p.m. the director of nurses (DON) stated she thought the wound nurse had seen the wound today but verified there was no documentation. DON verified there was no care plan in in the chart for wounds on R142's bottom. DON said, "We have a separate care plan that the wound nurse would put if she had seen a wound. If she is not here than I will put the care plan in if I know about it." The DON said, "I was told Tuesday that there was an incident written up for the skin Monday. The wound nurse looks at it the next day that she is here. Her schedule alternates and usually Wednesday is her wound day so that is when she would look at it." The DON stated nurses were able to update a care plan and they were suppose to. I have the wound nurse write on the care plan when a wound is healed and yellow the problem out. DON said, "I don't recall her [R142]	F 314		

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F 314	Continued From page 54	F 314		

having a wound." DON stated we don't stage other wounds but it is in area that would be a pressure ulcer.

During interview on 5/11/17 at 2:22 p.m. the DON stated for a resident with red skin or pressure areas staff should monitor the skin daily and implement treatment orders. If staff notice a change in skin they fill out risk management and go through the process. The DON said, "As far as I know, yes it was a change in skin condition for [R142] on 5/5/17." DON verified staff did not do a risk management on 5/5/17. Staff did not report the change in skin condition to the doctor or nurse practioner on 5/5/17. DON stated she expected staff to have updated the doctor on 5/5/17. Staff was to do a new tissue tolerance and new skin risk assessment. Staff should update the current care plan and notify the supervisors or wound nurse. The care plan should have been updated on 5/8/17, if not done before.

During interview on 5/11/17, at 3:30 p.m. the administrator stated he should have been notified Friday. The Administrator verfied he did not hear anything about possible open areas until Tuesday afternoon. Administrator said, "I would have expected nursing staff would have followed the protocol for new wounds."

Skin and Pressure ulcer policy reviewed 4/12, instructed staff, "To properly identify and assess residents whose clinical conditions increase the risk for development of skin issues, wounds and pressure ulcers, to implement preventative measures, and provide appropriate treatment measures for wounds according to the AHCPR [Agency for Healthcare Policy and Research]

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F 314	Continued From page 55 guidelines." The policy also instructed staff to keep head of bed at or below 30 degrees (unless medically indicated). Set knee gatch.	F 314		
F 318 SS=G	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform range of motion (ROM) services for 1 of 5 residents (R150) reviewed for activities of daily living (ADL's). This resulted in actual harm for R150 who had a decline in ROM, which also affected her ability to utilize a walker for ambulation. Findings include: R150's 30 day Minimum Data Set (MDS) dated 2/9/17, indicated she was severely cognitively impaired and required extensive assist of one staff for transfers, dressing and personal hygiene. R150's quarterly MDS dated 4/19/17, indicated she required extensive assist of two staff to complete transfers, dressing and personal hygiene, identifying a need for greater assistance.	F 318	F318 It is the policy of Crest View Lutheran Home to provide appropriate treatment and services to maintain or improve their ability to carry out activities of daily living for all residents. This includes providing range of motion (ROM) services for all residents identified on a ROM program. Resident R150 was screened by an occupational therapist, and received orders for occupational therapy for her contractures on 5/19/2017. Occupational therapy orders were for three sessions a week, for four weeks for contracture management, range of motion and hand splinting. Range of motion exercising and	6/20/17

