CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: D1BX

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STA	TE SURVEY AGEN	ICY	Fa	cility ID: 00005
1. MEDICARE/MEDICAID PROVIDER (L1) 245018 2.STATE VENDOR OR MEDICAID NO. (L2) 935840400	(L3) CREST VIEW LUTHERAN (L4) 4444 RESERVOIR BOULE						4. TYPE OF ACTION: 1. Initial 3. Termination	7 (L8) 2. Recertification 4. CHOW
		(L5) COLUMBIA	A HEIGHTS, M	IN .	(L6) 55421		 Validation On-Site Visit 	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD		CLIA	8. Full Survey After Con	nplaint
6. DATE OF SURVEY 06/25		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 IMR 12 RHC	15 ASC 16 HOSPICE		09/30	
2 AOA 3 Other		04.014	00 01 1/01	12 KHC	TO HOSTICE			
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED A	S:				
From (a):		X A. In Complia	nce With		And/Or Approved Wa	ivers Of The	Following Requirements:	
To (b):			Requirements ace Based On:		2. Technical F		6. Scope of Service	
12.Total Facility Beds	122 (L18)		Acceptable POC		3. 24 Hour RN 4. 7-Day RN 6 5. Life Safety	(Rural SNF)	7. Medical Direct8. Patient Room 9. Beds/Room	
13.Total Certified Beds	122 (L17)		mpliance with Progents and/or Applied		* Code: A*		(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN	1			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j)) (1):	(L15)	
122								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	E):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY A	AGENCY AP	PPROVAL	Date:
Jacqueline Stradtman, HF	E NE II		07/06/2012	(L19)	Shellae Dietri	ich, Prog	ram Specialist	07/11/2012 _(L20)
P	ART II - TO BE	E COMPLETED	BY HCFA R	EGIONA	L OFFICE OR SING	GLE STA	TE AGENCY	
19. DETERMINATION OF ELIGIBILIT	Y		MPLIANCE WITH	CIVIL			al Solvency (HCFA-2572)	EA 1512)
_X 1. Facility is Eligible to Pa	articipate	KI	GHTS ACT:			the Above :	nterest Disclosure Stmt (HC	FA-1513)
2. Facility is not Eligible	(L21)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION A	ACTION:	(L	30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY	00	INVOLUNTA	ARY
01/01/1967					01-Merger, Closure			eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Re		06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary T 04-Other Reason for Wit		OTHER	
	A. Suspension	n of Admissions:	(L44)		or other reason for with	indiawai	07-Provider S 00-Active	status Change
(L27)	B. Rescind Sus	pension Date:	(L44)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001			Posted 7/19/2012	ML		
	(L28)			(L31)				
					-			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	DATE				
	(L32)	06/27/2012		(L33)	DETERMINATIO:	N APPRO	VAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D1BX Facility ID: 00005

C&T REMARKS - CMS 1539 FORM

CCN: 24-5018

An extended NOTC survey was completed on May 2, 2012. The most serious deficiency was cited at a S/S level of J. Also at the time of the extended survey, conditions were found in the facility that constituted SQC to resident health or safety. The health surveyors identified two IJ situations on April 26, 2012 involving deficiencies F223 and F323. The IJ¿s were abated on May 1, 2012.

As a result of the survey findings, we imposed State Monitoring effective May 28, 2012. In addition, we recommended to the CMS RO imposition of the following enhanced remedies:

- Per instance civil money penalty of \$3500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$3500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1200.00. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012. (42 CFR 488.417 (b))
- Discretionary termination of the facility's Medicare and Medicaid provider agreement effective October 2, 2012. (Five month termination date)

The facility is therefore subject to a two year loss of NATCEP, effective May 2, 2012, due to the extended survey.

A Health PCR was completed on June 21, 2012 and a LSC PCR was completed on June 25, 2012 and the deficiencies issued at the time of the May 2, 2012 extended survey were found to be corrected as of June 11, 2012. As a result, this Department discontinued state monitoring effective June 11, 2012. In addition, we are recommending the following to the CMS RO:

- Per instance civil money penalty of \$3500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3500.00 remain in effect.
- Per instance civil money penalty of \$3500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3500.00 remain in effect.
- Per instance civil money penalty of \$1200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1200.00 remain in effect.
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012 be rescinded as of June 11, 2012.
- Discretionary termination of the facility's Medicare and Medicaid provider agreement effective October 2, 2012 be rescinded as of June 11, 2012.

The facility is subject to a two year loss of NATCEP, effective May 2, 2012 due to the extended survey.

Refer to the CMS-2567B forms for the results of the June 21, 2012 and June 25, 2012 revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5018 July 11, 2012

Ms. Talia Aramalay, Administrator Crest View Lutheran Home 4444 Reservoir Boulevard Northeast Columbia Heights, Minnesota 55421

Dear Ms. Aramalay:

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

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

Effective June 11, 2012 the above facility is certified for:

122 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900

St. Paul, MN 55164-0900

Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

July 6, 2012

Ms. Talia Aramalay, Administrator Crest View Lutheran Home 4444 Reservoir Boulevard Northeast Columbia Heights, Minnesota 55421

RE: Project Number S5018023 and H5018092

Dear Ms. Aramalay:

On May 23, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 28, 2012. (42 CFR 488.422)
- Per instance civil money penalty of \$3,500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3,500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$3,500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3,500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1,200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1,200.00. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012. (42 CFR 488.417 (b))
- Discretionary determination of your facility's Medicare and Medicaid provider agreement effective October 2, 2012.

This was based on the deficiencies cited by this Department for an extended survey completed on May 2, 2012 that included an investigation of complaint number H5018092 which was found unsubstantiated. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On June 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit and on June 25, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies

Crest View Lutheran Home July 6, 2012 Page 2

issued pursuant to an extended survey, completed on May 2, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 11, 2012. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on May 2, 2012, as of June 11, 2012.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 11, 2012.

However, as we notified you in our letter of May 23, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 2, 2012.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 23, 2012:

- Per instance civil money penalty of \$3,500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3,500.00 will remain in effect. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$3,500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3,500.00 will remain in effect. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1,200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1,200.00 will remain in effect. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012 be rescinded as of June 11, 2012 (42 CFR 488.417 (b))
- Discretionary determination of your facility's Medicare and Medicaid provider agreement effective October 2, 2012 be rescinded as of June 11, 2012.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

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

Feel free to contact me if you have questions.

Crest View Lutheran Home July 6, 2012 Page 3

Sincerely,

Brenda Fischer, Unit Supervisor

Granda Liscler

Licensing and Certification Program Division of Compliance Monitoring

Telephone: (320) 223-7338 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5018r112.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245018	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/21/2012
Name	e of Facility		Street Address, City, State, Zip Code	

CREST VIEW LUTHERAN HOME

Street Address, City, State, Zip Code
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

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

(Y4) Item		(Y5)	Date	(Y4) Item			(Y5)	Date	(Y4)	Item	((Y5)	Date
ID Prefix Reg. # LSC	F0166 483.10(f)(2)		Correction Completed 06/11/2012	ID Prefix Reg. # LSC	483.10			Correction Completed 06/11/2012		ID Prefix Reg. # LSC	F0223 483.13(b), 483	3.13(c)(1	Correction Completed 06/11/2012)(i)
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii), (c)(2		ID Prefix Reg. # LSC	483.1			Correction Completed 06/11/2012		Reg. #	F0241 483.15(a)		Correction Completed 06/11/2012
ID Prefix Reg. # LSC	483.15(b)		Correction Completed 06/11/2012	ID Prefix Reg. # LSC		5(c)(6)		Correction Completed 06/11/2012		ID Prefix Reg. # LSC	F0250 483.15(g)(1)		Correction Completed 06/11/2012
ID Prefix Reg. # LSC	F0252 483.15(h)(1)		Correction Completed 06/11/2012		483.2	72 0(b)(1)		Correction Completed 06/11/2012		Reg. #	F0276 483.20(c)		Correction Completed 06/11/2012
	F0278 483.20(g) - (i)	Correction Completed 06/11/2012	ID Prefix Reg. #	F027	79 0(d), 483.20	(k)(1)	Correction Completed 06/11/2012		ID Prefix Reg. #		183.10(k	
	су	Reviewed BF/sd Reviewed		Date: 07/06/12 Date:		Signature Signature	2	1979	1			Date: 06/2	21/12
CMS RO													

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245018	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/21/2012
Name	e of Facility		Street Address, City, State, Zip Code	
CF	REST VIEW LUTHERAN HOME		4444 RESERVOIR BOULEVARI	D NORTHEAST

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

COLUMBIA HEIGHTS, MN 55421

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0287	(Correction Completed 06/11/2012	ID Prefix	F0309		Correction Completed 06/11/2012		ID Prefix	F0314		Correction Completed 06/11/2012
Reg. # LSC	483.20(f)			Reg. # LSC	483.25				Reg. # LSC	483.25(c)		
	483.25(d)	(Correction Completed 06/11/2012		483.25(h)		Correction Completed 06/11/2012			483.25(n)		Correction Completed 06/11/2012
LSC				LSC								
Reviewed I	Ву	Reviewed	Ву	Date:	Signature	of Su	veyor:				Date:	
State Agen	ісу	BF/sd		07/06/12		21	1979				06/	/21/12
Reviewed I	Ву	Reviewed	Ву	Date:	Signature	of Su	rveyor:				Date:	
Followup t	to Survey Co 5/2/2	-			Check for any Uncorrecte	y Unco	rrected Deficiencies (CN	cienci IS-256	es. Was a 87) Sent to	Summary of the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245018	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 6/25/2012
Name of Facility	Street Address, City, State, Zip Code	

CREST VIEW LUTHERAN HOME

Street Address, City, State, Zip Code
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 06/11/2012	ID Prefix		Correction Completed	ID Prefix		Correction Completed
•	NFPA 101 K0050	-	Reg.# _ LSC _			Reg. # LSC		
Reg.#		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	Reg. #		
Reg. #		Correction Completed			Correction Completed			
.			Dag #			- ·		
Reviewed E	By Reviewed	I Bv	Date:	Signature of Sur	vevor:		Date	<u>.</u>
State Agen		,	07/06/12	1925	-			5. 6/25/12
Reviewed E		I By	Date:	Signature of Sur			Date	
Followup t	o Survey Completed or 4/25/2012	1:		Check for any Uncor Uncorrected Defic				S NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245018	(Y2) Multiple Construction A. Building B. Wing 02 - 2007 ADDITION	(Y3) Date of Revisit 6/25/2012
Name of Facility	Street Address, City, State, Zip Code	

CREST VIEW LUTHERAN HOME

Street Address, City, State, Zip Code
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		Correction Completed 06/11/2012	ID Prefix		Correction Completed		ID Prefix			Correction Completed
•	NFPA 101 K0050						Reg. # LSC			<u> </u>
.			ID Prefix Reg. # LSC		Correction Completed		Reg. #	_		Correction Completed
ID Prefix Reg. # LSC					Correction Completed					Correction Completed
Reg.#					Correction Completed					Correction Completed
Dog #			Dog #				Dag #			
Reviewed E	Sv Revi	ewed By	Date:	Signature of Sur	wovor:				Date:	
State Agen		-	07/06/12	Signature of Sur	veyor.				06/25	/12
Reviewed E		ewed By	Date:	Signature of Sur	veyor:				Date:	,12
Followup t	o Survey Complete 4/25/2012			Check for any Uncor Uncorrected Defic	rected Deficiencies (CN	cienci IS-256	es. Was a 67) Sent to	Summary of the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: D1BX

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00005
MEDICARE/MEDICAID PROVIDE (L1) 245018 2.STATE VENDOR OR MEDICAID No. (L2) 935840400		3. NAME AND AI (L3) CREST VIE (L4) 4444 RESEF (L5) COLUMBIA	W LUTHERAN	N HOME EVARD NO	ORTHEAST (L6) 55421	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU	05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 05/8 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	02/2012 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 IMR 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	122 (L18) 122 (L17)	Compliar1. X B. Not in Co		gram	And/Or Approved Waivers Of TP 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 122 (L37) (L38)		ICF (L42)	IMR (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REM See Attached Remarks	ARKS (IF APPLICABL		ELLATION DATE	Ξ):	10. OTLANE OVINVEY A CENVOY	ADDROVA D
Jacquelin Stradtman, H	IFE NEII	Date :	06/18/2012	(L19)	Mark Meath, Program	
	PART II - TO BE	COMPLETED	BY HCFA R	EGIONA	L OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to 2. Facility is not Eligible	Participate		MPLIANCE WITH GHTS ACT:	I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1967 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATION A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/	CARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION	OF APPROVAL D	DATE (L33)	DETERMINATION APPR	OVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D1BX Facility ID: 00005

C&T REMARKS - CMS 1539 FORM

CCN: 24-5018

On May 2, 2012 an extended survey was completed at this facility. Conditions in the facility constituted both substandard quality of care (SQC) and Immediate Jeopardy (IJ) to residents health and safety. As a result of the survey findings, we did not provide an opportunity to correct and imposed State monitoring effective May 28, 2012. In addition, this Department recommended the following remedies to the CMS Region V Office for imposition:

- Per instance civil money penalty of \$3500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$3500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1200.00. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012. (42 CFR 488.417 (b))
- Discretionary termination of your facility's Medicare and Medicaid provider agreement effective October 2, 2012.

Since the facility was subject to an extended survey as a result of finding SQC, Crest View Lutheran Home is prohibited from offering or conducting Nurse Assistant Training/Competency Evaluation (NATCEP) for two years beginning May 2, 2012.

Refer to the CMS 2567 for both health and life safety code including the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 0044

May 23, 2012

Ms. Talia Aramalay, Administrator Crest View Lutheran Home 4444 Reservoir Boulevard Northeast Columbia Heights, Minnesota 55421

RE: Project Number S5018023 and H5018090

Dear Ms. Aramalay:

On May 2, 2012, an extended 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. In addition, at the time of the May 2, 2012 extended survey the Minnesota Department of Health completed an investigation of complaint number H5018090.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and 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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 1, 2012, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301

Telephone: (320)223-7338 Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective May 28, 2012 (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty of \$3500.00 for the deficiency cited at F223, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$3500.00 for the deficiency cited at F323, effective May 2, 2012, for a total penalty of \$3500.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1200.00 for the deficiency cited at F226, effective May 2, 2012, for a total penalty of \$1200.00. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 12, 2012. (42 CFR 488.417 (b))
- Discretionary termination of your facility's Medicare and Medicaid provider agreement effective October 2, 2012.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 2, 2012. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may

request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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 and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Oliver Potts, Chief 330 Independence Avenue, SE Cohen Building, Room G-644 Washington, DC 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.

