Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 11, 2023

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

RE: CCN: 245018
Cycle Start Date: March 2, 2023

Dear Administrator:

On March 16, 2023, we notified you a remedy was imposed. On April 10, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 10, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 31, 2023 be discontinued as of April 10, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 16, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 31, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2023

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

Re: Reinspection Results
Event ID: A4I912

Dear Administrator:

On April 10, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 16, 2023

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

RE: CCN: 245018
Cycle Start Date: March 2, 2023

Dear Administrator:

On March 2, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 2, 2023, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 31, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 31, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 31, 2023 (42 CFR 488.417 (b)).

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

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 $11,292; 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.

If you have not achieved substantial compliance by March 31, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Crest View Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 31, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 2, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 03/02/2023

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
E 000	Initial Comments On 2/27/23 through 3/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/27/23 through 3/2/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F578 when R81's code status order for full code (initiation of cardiopulmonary resuscitation -CPR) was entered into point click care (PCC) however, the providers order for life sustaining treatment (POLST) indicated R81 wanted to be do not resuscitate (DNR). The IJ began on 1/19/23, and the immediacy was removed on 3/2/23. In addition to the recertification survey, the following complaints were reviewed during the survey. H50188750C (MN89448), H50188819C (MN86729), H50188818C (MN85254), H50188782C (MN84742), H50188778C (MN84596), H50188779C (MN84527) with	F 000		

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

Electronically Signed | 03/24/2023

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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F 000	Continued From page 1 deficiencies issued at F578, F582, F676, F695, F698, F700, F755, F757, F867, F880, F881. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		3/2/23

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F 578	Continued From page 2 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a do-not-resuscitate (DNR) order was accurately reflected throughout the medical record for 1 of 26 residents (R81) reviewed for advanced directives. This resulted in an immediate jeopardy (IJ) for R81 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 1/19/23, when the facility obtained a physician's order for R81 to have a full code status even though the physician order for life sustaining treatment (POLST) indicated do not resuscitate (DNR). The IJ was identified on 2/28/23. The administrator and director of nursing (DON) were notified of the IJ on 2/28/23, at 3:15 p.m. The immediate jeopardy was removed on	F 578	Facility CPR and POLSTS policy reviewed and updated 3/2023 R81 code status, care plan and POLSTS reviewed and updated. Staff education provided to professional nursing staff on the CPR and POLSTS P&P and talking with residents when there is a question regarding code status. Professional nursing staff not educated would receive education prior to next scheduled shift. All other residents code status, care and POLSTS reviewed and remain current. Facility will continue to discuss pending POLSTS at clinical IDT meeting daily Social Services or Designee will audit on admission, re-admission and quarterly at care conference	

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F 578	Continued From page 3 3/2/23, but noncompliance remained at the lower scope and severity level of D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R81's quarterly Minimum Data Set (MDS) dated 11/4/22, indicated intact cognition. R81's MDS dated 2/3/23, indicated the following diagnoses: alcohol dependence, alcoholic cirrhosis of the liver, and depression. R81's clinical profile in the electronic medical record (EMR) indicated R81 was her own representative. R81's care plan dated 10/21/21 indicated full code status. R81's hospital discharge summary dated 12/20/22, indicated a code status of DNR was confirmed while in the hospital. R81's physician orders in the EMR dated 1/19/23, indicated R81 was a full code. R81's POLST in the paper chart dated 1/11/23, indicated do not attempt resuscitation/DNR allow natural death and was signed by R81 and the nurse practitioner (NP). A care conference summary note dated 2/7/23, indicated R81 and the nursing supervisor were present at the care conference, but nursing was unable to review R81's code status due to R81 not being able to stay awake.	F 578	Administrator or Designee will monitor for compliance	

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F 578	Continued From page 4 R81's nursing progress notes were reviewed from 12/15/22, through 2/28/23, and lacked additional documentation the code status was reviewed. During review of the EMR on 2/27/23, at 1:26 p.m. R81's face sheet indicated full code status and under the miscellaneous tab, a document named POLST not valid, was the POLST dated 1/11/23, which indicated DNR. During interview on 2/28/23, at 10:42 a.m. registered nurse (RN)-B stated he would check for the code status of a resident on the profile in the EMR and on the paper chart under the advanced directives tab. RN-B reviewed R81's paper chart which indicated a POLST dated and signed on 1/11/23, by R81 and the NP. The POLST indicated R81 did not want to be resuscitated. Further, at 11:07 a.m. RN-B stated if there was a discrepancy, he would need to ask the supervisor, and would start CPR in an emergent situation. During interview on 2/28/23, at 10:50 a.m. R81 was sitting up in bed and alert. R81 stated, "let me die" if her heart stopped. During interview on 2/28/23, at 11:04 a.m. RN-D stated if there was a discrepancy on a resident's code status, and the resident was alert and oriented, she would ask the resident if they wanted full treatment, otherwise she would contact the family and the physician and added they could not have both full code and DNR status. RN-D further stated if a resident did not have a pulse, she would check the code status on the face sheet and added the code status which was also located in the hard chart.	F 578		

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F 578	Continued From page 5 During interview on 2/28/23, at 11:05 a.m. RN-E stated if a resident did not have a pulse, she would check the code status in the EMR and then in the hard chart, and if there was a discrepancy, would start CPR and then clarify the code status. During interview on 2/28/23, at 11:05 a.m. licensed practical nurse (LPN)-E stated if a resident did not have a pulse, he would look for the code status in the care plan behind the door, or in the EMR on the banner. He also stated there was a yellow POLST in the chart, and if there was a discrepancy, he would first administer CPR and sort the rest out later. During an interview on 2/28/23, at 11:23 a.m. the director of nursing (DON) stated staff went to "profile" or "miscellaneous" in point click care to find code status. When the POLST and orders don't match, residents were considered full code. DON verified R81's profile indicated full code. Staff were expected to check the paper chart to confirm. DON stated when the POLST was identified as "not valid", it indicated social services had an updated POLST form. The DON stated R81's POLST had recently been updated. However, the record lacked an updated POLST. When there was a discrepancy, she would expect the staff to administer CPR. During interview and record review on 2/28/23, at 11:38 a.m. the DON stated facility staff were concerned R81 may not have been coherent when the NP reviewed the POLST with R81 on 1/11/23, so a note was sent to the NP per the "patient portal" (an electronic communication) on 1/18/23. DON provided a copy of the patient portal note sent to the nurse practitioner 1/18/23. The note indicated facility staff requested R81's	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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F 578	Continued From page 6 POLST be reviewed a second time with the NP and R81 remain a full code until the POLST was reviewed a second time. The NP replied on 1/19/23, at 7:24 a.m. that R81 was coherent when the POLST was reviewed on 1/11/23. A policy, Cardiopulmonary Resuscitation dated 3/17, indicated if an individual resident, visitor, or staff is found unresponsive and without a pulse, a licensed staff person who is certified in CPR shall initiate CPR unless it is known that a do not resuscitate order that specifically prohibits CPR exists for that individual. Under the procedure If there was no response, no pulse and no respirations, the code status was checked under the advanced directives tab in the front of the chart. The IJ was removed on 3/2/23, at 2:45 p.m. when the facility implemented a removal plan which was verified by interview and document review. -On 2/28/23, reviewed the POLST and code status with R81. -On 3/1/23, the updated POLST with DNR status was signed by the NP and R81. R81's physician orders, code status, POLST, and care plan were updated with the DNR status. -On 3/1/23, audits were completed for all residents to ensure physician orders, code status, POLST, and care plan had no discrepancies. -On 3/1/23 and 3/2/23, the facility CPR and POLST policies/procedures were reviewed and updated. -On 3/1/23 and 3/2/23, education for all professional nursing staff on the CPR and POLST policies/procedures and talking to the resident when there's a question regarding code status was conducted. Professional nursing staff not educated would receive the education prior to the	F 578		