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F 318	Continued From page 56 R150's care plan dated April 2017, identified an alteration in mobility related to Alzheimer's dementia, contractures, muscle weakness and limited range of motion (ROM). The care plan directed staff to perform upper extremity range of motion daily and apply palm protectors to both hands. A facility document titled Willow Team 2, undated directed staff to apply hand splints at bedtime and remove in the morning. A facility document titled Therapy Re-Certification/Discharge dated 2/13/17, indicated the following: Patient to discharge OT (occupational therapy) at this time. Recommend continued use of palm protectors as needed and at night. Patient seen for ROM and contracture management. Patient set up with restorative nursing program for bilateral upper extremity ROM to prevent further contractures. During an observation on 5/10/17 at 7:44 a.m., R150 was lying in bed. On the bedside stand were 2 hand splints/palm protectors. One splint was on an upper shelf, the other splint was on a lower shelf behind a jug of water. R150 was not wearing any hand splints. During an additional observation on 5/11/17 at 8:59 a.m., the hand splints remained in the same location as the previous observation, and the resident was not wearing any hand splints. During an interview on 5/11/17 at 9:17 a.m., NA-I and NA-H stated they regularly took care of R150. NA-I stated the nursing staff on the unit did not perform any range of motion or ambulation services for R150. They stated therapy staff come and take R150 upstairs for range of motion	F 318	hand splinting will continue on an on-going basis while on the ROM program. For all other residents that this alleged deficient practice may have affected, a whole-house audit for all assistive devices was completed, as well as a review of every resident on the range of motion program by 6/5/2017. The policy and procedure for providing ROM and contracture management services was updated and reviewed by an interdisciplinary team on 6/5/2017. This policy defines an additional means of supervision of the CNAs executing the ROM and contracture management program, completed by floor nurses on their respective units and shifts. All staff will be reeducated on this policy and procedure by 6/16/2017. Audits for ROM and contracture management services will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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F 318	Continued From page 57	F 318		

and ambulation. NA-I also stated R150's palm protectors were supposed to be off at night and put back on in the morning. (The oppositite of the directions on the facility document titled Willow Team 2).

During interview on 5/11/17 at 9:33 a.m., R150 stated she has only had hand splints on once, "but then they disappeared."

During an interview on 5/11/17 at 10:28 a.m., the director of rehabilitation services (DOR) stated R150 was not currently receiving services from therapy. The DOR stated nursing staff should be assisting the resident with her ROM program.

During an interview on 5/11/17 at 10:39 a.m., licensed practical nurse (LPN)-B stated he was not aware R150 had hand splints.

During an observation on 5/11/17 at 1:01 p.m., physical therapist (PT)-A and occupational therapist (OT)-A assessed R150's hand contractures. OT-A stated R150's contractures had gotten worse. OT-A attempted to put R150's palm protectors on, but was unable. OT-A stated, "I was able to get them on before, she used to be able to move the little finger, now she can't." OT-A stated R150 always had some complaint of pain but R150's complaints had increased, stating "it's worse." OT-A stated both hand contractures had gotten worse, and stated R150 had been able to get her hands at least a little open previously but "now she can't at all." PT-A and OT-A then assisted R150 to ambulate using a walker PT-A had brought with him from the therapy department. After assisting R150 to stand with two, PT-A put R150's right hand on the walker and assisted her to grip the walker

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F 318	Continued From page 58 however, R150 was unable to open her left hand enough to grasp the walker. On 5/11/17 at 1:51 p.m., PT-A stated restorative and ambulation programs were put in place to prevent avoidable declines. During interview on 5/11/17 at 1:12 p.m., the director of nursing (DON) verified when an ambulation or restorative program is set up, it is supposed to indicate specifically that nursing will complete it. The DON further stated the NA's should know when they are responsible for the program. A facility policy related to restorative nursing was requested, but not received.	F 318		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		6/20/17

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F 323	Continued From page 59 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper application and assessment for the use of side rails/assistive devices, to ensure safe and appropriate use for 4 of 5 residents (R42, R91, R147, R126) recently admitted to the facility. The facility also failed to implement interventions to reduce the risk for falls for 1 of 4 residents (R39) reviewed for accidents. Findings included: R42's diagnoses included multiple fractures of ribs, repeated falls, muscle weakness (generalized), history of falling, osteoarthritis obtained from the May 2017 Medication Administration Record (MAR). R42's 30 day Minimum Data Set (MDS) dated 4/26/17, indicated R42 had intact cognition. On 5/8/17, at 4:18 p.m. during an interview with R42, R42's bed was observed to have two (half) 1/2 side rails affixed to it. When the right side rail close to door was touched it was noted to flex inward and outward approximately five inches and appeared to bow out slightly towards the door. R42 stated she used the side rails for bed mobility and transferring in and out of bed. When surveyor went to touch the right side rail, R42 gestured and stated in an agitated voice that she	F 323	F323 It is the policy of Crest View Lutheran Home that residents are able to reside in an environment that remains free from accident hazards, and receive assistance devices to prevent accidents, while maintaining resident independence and choice. This includes the use of bed side rails or other assistive devices, as well as the use of wheelchairs or other mobility devices. Residents R42, R91, R147, and R126 were comprehensively assessed for bed mobility. Resident R42 was assessed and was given two grab bars for bed mobility. Resident R91 was assessed and was determined to not need any assistive devices for bed mobility. Resident R147 was discharged from Crest View Lutheran Home to a home in the community, and no longer requires additional assessments. Resident R126 was assessed and was determined to not need any assistive devices for bed mobility. For all residents listed, care plans and Team Sheets were updated to accurately reflect the plan of care.	