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR FIFTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 2, 2012, three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This discretionary denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This discretionary denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2012 (five months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer, Unit Supervisor

Granda Liscler

Licensing and Certification Program Division of Compliance Monitoring

Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File



4444 RESERVOIR BLVD NE COLUMBIA HEIGHTS, MN 55421 763.782.1611 FAX 782.0857 WWW.CRESTVIEWCARES.ORG

June 8; 2012

Brenda Fisher, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, MN 56301

Addendum to Plan of Correction

F225 and F226:

100% of incident reports will be reviewed and completed by 6/11/12: 20% of incident reports will be audited to assure completion by 6/11/12

F242:

For Resident 116 an interview of shower and bath preferences per week was conducted and two showers per week are now provided for this resident. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Education will be provided for staff members regarding resident right to choose bathing schedules by 6/11/12.

F323:

Crest View Lutheran Home will only utilize wall outlets for medical equipment by 6/11/12.

Sincerely,

Talia Aramalay, LNHA Administrator

Crest View Lutheran Home

ally



4444 RESERVOIR BLVD NE COLUMBIA HEIGHTS, MN 55421 763.782.1611 FAX 782.0857 WWW.CRESTVIEWCARES.ORG

June 4, 2012

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, MN 56301

Re: Crest View Lutheran Home

Dear Ms. Fischer:

Enclosed please find our plan of correction for the survey that was completed on May 2, 2012. The enclosed plan will serve as our credible allegation of compliance. You can reach me at taramalay@crestviewcares.org or 763-782-1620 with any questions or concerns. Thank you.

Respectfully submitted,

Talia Aramalay, LNHA
Care Center Administrator

enclosures



JUN 0 5 2012

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
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Any deficiency statement ending with an asterick (*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

F 166 Continued From page 1 R132 had a diagnosis of dementia. The quarterly minimum data set assessment (MDS)dated 277/12, indicated the resident had short and long term memory loss and required extensive assistance with activities of daily living. During an interview at 9:40 a.m. on 4/24/12, R132's family member (FM)-B stated a pink sweater with pearls and embroidery was missing. FM-B stated on January 9, 2012 he filled out a report and gave it to the receptionist. FM-B stated the facility never responded and he felt there had not been a resolution to his complaint. During an interview at 2:00 p.m. on 4/27/12, MDS Coordinator (MDSC)-E stated a priority report (missing items report) would be filled out with the resident or family member and copies would be made for the Director of Nursing, Administrator, laundry and " about 12 other people". MDSC-E stated laundry and nursing would look for it, and if		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURV COMPLETEE	
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the item was not found the report would be given to the Administrator to replace or reimburse. She stated she did not know who followed up on the report and that the administrator would know the procedure and the "whole picture." During an interview at 3:00 p.m. on 4/30/12, Registered Nurse (RN)-C stated if there was missing clothing she would fill out a form and the resident or family member would report how much it cost. She would then look in the room and laundry, notify the nursing aides and give the form to the supervisor of the unit. During an interview at 9:50 a.m. on 5/1/12, Social Services Director (SSD), stated the priority reports are kept by the Administrator. SSD stated	F 166	R132 had a diagnominimum data set 2/7/12, indicated term memory loss assistance with a During an interview R132's family mer sweater with pearl FM-B stated on Jareport and gave it stated the facility report and gave it stated the facility report and gave it stated the facility report and gave it stated the facility resident or family made for the Directlaundry and "about a distant and report and that the procedure and the During an interview Registered Nurse missing clothing are resident or family much it cost. She and laundry, notificant to the super During an interview Services Director	posis of dementia. The quarterly assessment (MDS)dated the resident had short and long and required extensive ctivities of daily living. We at 9:40 a.m. on 4/24/12, and the response of the receptionist. FM-B and embroidery was missing. Invary 9, 2012 he filled out a to the receptionist. FM-B never responded and he felt in a resolution to his complaint. We at 2:00 p.m. on 4/27/12, MDS oc)-E stated a priority report fort) would be filled out with the member and copies would be correctly of Nursing, Administrator, but 12 other people. MDSC-E dinursing would look for it, and if found the report would be given for to replace or reimburse. She know who followed up on the end administrator would know the end administrator would know the end at 3:00 p.m. on 4/30/12, (RN)-C stated if there was the would fill out a form and the member would report how would then look in the room of the unit. We at 9:50 a.m. on 5/1/12, Social (SSD), stated the priority		sweater. Education will be placed for staff members regarding item reports by 06/11/12. Resident R132 was discharg 05/21/12. A review of current concern will be completed by the interdisciplinary team in momeeting by 06/11/12 to ensissues were addressed in a manner. A meeting will be the resident council by 06/1 review grievance practices/including the prompt responsation of the policy and procedure for grievances will be reviewed revised by the interdisciplin by 06/11/12. A review of the policies by the Medical Direct to complete to ensure policies by the Medical Direct to complete to ensure policies by the medical Direct to complete to ensure policies by the Medical Direct to the complete to ensure policies by the Medical Direct to the complete to ensure policies by the Medical Direct to the complete to ensure policies by the Medical Direct to the complete to th	g missing ged on reports orning sure that timely held with 11/12 to /protocols, onse to a dent ill be concerns or d and hary team he revised ector will olicies practice. hed as it	70 fee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, , , , ,	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE A. BUILDING	
	245018	B. WING _		05/02/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HO	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	AST
PREELY (FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION:
found it is her under gets reimbursed. Spriority reports and missing sweater, furny time." During an interview Administrator (ADM remember the mission would look into it. Ap.m. on 5/1/12 the report regarding the During an interview Receptionist-C (Remember the report hat contained priod was filled out by (Festated that the sixion of the sheet have so they must have stated she does not else made the copellar was last semorning the resident the sweater out of because he though facility. (FM)-B the hospital and when on 1/18/12, the sweater it might he 2/4/12 he felt it was (FM)-B stated "Income into R132".	e., look for the item and if not erstanding that the resident SSD stated she has had no it does not know about R132's urther stating " it was before wat 10:10 a.m. on 5/1/12, the M) stated she did not sing clothing item for R132, but A follow-up interview at 12:30 ADM stated she did not have a remissing clothing. In at 1:20 p.m. on 5/1/12, recep)-C stated she does not cort, but then retrieved a folder ority reports and found one that FM)-B dated 2/4/12. (Recep)-C designees listed on the bottom check marks next to their titles, received a copy. She further for remember if she or someone of the seen at 1:30 a.m. on 1/17/12 the seen at 1:30 a.m. on 1/17/12 the feen fell. (FM)-B noted he took the resident to the he came back at 10:30 a.m. weater was missing. (FM)-B ave gone to the laundry, but by as gone for good. In the report can't believe how people just is room and take her he second section of the report	F 166	responsibilities for the revised and procedure by 06/11/12. A review of the resident coun meeting minutes will be compared to designee to determine if grievoiced in this meeting were addressed. A review of grieval and resolution activity will be completed monthly by the Administrator or designee. The results of those reviews were reported to the CQI Committer review and further recommendations. Upon this system revisions and/or staff education will be implemented indicated. The Administrator or designeeresponsible for compliance. Date of Correction: 06/11/12	cil pleted or vances vances vill be ee for review, ed if

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245018	B. WING		05/02/2012
*	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME	444	ET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTH 1 LUMBIA HEIGHTS, MN 55421	EAST A TOTAL OF
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 166	Continued From pa	age 3 by staff" was blank.	F 166		
	Licensed Practical was given or filled copies and put the listed personnel at -C stated they wou in progress notes to find it in there ". not sure who is ulto the medical record 1/9/12-2/5/12 reveindicating a report Numerous attempersonnel at 9:12 a.m., on 5/1/12 we who received the priority report. 2) routed to the respective to the priority report. 2) routed to the priority then be routed by resident resides for second portion, "once completed, completed portior Services. 5) the Efollow-up with the item is found, the across the form a	Nate (LPN)-C stated if she out a report, she would make in all of the boxes of the the bottom of the sheet. (LPN) ald not likely document anything or the chart, stating "you won' (LPN)-C further stated she is imately responsible. Sing and social worker notes of a for the time period from saled no documentation of the missing clothing item. Its to interview laundry a.m., 9:24 a.m., and 10:05 are unsuccessful. Sing Items Policy dated 3/2010 wing: 1) "when a resident or ports a missing item, the person information would fill out a a copy of the report should be active staff listed in the bottom of the unit nurse to fill out the corn the unit nurse to fill out the corn the unit nurse will return the contone of Social Services will resident and/or family. If the word "FOUND" will be written and routed back to those who all report. 6) if the item is not			7012 70 D

CENTER	KS FOR MEDICARE	& WEDICAID SERVICES				(X3) DATE SUR	N/CV
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED ;	
		245018	B. WI			05/02/	/2012
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	HART	
CREST V	IEW LUTHERAN HO	ME		l .	144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	=A31	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5)
F 166		trator will decide how to	F	166			1.4.1 2.4.4.1.2.1
F 176 \$S=D	resolve missing ite follow the policy so follow up on the m 483.10(n) RESIDE DRUGS IF DEEM! An individual resid the interdisciplinar §483.20(d)(2)(ii), if practice is safe. This REQUIREME by: Based on observereiew the facility practice of self-ad safe for 1 of 1 res who was observereindings include: The resident had chronic obstructive trauma, and general R116 clinical recidated 4/4/12, which Albuterol Sulfate vial four times dailed dated 4/22/12, not all the resident dated 4/22/12, not all	ent may self-administer drugs if y team, as defined by has determined that this ENT is not met as evidenced ation, interview and record failed to determine if the iministration of medications was ident's (R116) in the sample d to self-administer medication. a diagnoses which included to self-administer medication. a diagnoses which included the pulmonary disorder, head the pulmonary disorder, head the pulmonary disorder, head the muscle weakness. ord contained physician's orders ich directed the resident receive 2.5 mg/3ML vial of nebulizer, 1 ily as needed. An new order oted the nebulizer treatment it at the bedside for the resident	L.	176	F176 Self Administration of It is the policy of Crest View Home that an individual resi self-administer drugs if the interdisciplinary team has determined that this practic For Resident R116 an assess self-administration of medic was completed. Correspond updates have been made to plan, care assignment sheet communicated to the reside and/or designated decision The primary physician was in of assessment results and a the current physician orders completed. Accommodation storage and self-administrat drugs have been made. Education/counseling will b provided for staff members self-administration of medic 06/11/12.	Lutheran dent may e is safe. Sment for cation ling the care and ent maker. Informed review of swas as for tion of the care are garding the care and the care and the care and the care are a safe and the care are a safe ar	7 (2017)

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
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F 176	observed in her roonebulizer machine and insisted she wisit. A staff person while the nebulizer On 4/27/12 at appresident was again nebulizer mask on nebulizer machine staff present in her was interviewed as present when she On 4/29/12 at 1:45 looked in the clinic find a self-administ assessment had be stated a resident with medication, should stated he had set	p.m., the resident was om holding an operating to her nose, and turned it off as done using it so she could was not present in the room machine had been operating. Toximately 12:00 p.m., the observed in her room with the her face and an operating attached to it. There were no bedroom. At 2:00 p.m., R116 and stated staff were not usually did her nebulizer treatment. To p.m., registered nurse (RN)-E all record, but was unable to tration medication (SAM) een completed for R116. He who self-administered any if have an assessment. He up her nebulizer machine with at morning, and she did it	F 176	For other residents who self-administer nebulizer treatments self-administration assessments be completed by 06/11/12. The results will be reported to the interdisciplinary team for results and procedure for administration of medication reviewed and revised by the interdisciplinary team by 06. The policy and procedure were reviewed by the Medical Direction ensure current standards of are in place. Staff members trained as it relates to their respective roles and resport regarding the self-administ policy by 06/11/12. Audits will be completed were self-administ will be completed were self-administ policy by 06/11/12.	ents, a ent will The eview and will be rector to practice will be resibilities ration reekly for4
F 223 SS=J	On 5/1/12 at 2:48 (LPN)-A was interphysicians order in do the nebulizer treat 483.13(b), 483.13 ABUSE/INVOLUNThe resident has sexual, physical, a	p.m., licensed practical nurse viewed and verified the ndicated the resident should not eatment independently. LPN-A ne room with the resident during ment earlier in the day. (c)(1)(i) FREE FROM ITARY SECLUSION the right to be free from verbal, and mental abuse, corporal nvoluntary seclusion.	F 22	weeks, monthly for 3 monthly according to the quality conscience administration of medications are continued compliant and the continued to th	chs, then ntrol on to nce with l further review aff