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F 578	Continued From page 7 next shift worked.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		4/6/23

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F 582	Continued From page 8 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) was provided to 2 of 3 residents (R91, R94) who continued to reside in the facility upon termination of Medicare A benefits. Findings include: The Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) informs resident/beneficiaries of potential liability for payment and related standard claim appeal rights. R91's census report printed 3/2/23, indicated 91's Medicare A benefit ended on 2/23/23. R91's census report further indicated R91 continued to reside in the facility. R91's CMS-10055 was requested however was	F 582	Crest View maintains that it notifies each resident in regard to payment status. All residents had the potential to be affected by this deficient practice. Resident #91 was discharged on 3/2/23. Resident #94 was discharged on 3/8/23. CMS 10055 form started to be used in March 2023. MDS Nurses reviewed the log to confirm if anyone needed the CMS 1055 and notices will be given as necessary. Staff that provide the notices were educated. Policies regarding beneficiary notice were created. MDS nurse or designee will monitor for compliance and report to the Administrator any noted issues	

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F 582	Continued From page 9 not provided. R94's census report printed 3/2/23, indicated R94's Medicare A benefit ended on 2/7/23. R94's census report further indicated R94 continued to reside in the facility. R94's CMS-10055 was requested however was not provided. When interviewed on 3/2/23, at 1:23 p.m. the administrator verified a CMS-10055 was not completed for R91 and R94. The administrator further stated the CMS-10055 was not used at the facility and residents were only provided Notice of Medicare Non-Coverage (NOMNC) forms when Medicare A benefits were expiring. A facility policy for beneficiary notification was requested however was not received.	F 582		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(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: §483.24(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 ...	F 676		4/6/23

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F 676	Continued From page 10 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(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 document review, the facility failed to maintain a walking program for 1 of 1 resident (R25) reviewed for activities of daily living (ADL) decline. Findings include: R25's quarterly Minimum Data Set (MDS) dated 2/21/23, indicated R25 had minimal cognitive impairment and required extensive one-person physical assistance with most ADLs. Walk in room and walk in corridor assessment indicated the activity did not occur. R25 used a wheelchair for mobility. R25's diagnoses included hemiplegia and hemiparesis (weakness or paralysis affecting one side of the body), diabetes, and peripheral	F 676	Facility ambulation and Restorative nursing policy and procedure reviewed and updated 3/2023. R25 could have been affected by deficient practice. R25 walking program reviewed and care plan remains current. All other residents on walking had the potential could have been affected by deficient practice. All other residents on walking programs will be reviewed and care plans updated as needed. Staff education in progress regarding facility ambulation policy and procedure. Facility will conduct audits on residents on an ambulation program 3/x week to ensure walking programs are being	

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F 676	Continued From page 11 vascular disease (condition affecting blood circulation). R25's annual MDS dated 11/22/22, indicated R25 required one-person physical assist to walk in room and that R25 used a walker and wheelchair for mobility. R25's ADL care plan dated 12/15/22, indicated R25 had an ADL self-care deficit with a goal to maintain current level of function. Interventions included, "Ambulate 1 time a day, 7 days a week CGA [contact guard assist] 30 feet [ft] with FWW [front wheel walker] and w/c [wheelchair] to follow." R25's physical therapy (PT) note dated 12/13/22, at 1:46 p.m. indicated, "At d/c [discharge from PT], he is CGA for transfer and ambulation c [with] FWW up to 30' [feet]. R25's PT discharge summary dated 12/13/22, indicated a discharge recommendation to be placed on an ambulation program with staff. R25's visual/bedside Kardex report (nursing care sheet) dated 3/1/23, indicated, "Ambulate 1 time a day, 7 days a week CGA 30ft with FWW and w/c to follow." R25's provider order dated 12/22/22, indicated, "Ambulate 1 time a day, 7 days a week CGA 30ft with FWW and w/c to follow every day shift." R25's walking program task report for 1/30/23 through 12/27/23, indicated resident refused three times and not applicable 19 times. R25's February treatment record (TAR) for	F 676	completed. Results of audits will be reviewed at next QAPI meeting. The amount of audits will be assessed at that time. Director of Nursing/Designee will monitor compliance.	

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F 676	Continued From page 12 2/28/23, indicated resident refused ambulation. R25's Resident Referral/Interdepartmental Communication dated 12/20/22, instructed nursing to ambulate R25 one time daily, seven days a week 30 feet with CGA using FWW and w/c to follow. During observation and interview on 2/28/23, at 4:04 p.m. R25 was in the dining room seated in a wheelchair. R25 stated he was not offered to walk today and had not been offered to walk in quite a while. He stated he wanted to walk every day to get strong and he would not refuse if offered. R25 stated he always says yes if they offered to walk him. During observation and interview on 3/1/23, at 9:02 a.m. R25 was in the dining room seated in a wheelchair. R25 stated he had not walked today and had not been offered to walk yesterday or today and staff probably would not offer to walk him today. During observation on 3/1/23, at 9:09 a.m. R25 self-propelled in hallway and stated, "I would be thrilled if I could walk to the washroom." During interview on 3/1/23, at 12:15 p.m. nursing assistant (NA)-D stated she was the restorative NA with the responsibility to walk residents who were on walking programs. NA-D stated R25 refused to walk, and she had never walked him. NA-D stated R25's legs were not strong enough to walk. During interview on 3/1/23, at 12:33 p.m. NA-E stated R25 did not walk anymore and had only seen him walk twice since last April. NA-E stated	F 676		

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F 676	Continued From page 13	F 676		

that the restorative nurse typically walked any resident on a walking program, but other NAs could walk them as well when they had enough staff and time. NA-E stated she never offered to walk R25.

During interview on 3/1/23, at 12:45 p.m. NA-F stated it was difficult for R25 to walk. NA-F stated the last time she had offered to walk R25 was a month ago and he declined because he was too weak. NA-F stated R25 had "not actually walked in months and months." NA-F confirmed R25 had a walking task and stated they should be offering to walk him every day. NA-F stated she indicated resident refused and did not verbally report it to a nurse.

R25's TAR for 3/7/23 and 2/14/23, indicated ambulation was completed and signed off by licensed practical nurse (LPN)-D.

During interview on 3/1/23, at 12:54 p.m. LPN-D stated R25 did not walk and she had not seen him walk in three to four months. LPN-D stated the NAs were supposed to walk residents who were on a walking program and report to the nurse. The nurse would sign it off as completed in the TAR and the NA would sign it as completed in their tasks. LPN-D did not inidicate any communication to leadership or therapy regarding R25 not completing the walking task.

R25's walking program task revision history indicated the walking task was last revised on 1/11/23 by LPN-C.

During interview on 3/1/23, at 1:30 p.m. LPN-C stated she had not seen R25 walk and was not aware he was on a walking program. LPN-C

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F 676	Continued From page 14	F 676		

reviewed point click care (PCC) and stated confirmed revising the task so that it would display on R25's Kardex so NAs would see the task would need to be completed. LPN-C further stated she would expect to be notified if a resident on a daily walking program routinely refused to ambulate.

During interview on 3/1/23, at 1:46 PM assistant director of nursing (ADON) stated she did not think R25 walked any more. ADON further stated if a resident was on a walking program, it should be indicated on the Kardex, and the NA's should be offering ambulation.

During observation on 3/1/23, at 2:11 p.m. NA-D and NA-F assisted R25 using a FWW and CGA to walk with shuffling steps approximately 20 feet. R25 sat down for one minute on the wheelchair the staff followed with, and then walked an additional 12 feet. R25 smiled and stated it had been a while since he did that.