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F 323	Continued From page 60 had brought the side rail issue it to the facility's attention two weeks ago and had been told that the maintenance guy was coming to fix it. R42's falls Care Area Assessment (CAA) dated 4/5/17, indicated resident was at risk related to weakness and being unsteady. R42's care plan dated 4/17/17, indicated resident had the potential/actual alteration in safety, falls related to weakness, incontinence, arthritis and pain. The care plan indicated R42 had two grab bars not side rails as observed. R42's medical record revealed, Side Rail Assessments dated 3/31/17, had been completed by two different nurse on the same date and both had indicated R42 had grab bars on the bed versus two side rails. The assessments indicated R42 required the side rails/grab bars for mobility, however did not indicate if the risks and benefits had been reviewed with resident, or whether staff had checked the side rails for proper placement and fit. On 5/10/17, at 7:48 a.m. R42 was overheard calling "good morning." Registered nurse (RN)-B went to room and R42 stated she wanted to get ready for the day. RN-B was then observed standing next to R42 as she transferred to wheelchair and used the right side rail when transferring off the bed into wheelchair. On 5/11/17, from 9:55 a.m. to 10:19 a.m., licensed practical nurse (LPN)-D (the unit coordinator), and maintenance staff, were observed to be checking all resident beds with side rails. Both staff verified the right side rail on R42's bed was loose. Maintenance staff was observed to attempt to tighten the side rail bolts	F 323	Resident R39 was comprehensively assessed for the risk of falls, and the appropriate use of interventions to limit or reduce falls. Their personalized care plan and CNA team sheet were updated to accurately reflect the updated plan of care. Resident R39 was also screened by an occupational and physical therapist team for proper wheelchair positioning and adaptive equipment. Her personalized care plan and CNA team sheet were updated to accurately reflect the recommendations made. For all other residents that this alleged deficient practice may have affected, a whole-house audit was completed for assistive devices for bed mobility. Each resident was comprehensively assessed for the use of assistive devices for bed mobility, and if bed side rail use was indicated, non-side rail alternatives were used. If bed side rails were indicated for use through the assessment, and other alternatives were trialed and not appropriate, or the resident's preference was to use a bed side rail, a risk a benefit consent form was completed with the resident and their representative. Risks associated with bed side rail use were discussed using the FDA "A Guide To Bed Safety". This federal guide highlights the risks and benefits of bed side rails. Once the comprehensive assessment for assistive devices for bed mobility were completed, all care plans and team sheets were updated to accurately reflect the devices used.	