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		245018	D. VVII			05/02	2012
	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	· 11
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From particle The facility must no or physical abuse, involuntary seclusi	ot use verbal, mental, sexual, corporal punishment, or	F 	223	The Director of Nursing or owill be responsible for com Date of Correction: 06/11/2	pliance.	,
	by: Based on observa and policy review residents were fre exhibited by 3 of 3 reviewed for abusinvestigation, residents were fre reporting constitut situation for R98, ensure residents what the potential tresided on the Event The administrator (DON) were notificate immediate jeo removed at 1:25 pand severity was a potential for no pattern. Findings Include: R98 displayed agreement to be a determine what in implemented to perform potential abuse.	and the Director of Nursing ed at 4:12 p.m. on 4/26/12 of pardy. The immediacy was p.m. on 5/1/12, and the scope reduced to no actual harm with more than minimal harm at a gressive and physically abusive so ther residents. The facility diassess these behaviors to aterventions could be rotect other vulnerable residents use.			It is the policy of Crest View Home that each resident has right to be free from verbal, physical and mental abuse, opunishment, and involuntary seclusion. For Resident(s) R98 and R29 assessment was completed safety risk. Safety checks and behavior logs were initiated residents. Safety checks are reviewed at morning meeting the IDT decides when to include decrease those checks base resident behavior. Correspondent behavior. Correspondent behavior assignment sheet communicated to the reside and/or designated decision. The primary physician was of the results and a review current physician orders was completed. Education will the second completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed. Education will the second contract of the results and a review completed.	Lutheran is the sexual, corporal a new regarding d for both then ng and rease or d on onding o the care t and ent maker. informed of the as	127 12 12 12 12 12 12 12 12 12 12 12 12 12
	R98 had diagnose behavior disturba	es which included dementia with nce, altered mental state, and			provided for staff members	regarumg	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	LTIPLE CONSTRUCTION (X3) DATE S COMPL		
		245018	B. WING		05/02	/2012
	ROVIDER OR SUPPLIER 'IEW LUTHERAN HO SUMMARY STA	TEMENT OF DEFICIENCIES	ID	REET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421 PROVIDER'S PLAN OF CORREC	CTION	(X5)
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F 223	data set (MDS) data resident had mode independent in wal had a history of phyothers such as hitting grabbing. A review of R98's procession following: 6/29/11- "Complaint been being angry at Observed resident resident to "be quied 8/31/11- "Resident resident during din point of staring at the dinner until the other resident would mode of the supervisor that she (unknown) resident wheelcher residents wheelcher residents wheelcher residents wheelcher residents wheelcher residents wheelcher resident (R160) continuities and resident (R160) continuities." 12/17/11- "Staff her scene. Staff saw recording to resident to the same resident to the same resident resident resident (R160) continuities."	ry. R98's quarterly minimum ed 2/11/12, indicated the rate cognitive impairment, was king around the facility, and visical behaviors towards ng, kicking, pushing, or progress notes indicated the resident has and mean towards dinner. At dinner telling another et or else." got into fight with another ner tonight. Resident made a the other resident all throughout er resident got angry. Neither	F 223	safety risk and interventions risk behaviors" by 06/11/12. Resident R160 was discharge 04/20/12. For other residents who may affected by this practice a review will be completed by 06/11/12 regarding risk for and safety. Observations of interactions with residents a resident to resident interact be completed by 06/11/12. review, system revisions and education will be implement indicated. The policy and procedure for risk and abuse prohibition we reviewed and revised by the interdisciplinary team by 06, review of the revised policie Medical Director will be come to ensure that policies meet standards of practice. Staff respective roles and responsing regarding safety risk and abuse prohibition by 06/11/12.	y be ecord abuse staff and cions will Upon this d/or staff red if a safety will be a safety will be a current members o their sibilities	

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05/02/2012

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST	
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F 223	noted." 3/2/12- "Upset at 1 (unknown) residen napkins and wipes was apparently eve	age 8 700 (5:00 p.m.) over another t cutting up tiny pieces of onto dining table. Perpetrator en coughing up napkins and vervone's side of the table.	F	223	Safety risk audits will be comweekly for 4 weeks, monthly months, then according to the quality control schedule on a plans and resident assessment of the control of the c	for 3 ne - care ents to ing and	-

Author investigated and found evidence of that. However, at intervention time, R98 apparently stood up and author heard another staff screaming help! Help! Stop! Stop! and R98 was ready to strike (unknown) resident with a rolled up sheet of paper- and possibly more. Author sprang up and restrained R98 from strike and calmly requested him to sit down."

4/20/12- R98 pushed R160 "to ground, landed on right side; resident R98 denied doing this and then walked away."

A review of R98 incident reports and investigations of these incidents indicated the following:

An incident report dated 5/13/11 indicated R98 collided with R29. They both began swearing at each other. R29 hit R98 on the arm, and R98 swung his walker in mid air at R29, and R98 and R29 were separated. The incident was reported to the state agency. The report sent to the state agency indicated R98 and R29 collided into each other but neither resident made contact with the other.

The incident report dated 9/4/11, indicated the receptionist reported to the nurse that she saw R98 attempting to tip R3739's wheelchair by lifting the residents wheelchair. The immediate

ted 3 to and planning for "at risk behavior." IDT reviews will be completed on allegations of abuse, neglect and misappropriation of property to ensure facility protocols are followed to ensure the environment is free from abuse. The results will be reported to the CQI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated.

The Director of Social Services or designee will be responsible for compliance.

Date of Correction: 06/11/12

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP	COM		OATE SURVEY OMPLETED	
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F 223	tell writer if he has statement from the evening indicated, the reception desk and swearing betw looking to see what was shoving his with wheelchair trying the stop it and paged she took over the to the state agency indicated the received R98 was shaking lacked evidence of that time. An incident report and R160 had a preceptionist report the cheek. R160 to press charges, was both resident advised that both same area. Howe how to keep them communicated to submitted to the sindicated staff we apart, however, it was communicated a psychiatric consumed and holding going to kick him immediate action	give the resident space and to any concerns. An attached e receptionist working that "I was working Sunday night at and I heard some shouting ween two residents. As I was at was going on I witnessed R98 talker against R3739' to push him over. I told them to the nurse for assistance and situation." This was submitted y and the investigative report ptionist heard yelling and noted R3739' wheelchair. The report of interventions put into place at dated 10/14/11, indicated R98 hysical altercation. The ted that R98 punched R160 on called the police but chose not The immediate intervention is were separated and staff was residents are not together in the ver, there was no indication on apart or how this would be staff. This report was tate. The investigative report re told to keep the residents was unclear how and when this ed to staff. R98 was referred for	F	223			2003 2003 2003 2003 2003 2003 2003 2003	

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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME CALIDINAL ACCOUNTY COLUMBIA HEIGHTS, MN 55421	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
CREST VIEW LUTHERAN HOME (A44 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421) (CA9) ID PRIEFIX (EACH DEPICIENCY MUST BE PIECEDED BY FULL TAG PROVIDERS PLAN OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION) F 223 Continued From page 10 However, there was no indication this was communicated to staff and how they were going to monitor the residents. This incident was not investigated or submitted to the state agency. An incident report dated 4/20/12, indicated a resident to resident alforcation between R98 and R169. R98 pushed R160 tower until R160 fell over and landed on his right side. R160 complained of right hip pain and was sent for an X-ray which showed a right femur fracture and was admitted to the hospital. The investigative report indicated R160 had a history of following R88 making inappropriate comments to him. The report also stated R98 keeps to himself but thas issues when someone else gets into his personal space. Aithough the facility was aware R98 and R160 had previous physical altercations and R98 "had issues when someone gets into his personal space. Although the facility was ware R98 and R160 had previous physical altercations and R98 "had issues when someone gets into his personal space. A review of R98's psychology dated reports indicated the following: On 11/2/111, R98 had significant defects in insight and had long standing problems with anger management. The notes also indicated "He has been prone to anger issues such of his life, and seem to regard confrontation and aggression as socially acceptable." His risk to others was moderate and seemed physically capable of harming others when agiltated. The treatment plan and recommendations were, "He			245018			05/0	2/2012
F 223 Continued From page 10 However, there was no indication this was communicated to staff and how they were going to monitor the residents. This incident was not investigated or submitted to the state agency. An incident report dated 4/20/12, indicated a resident to resident altercation between R98 and R160, R98 pushed R160 two until R160 fell over and landed on his right side. R160 complained of right hip pain and was sent for an X-ray which showed a right forum fracture and was admitted to the hospital. The investigative report indicated R160 had a history of following R98 making inappropriate comments to him. The report also stated R98 keeps to himself but has issues when someone else gets into his personal space. Although the facility was aware R98 and R760 had previous physical altercations and R98 "had issues when someone eyes lest into his personal space. Although the facility was aware R98 and R760 had previous physical altercations and R98 "had issues when someone was lin his personal space. A review of R98's psychology dated reports indicated the following: On 11/21/11, R98 had significant defects in insight and had long standing problems with anger management. The notes also indicated "He has been prone to anger issues much of his life, and seem to regard confrontation and aggression as socially acceptable," His risk to others was moderate and seemed physically capable of harming others when agitated. The facility had returned the regard confrontation and aggression as and recommendations were, "He			ME	S	4444 RESERVOIR BOULEVARD NO	ORTHEAST	
However, there was no indication this was communicated to staff and how they were going to monitor the residents. This incident was not investigated or submitted to the state agency. An incident report dated 4/20/12, indicated a resident to resident altercation between R98 and R160, R98 pushed R160 twice until R160 fell over and landed on his right side. R160 complained of right hip pain and was sent for an X-ray which showed a right femur fracture and was admitted to the hospital. The investigative report indicated R160 had a history of following R98 making inappropriate comments to him. The report also stated R98 keeps to himself but has issues when someone else gets into his personal space. Although the facility was aware R98 and R160 had previous physical altercations and R98 "had issues when someone gets into his personal space. Although the facility was aware R98 explosive behavior if someone was in his personal space. A review of R98's psychology dated reports indicated the following: On 11/21/11, R98 had significant defects in insight and had long standing problems with anger management. The notes also indicated "He has been prone to anger issues much of his life, and seem to regard confrontation and aggression as socially acceptable." His risk to others was moderate and seemed physically capable of harming others when agitated. The treatment plan and recommendations were, "He	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL.	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION
higher and a following manner of the first o	F 223	However, there wa communicated to sto monitor the resident to monitor the resident resident to resident to resident to resident to resident R160. R98 pushed and landed on his right hip pain and wishowed a right fent to the hospital. The R160 had a history inappropriate commistated R98 keeps someone else gets Although the facility had previous physissues when some space" there were to keep R98 and Finot identified interexplosive behavior personal space. A review of R98's indicated the following manageme "He has been profife, and seem to raggression as soo others was moder capable of harmin treatment plan and	is no indication this was staff and how they were going dents. This incident was not omitted to the state agency. dated 4/20/12, indicated a at altercation between R98 and I R160 twice until R160 fell over right side. R160 complained of was sent for an X-ray which nur fracture and was admitted a investigative report indicated y of following R98 making ments to him. The report also to himself but has issues when is into his personal space, by was aware R98 and R160 decene gets into his personal and interventions implemented R29 separated. The facility had eventions to reduce R98 rif someone was in his psychology dated reports wing: had significant defects in nig standing problems with nit. The notes also indicated ne to anger issues much of his regard confrontation and cially acceptable." His risk to rate and seemed physically nig others when agitated. The direcommendations were, "He	F 22			20.012 20

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F 223	concede. Thus his with staff and othe	ble option, and he is not one to potential for further altercation residents is significant. His mpaired judgement, etc only	F 	223	·· ·		
	behavior/ verbaliza Treatment plan wa follow resident to f assist with reducin volatile behaviors. protocol around pr patients (ex appro state your objectiv	ad "ongoing aggressive ation continue reportedly." as "Will remain available to acilitate adjustment process, g frequency and intensity of staff are advised to follow rovision of care to dementia ach from front, use names) e, assess mood, if irritable, These recommendations were lan of care.					(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	management issu having medium ris verbally and physi treatment plan was afety protocol cloverbal and physic distance, reading the front, make eyannounce what you a safe distance from the front of the	was identified as having "anger es." R98 was identified as sk and was "capable of growing cally aggressive quickly." The s "Staff are advised to follow sely with (R98) with his risk of al aggression (ex-keep a safe agitation, approach him from re contact, use names, and ou are there to do). Keep him at om other residents when atment plan was not included on					1.12 1.12
	although at this tin R98 risk was low somewhat in term new recommenda	nad an "irritable presentation" me the psychologist indicated as R98 "has lessened as of risk towards others." No ations were identified at this no further psychology notes					12 15 15 15 15 15 15 15 15 15 15 15 15 15

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		ATE SURVEY OMPLETED	
		245018	B. WING		05/0	2/2012	
	ROVIDER OR SUPPLIER	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE	
F 223	Continued From pa		F 223			127 %	
	resident had behave with other resident a checklist includir cognitive status, as may contribute to cresident of daily rofrustration, remind throughout the day allow for choices the fluid intake, and perfocus area of the paggression with the other residents as included those lists with social worker remove resident to persistent and/or Although the facility of resident alterca interventions to prefrom confrontation the facility was aw specific behaviora the psychologist in had not be included.	dated 2/13/12, indicated the vioral symptoms of altercations s. The approach's consisted of a observe for changes in a seess for medical reason that changes in mentation, inform utine, validate feelings of and re-orientate as needed and re-orientate and re-				N. A.	
	newspaper. Ther area and staff wel against the wall no						
	registered nurse (I at 6:10 a.m. on 4/25/12 RN)- D stated R98 gets up very ng around 4:00 a.m., and sits					

1 1946 2 194

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	•	COMPLE	
		245018	B, Wil	4G		05/0	2/2012
	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORT OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	paper. She stated residen	room/ chapel to read his she was not aware of any t altercations involving R98 and aviors they needed to be	F	223	<u>.</u>		
	When interviewed licensed practical to get up very early and R160 had pretried to keep them	at 6:20 a.m. on 4/25/12, nurse (LPN)- F stated R98 likes y in the morning. He knew R98 vious incidents, and they just apart. He was unaware of any rs they were to be monitoring					1 7.32 10180 1 7.28
	trained medication never seen R98 "c	at 6:35 a.m. on 4/25/12, n aide (TMA)-A stated he had cross" with any other residents, s sure "no other residents are					in the second
	stated she didn't k	at 6:50 p.m. on 4/25/12 LPN-E mow anything about R98 having sident altercations with anyone. of any behaviors staff needed s.					
	stated she was no behaviors and wa	at 7:15 a.m. on 4/25/12 NA-E of aware R98 had any previous s never instructed to watch him or interaction with other					
	LPN-G stated she	I at 7:25 a.m. on 4/25/12 was not aware of any behavior off needed to do with R98.	, p.				
		I at 7:26 a.m. on 4/25/12 TMA-B eard in the past that R98 and					

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CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 05/02/2012			
		245018	B. WING					
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	COMPLETION DATE	
F 223	When interviewed LPN-H stated R98 very surprised when pushing R160. She behaviors. When interviewed social service direct know much about facility since 2/13/r previous altercation the information was the other social work stated if she had know altercations with onensured intervention R98 and other resumet with R98 for constant with R98 for constant with R98 and the psychologist to not put any new in and did not get and psychologist to get and check if he had R98. The facility provid was faxed to the filt was dated by the surprised was dated by the surprised was dated by the surprised R98 and the facility provided was dated by the surprised R98.	the staff needed to do. at 7:30 a.m. on 4/25/12, is "pretty quiet" so she was en she heard about him e was not aware R98 had any on 4/25/12 at 8:15 a.m., the ctor (SSD) stated she did not R98 as had only been at the 12. She was not aware R98 had ns with residents and stated as not passed on to her when orkers left the facility. SSD known about R98's previous ther residents she would have ons were in place to protect idents. She stated she had not one on one interventions, but R160 and he was not a "bully-e stated after the altercation R160 on 4/20/12, she called of meet with R98. The SSD had atterventions into place for R98 by recommendations from the ow to protect other vulnerable stated she would call the out the dictation from that visit and new recommendations for ed the psychology note which facility on 4/25/12 at 12:42 p.m. e psychologist on 4/23/12, and		223			1 1/2012 1 1/2012 1 1/2013 1 1	
	the treatment plan follows:	n and recommendations were as						