During interview on 3/1/23, at 2:20 p.m. physical therapist stated R25 was discharged from PT on 12/13/22 on a walking program and was not aware ambulation was not occurring. Nursing was provided a referral using an interdepartmental communication form. The expectation was staff would be walking any resident on a walking program and would notify PT if they routinely refused or the resident was not physically able to complete the task.

During interview on 3/1/23, at 2:30 p.m. director of nursing stated she expected residents on a walking program would be walked by staff. R25 should have been offered to walk daily. Nursing should notify therapy if resident consistantly

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F 676	Continued From page 15 unable to complete a walking task. Facility policy Ambulation dated 7/04, indicated, residents would be encouraged and assisted to ambulate for increased independence, to improve morale, and to increase circulation. Walking programs could be initiated by therapy or nursing and communication would occur between nursing and therapy. Facility policy Restorative Nursing Program dated 1/10, indicated the program was to assist residents to achieve and maintain optimal health and the highest practicable physical, mental and psychological well being.	F 676		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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 document review the facility failed to ensure residents were appropriately assessed post dialysis treatments and resident's health status communicated between dialysis center and facility for 1 of 1 resident (R90) reviewed for dialysis. Findings include: R90's admission Minimum Data Set (MDS) dated 2/8/23, indicated R90 was cognitively intact, received dialysis treatment, and had diagnoses	F 698	Dialysis Policy and Procedure reviewed and remains current 3/2023 R1 could have been affected by deficient practice. R1 care plan and physician orders reviewed and updated for nursing staff to assess resident pre and post dialysis, review dialysis run sheet upon return from dialysis, document findings and communicate to dialysis and provider if resident is a change from baseline.	4/6/23

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F 698	Continued From page 16 including end stage renal disease (advanced state with loss of function), diabetes, syncope (feeling lightheaded) and collapse. R90's care plan dated 2/2/23, indicated R90 received dialysis related to renal failure and instructed staff to monitor, document and report signs of infection at the access site, bleeding, changes in level of consciousness and changes in heart and lung sounds. R90's care plan instructed staff to obtain vital signs (VS) and weight per protocol and report significant changes in pulse, respirations, and blood pressure immediately. R90's physician orders indicated R90 had dialysis three times a week and instructed staff to check dialysis site in chest daily for signs of infection. R90's orders lacked further instruction for post dialysis treatment assessment. R90's VS record indicated last documented VS dated 2/25/23, at 22:12 p.m. (10:12 p.m.) During interview on 2/28/23, at 8:28 a.m. R90 stated dialysis was Mondays, Wednesdays, and Fridays. During observation on 3/1/23, at 9:27 a.m. licensed practical nurse (LPN)-D provided wound care and flushed R90's port in preparation for dialysis. Nursing assistant (NA)-D and NA-F provided morning personal care, groomed, dressed, and transferred R90 to a wheelchair using a Hoyer lift. No other assessment or VS obtained. During interview on 3/2/23, at 11:05 a.m. registered nurse (RN)-F stated VS and access	F 698	All other residents receiving dialysis had the potential to be affected by the deficient practice. All other residents receiving dialysis have been reviewed. Care plans and physician orders reviewed and updated for nursing staff to assess resident pre and post dialysis, review dialysis run sheet upon return from dialysis, document findings and communicate to dialysis and provider if resident is a change from baseline. Staff education in progress regarding facility Dialysis assessment Policy and Procedure. Facility will audit dialysis assessments documented in nursing progress notes and dialysis run sheets 3X/week until compliance is met. Results of audits will be reviewed at next QAPI meeting. Amount of audits will be assessed at that time. Director of Nursing/Designee will monitor compliance.	

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F 698	Continued From page 17 site should always be assessed before and after dialysis treatment. RN-F further stated dialysis center should send a run sheet (summary of resident's status during treatment) which should be reviewed by the nurse caring for the resident so they are aware of any complications which may have occurred. RN-F stated the run sheet should be kept in the resident's chart. During interview on 3/2/23, at 11:08 a.m. LPN-C stated the dialysis facility was supposed to send the run sheet back with the resident and the nurse caring for the resident should review it. If the run sheet did not return with the resident, the nurse should call the facility and request one. LPN-C further stated nurses should assess dialysis resident's weight, VS, and access site before and after treatment. During interview on 3/2/23, at 11:58 a.m. RN-C stated VS should be checked before and after dialysis treatment. RN-C further stated mental status, respiratory status, and access site should also be assessed after treatment and the run sheet should be reviewed for any pertinent information. During interview on 3/2/23, at 12:01 p.m. R90 stated could not recall staff ever listening to her lungs post dialysis or checking the access site and they would occasionally check VS. R90 stated she would not refuse such assessments and she always took and brought back an envelope from dialysis and gave to staff. During interview on 3/2/23, at 12:09 p.m. director of nursing stated expectation was for nurses to review the run sheet post dialysis, document pertinent information and file the run sheet in the	F 698		

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F 698	Continued From page 18 resident's hard chart. DON further stated expectation for nurses to assess the resident's mental and respiratory status, access site and VS after every dialysis treatment. Assessment should be documented in a progress note and VS should be documented in point click care (PCC). DON confirmed R90 had dialysis on 3/1/23 and her last assessment and VS were documented on 2/28/23, at 12:33 p.m. DON stated residents took a referral to dialysis in an envelope and that the dialysis center would send the envelope back with a run sheet. DON expectation was there would be a run sheet filed in R90's hard chart for every dialysis treatment and could not explain why the run sheets were not there. Facility policy Dialysis Care dated 3/17, indicated the policy of the facility was to "maintain communication with and coordination of services with outside dialysis providers for the people we serve." The policy further indicated, "Nursing will monitor referrals to/from dialysis center to ensure that information regarding the resident's health status are communicated between the facility and the dialysis center." The policy indicated a pre and post dialysis assessment should include a complete nursing assessment and VS prior to and upon return from dialysis and documented appropriately. Facility policy Dialysis Assessment dated 5/18, indicated, to ensure any change in condition a resident had prior to or after a dialysis run should be communicated to the dialysis center and the primary care provider. "A general assessment will be completed prior to and post dialysis run."	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		4/6/23

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F 700	Continued From page 19 §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure ongoing assessments for safety and appropriate use of grab bars were completed for 1 of 1 resident (R11) who was observed to have grab bars affixed to their bed. Findings include: R11's quarterly Minimum Data Set (MDS) dated 1/13/23, indicated R11 was cognitively intact and had diagnoses of chronic pain and heart failure. Furthermore, R11's MDS indicated R11 did not use bed rails.	F 700	Facility physical device policy and procedure reviewed 3/2023. R11 could have been affected by deficient practice. R11 physical device assessment completed for safety and appropriate use and care plan reviewed and updated and risks and benefits of using grab bars discussed with R11. All residents have the potential to be affected by deficient practice. Facility identified all residents with bedrails and grab bars. Physical device assessment	

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F 700	Continued From page 20 R11's medical record lacked indication R11 was assessed for grab bar use since 11/2021. R11's care plan revised 1/20/19, indicated R11 had an alteration in activities of daily living (ADL) related to decreased mobility and utilized two grab bars for independent bed mobility and repositioning. During an observation on 2/27/23, at 12:49 p.m. R11 was laying in bed. R11's bed had bilateral grab bars. When interviewed on 2/27/23, at 12:49 p.m. R11 stated the grab bars helped him with getting out of bed and was not aware of any safety assessment related to them. When interviewed on 3/2/23, at 9:56 a.m. registered nurse (RN)-A verified R11's grab bars were present. RN-A further stated residents required consent and an assessment for safe use. When interviewed on 3/2/23, at 1:45 p.m. the Director of Nursing (DON) expected bed rails and grab bars to be assessed in the resident's physical device assessment. DON verified R11's grab bars were not included in R11's physical device assessments for the past year. DON further stated this was a miss and should have been completed. A facility assessment titled Physical Devices- Bed Mobility revised 4/2017, directed staff to complete the physical device evaluation upon admission, re-admission, significant change and annually.	F 700	completed, care plans have been reviewed and updated and risks and benefits of using grab bars and bed rails were discussed with residents and or representative. These were completed by 3/24/23. Staff education in progress regarding facility physical device assessment policy and procedure. This will be completed by 4/6/23. Facility will discuss residents who have new orders for grab bars or side rails at clinical IDT meeting, ensuring physical device assessment is completed, R&B explained to resident and care plan updated. Director or nursing/Designee will monitor compliance	