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F 323	Continued From page 61 and nuts however, was not able to get it to tighten stating he would follow up later in the day. When asked how the maintenance department was informed of loose side rails the maintenance staff stated staff were supposed to fill out maintenance slips. When asked whether the facility had a system for checking side rails and grab bars to make sure they were affixed to the bed properly, he stated the facility had monthly bed audits done and he would provide the documentation. On 5/11/17, at 10:23 a.m. LPN-D reviewed the medical record and verified R42 had not been provided informaiton about risks and benefits for use of the side rails. LPN-D verified R42's care plan indicated resident had grab bars not side rails as observed during the tour. R147 on 5/8/17, at 1:33 p.m. was observed lying in bed and two half (1/2) side rails were observed affixed to the bed frame. Both side rails were noted to be have approximately two inches flex at the time of the room tour. R147's diagnoses included diabetes mellitus, retention of urine and acquired absence of right leg below knee obtained from the quarterly MDS dated 3/8/17. Falls CAA dated 11/8/16, identified R147 was at risk for falls related to requiring extensive assistance with cares, was unsteady and used psychotropic medications. CAA directed staff to assist with transfers. R147's care plan dated 2/17, indicated R147 had potential/actual alteration in safety, falls related to weakness, pain, medication and right below knee amputation. Care plan did not indicate R147 had side rails attached in bed. On 5/11/17, at 10:23 a.m. LPN-D stated she had	F 323	In addition, a whole-house audit was completed for all resident fall interventions added to the plans of care, post-fall. Personalized care plans and resident team sheets were updated, as needed, to accurately reflect recommended fall interventions. The policy and procedure for assessing residents for assistive devices for bed mobility was reviewed and updated by an interdisciplinary team on 6/5/2017. The policy defines the process for assessing, trialing possible alternatives to bed side rails, risk and benefits consents for bed side rails, and care planning assistive devices for bed mobility. In addition, the policy and procedure for care planning and implementing care interventions related to falls was updated and reviewed by an interdisciplinary team on 6/5/2017. All staff will be reeducated on these policies and procedures by 6/16/2017. Audits for assistive bed mobility devices will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Audits for fall interventions will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit	

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F 323	Continued From page 62 been doing the physical device assessments and had not gotten to R147's unit so had not conducted it. R91's diagnoses included hypertension and femur fracture obtained from the 30 day MDS dated 4/6/17. In addition, the MDS indicated R91 had intact cognition. Falls CAA dated 3/16/17, indicated R91 was at risk for falls related to unsteady gait and had a femur fracture and staff was directed to assist with transfers and ambulation. R91's care plan dated 3/17, indicated R91 had potential/actual alteration in safety, falls related to weakness, pain, incontinence and femur fracture sustained 3/2017. R91's care plan did not indicate he had side rails attached in bed. On 5/8/17, at 1:22 p.m. during the room tour and interview, two side rails were observed affixed to the resident's bed. Both side rails were observed to be loose and to flex approximately four inches either way. On 5/11/17, from 9:55 a.m. to 10:19 a.m., licensed practical nurse (LPN)-D (the unit coordinator), and maintenance staff, were observed to be checking all resident beds with side rails. At 10:05 a.m. the maintenance staff and LPN-D went to R91's room. The maintenance staff indicated the resident's side rails were properly affixed to bed and stated the rails had come with bed. When R91 was asked whether he used the side rails he stated "No." R126's room was observed on 5/9/17, at 11:05 a.m. The resident's bed was observed to have two half side rails in place in the up position. The right side rail was noted to be loose and flexed about two inches, and the rail on the left side was	F 323	findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 63 loose and flexed approximately four inches. R126's diagnoses included Parkinson's and depression obtained from the quarterly MDS dated 3/30/17. In addition, the MDS indicated R126 had intact cognition. A falls CAA dated 11/21/16, identified R126 was at risk related to weakness, pain, was unsteady and needed assistance. The resident's care plan dated 12/16, indicated R126 had the potential for alteration in safety, falls, related to weakness, Parkinson's, incontinence and pain. Care plan indicated R126 had grab bars attached to the bed. On 5/11/17, at 10:23 a.m. LPN-D reviewed the medical record and verified R126's care plan indicated resident had grab bars not side rails as observed during the tour. LPN-D stated she had been doing the physical device assessment and had started in another unit however had not gotten to this resident's unit yet. On 5/11/17, at 2:11 p.m. the director of nursing (DON) stated they were working on getting device assessments completed for all residents. The DON stated, "we are working on a new physical device assessment." The DON further stated she would have expected resident care plans to reflect the actual physical safety devices a resident used. The facility's Physical Devices policy revised 4/17, directed: "1. The unit nurse or designee will complete the physical device evaluation on admission, re-admission, significant change of condition and annually. 2. The unit nurse or designee will request physical devices based on the evaluation.	F 323		

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	245018	A. BUILDING _____ B. WING _____	05/11/2017

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F 323	Continued From page 64 3. The unit nurse or designee is responsible for updating the care plan and team sheet..."	F 323		

R39's quarterly Minimum Data Set (MDS) dated 1/28/17, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living. R39's care plan dated April 2017, indicated a potential for alteration in safety related to weakness, balance impairment and cognitive deficits. The care plan directed staff to ensure foot pedals were on when in wheel chair and use Dycem in wheel chair.