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

245018

A. BUILDING
B. WING ___

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 15	F 223		• • • • • • • • • • • • • • • • • • • •
	"Preventive measures/ safety planning in light of this recent incident should involve staff awareness of risk factors, particularly other parties attempting to engage with (R98) in ways that do not agree with him. That (R98) is often sitting in view of staff, should be something that can be diverted by staff before escalating." When interviewed at 9:55 a.m. on 4/25/12, meal service assistant (MSA)-Z stated R98 and R160			0.1 (A.2 0.1 (C.2) 0.1 (C.2) 0.1 (C.2)
	had been angry with each other for "a while." She stated several months ago in the dining room R98 and R160 were hitting each other and were moved to separate tables. She was unsure if this was reported. She stated she was working the day of the 4/20/12 incident and R98 was sitting in the main dayroom and R160 came walking in. When she saw they were both in the same room, she said "Oh boy." She stated R98 gets angry but if you don't say anything to him he is fine. MSA-Z stated she told the receptionist to watch out for "those two" and walked away. "It seemed like there may have been a problem" when she left.			1
	When interviewed at 11:15 a.m. on 4/25/12, the director of nursing (DON) stated R98 was pleasant and sits in the main dayroom almost all the time. She stated R98 "needs his space" and will yell if anyone gets into his space. She stated she knew that R98 and R160 had issues with each other in the past. The DON stated staff does keep an eye on R98, however, she did state the main dayroom was not staffed nor was it visible to staff at all angles in order to observe any altercations with other resident. She verified R98's plan of care did not include specific			

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PRINTED: 05/17/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ 05/02/2012

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		243010			007	V212014
•	ROVIDER OR SUPPLIER			44	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAST	
CREST V	IEW LUTHERAN HOI	VIE		С	OLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE.
				000		: 21 X 200
F 223	interventions to pre	vent further resident to	r	223		
•	resident altercation	ļ				
	administrator state	on 4/25/12 at 2:00 p.m., the d R98 is mobile and the facility to keep him out of public				
	places." She stated	i R98 can be "provoked" by ne keeps to himself.				192
	towards other resid	ncidents of abusive behavior dents from 6-29-11 through uded: verbal abuse,				
	threatening to kick strike at a resident cheek, attempting	a resident, raising his hands to , caused an abrasion on R160 to tip a resident out of a ushing a resident down to the				
	ground resulting in lacked interventior from R98's behavi	a hip fracture. The facility as to protect other residents ors, or protect R98 from a from other residents.				115
	'	ected from resident to resident				
	abuse although the	e facility was aware of a history tween R98 and R160. The	,			
	facility failed to en	sure other residents were 60's behaviors, and ensure				
	R160 was free fro his behaviors.	m resident retaliation related to				
	P160 had diagnos	ses including manic depression,				
	anxiety disorder, o	lependent personality disorder, I history of a stroke. R160				7,42,4
	quarterly MDS dat	ted 1-3-12 identified the resident initive impairment, was				
	verbal behaviors t	ing around the facility, and had owards others such as aming, or cursing at others 1-3				
	days in the prior 7	day assessment period.				
L	.1	Class ID: D4PV4	4	Ľ	acility ID: 00005 If continuation she	et Page 17 of 162

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S COMPLI		
		245018	B. WING		05/0	2/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 223	Continued From pa	age 17	F 223				
		ntegrated progress notes ving:	•				
	engaged in an unw which R160 sustai	ts (R98 and R160) were vitnessed physical altercation in ned some abrasions on his called police but charges were ie."				2012 - 2012 - 2011 - 2012 - 2011	
-	and other resident	nas been overheard by staff s make inappropriate r residents such as 'maybe you nipples pierced!"					
	at 1530 and noted resident who is co	in Linden station dining room to be yelling at (unknown) nfused and yells out frequently. resident saying to shut up and ve."					
	ground, resident for complained of hip note dated 4/20/12 returned showing	(R98) pushed (R160) to ell on right side, (R160) pain." The integrated progress 2, identified R160's X-ray a right femur fracture and was nospital on 4-20-12.					
	identified as a follo 4/20/12, noted "The few other altercation past. This residen (R98) and repeate to bedthis residen	ogress note dated 4/23/12, by up from the incident on his resident (R160) has had a cons with resident (R98) in the thas had a habit of seeking out odly saying things like "go backent will follow (R98). He has a land routinely repeats himself others."					

STATEMENT AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	COMPLETED	
		245018	B. WING		05/02	2/2012
	PROVIDER OR SUPPLIER		4	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORT OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	/EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	A resident incide R160 stated (R9) no reason. He way (R98) suddenly of closed fist." The indicated, "Isolat residentBoth re urged to avoid cot that both resident area." Although to assure resident there was no ind communicated the are kept separate The one psycho dated 10/31/11, psychological ev boundaries and with another resident th Apparently, this concerned about resident and sai his power to state recommendation included: " Is is rather low and may be difficult things in simple manner is advis R160's plan of resident with me personality discoprevious psychi approach's included	nt report from 10/14/11, noted 8) "struck him on the cheek for as by the bird cage and resident got up and punched him with a sanalysis and interventions ed incidence involving another esidents were separated and ontact. Staff advised to ensure its are not together in the same the incident report directed staff ints are not in the same area, lication of how this would be to staff and how to assure they see. Iogy note provided by the facility noted R160 was referred for a valuation "out of concern about some presentation of irritability ident his only concern was a sat got in his business and hit him is the altercation that people were it. He gave me the name of the id that he has done everything in y away from him." The ns on the psychology note suspect his intellectual functioning d, therefore, abstract concepts for him to understand. Keeping sentences and in a concrete	F 223			

THE STATE OF STATE OF THE STATE

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SU COMPLE	
	245018	B. WI	1G		05/02	2/2012
ROVIDER OR SUPPLIER	ME	•	444	44 RESERVOIR BOULEVARD NORTH	EAST	
(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION : DATE
that behavior was) feelings, provide sa and others (it did n psychology consul care lacked monit regarding resident include ensuring R same area, and direcommendations. R160's safety risk lacked the identific Although there wa assessment to ide left blank. When interviewed stated R160 and F staff didn't have arresidents behavior them apart." When interviewed TMA-A stated he problems with resporticular behavior when interviewed LPN-C stated she and R98 had gotte she had not heard suppose to monite R98 "did not like each other but the stated she like each other but the	offer support, validate afe environment for resident of clarify what that meant), and it if needed. R160's plan of oring R160's behaviors to resident altercations, did not a t160 and R98 were not in the d not address the psychology assessment dated 4/19/12, cation of any other behaviors, and area on the safety risk antify behaviors, this area was on 4/25/12 at 6:20 a.m., LPN-FR98 had a previous incident but my particular direction on the rs, the staff just tried to "keep on 4/25/12 at 6:35 a.m., had never seen R160 have any idents. He stated staff had no r interventions to do with R160. If on 4/25/12 at 7:25 a.m., knew of a "couple times" R160 en into altercations. She stated it of anything special they were or for; she just knew R160 and each other." If on 4/25/12 at 7:26 a.m., a knew R98 and R160 did not at didn't know of any monitoring at didn't know of any monitoring and care	F	223			
or special instruct	iono stan naa rogaranig 11100.					<u> </u>
	ROVIDER OR SUPPLIER //EW LUTHERAN HO SUMMARY STA (EACH DEFICIENC REGULATORY OR I Continued From pathat behavior was) feelings, provide stand others (it did national psychology consultate care lacked monitate regarding resident include ensuring Rame area, and direcommendations. R160's safety risk lacked the identific Although there was assessment to ideleft blank. When interviewed stated R160 and Fataff didn't have as residents behavior them apart." When interviewed TMA-A stated he problems with respectively behavior them apart. When interviewed TMA-B stated she and R98 had gotte she had not heard suppose to monitate R98 "did not like each other but the state of the problems with the suppose to monitate R98 "did not like each other but the state of the problems with respectively. When interviewed the problems with respectively.	ROVIDER OR SUPPLIER //EW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 that behavior was), offer support, validate feelings, provide safe environment for resident and others (it did not clarify what that meant), and psychology consult if needed. R160's plan of care lacked monitoring R160's behaviors regarding resident to resident altercations, did not include ensuring R160 and R98 were not in the same area, and did not address the psychology recommendations. R160's safety risk assessment dated 4/19/12, lacked the identification of any other behaviors. Although there was an area on the safety risk assessment to identify behaviors, this area was left blank. 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When interviewed on 4/25/12 at 7:26 a.m., TMA-B stated she knew R98 and R160 did not like each other but didn't know of any monitoring	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 that behavior was), offer support, validate feelings, provide safe environment for resident and others (it did not clarify what that meant), and psychology consult if needed. R160's plan of care lacked monitoring R160's behaviors regarding resident to resident altercations, did not include ensuring R160 and R98 were not in the same area, and did not address the psychology recommendations. R160's safety risk assessment dated 4/19/12, lacked the identification of any other behaviors. Although there was an area on the safety risk assessment to identify behaviors, this area was left blank. 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ROVIDER OR SUPPLIER Z45018 ROVIDER OR SUPPLIER ZEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 that behavior was), offer support, validate feelings, provide safe, environment for president and others (if did not clarify what that meant), and psychology consult if needed. R160's plan of care lacked monitoring R160's behaviors regarding resident to resident altercations, did not include ensuring R160 and R98 were not in the same area, and did not address the psychology recommendations. R160's safety risk assessment dated 4/19/12, lacked the identification of any other behaviors. Although there was an area on the safety risk assessment to identify behaviors, this area was left blank. 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When interviewed on 4/25/12 at 7:26 a.m., TMA-B stated she knew R98 and R160 did not like each other but didn't know of any monitoring	A BUILDING 245018 ROWIDER OR SUPPLIER ROWIDER OR SUPPLIER REW LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECIBED BY TPLI. REGULATORY OR LSC IDENTIFYING REGMANTON) Continued From page 19 that behavior was), offer support, validate feelings, provide safe environment for resident and others (it clid not clarify what that meant), and psychology consult if needed. R160's plan of care lacked monitoring R160's behaviors regarding resident to resident altercations, did not include ensuring R160 and R98 were not in the same area, and did not address the psychology recommendations. R160's safety risk assessment dated 4/19/12, lacked the identification of any other behaviors. 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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLE	
		245018	B. WING		05/0	2/2012
	ROVIDER OR SUPPLIER	ME		TREET ADDRESS, CITY, STATE, ZIP COL 4444 RESERVOIR BOULEVARD NOP COLUMBIA HEIGHTS, MN 5542	RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) . COMPLETION DATE
F 223	•		F 22	3		1.452
	social service direct busy body" and car stated R160 was not people's faces." She any previous alterct as she just started information was no	on 4/25/12 at 8:40 a.m., the stor (SSD) stated R160 is "a be "annoying to people." She ever "malicious, he just gets in se stated she was not aware of ations between R160 and R98 in February and this t passed onto her. SSD eve been nice to know; they problem here."				79.0 VED
	MSA-Z she stated with each other and stated she tried to dining area because physical alteration tried to keep an eye	on 4/25/12 at 9:55 a.m., with R160 and R98 had a history did not like each other. She keep them separate in the se they had gotten into a in the past. MSA-Z stated she e on R98 and R160 when they her so there was not an				
	DON stated R160 R98 in the past. So people out" to "get "intrusive." Although had these behavior these were identified.	on 4/25/12 at 11:15 a.m., the had "several" altercations with he stated R160 will "seek to them" and R160 can be gh the facility was aware R160 rs, the DON verified none of ed on the plan of care or e R160 and other residents				- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	R160 had incidents residents from 10/4	s of behaviors towards other 4/11 to 4/20/12 which included:				, ;
	intrusiveness, anta	gonistic behaviors, verbal				

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN (OF CORRECTION .	IDENTIFICATION NUMBER:	A. BUI	LDING	G	COMPLE	IED
		245018	B. WIN	1G _		05/0	2/2012
	ROVIDER OR SUPPLIER /IEW LUTHERAN HON	ЛЕ		44	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHI COLUMBIA HEIGHTS, MN 55421		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	abuse, repeated ph and yelling at confulacked interventions from R160's behaving potential retaliation. R29 was identified towards others and interventions to probehaviors, or protect retaliation from other R29 had diagnoses defiance disorder, retaliation from other R29 had diagnoses defiance disorder, retaliation from the R29 had diagnoses defiance disorder, retaliation from other syndrome. The annual minimu MDS) dated 6/21/1 intact and he had vetowards others that living environment, ambulatory, but use independent with loon the care area asse 6/22/11 indicated R reassurance due to noted he had a pote would be addressed minimize risks and psychologist was whis behavioral disturble of defensive or defensive or defensive would get upset when he wanted to medication passes.	ysical altercations with R98 sed residents. The facility set to protect other residents ors, or protect R160 from from other residents. with aggressive behaviors the facility lacked tect other residents from the cet the resident from potential er residents. which included: oppositional mood disorder, and organic makes assessment (1, noted R29's cognition was erbal and physical behaviors significantly disrupted care or alt noted he was not as a wheelchair and was comotion on and off the unit. It is sent (CAA) completed on 29 required redirection and inappropriate behaviors. It ential behavioral problem that if in the plan of care to a referral to the house arranted. The CAA identified rbances had a pattern and twe in nature. It noted R29 en he needed to be toileted, or be waited on for meals and The CAA noted he liked to became aggressive when a	F:	223			

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE	
		245018	A. BUILDING B. WING		05/0	2/2012
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	resident's cognition continued to demo behaviors towards pushing, grabbing, cursing. The MDS behaviors not direct independent in his living unit and did his range of motion. A copy of the residentified R29 had yelled at staff and The care plan includentified R29 had yelled at staff and The care plan includentified R29 had yelled at staff and The care plan includentified R29 had yelled at staff and The care plan includentified R29 had yelled at staff and The care plan includents as: encourage to epsychologist, combehavior, anticipal "behavioral contrainformation to include to the staff and The care plan includent to the staff and The care plan includents as: encourage to epsychologist, combehavioral contrainformation to include the staff and The care plan includent to the staff and The care plan includent	dated 3/21/12, indicated the was still intact and he nstrate verbal and physical others such as: hitting, kicking, threatening, screaming and also noted he had other cted toward others. R29 was wheelchair on and off of his not have any impairment with h. Jent's current plan of care was cility on 4/25/12. The care plan a history of aggression and grabbed staff inappropriately. Uded a goal to "not harm self or d various interventions such express feelings, refer to pliment on good mood and the needs, and use the ct". The care plan lacked ude his history of aggressive residents, addressing the list only staff. On 4/27/12 at 12:00 p.m., nurse (LPN) -D and R29's stated R29 once had a ct, but neither of them could	F 223			\$100 0.176 1.186 1