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F 755	Continued From page 21	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure accurate administration of initial COVID-19 vaccination	F 755	Facility reviewed the Managing Medication Errors and adverse consequences and medication	4/6/23

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F 755	Continued From page 22 series for 1 of 5 residents (R56) reviewed for COVID-19 vaccinations who received an incorrect initial COVID-19 vaccine. Findings include: R56's immunization record in point click care (PCC) lacked documentation of R56 receiving an initial primary series of COVID-19 vaccinations. R56's medication administration record (MAR) dated December 2022, indicated R56 received the Pfizer bivalent booster vaccine in the right arm with no immediate adverse reactions noted. R56's progress note dated 12/16/22, indicated R56 received Pfizer bivalent booster with no immediate adverse reactions and lacked documentation the physician was notified of the medication error. R56's progress notes were reviewed from 12/16/22, through 3/2/23, and lacked documentation the physician was notified of the medication error and lacked documentation on any follow-up from the medication error. During interview on 3/2/23, at 4:13 p.m. licensed practical nurse (LPN)-B stated R56 received the bivalent booster on 12/16/22, instead of the "regular" Pfizer and needed another dose because R56 had not had a second dose and would be eligible after March 16, 2023, for a second dose. LPN-B stated physician notifications were documented in the progress notes and verified there was no documentation of the physician being notified of R56 receiving the incorrect COVID-19 vaccine.	F 755	administration P&P reviewed 3/2023 and remains current. R56 could have been affected by the deficient practice.R56 provider and family updated regarding omission of the initial Covid 19 vaccine series, medication error form completed, and pharmacy contacted about next steps for resident to receiving Covid 19 vaccine. Pharmacy responded that there were no official guidelines for this situation. Recommended to start primary 3-6 months from bivalent dose. Medical Director was contacted and agreed with the recommendation with the consent of resident/ representative for continuing with the vaccine. Resident/Representative have not given their final decision. All other residents had the potential to be affected by the deficient practice. Covid Nurse/Staff Development Nurse received education regarding following CDC guideline regarding Covid-19 vaccine administration. Facility conducted audits of all residents Covid 19 vaccination series and all residents have received the Covid-19 initial series vaccination and Electronic Medical Record updated. Staff education in progress regarding residents receiving initial Covid-19 vaccination series. Audits will be conducted for all new admissions regarding Covid-19 vaccination initial series. ADON/Designee will monitor compliance.	

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F 755	Continued From page 23 During interview on 3/2/23, at 5:04 p.m. the clinical pharmacist stated a potential outcome for not being fully vaccinated was it could lead to lower immunity and risk for COVID infection. During interview on 3/2/23, at 5:13 p.m. the director of nursing (DON) stated Pfizer had an initial two step vaccination series, if R56 received the bivalent booster prior to completing the initial Pfizer two step series, a medication error occurred and a medication error report should be completed as well as the physician should have been notified. The DON's expectation was nursing staff document the physician notification under progress notes and stated the physician would need to be notified to determine next steps for completing the COVID-19 vaccination series. A policy, Managing Medication Errors and Adverse Consequences dated 3/13, indicated the nurse or trained medication aide (TMA) would follow relevant clinical guidelines and manufacturer's specifications for use, dose, administration, during, and monitoring of the medication. When it is found that there is/are clinically significant medication consequences and medication errors, the resident's primary physician must be notified immediately.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		4/6/23

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F 757	Continued From page 24 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor side effects for 1 of 3 (R43) residents reviewed for anticoagulation (blood thinner) therapy. Findings include: R43's annual Minimum Data Set (MDS) dated 12/21/22, indicated R43 was cognitively intact and had diagnoses of heart disease and pulmonary embolism (blood clot in lung). Furthermore, R43's MDS indicated R43 received anticoagulation therapy. R43's provider order summary printed 3/2/23, indicated R43 required Rivaroxaban (anticoagulation medication) 20 milligrams(mg) tablet daily to prevent blood clots. R43's weekly skin assessment dated 2/27/23, indicated no skin concerns.	F 757	Facility implemented an Anticoagulation Policy and Procedure 3/2023. Reviewed with Pharmacy Consultant 3/2023. R43 had the potential to be affected by the deficient practice. R43 Electronic Medical Record and care plan reviewed and updated regarding monitoring for side effects of anticoagulation therapy. R43 Risk management completed for bruises noted on left hand, provider and representative contacted. R43 received new gloves to protect hands. All other residents had the potential to be affected by the deficient practice. Facility will review all other residents on anticoagulation therapy. Electronic medical record and care plan will be updated regarding monitoring for side effects of anticoagulation therapy.	

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F 757	Continued From page 25 R43's care plan dated 1/27/23, indicated R43 had alterations to skin related to decreased mobility, edema, history of pressure ulcer and aspirin use and directed staff to monitor R43's skin with cares. R3's R43's care plan further indicated R43 had fragile skin on hands however refused Geri sleeve protection. R43's medical record lacked evidence R43 required monitoring for side effects of anticoagulation therapy. During an observation on 2/27/23, at 5:29 p.m. R43 had several bruises on left hand. One bruise near knuckle on left hand appeared to be raised. When interviewed on 2/27/23, at 5:29 p.m. R43 stated he was on blood thinners and frequently had bruises. R43 further stated the bruise on the knuckle was "like a blood blister". During a follow up interview on 3/1/23, at 12:29 p.m. R43 stated he placed some tape over the bruise on the knuckle as he did not want it to pop. When interviewed on 3/1/23, at 12:32 p.m. nursing assistant (NA)-A stated if any skin issues or bruising was noted on residents, she would let the nurse know right away. NA-A further stated she was unaware of any bruising on R43's hands and wasn't sure why there was tape on the left hand. When interviewed on 3/1/23, at 12:34 p.m. licensed practical nurse (LPN)-A stated residents on anticoagulation therapy needed to be monitored for bleeding or bruising. LPN-A further stated monitoring was an order that would be signed off each shift and would reflect on the	F 757	Staff education in progress regarding facility anticoagulation side effect monitoring policy and procedure. Pharmacy Consultant will complete chart reviews monthly to monitor compliance for all residents on anticoagulation therapy and make recommendations for monitoring if needed. ADON/designee will monitor compliance.	

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F 757	Continued From page 26 treatment record. LPN-A verified R43 was on anticoagulation therapy with no side effect monitoring in place. LPN-A had not been notified of any skin concerns for R43 and was unaware of any bruising. When interviewed on 3/1/23, at 12:59 p.m. LPN-C verified residents on anticoagulation therapy required monitoring for side effects. LPN-C further stated it was a nursing driven order and verified no monitoring was in place to monitor side effects of R43's anticoagulation therapy. When interviewed on 3/2/23, at 12:37 p.m. the clinical pharmacist (CP) stated she was unsure of how the facility policy directed staff to monitor anticoagulation therapy. CP reviewed labs, vital signs, and nursing notes to help identify concerns during the monthly medication review. CP further stated ensuring an order for anticoagulation monitoring was in place was not something she had needed to recommend at this point and would need to review the facility policy to determine if it was needed. When interviewed on 3/2/23, at 1:45 p.m. the director of nursing (DON) expected staff to monitor for bruising, bleeding, or any adverse reactions when residents are on anticoagulation therapy. DON further stated any bruising was expected to be documented in the progress notes and also expected an order for daily monitoring of side effects would be placed. A facility policy on anticoagulation therapy monitoring was requested however was not received.	F 757		
F 867 SS=F	QAPI/QAA Improvement Activities	F 867		4/6/23

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F 867	Continued From page 27 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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F 867	Continued From page 28 prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F 867		

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F 867	Continued From page 29 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the quality assessment and assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in	F 867	Crest View maintains that auditing regarding concerns are regularly being completed. All residents had the potential to be affected by the deficient practice.	