A review of a facility document titled Fall, dated 4/13/17, indicated R39 fell after sliding out of her wheel chair. A Crest View Lutheran Home Progress Note dated 4/14/17, indicated R150 had a history of falls and attempting unsafe transfers. The note indicated the resident had foot pedals placed on the wheelchair to prevent the resident from sliding out of the chair.

During an observation on 5/9/17, at 2:26 p.m., R39 was seated in a standard wheelchair. R39 was seated with her hips at the front edge of the seat with the backrest of the wheelchair even with the top of her shoulders. There were no foot pedals on R39's chair.

During observations on 5/10/17, at 9:58 a.m., R39 was seated in her wheelchair. There were no foot pedals on the chair, and R39's legs were dangling approximately six inches above the floor. At 12:48 p.m., she sat in the dayroom in the chair with no foot pedals. At 1:14 p.m., staff escorted R39 from her room in her wheel chair. There were no foot pedals on the chair.

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F 323	Continued From page 65 During observations on 5/11/17, at 8:04 a.m., R39's wheel chair was observed in her room. The chair did not have Dycem and no foot pedals were visible in the room. At 8:55 a.m., R39 was again observed in her wheel chair with no foot pedals and her feet dangling. During an interview on 5/0/17, at 1:35 p.m., nursing assistant (NA)-J stated R39 had not fallen in about six months, but stated she stated she does slide out of her wheel chair. NA-J stated she was unsure what R39's fall interventions were. During an interview on 5/11/17, at 10:40 a.m., LPN-B stated R39 has had falls. He stated when she is up in her wheelchair staff keep an eye on her and if she is sleepy, staff lay her down. During interview on 5/11/17, at 10:43 a.m., NA- B stated she was not aware R39 was supposed to have foot pedals on at all times. During an interview on 5/11/17, the director of nursing stated the interdisciplinary team (IDT) reviews all falls and implements interventions on the plan of care. She stated she expected the staff to follow the interventions put in place by the IDT. A facility policy titled Crest View Lutheran Home Fall Report and Assessment, dated May 2017, indicated the plan of care and the nursing assistant care sheets are updated following falls to include follow up measures taken to prevent further falls.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		6/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 66 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	Continued From page 67 Based on observation, interview and document review, the facility failed to provide medical justification for the continued use of a psychotropic medication for 1 of 5 residents (R150) reviewed for unnecessary medications. Findings include: R150's quarterly Minimum Data Set (MDS) dated 4/19/17, indicated she was severely cognitively impaired and required extensive assistance with activities of daily living. R150's care plan dated 4/17, indicated a potential for alteration in psychosocial well being related to dementia and identified the use of an anti-psychotic medication. A Crest View Lutheran Home Order Summary Report dated 3/16/17, directed Risperdal (antipsychotic) tablet 0.5 milligrams (mg) by mouth once daily at bedtime for agitation related to dementia. The order summary indicated the medication had initially been ordered at admission on 1/12/17. While R150 had been admitted to the facility on an anti-psychotic medication, there was no evidence the facility had assessed R150's ongoing use of the anti-psychotic medication. A review of a Psychotherapeutic drug assessment dated 4/14/17, indicated R150's use of Risperdal 0.5 mg daily. The assessment indicated R150 did not have behaviors that caused her to be a danger to herself or others, nor did the behaviors cause impairment in her ability to function. A section related to potential causes of behavior that addressed whether other causes had been ruled out, had been left blank. Also incomplete was the section regarding documentation of attempts to taper or reduce dose.	F 329	F329 It is the policy of Crest View Lutheran Home that all residents have drug regimens that are free from unnecessary medications. This includes excessive medication doses or duration. Drug regimens need to also include indications for use. Resident R150's drug regimen was reviewed, and received an order on 5/16/2017 to reduce her Risperdal from 0.5mg daily to 0.25mg daily. A new psychotherapeutic drug assessment was completed on 6/2/2017. For all other residents that this alleged deficient practice may have affected, a whole-house audit was completed for the use of antipsychotic medications and unnecessary drugs by the consultant pharmacist. All recommendations from this review were given to the respective Nurse Supervisors/LPN Coordinators for their follow-up. The policy and procedure for antipsychotic monitoring and medication reviews was reviewed and updated by an interdisciplinary team on 6/5/2017. The policies define the procedure for scheduling reviews of antipsychotic medications prior to 14-days for all new admissions, and quarterly thereafter. It also describes in detail the procedure for pharmacy medication reviews of unnecessary medications.	