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPL		
	•	245018	B. WING		05/0	2/2012	
	ROVIDER OR SUPPLIER	PME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE :	
F 223	Continued From p The facility incider occurrences:	age 23 It reports identified the following	F 223				
	his right forearm a physician and fam to the cause of the check mark for "b interdisciplinary te	o p.m., staff observed R29 put cross R22's neck. The ily were notified. An analysis as e occurrence was noted by a ehavior". The review by the am (IDT) on 5/23/11, noted R22 not to make comments to eavior.					
	and observed a R R98 stated that R3 The physician and section to identify left blank. The IDT noted R29's psych	200 p.m., R29 staff heard a noise 98 holding on to R29's shirt. 29 had threatened to kick him. I family were notified. The an analysis of the cause was reviewed it on 12/19/121, and notropic medications were re the incident, and that both each other.		·		1 100 m	
	R16 who was sitting to make a high pit squeezed R16's right R29 stated "Yeah way". The nurse protified. The analysis a check marks for The incident report medications had right incident was reviet they noted they with the make a high protection.	5 p.m., R29 wheeled up behind ng in a wheelchair. R29 began ched yell and reached out and ght shoulder near the neck. I touched her, she was in my tractitioner and family were yes of occurrence was noted by "behavior" and "medications". It noted his psychotropic recently been decreased. The wed by the IDT on 2/6/12, and yes in the nurse practitioner					
	On 3/12/12 at 4:0	se in medications. O p.m., R29 punched R3829 in ead. R29 stated " she did not					

5 35

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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	
		245018	B. WII	\G		05/0	2/2012
	PROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORT OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 223	move out of my was happened. The fail were notified. An a occurrence was not "behavior". The ind 3/13/12, and the conurse practitioner to the conurse practitioner of the occurrence occurrence of the occurrence of the occurrence of the occurrence occurrence of the occurrence occurrence occurrence occurrence occurrence occurrence occurrence occurrence occurrence occurrenc	mily and nurse practitioner nalysis as to the cause of the oted with a check mark for cident was reviewed by IDT on omments section noted "ask to check labs". In p.m., R29 pinched R3913 on the stated the resident was in need to get through. The nurse mily were notified. The analysis was identified by a check mark a IDT reviewed the incident on the nurse practitioner would be stions. Incident reports, the following ed in the facility Integrated PN): The second with a raised hand and R29 stated R3913 "did not the psychology progress notes are resident had been receiving east 4/18/11. The notes		223			

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STATEMENT	OF DEF	ICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING ____

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 25 position that allows easy access to leave and go back to his room.	F 223			
	6/13/11- Recurrent altercation with a female resident. Verbally aggressive towards staff. Reward appropriate behaviors and choices.				
	7/25/11- Episodes of screaming or calling have reduced in intensity and frequency. Highly impulsive and lacks insight into his impulsivity. Try again to get a behavior program going.			in a second	
	The PPN's dated 8/22/11,10/3/11,11/28/12, 12/12/11 and 2/6/12 identified R29 seemed to be doing better because of living on another unit and staff were anticipating and meeting his needs.				
	The PPN dated 3/19/12 indicated R29's obsessive thinking continued, but lacked notation of the resident's aggressions on 2/3/12 when he squeezed a resident's shoulder/neck area, and on 3/12/12 when he punched a resident in the back of the head.				
	The Care Conference Summary note for the time period of 1/3/12 to 4/24/12 lacked any mention of the resident's aggressive behaviors during that time period. The note indicated R29 attended the conference, and the staff talked to him about not making threats to the staff while he waited for their help. The note did not indicate there had been any discussion about his aggression to fellow residents, and the development of a plan to discourage the behaviors that may put others at risk.				
	When interviewed on 4/26/12 at 11:50 p.m.,				

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		245018	B. Wil	√G		05/02	/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	EAST		
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F 223	Resident 116, who cognitively intact, s	m the facility identified as stated a few weeks ago she ng attacked by R98. She stated e of R29 and had a hold of his	F	223		-	14 10Z
	stated R29 had a hothers, but he had past few weeks. Red watching telev	on 4/29/12 at 1:24 p.m., RN-E history of aggression towards not had any behaviors for the 29 was observed lying in his vision. When interviewed, he ing find and relaxing.		•	•		11 - 12 - 221
	(TMA)-A was inter been aggressive in residents, but had	B a.m., trained medication aide viewed and stated R29 had the past toward other not been recently. He stated he ine, and would become ald not follow it.					
	lying on his bed an p.m., R29's nurse problem was impustated he had bee so recently. She h	55 a.m., R29 was observed and watching television. At 12:00 practitioner stated the R29's also control, not psychoses. She an aggressive in the past, less ad been adjusting his crease his behaviors and he					, v Iza
	at a table with 4 o	.m., R29 was observed seated ther residents playing card at the surveyor. At 5:45 p.m., d seated outside of R157's ing with her.					:: #1.
	facility social work	d on 5/1/12 at 9:39 a.m., the ker stated R29 was on the load. She verified that his					.:

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		ECONSTRUCTION	COMPLE	
		245018	B. WI	√G		05/0	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTI OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE
F 223	existing care plan signs to look for ar for his aggressive residents. She state impatient, and was When interviewed director of nursing more aggressive in was better. She state incidents of aggremonth, and verifie in the facility that or R29 became aggreare plan lacked saggression such a signs. She stated behavior, the facility behavior to ensure other residents. R29 had multiple towards other residents. The facility lacked interesidents from the from potential retaincluded a compretence residents (Fibehaviors, updating include specific in recognition of residents for execution of the residents fo	did not contain the warning nd interventions to implement behaviors towards other ted R29 was impulsive,	II.	223			28-11
1	· ·						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

245018

A. BUILDING

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F 223

F 225

05/02/2012 **

(X5) COMPLETION DATE

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NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

CONTRACTOR CONTRACTOR

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

.,,,	
F 223	Continued From page 28
	supervision. Direct care staff were interviewed and were able to explain their responsibility for
	identification of resident to resident abuse as well as precursor behaviors to be watchful of and
	appropriate interventions for R98, R160, and R29. The immediacy was removed at 1:25 p.m.
	on 5/1/12, and the scope and severity was reduced to no actual harm with a potential for no
	more than minimal harm, isolated.
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=E	INVESTIGATE/REPORT

ALLEGATIONS/INDIVIDUALS

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

F225 Staff Treatment of Residents

It is the policy of Crest View Lutheran Home to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

For Resident R83, R165, R120, R104, R92, R22, and R95 the reports were reviewed and followed up on by the interdisciplinary team.

	CENTEROT ON MEDIONICE & MEDIONICE		TOWNSHITE		NO DATE C		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018 B. WING				05/02/2012	
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421	EAST	* (3.2) * (3.1) * (3.1)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	П	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	to the administrator representative and with State law (inclu- certification agency incident, and if the	vestigations must be reported	F 2	25	Corresponding updates have made to the care plans, care assignment sheets and communicated to the staff responsible for their care. Ewill be provided for staff me regarding incident reporting and abuse prohibition by 06	members ducation embers g process	. 13912 VO
	by: Based on interview review the facility for potential abuse, source and misapped were immediately rand to the state ago thorough investigated (R55, R7, R83, R1, R22, R95) in the stabuse, and misapped Findings include: Resident 55 (R55) unknown origin, the investigated or immagency and the addressed and the addres	NT is not met as evidenced w, record review, and policy ailed to ensure all allegations neglect, injuries of unknown propriation of resident property reported to the administrator rency, along with conducting a ation for 10 of 17 residents 65, R120, R104, R14, R92, ample reviewed for alleged propriation of resident property. The distribution of the state of the sta			Resident R55 expired on 05/Resident R7 expired on 04/2 R14 expired on 05/02/12. For other residents who may affected by this practice a result of current incident reporting and investigation has taken placed results will be reported to the Committee for further review recommendations. Upon the system revisions and/or state education will be implement indicated. The policy and procedure for prohibition and incident repand follow up will be review revised by the interdisciplination of the policy and procedure for prohibition and incident repand follow up will be review revised by the interdisciplination of the policy and procedure for prohibition and incident repand follow up will be review revised by the interdisciplination of the policy and procedure for prohibition and incident repand follow up will be review revised by the interdisciplination.	y be andom orts on /12 to de. Audit ne CQI w and is review, ff ted if or abuse porting yed and ary team	

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			
	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION	' IDENTIFICATION MIMBER	A. BUILDING		
		B. WING		
	245018	D. WING		
		STREET ADDRESS, CITY, STATE,		

(X3) DATE SURVEY COMPLETED

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4)10	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL OF DEFICIENCY OF LOCAL PROPERTY OF LOCAL PROPER	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE	
TAG REG	SULATORY OR LSC IDENTIFYING INFORMATION)	17.00	DEFICIENCY)	<u> </u>	i
			to ensure current standards of	.,	
F 225 Continu	ued From page 30	F 225	practice are in place. Facility staff	26. 1 11	
The ca	re plan dated 1/25/12, noted the resident	1	members will be trained as it relates		
was re	sistive to cares.		to their respective roles and		
The fa	cility Resident Skin Changes Report		responsibilities for the revised		
/RSCR	(a) form dated 4/2/12, noted R55 was found		policies and procedures regarding		
with ne	ew purple bruises. The left arm contained the following sizes: 1.0 cm X 1.0 cm, 2.0		abuse prohibition and incident report	1 12	
l cm X 2	2.0 cm, and a 6.0 cm X 8.0 cm. The right		completion by 06/11/12.		
arm co	ontained a 1.0 cm X 2.2 cm and a 3.5 cm X		t. thistand	*	
4.2 cm	n. The incident report noted R55 was ewed and yelled "Leave me alone!" The		Audits will be completed weekly for 4		
l "imme	ediate Investigation" field (a place to		weeks, monthly for 3 months, then		
docum	nent) on the RSCR was left blank. The		according to the quality control		
report	noted the family and physician were d on 4/2/12; however the administrator and		schedule to ensure continued		
the sta	ate agency were not notified. The		compliance with facility protocols. A	į	
"inves	stigation Notes" field was left blank. The		meeting will be held with a group of		
RSCR	R had an attached form titled "Investigation		residents and or designated decision		
Notes	for Injury of Unknown Origin" (INIUO), contained fields to document identified		makers by 06/11/12 to ensure		
diagno	osis or behaviors prior to the incident and		concerns are followed up on by staff members and resolutions are		
staff in	nterviews for the current shift and prior two		provided. Upon this review, system		
shifts.	. These areas were also left blank.		revisions and/or staff education will	1	\cdot
On 4/	30/12 at 3:30 p.m., the director of nursing		be implemented if indicated.	ŀ	
LOON	N and administrator (ADM) stated this		be implemented if indicated.		
incide	ent should have been reported to the ADM state agency because R55 had impaired	} 	The Administrator or designee will be		-
cogni	ition and the injury was unexplained with		responsible for compliance.	•	
multir	ple bruising noted in the same area. They		responsible for compliances	. 131	
	ed a thorough investigation had not been		Date of Correction: 06/11/12		-
. comp	pleted.		Date of confederation and the		-
Altho	ough R55 received multiple bruises, a ough investigation was not completed to			Ì	
inclu	de the resident's diagnosis and behaviors				:
prior	to the incident and the completion of staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		245018	B. WING _		05/02	2/2012
,	ROVIDER OR SUPPLIER	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	HEAST	· į
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225		age 31 who discovered the injury, and or the resident on prior shifts.	F 225			
	origin that were no immediately to the R7 had diagnoses quarterly MDS date cognition was mod dependent on staff mobility. The MDS demonstrate behave A RSCR form date bruises next to eacleft shoulder which and 3.0 cm X 3.0 cm unable to explain with was on anticoagulate the and the reportant physician were family was notified state agency was Notes' field of the had slumped into the and the resident's On 4/30/12 at 3:30 CEO were all presistated the state agenctified due to the the resident could	which included dementia. The ed 3/24/12, noted the resident's lerately impaired and she was for toileting, dressing and bed noted the resident did not viors. ed 4/17/12, noted R7 had 2 ch other on the back side of the measured 4.0 cm X 3.0 cm, cm. and the resident was what happened. The igation" field noted the resident eant (prevents blood clotting) at indicated the administrator is immediately notified, and the the next day; however the not notified. The "Investigation form referenced the resident the E-Z stand sling 6 days prior,	· ·			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 05/02/2012 245018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST **CREST VIEW LUTHERAN HOME** COLUMBIA HEIGHTS, MN 55421 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 F 225 Continued From page 32 Although R7 had two bruises in an area that may have been explained by slumping into the E-Z stand on 4/11/12, the bruising would have been evident at the time, and a RSCR was not completed until 4/17/12. A thorough investigation was not completed to include the resident's diagnosis and behaviors prior to the incident and the completion of staff interviews of those who discovered the injury, and those who cared for the resident on prior shifts. Resident 83 (R83) had multiple bruises of unknown origin that were not thoroughly investigated or immediately reported to the state agency. R83 had diagnoses which included dementia. The quarterly MDS dated 1/14/12, identified the residents cognition as severely impaired, she J) required extensive assistance with dressing and mobility, and was dependent on staff for hygiene. The MDS noted the resident did not demonstrate any type of behaviors. The care plan dated 4/23/12, did not indicate the resident was resistive to cares. A RSCR form dated 4/10/12, noted R83 had a purple/blue 4.0 cm X 3.0 cm bruise to the palm of the right hand. The report noted the resident was sleeping and therefore it could not be explained. The "Immediate Investigation" field was left blank. The report noted the administrator, the family, and the physician were notified; however the state agency was not. The "Investigation Notes" field was left blank. On 4/30/12 at 3:30 p.m., the ADM stated the

injury should have been reported to the state

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PRINTED: 05/17/2012

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WIN	IG		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	IEAST	: .:.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE .	(X5) COMPLETION DATE
F 225	agency since it was or anyone else. The agreed the investig incomplete. Although R83 had a thorough investigatinclude the resident prior to the incident cared for R83 on prior to the incident the admission MD resident was sever required extensive hygiene, and mobil resident did not debehaviors, but had care plan dated 3/1 resident was resist A RSCR form date abrasion on the left cm long. The "Invereport completed benoted the resident."	s not explained by the resident e ADM, DON and CEO all pation on the report was a bruise of unknown origin, a tion was not completed to at's diagnosis and behaviors t, and interviewing staff who prior shifts. (5) had an abrasion of at was not thoroughly nediately reported to the state ministrator. (8) dated 3/12/12, noted the rely impaired in cognition and assistance with dressing, lity. The MDS noted the monstrate verbal or physical other types of behaviors. The 14/12, did not indicate the cive to cares. (6) d 4/5/12, noted R165 had an at thip that was 10.0 cm X 1.0 estigation Notes" section on the py a registered nurse on 4/5/12, had a fall on 4/1/12, and was		225			
	administrator (ADN not notified. On 4/30/12 at 3:30	ide. The report indicated the M) and the state agency were p.m., the ADM, DON and ent to review the incident. The					
		the large size of the injury and	Į Į				