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F 867	Continued From page 30 identifying and implementing appropriate action plans to correct quality deficiencies identified during previous surveys related to infection control, respiratory therapy and advanced directives resulting in deficiencies identified during this survey. In addition, the facility failed to review and/or revise policies affecting resident care periodically to ensure the policy/practice was still appropriate. This deficient practice had the potential to affect all 95 residents currently residing in the facility. Findings include: The Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data was converted to quality measures (QM) to evaluate nursing home's performance) dated 2/16/23, identified the following prior deficiencies by month and year: -F578-Request/Refuse/Discontinue treatment; Formulate advance directives was cited on prior surveys 10/7/21, 11/19 and 3/18. All were cited at a scope and severity (S&S) of a D. -F880-Infection control was cited on prior surveys on 10/7/21, at a S&S of a D; and on 11/19 and 10/18 both at a S&S of an E. See also F578. Based on interview, and record review, the facility failed to ensure a do-not-resuscitate (DNR) order was accurately reflected throughout the medical record for 1 of 26 residents (R81) reviewed for advanced directives. This resulted in an immediate jeopardy (IJ) for R81 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations.	F 867	QAPI procedures are being updated to regularly include audit reports/discussions. Policies reviewed since the survey have included Ambulation policy, Antibiotic Stewardship Policy, Dialysis Care, Handwashing, gloving, Influenza, Medication Administration, Physical Devices-Bed Mobility, Restorative nursing. These policies will be discussed at the next QAPI meeting. CASPER report was reviewed at March QAPI meeting. The Work Flow of QAPI will be discussed at the April QAPI meeting	

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	245018	A. BUILDING _____ B. WING _____	C 03/02/2023

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

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F 867	Continued From page 31 See also F880. Based on observation, interview and document review, the facility failed to ensure resident ice packs were stored separately from resident food in 2 of 4 nursing unit resident refrigerators. This had the potential to impact 73 residents residing on those units. Furthermore, the facility failed to ensure current standards of practice for glove use and handwashing were being followed for 1 of 1 resident (R31), when staff provided personal care. January and February 2023 QAPI meeting minutes indicated survey prep (preparing for survey at any time) with infection control, assessments, and POLSTS listed as areas of concerns from last survey. The meetings indicated, "no changes at this time." During interview on 3/2/23, at 4:45 p.m. administrator stated areas of concern were identified during each QAPI meeting, and confirmed, "we have not followed up appropriately with the previous survey deficiencies." Administrator further stated there was no continued auditing occurring and stated, "We should periodically monitor to check if we are still in compliance and not just say no action needed at this time." Administrator further stated all policies should be reviewed and revised as needed periodically and many of their policies are outdated and have not been reviewed in many years. Facility policies used during survey with last review/revision date: Ambulation Policy 7/04 Antibiotic Stewardship Policy 1/9/19 Dialysis Care 3/17	F 867		

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F 867	Continued From page 32 Hand Washing 7/2020 Influenza Policy 9/08 Managing Medication Errors and Adverse Consequences 3/13 Medication Administration 12/31/19 Physical Devices - Bed Mobility 4/17 Restorative Nursing 1/10 The facility QAPI 2022 plan dated 3/2/21, indicated data would be collected from a variety of areas to include CASPER report and survey results and the performance indicators would be monitored and tracked through internal audits, quality measures and quality indicators. The plan further indicated the QAPI plan would be reviewed and revised on an annual basis. The undated facility QAPI charter indicated the administrator would ensure the QAPI plan was on an annual basis. The charter indicated, "To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and is performed consistently."	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/6/23

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F 880	Continued From page 33 §483.80(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: §483.80(a)(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; §483.80(a)(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 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	F 880		

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F 880	Continued From page 34 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 resident ice packs were stored separately from resident food in 2 of 4 nursing unit resident refrigerators. This had the potential to impact 73 residents residing on those units. Furthermore, the facility failed to ensure current standards of practice for glove use and handwashing were being followed for 1 of 1 resident (R31), when staff provided personal care. Findings include: Ice pack storage for resident use An observation on 2/27/23, at 3:03 p.m. the unit-A resident refrigerator sign indicated refrigerator storage was only for items intended for human consumption. Inside the refrigerator's freezer	F 880	Facility reviewed infection control policy, gloving policy procedure, and handwashing policy and procedure on 3/2023 and remains current. R 31 care plan reviewed and remains current. The resident had the potential to be affected by the deficient practice. All other residents were a potential risk for the deficient practice. Facility has stored all ice packs separately from resident food storage areas and placed in designated storage area. Any ice packs found in resident food storage areas were thrown away. Facility will be changing to disposable ice packs for resident use that will be disposed of after each use. Staff education in process regarding proper storage of ice packs.	

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F 880	Continued From page 35 several blue gel ice packs were noted along with smaller white reusable shipping ice packs. An observation on 2/27/23, at 7:02 p.m. unit B and C's resident refrigerator sign indicated refrigerator storage was only for items intended for human consumption. Inside the refrigerator's freezer two blue gel ice packs were noted along with one smaller white reusable shipping ice pack. When interviewed on 3/2/23, at 7:32 a.m. registered nurse (RN)-C stated if a resident requested an ice pack to use, the facility had ice packs in a freezer located in the medication room. Ice packs were used on various body parts to help with swelling or pain control. The resident refrigerator was only for food storage. RN-C verified an ice pack was in unit B and C's refrigerator and further stated it looked like one from pharmacy. RN-C removed the ice pack and threw it away. When interviewed on 3/2/23, at 9:34 a.m. trained medication assistant (TMA)-A stated the medication room contained a freezer that stored ice packs for resident use to help with swelling or pain control. TMA-A verified the unit-A refrigerator should not have ice packs stored there and the refrigerator was only for food storage. Upon review of unit-A refrigerator, TMA-A verified there were three gel ice packs and several smaller white ice packs in the resident refrigerator. TMA-A stated they should not be there. When interviewed on 3/2/23, at 1:45 p.m. the director of nursing (DON) expected resident refrigerators to contain food only. Furthermore,	F 880	Staff education in process regarding hand hygiene, glove use, and Infection control policy and procedures. Facility will conduct audits every shift every day regarding ice packs stored separately from resident food storage areas. Hand Hygiene and gloving will be audited every shift every day for 1 week. Frequency will be determined after the results of the audit. Results of audits will be reviewed at next QAPI meeting. Amount of audits will be assessed at that time. ADON/ infection preventionist/designee will monitor compliance.	

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F 880	Continued From page 36	F 880		

the DON stated there were freezers for ice packs in the storage room. Storing resident care items separate from food was important to minimize risk of infection or food contamination.

Personal care

R31's quarterly Minimum Data Set (MDS) dated 12/6/22, indicated R31 was cognitively intact and had diagnoses of heart failure. Furthermore, R31's MDS indicated R31 required extensive assist of one for toileting.