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F 329	Continued From page 68 An Omnicare of Minnesota pharmacy Consultation Report dated 2/14/17, indicated the following recommendation: R150 receives an antipsychotic, Risperdal. Federal regulations require anti-psychotic use only with one or more of the following conditions: conditions other than dementia, schizophrenia, delusional disorder, psychosis, mania, bipolar. The report further indicated "Symptoms or behaviors must present a danger to the resident or other, and one or both of the following: a) symptoms due to mania or psychosis or b) care planned interventions have been attempted, except in an emergency". The physician had subsequently signed the pharmacy report, and had documented, "will review @ (at) visit." A review of a Physician Progress Note dated 3/16/17, identified R150 as having dementia. The note indicated she had "no behaviors related to her dementia." The assessment identified a diagnosis of Dementia without behavioral disturbance. There was no follow up note regarding the resident's continued use of the Risperdal. On 5/11/17, at 6:55 a.m., NA-H stated R150 "sometimes has behaviors." NA-H stated R150 would tell staff to leave her alone and refused to lay down after lunch. On 5/11/17, at 8:28 a.m., trained medication aide (TMA)- C stated R150 got combative if staff tried to place something in her hand and she did not like her nails cut. TMA-C stated staff leave her for awhile a re-approach and it's better the next time. On 5/11/17, at 8:59 a.m., nursing assistant	F 329	All staff will be reeducated on these policies and procedure by 6/16/2017. Audits for antipsychotic medications and unnecessary drugs will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing and Director of Social Services will be responsible for compliance. Compliance date: 6/20/2017	

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F 329	Continued From page 69	F 329		

(NA)-H and NA-I performed morning cares for R150. During the cares, R150 stated, "You don't have to scrub so hard, I don't get that dirty." While turning R150 side to side, R150 calmly stated, "I don't care." While NA-H and NA-I assisted R150 with dressing, R150 offered only minor complaints and stated, "I'm not going to come here anymore," but did not resist care.

On 5/11/17, at 9:17 a.m., NA-I stated R150 only had behaviors when staff "come at her and don't tell her what your doing."

On 5/11/17, at 9:58 a.m., the director of nursing (DON) stated the pharmacist reviewed charts monthly. She stated the pharmacist gave recommendations and the recommendations were given to the primary physicians. The DON stated, "we let them (physicians) decide if they agree or disagree." The DON stated social services reviewed behaviors at care conference.

On 5/11/17, at 1:52 p.m., social services (SS)-A stated R150 was fairly new to the facility and R150 had been on the medication prior to admission. She also stated pharmacy reviewed medications and she was told about recommendations. SS-A stated the facility had a behavioral interdisciplinary team (IDT), but had not reviewed R150's behaviors or medications. She stated the IDT did not review medications unless the resident saw the psychologist. SS-A stated she had not discussed R150's medications with her family and stated, "I was planning to do that on the 17th (5/17/17)."

A facility policy titled Crest View Lutheran Home Medication Regimen Review, dated 11/16, indicated the facility should independently review

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F 329	Continued From page 70 each resident's medication regimen with the IDT member, resident or responsible party, as needed. The policy further indicated the facility should encourage the prescriber to either accept and act on the recommendations of the consultant pharmacist or reject recommendations and provide an explanation as to why the recommendations was rejected.	F 329		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		6/20/17

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F 441	Continued From page 71 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a	F 441	F441	