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TATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WI	IG		05/02	/2012
• • • • • • • • • • • • • • • • • • • •	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	because R165's co could not explain the reported to the AD had not.	ognition was impaired and ne injury, it should have been M and the state-agency, but-it-	F:	225			1 162
	completed to inclu- behaviors prior to interviews conduct injury, and those w prior shifts. The fa- however documen	nvestigation was not de the resident's diagnosis and the incident, nor were staff and of those who discovered the who cared for the resident two cility linked it to a fall on 4/1/12, tation lacked to indicate that dentified at the time of that fall.					77 - 4V
	director of nursing documentation to trended the incide	on 5/1/12 at 8:00 a.m., the stated the facility did not have indicate the facility tracked and ints along with care givers in otential patterns related to the fing.					: : : : : : : : : : : : : : : : : : :
	DON, ADM, and C unknown origin wa explained by resid by anyone, one the and if there had be observed at once, time. They agreed	on 4/26/12 at 2:55 p.m., the CEO all agreed that an injury of as one that could not be ent, one that was not observed at was in suspicious location, een a number of injuries or a number of incidents over I all incidents should be gated if they met the criteria					
	the ADM and CEC	d on 4/29/2012 at 12:30 p.m., O stated although they reviewed SCR, the director of nursing was suring the investigations were					

1 3 36

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STATE	MENT OF	DEFICIE	NCIES
		ODDECT	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

245018

Mark William Market Commission Commission Commission Commission Commission Commission Commission Commission Com

B. WING _____

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 35	F 225		
	thoroughly reviewed and processed.			
		·= · ·		
	Resident 120 (R120) was allegedly slapped by a nursing assistant, and it was not reported			
	immediately to the state agency, or thoroughly			SECTION
	investigated.			107. VED
1	When reviewed, the facility submitted a report to			12 13 13 13 13 13
	the state agency on 1/6/12 regarding an incident			
	of alleged abuse which was reported to the facility			
	on 1/1/12. According to the report, R120's family member reported R120 had stated she was			
	slapped by a nursing assistant on the day shift.			
	The investigative report the facility submitted to	Į		1
	the state agency noted the supervisor interviewed R120, and R120 denied ever being hit and the		•	
	supervisor was unable to contact the family			
	member that had made the complaint for further	ļ		
	information.			2.
	When interviewed on 5/1/12 at 8:00 a.m., the			
	director of nursing stated the incident should have been reported to the state agency immediately		,	
	since it was an allegation of abuse, but because			
	the resident denied being slapped when asked,			: '
	they did not. She verified the investigation lacked interviews with other staff members who had			<u> </u>
	been working, other than the one staff person			14.13
	involved. She stated there was no further			1 1945
	investigation besides what was submitted to the state agency to ensure abuse had not occurred.			
	The investigation did not include interviews with	•		
	staff members having contact with resident during the period of alleged incident, interviews with family, and a review of all circumstances	3		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WIN	1G		05/02	2/2012
	ROVIDER OR SUPPLIER INTERNATION HO	ME		444	ET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421	≅AST	\
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	cident.	F	225			6.
	Resident 104 (R10 staff, and the facilit investigation into the	4).was allegedly slapped by y lacked a thorough ne matter.	•				, - 4
	been slapped by a down on the bed. A report submitted to and the report indi- conducted with 3 s	a nurse on 1/31/12, she has staff member and thrown Although the investigative the state agency on 1/31/12, cated interviews had been staff members who had worked					. 6.8 . 1.69 1.693
	roommate. The fa	ift, as well as R104's acility was unable to provide ence of the staff who were when the interviews occurred.	and the second s				
	director of nursing investigation, but of	on 5/1/12 at 8:00 a.m., the stated she had conducted the did not keep her notes of the ne submitted the report to the					***
	state agency. She information by loo	stated she could retrieve the king back at the schedules ation was not received.					
	Resident 14 (R14) was not thoroughl) sustained a laceration which y investigated.					
	right eye on 1/30/ According to the ragency, on 1/30/1	1.5 inch laceration above her 12, which required sutures. eport submitted to the state 2 the resident was found lying and fallen out of her wheelchair.					. + 12 2 3 3 1
	DON stated there investigation. The	on 5/1/12 at 8:00 a.m., the had been no further investigation lacked an person/persons reporting the					

1.7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WIN	G_		05/0	2/2012
	ROVIDER OR SUPPLIER /IEW LUTHERAN HO	ME	'	44	EET ADDRESS, CITY, STATE, ZIP CO 144 RESERVOIR BOULEVARD NO OLUMBIA HEIGHTS, MN 5542	RTHEAST	3.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) . COMPLETION DATE
F 225	and a review of all incident. Although was timely, the face evidence they had investigation to ensure provided in accordance that no neglect had resident 92 (R92) during cold weather investigated. R92 was found out coat 2/12/12. The farment. When a.m., the DON statinvestigation. Although the incide agency timely and) was immediately lacked evidence the	of the resident medical record, circumstances surrounding the the report to the state agency lifty was unable to provide conducted a thorough sure the residents care was ance with the plan of care and	F2	225			
	such as: how long who was responsib time, and whether	the resident had been outside, ble for her well-being at the the plan of care was being der to determine if indeed any			,		
	someone was roug appointment, and facility did not repo	reported to the facility staff gh with her during an outside she sustained a bruise. The ort the incident to the state t a thorough investigation.	,				
	I		1		ì		

PRINTED: 05/17/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/02/2012 245018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST CREST VIEW LUTHERAN HOME COLUMBIA HEIGHTS, MN 55421 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) F 225 F 225 Continued From page 38 R22 quarterly MDS dated 3-21-11 identified the resident had no cognitive impairment and was a one person assist with most activities of daily living. R22 progress notes dated 10/21/11 indicated, "Writer noticed a 3.5 cm x 4.5 cm bruise on the back of the left hand and a 5 cm x 3.5 cm bruise on her left elbow. Residents says it occurred at dialysis. Resident said the nurse was a little rough when holding her hand." A "Resident skin changes report" dated 10/21/11 indicated the same explanation and measurements of the bruise as the progress report dated 10/21/11. The intervention stated "Staff will send a note to dialysis to be more gentle as resident bruises easily." The spot on the form for the investigation was blank.

FORM CMS-2567(02-99) Previous Versions Obsolete

When interviewed on 4/26/12 at 2:55 p.m., the administrator stated a thorough investigation was

reported to the state agency.

not completed, and the incident should have been

R22 accused an outside service staff member of being rough with her and leaving a bruise, and the facility lacked evidence that a thorough investigation into the matter was conducted to include a further review of the resident's complaint report and further interview with the resident, and interviews with family and all circumstances surrounding the incident.

Resident 95 (R95) reported missing personal property, and the facility did not report it to the administrator and state agency and lacked an

: _ ESSESSE WELLERSHIP _ COMMUNICALISTE

Event ID: D18X11

Facility ID: 00005

If continuation sheet Page 39 of 162

1.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING				
		245018	B. WHYC			05/02	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME		5	4444	ET ADDRESS, CITY, STATE, ZIP CODE 4 RESERVOIR BOULEVARD NORTHE LUMBIA HEIGHTS, MN 55421	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	investigation in to the R95 had diagnosis quarterly MDS date	he matter. including hypertension. R95's ed 3/6/12, indicated he is	F 22	25			
	and that he is mode The plan of care up has short term mer plan did not indicate	able to report the day of week erately cognitively impaired. odated 2/29/12, indicated he mory loss, at times. The care e R95 has any long term at he has impaired decision					
	10/12/11, was revie reported to this writ this week. He want wouldn't tell me any	ted Progress Notes dated ewed and indicated "Resident ter that somebody robbed him ted to speak to the boss and symore about the incident. of the the residents request".					
	informed by R95 of	7/12, LPN- C stated she was f the missing money and she sor but could not remember					
•	robbed "they took e had 3 of them; it wa keep much money facility did not do as	27/12, R95 stated he was everything in my coin purses. I as about \$90 in total. I don't in my purses anymore. The nything about it either, that is is facility; they don't follow ng".					
	the director of nurs of R95 reporting of verified they should	/27/12, the administrator and ing stated they were not aware any missing money. They have been notified and the d have been notified.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MANAGE VIII GENALUM COM SOMES SOMES COMPUNIONES COMA SUMMANAMA AND COMPUNIONES COMPUNIONES COMPUNIONES COMPUNI COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES COMPUNIONES C PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		•		OMB NO.		
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		00	
AND PLAN OF	CORRECTION				05/02	/2012
		245018	1		03/02	1.1
	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH	IEAST	
		* # F = -	44	OLUMBIA HEIGHTS, MN 55421		٠,
CREST V	IEW LUTHERAN HO	WE		PROMINER'S PLAN OF CORRE	CTION	(X5) COMPLETION
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	CULU DE	DATE
TAG						67
			F 225			
F 225	Continued From p	age 40				· ;
	The facility lacked	a thorough investigation to of the resident's complaint				
	1 1 1 - 5-110	with etall meruners navny				
	1 1	ant dilling the behod of divases				
in	incident, interview	s with family, roommates or				
	visitors.					
						1
	The facility's Abu	se Prevention Policy dated ntained the following directive:				•
	1 - 1	CALANTIATOR CASES UI LOSIUVIU				
	i ii ont no	aloct of abuse, illuluming injurior	3			
	1	a and missing good or				
		thoroughly investigated and he administrator or designee.				
	industrial or our	heraniiaieii Gasos iliust uto ~-				
	I was also that a	nnminiale state auction				
	physician, famil	ies, and or representative."	}			
	- c :::h.coolio	y's definition of an INJURY OF	ļ 			. 2
	LIBRORIAN CONTRACTOR	HRUE Was defilied as an infort				*
	lu iin hofh	AF THE TOUCHING CONTUNIONS 111				
	lant common of the	sa inium/was noi observeu er un	ey t.			
	I IO I The initi	not be explained by the residentry is suspicious because of the	- 1			
	والمساعة الماسان	CEL TRO INCANDEL HIGH IN GO GO				
	- I	ranie in iraliilla) oi tile numboi o	1			
	Liniuries at one t	particular point in time, or the				
	incidence of inj					
	The policy note	d "reports of mistreatment,				
	market or shill	se including illigities of whichour	1			
	Leasuron and mis	sannronriation of broberry are				
	1	noroughly investigated.				
	The facility's po	olicy directed the investigation				
į	would consist	of at least the following:				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391	
S	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
А	IND PEAN OF	COMMEDITOR					!	
			245018	B. WI	√G		05/02/	2012
1	NAME OF PROVIDER OR SUPPLIER				STRE	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE	EAST	•
	CREST V	IEW LUTHERAN HO	ME		C	OLUMBIA HEIGHTS, MN 55421		· .
_	(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	F 225	Continued From pa A review of the cor Interview with the p incident	age 41 npleted complaint report person/persons reporting the	F	225			7 162
		An interview with water indicated Interviews with states index in the resident during the Interviews with fan	vitnesses to the incident ident medical record if ident medical record if if members having contact with period of alleged incident hily, roommates and visitors umstances surrounding the					90% 7-9 8-8
	F 226	incident of suspectinjuries of unknow misapplication of preported to the Adnoted the administration findings to the immediately. 483.13(c) DEVEL	cluded the directive " An ted incidentincluding n origin source and property should be immediately ministrator". The policy also strator or designee would report e State Licensing agency	F	226	F226 Staff Treatment of Re	sidents	- N
	SS=F	The facility must of policies and process	JSE/NEGLECT, ETC POLICIES facility must develop and implement written cies and procedures that prohibit treatment, neglect, and abuse of residents misappropriation of resident property.			It is the policy of Crest View Home to develop and imple policies and procedures reg screening and training emp	ement parding loyees to	
		by: Based on interview document review their abuse prohib appropriate report of alleged violation of unknown origin	ENT is not met as evidenced ew, record review, and the facility failed to followed bition policy regarding ting and thorough investigations on a buse, neglect or injuries for 10 of 17 residents (R55, R22, R95, R120, R104, R14, &			prevent, identify, and report neglect, and mistreatment misappropriation of proper interpretive guidelines for refer to seven key compon reviewed by surveyors to diffacility is meeting the int F226.	ty. The this F-tag ents to be letermine	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING DEFINATOR APPROVED (X3) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED

		A. BO	LUIN	·		1
	245018	B. WII	VG		05/02	/2012
	ME		4	444 RESERVOIR BOULEVARD NORTHE	AST	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
Continued From particles R92) in the sample The facility also fail prevention plan relatemployees for 5 of NA-K, NA-L, LPN-the previous four mailed to ensure the prevention comport protection which have residents who residents	who were reviewed for abuse. ed to implement their abuse ated to the screening of new 5 new employees (NA-J, I and LED-E) that were hired in conths. In addition the facility expolicy contained all abuse tents to ensure resident ad the potential to effect all 144 ded in the facility. The Prevention Policy dated ained the following directive: " tantiated cases of resident ect, or abuse, including injuries and misappropriation of coroughly investigated and administrator or designee. tantiated cases must also be coropriate state agency,	F	226	assessments, care plan update training of employees, protect a resident during an investigative protocols. Feemployees who may have been affected by this practice employees will be audited for referenchecks and completed if necesto 11/12. Screening: An audit will be completed by 06/11/12 for a sample of employee records ensure that prescreening was completed. Training: Random interviews members will be conducted to 06/11/12 to ensure their understanding of their roles	tion of tion or other en loyee ence essary by random to s of staff by and	100 (C)
UNKNOWN SOUF that meets both of The source of the person or could no and 2.) The injury extent of the injury generally vulnerab injuries at one part incidence of injuries The policy noted "I neglect, or abuse,	the following conditions: 1.) injury was not observed by any it be explained by the resident, is suspicious because of the the location (not in an area le to trauma) or the number of icular point in time; or the sover time. reports of mistreatment, including injuries of unknown			responsibilities as it relates to abuse prohibition/prevention and procedures. All staff metwill be held by 06/11/12 to rethe abuse prohibition policy. Prevention: A meeting will be with individual residents or a group of residents by 06/11, ensure that allegations of all neglect, misappropriation, or	to the in policy eetings review	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa R92) in the sample The facility also fail prevention plan rela employees for 5 of NA-K, NA-L, LPN-J the previous four m failed to ensure the prevention compon protection which ha residents who resid .Findings include: The facility's Abus Revised 3/10, cont Suspected or subs mistreatment, negl of unknown origin, property shall be th documented by the Suspected or subs reported to the app physician, families The facility policy's UNKNOWN SOUP that meets both of The source of the person or could no and 2.) The injury i extent of the injury generally vulnerab injuries at one part incidence of injurie The policy noted "I neglect, or abuse,	PROVIDER OR SUPPLIER VIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 R92) in the sample who were reviewed for abuse. The facility also failed to implement their abuse prevention plan related to the screening of new employees for 5 of 5 new employees (NA-J, NA-K, NA-L, LPN-J and LED-E) that were hired in the previous four months. In addition the facility failed to ensure the policy contained all abuse prevention components to ensure resident protection which had the potential to effect all 144 residents who resided in the facility.	PROVIDER OR SUPPLIER VIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 R92) in the sample who were reviewed for abuse. The facility also failed to implement their abuse prevention plan related to the screening of new employees for 5 of 5 new employees (NA-J, NA-K, NA-L, LPN-J and LED-E) that were hired in the previous four months. In addition the facility failed to ensure the policy contained all abuse prevention components to ensure resident protection which had the potential to effect all 144 residents who resided in the facility. Findings include: The facility's Abuse Prevention Policy dated Revised 3/10, contained the following directive: "Suspected or substantiated cases of resident mistreatment, neglect, or abuse, including injuries of unknown origin, and misappropriation of property shall be thoroughly investigated and documented by the administrator or designee. Suspected or substantiated cases must also be reported to the appropriate state agency, physician, families, and or representative. " The facility policy's definition of an INJURY OF UNKNOWN SOURCE was defined as an injury that meets both of the following conditions: 1.) The source of the injury was not observed by any person or could not be explained by the resident, and 2.) The injury is suspicious because of the extent of the injury, the location (not in an area generally vulnerable to trauma) or the number of injuries at one particular point in time; or the incidence of injuries over time. The policy noted "reports of mistreatment, neglect, or abuse, including injuries of unknown	PROVIDER OR SUPPLIER VIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 R92) in the sample who were reviewed for abuse. The facility also failed to implement their abuse brevention plan related to the screening of new employees for 5 of 5 new employees (NA-J, NA-K, NA-L, LPN-J and LED-E) that were hired in the previous four months. In addition the facility failed to ensure the policy contained all abuse prevention components to ensure resident protection which had the potential to effect all 144 residents who resided in the facility. Findings include: The facility's Abuse Prevention Policy dated Revised 3/10, contained the following directive: "Suspected or substantiated cases of resident mistreatment, neglect, or abuse, including injuries of unknown origin, and misappropriation of property shall be thoroughly investigated and documented by the administrator or designee. Suspected or substantiated cases must also be reported to the appropriate state agency, physician, families, and or representative. " The facility policy's definition of an INJURY OF UNKNOWN SOURCE was defined as an injury that meets both of the following conditions: 1.) The source of the injury was not observed by any person or could not be explained by the resident, and 2.) The injury is suspicious because of the extent of the injury, the location (not in an area generally vulnerable to trauma) or the number of injuries at one particular point in time; or the incidence of injuries over time. The policy noted "reports of mistreatment, neglect, or abuse, including injuries of unknown	PROVIDER OR SUPPLIER WIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 R92) in the sample who were reviewed for abuse. The facility also failed to implement their abuse prevention plan related to the screening of new employees for 5 of 5 new employees (NA-J, NA-K, NA-L, LPN-J and LED-E) that were hired in the previous four months. In addition the facility failed to ensure the policy contained all abuse prevention components to ensure resident protection which had the potential to effect all 144 residents who resided in the facility. 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A meeting will be condition of property shall be thoroughly investigated and documented by the administrator or designee. Sometime Appropriate state agency, physician, families, and or representative." Training: Random interview, members will be conducted 06/11/12 to ensure their understanding of their roles responsibilities as it relates to abuse prohibition/prevention and procedures. All staff me will be held by 06/11/12 to the abuse prohibition policy with individual residents	PROVIDER OR SUPPLIER VIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 R92) in the sample who were reviewed for abuse. The facility also falled to implement their abuse prevention plan related to the screening of new employees for 5 of 5 new employees (N.AJ., N.AK., N.AL, L.PNJ and LED-E) that were hired in the previous four months. 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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 43 promptly and thoroughly investigated. The facility's policy directed the investigation would consist of at least the following: A review of the completed complaint report Interview with the person/persons reporting the incident An interview with witnesses to the incident A review of the resident medical record if indicated Interviews with staff members having contact with resident during the period of alleged incident Interviews with family, roommates and visitors A review of all circumstances surrounding the incident The policy also included the directive " An incident of suspected incidentincluding injuries of unknown origin source and misapplication of property should be immediately reported to the Administrator." The policy also noted the administrator or designee would report such findings to the State Licensing agency immediately. Resident 55 (R55) had multiple bruises of unknown origin, that were not thoroughly investigated or immediately reported to the state agency and the administrator as directed by their facility policy. A facility Resident Skin Change Reports (RSCR) form dated 4/2/12 noted R55's left arm contained three bruises of the following sizes: 1.0 cm X 1.0 cm, 2.0 cm X 2.0 cm, and a 6.0 cm X 8.0 cm. The right arm contained a 1.0 cm X 2.2 cm and a 3.5 cm X 4.2 cm had multiple new purple bruises on her arm. The RSCR indicated the	F 226	by staff members and that they and/or the designated decision maker received resolution to concerns. Identification: Random care observation audits will be completed weekly for 4 weeks and then randomly to ensure care is being provided in accordance to individualized care plan. A random audit of incident and accident reports will be completed by 06/11/12 to determine if trends or patterns have been identified for potential abuse. Investigation: A post incident review will be completed on incident/accident or injuries of unknown origin by the IDT to identify gaps in facility protocols and to ensure an environment where residents are free from potential abuse. Protection: A review of investigations will be completed by 06/11/12 to determine if immediate steps were taken to protect residents from harm during an investigation.	
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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/17/2012 APPROVED 0938-0391
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F 226	notified. The facility evidence the injury	age 44 he state agency were not v was unable to provide of unknown origin was ated, as directed by their	F	226	Reporting/Response: An aud completed by 06/11/12 of investigations to ensure reportimelines were met and investigations completed.		
:	(DON) and administ incident should have and state agency by the resident and in the same area.	p.m., the director of nursing strator (ADM) stated this we been reported to the ADM secause it was not explained multiple bruises were noted They verified a thorough ot been completed.			The policy and procedure fo prohibition will be reviewed revised by the interdiscipling by 06/11/12. The Medical D	and ary team Director	195 115

Resident 7 (R7) had multiple bruises of unknown origin that were not thoroughly investigated or immediately reported to the state agency as directed by their facility policy.

A RSCR form dated 4/17/12, noted R7 had 2 bruises next to each other on the back side of the left shoulder which measured 4.0 cm X 3.0 cm, and 3.0 cm X 3.0 cm. and the resident was unable to explain what happened. The report indicated the state agency was not notified. The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated to include all the directives in their policy.

On 4/30/12 at 3:30 p.m., the ADM, DON, and CEO were all present to review the incident. They stated the state agency should have been notified due to the size of the injury and because the resident could not explain it. They stated the investigation regarding the incident was not thorough.

Resident 83 (R83) had multiple bruises of

The policy and procedure for abuse prohibition will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policies to ensure current standards of practice are in place. The CQI Committee will review the policy to ensure all components are present: screening, training, prevention, identification, investigation, protection, reporting, and response.

Staff members will be trained as it relates to their respective roles and responsibilities for the abuse prohibition policies and procedures by 06/11/12.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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F 226	Continued From page 45 unknown origin that were not thoroughly investigated or immediately reported to the state agency as directed by their facility policy. A RSCR form dated 4/10/12, noted R83 had a purple/blue 4.0 cm X 3.0 cm bruise to the palm of the right hand. The report noted the resident was sleeping and therefore it could not be explained. The report indicated the state agency was not notified. The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated to include all the directives in their policy. On 4/30/12 at 3:30 p.m., the ADM stated the injury should have been reported to the state agency since it was not explained by the resident or anyone else. The ADM, DON and CEO all agreed the investigation on the report was incomplete. Resident 165 (R165) was severely impaired in cognition, and had an abrasion of unknown origin which was not thoroughly investigated or immediately reported to the state agency and the administrator as directed by their facility policy. A RSCR form dated 4/5/12, noted R165 had an abrasion on the left hip that was 10.0 cm X 1.0 cm long which was unexplained. The report indicated neither the administrator or the state agency were notified. The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated to include all the directives in their policy. On 4/30/12 at 3:30 p.m., the ADM, DON and CEO were all present to review the incident. The		For Resident R83, R165, R120, R104, R92, R22, and R95 the reports were reviewed and followed up on by the interdisciplinary team. Corresponding updates have been made to the care plans, care assignment sheets and communicated to the staff members responsible for their care. Education will be provided for staff members regarding incident reporting process and abuse prohibition by 06/11/12. For Employee(s) NA-J, NA-K, NA-L, LPN-J, and LED-L reference checks will be completed by 06/11/12. Department supervisors responsible for completing reference checks will be educated by 06/11/12. Resident R55 expired on 05/27/12. Resident R7 expired on 04/28/12. R14 expired on 05/02/12. For other residents who may be affected by this practice a review of 20% of current incident reports will be completed by 06/11/12. This will include reporting timelines,	1 002 1 0012 1 0012
	ADM stated due to the large size of the injury and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP LDING	LE CONSTRUCTION	COMPLETED	
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F 226	because the reside and could not expended and could not expended to the sended and could not expended and could not expended and the sended and sended appointment of the sended appointment of the sended appointment of the sended and sended an	ent's cognition was impaired lain the injury, it should have he ADM and the state agency. I reported rough treatment at an ent, and the facility did not state agency or complete a ation as directed by their facility did contained a progress notes at indicated the author of the 5 cm x 4.5 cm bruise on the and and a 5 cm x 3.5 cm bruise which the resident said had an outside appointment due to little rough when holding her y was unable to provide ry of unknown origin was igated to include all the policy. d on 4/26/12 at 2:55 p.m. the ted a thorough investigation was ould have been reported to the directed by the facility abuse		226	Audits will be completed we weeks, monthly for 3 month then according the quality of schedule to ensure screening training, prevention, identify investigation, and protection place. The results of those as the reported to the CQI Comfor further review and recommendations. The Director of Nursing or will be responsible for common Date of Correction: 06/11/	ns, and ontrol ontrol of, ication, is/are in audits will omittee designee pliance.	

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F 226	Continued From page 47 had robbed him that week, and he wanted to speak to the boss about it. The facility was unable	F 226			
	to provide evidence the report of missing money reported or thoroughly investigated to include all the directives in their policy.				
	On 4/27/12 at 12:20 p.m., administrator and the director of nursing stated they were not aware of R95 reporting missing money. They verified they should have been notified and they did not notify the state agency.				
	Resident 120 (R120) was allegedly slapped by a nursing assistant on 1/1/12, and it was not reported immediately to the state agency, or thoroughly investigated as directed by their facility policy.				- 1
	The facility submitted the report to the state agency on 1/6/12 regarding an incident of alleged abuse which was reported to the facility on 1/1/12. According to the report, R120's family member-X reported R120 told them she was slapped by a nursing assistant on the day shift. The investigative report the facility submitted to the state agency noted the supervisor interviewed				
	R120, and R120 denied ever being hit. The supervisor was unable to contact the family member-X that had made the complaint for further information.				
	When interviewed on 5/1/12 at 8:00 a.m., the director of nursing stated the incident should have been reported to the state agency immediately since it was an allegation of abuse. She verified the investigation lacked interviews with other staff members who had been working, other than the one staff person involved. She stated there was		-	4	÷.
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F 226	Continued From page 48 no further investigation besides what was submitted to the state agency to ensure abuse had not occurred. The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated to include all the directives in their policy.	F 226		1.2013
	Resident 104 (R104) was allegedly slapped by staff on 1/31/12, and the facility lacked a thorough investigation into the matter as directed by their facility policy.			VED
	R104 reported to a nurse on 1/31/12, she has been slapped by a staff member and thrown down on the bed. Although the investigative report submitted to the state agency on 1/31/12. The report indicated interviews had been conducted with 3 staff members who had worked on that evening shift, as well as R104's roommate. The facility was unable to provide evidence of which staff members were interviewed, and when these interviews occurred. Although the investigative report was submitted to the state agency timely, the facility was unable to provide evidence the allegation was thoroughly investigated to include all the directives in their policy.			
	When interviewed on 5/1/12 at 8:00 a.m., the director of nursing stated she had conducted the investigation, but did not keep her notes of the interviews once she submitted the initial investigation to the state agency.			(1) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
	Resident 14 (R14) sustained a laceration to the right eye on 1/30/12 which was not thoroughly investigated as directed by their facility policy.			eet Page 49 of 162

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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F 226	right eye on 1/30/1. According to the reagency, on 1/30/12 on the floor, and he Although the facilit agency timely, the evidence they had investigation in accensure the resider accordance with the neglect had occurred. When interviewed DON stated there investigation beside the state agency. Resident 92 (R92) during cold weather thoroughly investigation beside the state agency time provide evidence was completed the their policy to determine the state agency time provide. When interviewed DON stated there investigation beside the state agency time provide evidence was completed the their policy to determine the state agency time provide evidence was completed the their policy to determine the state agency the	2. which required sutures. 2. which required sutures. 2 the resident was found lying ad fallen out of her wheelchair. 3. y submitted a report the state facility was unable to provide conducted a thorough cordance with their policy to his care was provided in he plan of care and that no red. on 5/1/12 at 8:00 a.m., the had been no further le what had been submitted to was found outside the building er on 2/12/12, and it was not gated as directed by their facility attained of the building without a temperature was 27 degrees noident was reported to the ly, but the facility was unable to that a thorough investigation at included all the directives in a tincluded all the directives in the lad been no further des what had been submitted to	F:	2226		•	10 (20) (20) (20) (20) (20) (20) (20) (20	