An observation on 3/1/23, at 10:13 a.m. nursing assistant (NA)-B and NA-C entered R31's room to assist R31 off the bedpan. NA-B and NA-C assisted R31 to turn, and NA-B removed the bedpan from underneath R31. The urine in the bedpan was discarded before NA-B provided R31 perineal care. Without removing soiled gloves or performing hand hygiene, NA-B placed a clean brief under R31 and assisted R31 to roll onto her back. NA-B realized R31's pants were wet with urine. NA-B then removed soiled gloves and without performing hand hygiene obtained new pants from R31's closet. Without performing hand hygiene, NA-B donned clean gloves and assisted R31 to remove the soiled pants. The soiled pants were placed at the bottom of R31's bed on top of the clean sheets and blanket. NA-B took the dirty pants and placed them in a laundry bag. Without removing soiled gloves or performing hand hygiene, NA-B and NA-C assisted R31 to pull up her pants. NA-B and NA-C then removed gloves without performing hand hygiene and continued to assist R31 with the Hoyer lift into the wheelchair.

When interviewed on 3/1/23, at 10:29 p.m. NA-B

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F 880	Continued From page 37 verified he did not perform hand hygiene after removing soiled gloves as there was not hand sanitizer in the room. Furthermore, NA-B stated performing hand hygiene should have been done and was important to minimize infection. When interviewed on 3/1/23, at 12:59 p.m. licensed practical nurse (LPN)-C stated hand hygiene was required in between glove changes and when moving from any dirty or soiled tasks to clean ones. When interviewed on 3/2/23, at 1:45 p.m. the DON stated staff were expected to remove gloves and perform hand hygiene when moving from any dirty area to clean areas. DON further stated this was important to prevent the spread of bacteria and infection. A facility policy titled Hand Washing Policy and Procedures revised 7/2020, directed staff to hand wash or hand sanitize before and after providing personal cares for a resident, after touching anything that may have been contaminated with bodily fluids and after removing gloves.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(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: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced	F 881		4/6/23

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F 881	Continued From page 38 by: Based on interview and document review, the facility failed to assess appropriateness of antibiotic use was completed for 1 of 1 residents (R60) who was prescribed oral antibiotics for a skin infection. Findings include: R60's quarterly Minimum Data Set (MDS) dated 1/24/23, indicated R60 had moderate cognitive impairment and diagnoses of chronic obstructive pulmonary disease (COPD). R60's provider order dated 2/24/23, indicated R60 required Doxycycline (antibiotic) tablet 100 milligrams(mg) by mouth twice daily for cyst/cellulitis (skin infection) for 10 days. R60's provider order dated 2/27/23, indicated R60 required a 72-hour time out assessment on the evening of 2/27/23. R60's medical record lacked evidence a 72-hour antibiotic time out assessment was completed. When interviewed on 3/1/23, at 10:51 a.m. licensed practical nurse (LPN)-A verified R60 was on Doxycycline for a cyst on his buttock. LPN-A stated when residents were placed on antibiotics, nurses were required to complete a 72-hour assessment to determine if the antibiotics were working. LPN-A verified R60 had started Doxycycline on 2/27/22, but was unable to find a 72-hour assessment in R60's medical record. When interviewed on 3/1/23, at 12:59 p.m. LPN-C stated residents receiving antibiotics required a 72-hour nursing assessment to	F 881	Facility reviewed Antibiotic Stewardship P&P updated 3/2023 R60 has completed antibiotic therapy without adverse effects but had the potential to be affected by deficient practice. All residents had the potential to be affected by the deficient practice. . Staff education in progress regarding Antibiotic Stewardship policy and Procedure and regarding purpose of the 72-hour time out assessment Facility will audit 72-hour time out assessments for residents receiving antibiotic therapy ongoing. Results will be discussed during the regular scheduled QAPI meeting. ADON/infection preventionist/Designee will monitor compliance.	

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F 881	Continued From page 39 evaluate the effectiveness of the antibiotic treatment. LPN-C acknowledged R60 had not had a 72-hour assessment completed. Furthermore, LPN-C verified there was an order to complete one on 2/27/23, however the assessment was not done. When interviewed on 3/2/23, at 10:13 a.m. the infection preventionist (IP) stated completion of the 72-hour assessment was part of the antibiotic stewardship program. The 72-hour assessment was in the electronic medical record. The nurse sees an order, completes the assessment, and then updates the provider to determine the appropriateness of the antibiotic and if it needed to be stopped, continued, or changed to something else. When interviewed on 3/2/23, at 1:45 p.m. the director of nursing (DON) expected staff to complete a 72-hour time out assessment and further stated this is part of the antibiotic stewardship policy. DON further stated the assessment was important to minimize antibiotic use when able to and ensure antibiotic treatment was effective for the residents. A facility policy titled Antibiotic Stewardship revised 1/2019, directed all residents would participate in the facility antibiotic stewardship program. Furthermore, the policy directed staff to reassess antibiotic therapy and to consider if the antibiotic was warranted and effective. Providers will be notified of the process.	F 881		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Crest View Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with additions in 1968 and 2007 and was determined to be built of Type II (111) construction. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 106 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 17.4.4 This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 03/02/2023 between 09:00 AM and 12:30 PM, it was revealed by observation a smoke detector was hanging from it wires in the ceiling in a housekeeping closet across from room 13. An interview with the Assistant Maintenance Tech and the Campus Administrator verified this	K 345	Fire Alarm was fixed on March 3, 2023. Maintenance staff have verified that what was on the last inspection report was correct to confirm that no other detectors were affected. No residents were affected by this and were at minimal risk. The Company that did the testing was contacted and a clarification to the testing was issued. They conducted their own education to their staff.	4/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 deficient finding at the time of discovery.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/02/2023, at 11:45 AM. it was revealed by observation that there was storage within 18	K 353	Red tape was added to remind staff to not go above the line and updated signs were made to remind staff regarding placement of items. Weekly audits will be conducted between Nursing and maintenance to confirm. This will be reassessed at the June QAPI meeting	4/6/23

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	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2023**

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

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K 353	Continued From page 4 inches of a sprinkler head in the Linen Storage Room W2. An interview with the Assistance Maintenance Tech and the Campus Administrator verified this deficient finding at the time of discovery.	K 353		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health	K 920	A whole house audit was completed. All cords were found to be in compliance. Education to staff is being completed. A	4/6/23

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	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2023**

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K 920	Continued From page 5 Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/02/2023 between 09:00 AM and 12:30 PM, it was revealed by observation there was a refrigerator plugged into a power strip in room 40. 2. On 03/02/2023 between 09:00 AM and 12:30 PM, it was revealed by observation there were medical devices plugged into a power strip. An interview with the Assistant Maintenance Tech and the Campus Administrator verified this deficient finding at the time of discovery.	K 920	bimonthly audit will be conducted by maintenance and other designated staff. This will be reassessed at the June QAPI meeting.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: A4I911

Dear Administrator:

The above facility was surveyed on February 27, 2023 through March 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 03/02/2023

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/27/23 through 3/2/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued 0302, 1375, and 1540. Please indicate in your electronic plan of correction you have	2 000		

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		4/6/23

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2 302	Continued From page 3 Based on interview and record review, the facility failed to ensure consumers were provided a description of the Alzheimer's disease or related disorder training in a written or electronic form. Findings include: The facility admit packet lacked written information to consumers regarding information on Alzheimer's or dementia training. During interview on 3/2/23, at 3:48 p.m. administrator stated unable to find evidence that the facility notified the consumer electronically or in writing of dementia training including covered topics, who is trained and frequency of trainings. Suggested Methods of Correction: The administrator or designee could add information describing the staff training program, categories of employees trained and the frequency of training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident ice	21375	Corrected	4/6/23