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F 441	Continued From page 72 comprehensive infection control program was implemented to include surveillance designed to identify infections so as to prevent the spread to other residents. This had the potential to affect all 113 residents currently residing in the facility. Findings include: On 5/11/17, at 2:24 p.m., RN (registered nurse)-C identified herself as the facility infection control nurse, and had been in that role since 2/28/17. RN-C stated the nursing home had a consultant contracted to educate her, but otherwise had "not been told much about the process." RN-C said she'd "found a map and put (resident) room numbers on it", plotted any illnesses, then correlated it once a month. RN-C said she was trying to do this the first week of the month. In addition, RN-C stated on a monthly basis, the antibiotic use history from was received from their consultant pharmacy and cultures of infectious agents were received monthly on a report from the local hospital laboratory. RN-C said, "I basically look at the two (reports) and make a report." RN-C stated the report was included in the the weekly Interdisciplinary Team (IDT) meeting. RN-C stated the members of the IDT communicate were then expected to communicate to the line staff. RN-C stated she did not always attend the IDT meeting but that her report went to the Quality Assurance Program Improvement (QAPI) meeting every three months. During the 5/11/17 interview with RN-C at 2:24 p.m., she said there were more outbreaks of urinary tract infections (UTI's) on the transitional care unit (TCU). In addition, RN-C stated the facility had two cases of clostridium difficile in	F 441	It is the policy of Crest View Lutheran Home to implement a comprehensive Infection Control program that includes the surveillance and review of resident, staff and visitor infections, as well as educates all staff members on the proper techniques to limit or eliminate the spread of infections. For all residents that this alleged deficient practice may have affected, a review of current practices of infection surveillance occurred. The policy and procedure for the Infection Control Program was reviewed and updated by an interdisciplinary team on 6/5/2017. The current practice was changed to include daily monitoring of infections and anti-biotic stewardship. The procedure details how the Infection Prevention RN receives and monitors all infections daily to identify any possible trends that may occur. If trends in infections occur, actions will be taken immediately, such as staff education of infection control protocols, to limit or eliminate the spread of infections. Audits for the infection control program will be completed twice weekly for four weeks, weekly for four weeks, and scheduled no fewer than bi-weekly thereafter by the Director of Nursing, based on the audit findings. Audits will be completed to monitor that infections are being identified immediately, that trends are being reported immediately for timely follow-up and interventions, and that staff are following current protocols to limit or eliminate the spread of infections.	

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F 441	Continued From page 73 April 2017 and that she had been unaware until she'd completed her report. RN-C stated she had not yet received the April report from the local hospital laboratory, and verified she had no process to track infections in real time. RN-C stated there was a need for improved tracking of current infections. RN-C provided the document used for infection control tracking which included: resident name, onset date of infection, and antibiotic treatment. The log failed to include other components such as: symptom onset, site, infection related diagnosis, culture/results, X-ray/results, organism, any isolation protocols implemented, or date infection resolved. Infection Control logs were provided from January and February of 2017. However, RN-C did not provide any other tracking/logs.	F 441	Outcomes and results from these audits will be brought to the facility's next two monthly QAPI meetings for review and recommendations. The Director of Nursing will be responsible for compliance. Compliance date: 6/20/2017	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS FIRE SAFETY 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 10, 2017. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CREST VIEW LUTHERAN HOME	**4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with additions in 1968 and 2007 and was determined to be built of Type II (111) construction. Since both the original building and the addition are of conforming construction, they were surveyed as one building. 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 122 beds and had a census of 113 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245018	DATE SURVEY COMPLETE: 05/10/2017
NAME OF PROVIDER OR SUPPLIER **CREST VIEW LUTHERAN HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN. 55421**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 341	NFPA 101 Fire Alarm System - Installation

Fire Alarm System - Installation
A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.
18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8

This Standard is not met as evidenced by:
Based on observation and staff interview, the facility did not properly install components of the fire alarm system in accordance with NFPA 72. 19.3.4.1, 9.6.1.8. This deficient practice could affect all residents in the room.

Findings include:

On a facility tour between the hours of 1000 and 1400 on May 10, 2017, observation revealed that a smoke detector has not been installed within five feet of the fire alarm panel.

This deficient practice was verified by the Maintenance Director at the time of discovery.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The above isolated deficiencies pose no actual harm to the residents