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21375	Continued From page 4 packs were stored separately from resident food in 2 of 4 nursing unit resident refrigerators. This had the potential to impact 73 residents residing on those units. Furthermore, the facility failed to ensure current standards of practice for glove use and handwashing were being followed for 1 of 1 resident (R31), when staff provided personal care. Findings include: Ice pack storage for resident use An observation on 2/27/23, at 3:03 p.m. the unit-A resident refrigerator sign indicated refrigerator storage was only for items intended for human consumption. Inside the refrigerator's freezer several blue gel ice packs were noted along with smaller white reusable shipping ice packs. An observation on 2/27/23, at 7:02 p.m. unit B and C's resident refrigerator sign indicated refrigerator storage was only for items intended for human consumption. Inside the refrigerator's freezer two blue gel ice packs were noted along with one smaller white reusable shipping ice pack. When interviewed on 3/2/23, at 7:32 a.m. registered nurse (RN)-C stated if a resident requested an ice pack to use, the facility had ice packs in a freezer located in the medication room. Ice packs were used on various body parts to help with swelling or pain control. The resident refrigerator was only for food storage. RN-C verified an ice pack was in unit B and C's refrigerator and further stated it looked like one from pharmacy. RN-C removed the ice pack and threw it away.	21375		

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21375	Continued From page 5 When interviewed on 3/2/23, at 9:34 a.m. trained medication assistant (TMA)-A stated the medication room contained a freezer that stored ice packs for resident use to help with swelling or pain control. TMA-A verified the unit-A refrigerator should not have ice packs stored there and the refrigerator was only for food storage. Upon review of unit-A refrigerator, TMA-A verified there were three gel ice packs and several smaller white ice packs in the resident refrigerator. TMA-A stated they should not be there. When interviewed on 3/2/23, at 1:45 p.m. the director of nursing (DON) expected resident refrigerators to contain food only. Furthermore, the DON stated there were freezers for ice packs in the storage room. Storing resident care items separate from food was important to minimize risk of infection or food contamination. Personal care R31's quarterly Minimum Data Set (MDS) dated 12/6/22, indicated R31 was cognitively intact and had diagnoses of heart failure. Furthermore, R31's MDS indicated R31 required extensive assist of one for toileting. An observation on 3/1/23, at 10:13 a.m. nursing assistant (NA)-B and NA-C entered R31's room to assist R31 off the bedpan. NA-B and NA-C assisted R31 to turn, and NA-B removed the bedpan from underneath R31. The urine in the bedpan was discarded before NA-B provided R31 perineal care. Without removing soiled gloves or performing hand hygiene, NA-B placed a clean brief under R31 and assisted R31 to roll onto her back. NA-B realized R31's pants were wet with urine. NA-B then removed soiled gloves and	21375		

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21375	Continued From page 6 without performing hand hygiene obtained new pants from R31's closet. Without performing hand hygiene, NA-B donned clean gloves and assisted R31 to remove the soiled pants. The soiled pants were placed at the bottom of R31's bed on top of the clean sheets and blanket. NA-B took the dirty pants and placed them in a laundry bag. Without removing soiled gloves or performing hand hygiene, NA-B and NA-C assisted R31 to pull up her pants. NA-B and NA-C then removed gloves without performing hand hygiene and continued to assist R31 with the Hoyer lift into the wheelchair. When interviewed on 3/1/23, at 10:29 p.m. NA-B verified he did not perform hand hygiene after removing soiled gloves as there was not hand sanitizer in the room. Furthermore, NA-B stated performing hand hygiene should have been done and was important to minimize infection. When interviewed on 3/1/23, at 12:59 p.m. licensed practical nurse (LPN)-C stated hand hygiene was required in between glove changes and when moving from any dirty or soiled tasks to clean ones. When interviewed on 3/2/23, at 1:45 p.m. the DON stated staff were expected to remove gloves and perform hand hygiene when moving from any dirty area to clean areas. DON further stated this was important to prevent the spread of bacteria and infection. A facility policy titled Hand Washing Policy and Procedures revised 7/2020, directed staff to hand wash or hand sanitize before and after providing personal cares for a resident, after touching anything that may have been contaminated with bodily fluids and after removing gloves.	21375		

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21375	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review/revise facility policies regarding hand hygiene. The DON, or designee, could then educate staff and perform audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		4/6/23

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21426	Continued From page 8 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R9, R14, R56) were administered a step two tuberculosis skin test (TST) within 72 hours of admission or three months prior to admisssion. In addition the facilty failed to ensure 3 of 5 residents (R14, R56, R89) were screened for active tuberculin symptoms. R9's record revealed an admission date and a tuberculin symptom screening date of 1/5/21. R9's step one TST was administered on 1/6/21 and a step two TST was not completed. R14's record revealed an admission date of 9/1/21. R14's step one TST was administered on 9/31/21 and no step two TST was administered. R14's record lacked a tuberculin symptom screening. R56's record revealed an admission date 7/8/22. R56's step one TST was administered on 7/9/22 and no step two TST was administered. R56's record lacked a tuberculin symptom screening. R89's record revealed an admission date of 7/22/22. R9's step one TST was administered on 8/1/22 and no step two TST was administered. R89's record lacked a tuberculin symptom screening. During an interview on 3/2/23, at 5:13 p.m. the assistant director of nursing (ADON) verified R9, R14, and R56 had no documentation a step two TST had been administered. She further verified there was no documentation R14, R56, and R89 had been screened for symptoms of tuberculosis. The ADON stated when a resident was admitted to the facility, the symptom screening should be done on the first day and then the step one TST	21426	Corrected	

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21426	Continued From page 9 was scheduled for the next day. The expectation was the nurse would document where and when they administered the immunization and then document it in point click care (computer program for medical documentation) and under immunizations. During an interview on 3/2/23, at 5:30 p.m. the director of nursing (DON) stated when a resident was admitted to the facility the expectation was the resident should be screened for tuberculosis, a two step Mantoux should be offered, and the results should be documented. A policy on tuberculosis was requested but not received. SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designee could monitor to assure tuberculin screening procedure was developed and implemented to ensure residents were free of tuberculosis upon admission to the facility. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist	21540		4/6/23

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21540	Continued From page 10 believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor side effects for 1 of 3 (R43) residents reviewed for anticoagulation (blood thinner) therapy. Findings include: R43's annual Minimum Data Set (MDS) dated 12/21/22, indicated R43 was cognitively intact and had diagnoses of heart disease and pulmonary embolism (blood clot in lung). Furthermore, R43's MDS indicated R43 received anticoagulation therapy. R43's provider order summary printed 3/2/23, indicated R43 required Rivaroxaban (anticoagulation medication) 20 milligrams(mg) tablet daily to prevent blood clots. R43's weekly skin assessment dated 2/27/23, indicated no skin concerns. R43's care plan dated 1/27/23, indicated R43 had	21540	Corrected	

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21540	Continued From page 11 alterations to skin related to decreased mobility, edema, history of pressure ulcer and aspirin use and directed staff to monitor R43's skin with cares. R3's R43's care plan further indicated R43 had fragile skin on hands however refused Geri sleeve protection. R43's medical record lacked evidence R43 required monitoring for side effects of anticoagulation therapy. During an observation on 2/27/23, at 5:29 p.m. R43 had several bruises on left hand. One bruise near knuckle on left hand appeared to be raised. When interviewed on 2/27/23, at 5:29 p.m. R43 stated he was on blood thinners and frequently had bruises. R43 further stated the bruise on the knuckle was "like a blood blister". During a follow up interview on 3/1/23, at 12:29 p.m. R43 stated he placed some tape over the bruise on the knuckle as he did not want it to pop. When interviewed on 3/1/23, at 12:32 p.m. nursing assistant (NA)-A stated if any skin issues or bruising was noted on residents, she would let the nurse know right away. NA-A further stated she was unaware of any bruising on R43's hands and wasn't sure why there was tape on the left hand. When interviewed on 3/1/23, at 12:34 p.m. licensed practical nurse (LPN)-A stated residents on anticoagulation therapy needed to be monitored for bleeding or bruising. LPN-A further stated monitoring was an order that would be signed off each shift and would reflect on the treatment record. LPN-A verified R43 was on anticoagulation therapy with no side effect	21540		

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21540	Continued From page 12 monitoring in place. LPN-A had not been notified of any skin concerns for R43 and was unaware of any bruising. When interviewed on 3/1/23, at 12:59 p.m. LPN-C verified residents on anticoagulation therapy required monitoring for side effects. LPN-C further stated it was a nursing driven order and verified no monitoring was in place to monitor side effects of R43's anticoagulation therapy. When interviewed on 3/2/23, at 12:37 p.m. the clinical pharmacist (CP) stated she was unsure of how the facility policy directed staff to monitor anticoagulation therapy. CP reviewed labs, vital signs, and nursing notes to help identify concerns during the monthly medication review. CP further stated ensuring an order for anticoagulation monitoring was in place was not something she had needed to recommend at this point and would need to review the facility policy to determine if it was needed. When interviewed on 3/2/23, at 1:45 p.m. the director of nursing (DON) expected staff to monitor for bruising, bleeding, or any adverse reactions when residents are on anticoagulation therapy. DON further stated any bruising was expected to be documented in the progress notes and also expected an order for daily monitoring of side effects would be placed. A facility policy on anticoagulation therapy monitoring was requested however was not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise	21540		

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21540	Continued From page 13 policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a do-not-resuscitate (DNR) order was accurately reflected throughout the medical record for 1 of 26 residents (R81) reviewed for advanced directives. This resulted in an immediate jeopardy (IJ) for R81 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations.	21840	Corrected	3/2/23

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21840	Continued From page 14 The IJ began on 1/19/23, when the facility obtained a physician's order for R81 to have a full code status even though the physician order for life sustaining treatment (POLST) indicated do not resuscitate (DNR). The IJ was identified on 2/28/23. The administrator and director of nursing (DON) were notified of the IJ on 2/28/23, at 3:15 p.m. The immediate jeopardy was removed on 3/2/23, but noncompliance remained at the lower scope and severity level of D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R81's quarterly Minimum Data Set (MDS) dated 11/4/22, indicated intact cognition. R81's MDS dated 2/3/23, indicated the following diagnoses: alcohol dependence, alcoholic cirrhosis of the liver, and depression. R81's clinical profile in the electronic medical record (EMR) indicated R81 was her own representative. R81's care plan dated 10/21/21 indicated full code status. R81's hospital discharge summary dated 12/20/22, indicated a code status of DNR was confirmed while in the hospital. R81's physician orders in the EMR dated 1/19/23, indicated R81 was a full code. R81's POLST in the paper chart dated 1/11/23, indicated do not attempt resuscitation/DNR allow natural death and was signed by R81 and the nurse practitioner (NP).	21840		

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21840	Continued From page 15 A care conference summary note dated 2/7/23, indicated R81 and the nursing supervisor were present at the care conference, but nursing was unable to review R81's code status due to R81 not being able to stay awake. R81's nursing progress notes were reviewed from 12/15/22, through 2/28/23, and lacked additional documentation the code status was reviewed. During review of the EMR on 2/27/23, at 1:26 p.m. R81's face sheet indicated full code status and under the miscellaneous tab, a document named POLST not valid, was the POLST dated 1/11/23, which indicated DNR. During interview on 2/28/23, at 10:42 a.m. registered nurse (RN)-B stated he would check for the code status of a resident on the profile in the EMR and on the paper chart under the advanced directives tab. RN-B reviewed R81's paper chart which indicated a POLST dated and signed on 1/11/23, by R81 and the NP. The POLST indicated R81 did not want to be resuscitated. Further, at 11:07 a.m. RN-B stated if there was a discrepancy, he would need to ask the supervisor, and would start CPR in an emergent situation. During interview on 2/28/23, at 10:50 a.m. R81 was sitting up in bed and alert. R81 stated, "let me die" if her heart stopped. During interview on 2/28/23, at 11:04 a.m. RN-D stated if there was a discrepancy on a resident's code status, and the resident was alert and oriented, she would ask the resident if they wanted full treatment, otherwise she would contact the family and the physician and added	21840		

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21840	Continued From page 16 they could not have both full code and DNR status. RN-D further stated if a resident did not have a pulse, she would check the code status on the face sheet and added the code status which was also located in the hard chart. During interview on 2/28/23, at 11:05 a.m. RN-E stated if a resident did not have a pulse, she would check the code status in the EMR and then in the hard chart, and if there was a discrepancy, would start CPR and then clarify the code status. During interview on 2/28/23, at 11:05 a.m. licensed practical nurse (LPN)-E stated if a resident did not have a pulse, he would look for the code status in the care plan behind the door, or in the EMR on the banner. He also stated there was a yellow POLST in the chart, and if there was a discrepancy, he would first administer CPR and sort the rest out later. During an interview on 2/28/23, at 11:23 a.m. the director of nursing (DON) stated staff went to "profile" or "miscellaneous" in point click care to find code status. When the POLST and orders don't match, residents were considered full code. DON verified R81's profile indicated full code. Staff were expected to check the paper chart to confirm. DON stated when the POLST was identified as "not valid", it indicated social services had an updated POLST form. The DON stated R81's POLST had recently been updated. However, the record lacked an updated POLST. When there was a discrepancy, she would expect the staff to administer CPR. During interview and record review on 2/28/23, at 11:38 a.m. the DON stated facility staff were concerned R81 may not have been coherent when the NP reviewed the POLST with R81 on	21840		

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21840	Continued From page 17 1/11/23, so a note was sent to the NP per the "patient portal" (an electronic communication) on 1/18/23. DON provided a copy of the patient portal note sent to the nurse practitioner 1/18/23. The note indicated facility staff requested R81's POLST be reviewed a second time with the NP and R81 remain a full code until the POLST was reviewed a second time. The NP replied on 1/19/23, at 7:24 a.m. that R81 was coherent when the POLST was reviewed on 1/11/23. A policy, Cardiopulmonary Resuscitation dated 3/17, indicated if an individual resident, visitor, or staff is found unresponsive and without a pulse, a licensed staff person who is certified in CPR shall initiate CPR unless it is known that a do not resuscitate order that specifically prohibits CPR exists for that individual. Under the procedure If there was no response, no pulse and no respirations, the code status was checked under the advanced directives tab in the front of the chart. The IJ was removed on 3/2/23, at 2:45 p.m. when the facility implemented a removal plan which was verified by interview and document review. -On 2/28/23, reviewed the POLST and code status with R81. -On 3/1/23, the updated POLST with DNR status was signed by the NP and R81. R81's physician orders, code status, POLST, and care plan were updated with the DNR status. -On 3/1/23, audits were completed for all residents to ensure physician orders, code status, POLST, and care plan had no discrepancies. -On 3/1/23 and 3/2/23, the facility CPR and POLST policies/procedures were reviewed and updated. -On 3/1/23 and 3/2/23, education for all professional nursing staff on the CPR and POLST	21840		

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21840	Continued From page 18 policies/procedures and talking to the resident when there's a question regarding code status was conducted. Professional nursing staff not educated would receive the education prior to the next shift worked. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review the facility policy related to advanced directives and provide education to all staff. The quality assurance designee could monitor records for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	21840		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council within the past 12 months. This had the potential to effect all 95 residents residing in the facilty.	21942	Corrected	4/6/23

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21942	Continued From page 19 Findings include: During an interview on 3/2/23, at 4:10 p.m. the administrator stated there was no family council and she didn't have documentation one had been attempted in the last year. During an interview on 3/2/23, at 5:48 p.m. the administrator stated the facility did not have a policy on family council. SUGGESTED METHOD OF CORRECTION: The facility's social worker could contact resident family members via any method, to invite to participate in a family council meeting. The frequency of the family council meetings could be determined by the family council. Documentation of all meetings and attempts should be maintained. If the first attempt does not yield results, the facility could make another attempt later in the same year. The administrator or designee could monitor the attempts to organize a family council. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21942		