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F 226	p.m., the DON, AD injuries of unknown be explained by resobserved by anyon location, and if the injuries observed a incidents over time	M, and CEO all agreed that an origin was one that could not sident, one that was not	F	226			(18) (18) (18) (18) (18) (18) (18) (18)
	the administrator a they reviewed and director of nursing the investigations	on 4/29/2012 at 12:30 p.m., and CEO stated that although signed the incidents, the was responsible for ensuring were thoroughly reviewed and lso stated their facility policy ted as directed.					
	was reviewed. It wand language that reader. This had the residents that residents	GE se Prohibition Policy dated 3/10 as noted to contain directives could be misinterpreted to a ne potential to affect all 114 ded in the facility. The policy wing discrepancies:					: ::::::::::::::::::::::::::::::::::::
	volunteers, family be encouraged" to When interviewed 2:55 p.m., the dire administrator (ADI (CEO) all agreed to	n 5, noted "staff members, members, and others "should report incidents of abuse" about the policy on 4/26/12 at ctor of nursing (DON), W), and chief executive officer the language would be more staff "must" report, as opposed ouraged" to report.					2000 - 20

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F 226	Continued From page 51	F 226		: 139
	Page 8, Procedure 1, of the policy noted "An incident or suspected incident of mistreatment, neglect, or abuse "should be reported immediately to the Administrator".			
:	Page 8, Procedure 2 contained conflicting language as it read to report abuse/neglect/mistreatment to the state licensing "immediately (with in 24 hours)." The directive also lacked how soon the report needed to be submitted to the Minnesota Department of Health Office of Health Facility Complaints.			5 1042 5 1045 0 6 10 10 200 6 10 200
	Page 8, Procedure 2 indicated, "In the case of resident-to-resident abuse, the Common Entry Point does not need to be contacted unless there is serious injury or harm as a result of the incident. However, this type of incident still needs to be reported to MDH (the state agency)." The directive lacked clarification of whether it was serious injury or harm that needed to be reported to the state agency, or resident to resident abuse that resulted in serious injury or harm that was required to be reported to the state agency.			
	Page 8, Procedure 3, lacked specific criteria to consider for the reporting of "suspicious injuries". It lacked a reference to the criteria which could be found on p.4, "injury of unknown source" of the same policy.			in the second se
	Procedure 7 noted employees accused of resident abuse shall be barred from any further contact with the "involved resident", rather than al residents pending the investigation. When interviewed on 4/26/12 at 2:55 p.m., the DON, ADM, and CEO agreed the language would be	1	To alife. 10: 00005	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 226	reported to the Adithat the accuser we resident contact, in Page 12, proceduraccused is an employed accused the suspended been completed 4/26/12 at 2:55 p.r agreed the languaread the employed not have any direpending the investigation of the pending the investigation of the staff to alert the strincidents. It lacked report needed to with state law. When interviewed the administrator language needed in the process of directives could be various readers of the screen of the staff to alert the stringuage needed in the process of directives could be various readers of the screen of the scr	incidents "must" be iministrator immediately, and would be barred from "all" in order to protect the residents. The 4, of the policy noted "If the policy of the facility, he/she ad" until the investigation has ". When interviewed on in., the DON, ADM, and CEO all ge would be more clear if it a "will be" suspended or would contact with "all" residents tigation. The External Reporting: directed that agency of any reportable did a directive to how timely the policy to be improved, and they were re-writing it. They verified the e understood differently by	F 226			2. 30. 32 2. 30. 32 2. 30. 32 3. 32 32 32 32 32 32 32 32 32 32 32 32 32 3

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05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) . COMPLETION DATE	
F 226	Continued From page 53 hiring the candidate must conduct reference checks of the candidate's prior employment and	F 226			
	minimally, "reference checks must document dates of employment and position held".				
	Nursing assistant (NA)- J was hired by the facility on 2/28/12. The application contained prior employment information, however the employee file lacked documentation the facility contacted the prior place of employment for verification as outlined in their policy.				
	NA-K was hired by the facility on 3/16/12. The application contained prior employment information, however the employee file lacked documentation the facility contacted the prior place of employment for verification as outlined in their policy.				
	NA-L was hired by the facility on 4/25/12. The application contained prior employment information, however the employee file lacked documentation the facility contacted the prior place of employment for verification as outlined in their policy.				4.7
	Licensed practical nurse-J was hired by the facility on 1/19/12. The application contained prior employment information, however the employee file lacked documentation the facility contacted the prior place of employment for verification as outlined in their policy.			7 - 10+1 7 - 4 - 10+1 7 - 4 - 10-2	
	Life enrichment director-L was hired by the facility on 4/10/12. The application contained prior employment information, however the employee file lacked documentation the facility contacted the prior place of employment for verification as	1	Via atiquation obo	ot Page 54 of 16	32

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STATEMENT	OF DEFICIENCIES
	CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

245018

B. WING ____

05/02/2012 -

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

			GOEOMBIA TIEIOTTTO, MILE GO 121			
(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		4:002		
F 226		F 226				
	outlined in their policy.			(4)		
F 241 SS=E	When interviewed on 4/26/12 at 11:00 a.m., the director of nursing verified the employee files lacked documented evidence the facility's hiring agent had contacted the newly hired employees prior place of employment before they were hired. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	rzat Digiticy			
	The facility must promote care for residents in a		It is the policy of Crest View Lutheran			
	manner and in an environment that maintains or		Home to promote care for residents			
	enhances each resident's dignity and respect in	-	in a manner and in an environment			
	full recognition of his or her individuality.		that maintains or enhances each			
			resident's dignity and respect in full			
	This REQUIREMENT is not met as evidenced		recognition of his or her individuality.			
	by: Based on observation, interview, and document review, the facility failed to provide meal service		Resident R24 was served her meal	sans		
	in a manner that would promote dignity for 1 of 22		upon notification. For Resident(s)			
	residents (R24) who was not assisted in a timely		R50, R104, R19, R30, R134, and R167	: '6;?		
	manner, and for 8 of 22 residents (R50, R104, R19, R55, R30, R134, R90 and R167) who were		the tray tables were removed and			
	seated at tray tables instead of dining tables. In		regular dining tables were put into	:		
	addition, the dining room atmosphere was not respectful for 4 of 22 residents (R51, R61, R40,		place. For Resident R90, his spouse uses a tray table to set his food on			
	and R125) in the Willow Dining Room were		when she visits at brunch and assists			
	directly affected by the maladaptive behavior of		him with dining. For all other meals			
	another resident (R165) in the Willow Dining Room.		R90 will be placed at a regular dining	:		
,	NOOM.		table. For Resident(s) R51, R61, R40,			
	Findings include:		and R125 a new behavior plan will be			
	R24 was not assisted with her meal for 1 hour		created for R165 to assist with a			
	and 6 minutes after it was served.		more positive dining experience. A	• • •		
	R24's diagnosis included Alzheimer's disease.		plan was initiated for R165 to ensure			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		OOMI EE	100
	245018	B. WING_		05/02	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOS	ME	4	REET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 554	ORTHEAST	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
1/27/12, identified sunderstood, had sh problems, and was for eating. R24 was observed 4:45 p.m. on 4/23/1 Her meal was place She sat without attent wo tablemate's Nursing assistant (out desserts, at 5:4 that she had without When asked, NA-E R24, but she didn't NA-B placed R24's would re-heat it who to eat. R24 continued to satablemate's ate the nothing to eat. At 8 (RN)-B brought R2 assist her. R24 had hour and 6 minutes to eat, even though their meals. R50, R104, R19, Rayere seated at tray room instead of sitt their peers sat and R50's diagnoses in stroke. The quarter	num data set (MDS) dated she was never/rarely fort and long term memory totally dependent upon staff during the evening meal at 2 in the Willow dining room. The din front of her at 5:22 p.m. to empting to feed herself while is were feeding themselves. NA)-B was observed passing as she removed R24's plate at any explanation to R24. The stated she assigned to feed have any time to do this task. The plate in the refrigerator and en she had time to assist R24 with at the table while her sir meal. R24 sat there with 5:51 p.m. registered nurse 4 her meal and sat down to do been sitting at the table for 1 is before any staff assisted her in her table mates were eating ting at the dining tables with	F 241	she has the ability to leafor calming and so othe may enjoy mealtime. Coupdates have been made plan, care assignment should be completed to the read of assessment results at the current physician of completed by 06/11/12 will be provided for state on the policy for dignity positive dining experient 06/11/12. Resident R55 expired of For other residents who affected by this practice be completed weekly for monthly for 3 months, according to the quality schedule regarding directly dignity to ensure residents who affected by this practice be completed with dignity and for other residents who affected by this practice be completed with dignity and for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice be completed weekly for other residents who affected by this practice.	r residents or responding le to the care heet and esident sion maker. was informed and a review of reders will be a Education of members and a rece by and a rece by and then by control ling with ents are being and respect.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X3) MULTIPLE CONSTAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X7) MULTIPLE CONSTAND PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/			COMPLETED				
		245018	B. WIN	1G		05/02	/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	with set up assista: 8/21/11, included " 11/28/11, included day." R50 was observed 4:45 p.m. on 4/23/ Even though there residents to sit at, you enter the dinin the wall. He had a him to place his m know why he sat a would like to sit at R50 pointed to a n men. When asked him to eat at, R50 R104's diagnoses significant change she had severe coindicated it was very with groups of peceating with staff as R104's plan of car ate independently	age 56 Il problems, and fed himself nce. R50's plan of care dated Staff to set up tray" and "allow choices throughout the during the evening meal at 12 in the Willow dining room. were large tables available for R50 sat on the right side (as g room) with his back against in over bed tray table in front of eal. R50 stated he did not t the tray table, and added "I that table with all the men." earby table that seated four d if a table had been offered to stated "No, I have to sit here." included dementia. The MDS dated 3/16/12 identified any important for her to do things apple. She was independent sistance to set her meal up. e dated 2/5/11 indicated she with "tray set up" and 3/5/12 e socialization and leisure	F	241	according to the quality cont schedule regarding dining widignity to ensure residents a provided with dignity and re. The policy for dining services reviewed and revised by the interdisciplinary team by 06, review of policies by the Me Director will be completed to current standards of practice place. Staff members will be as it relates to their respection and responsibilities regarding services policy and procedure dignity rights by 06/11/12. Audit results will be reported CQI Committee for review a further recommendations. Ureview, system revisions and education will be implement indicated. The Director of Nursing or displacements.	ith re being spect. s will be /11/12. A dical o ensure e are in e trained ve roles ing dining res and d to the ind Jpon this d/or staff ted if	1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.
	4:45 p.m. to 6:30 dining room seate against the wall in her peers sat and	ed during the evening meal at p.m. on 4/23/12 in the Willow ed at an over the bed tray table, stead of a dining table where ate. R104 was unable to ions by the surveyor.			will be responsible for comp	oliance.	12 13 14 14 15 14 12 15 16 14 12 15 16 16 16 16 16 16 16 16 16 16 16 16 16
	R19's diagnoses i	ncluded Alzheimer's disease.					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (XA. BUILDING		(X3) DATE SURVEY COMPLETED		
		245018	B. WIN	G		05/02	2/2012
	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME		444	ET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE 🏻 🔓	(X5) · COMPLETION DATE ·
F 241	resident had sever interview for daily properly somewhat importance people. She requirencouragement or plan of care dated separate table to distealing and d/t (during and d/t) (during room. She table with her back the dining room. Fat 5:20 p.m. and feincluding ice creangreen beans. No cuse silverware until (TMA)-D sat down eat at 6:00 p.m., b	age 57 ated 3/23/12 identified the e cognitive impairment and the oreferences indicated it was int to do things with groups of red supervision, oversight, cueing for meal times. R19 3/16/12 indicated "sits at ecrease food and liquid ue to) spastic movements." during the evening meal at o.m. on 4/23/12 in the Willow sat at an over the bed tray to the wall facing out toward R19 was given her plate of food ad herself with her fingers, in, hamburger hot dish and one assisted or cued R19 to ill a trained medication aide and attempted to assist R19 to ut R19 refused to eat at that of able to answer questions by	F2	441			2012 N. V.
	malnutrition. The identified she had problems, severely skills and required eating. R55's plar "tray set up" and ""encourage social R55 was observed 4:45 p.m. to 6:30 pleft hand side of the bed tray table rath	ncluded dementia and annual MDS dated 2/2/12 long and short term memory impaired decision making extensive assistance with of care dated 4/21/12 included assist with part of meal" and ization and leisure activities." If during the evening meal at o.m. on 4/23/12. R55 sat on the de dining room with an over the er to eat her meal instead of a					
	dining room tables	s that was used by her peers for			•.	·- ···	

STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WIN	IG		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	R30's diagnoses in annual MDS dated had severe cognitic supervision, oversifor meals. R30's pincluded she requirencourage socialic R30 was observed 4:45 p.m. to 6:30 pover the bed tray to meal instead of a date. During the meto identify where it located on her tray questions by the sexpsychotic disorder 1/11/12 indicated and required limite R134's plan of car required tray set undirent meal in with a bed tray table dining room table independent with meal at approximal was observed sea	d herself her meal but was questions by the surveyor. Included dementia. R30's 1/26/12 identified the resident we impairment and required ight, encouragement or cueing plan of care dated 4/19/12 red tray set up and to zation and leisure activities." I during the evening meal at o.m. on 4/23/12, she sat with an able in the dining room for her dining room table that her peers eal R30 would ask passerby's ems the food items were of the was not able to answer urveyor. Included dementia and of the quarterly MDS dated moderate cognitive impairment ed assistance with eating. The quarterly MDS dated moderate with eating of a the Willow dining room seated on the Willow dining room seated on the Willow dining room seated on the willow dining the evening ately 5:45 pm on 4-23-12, R134 ated at a dining room table with	F	241			
	had on 4-24-12.	not use the bed tray table as he					1.3

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	F OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA (X3) DA (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA (X3) DA (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DA		(X3) DATE SU COMPLE	JRVEY TED			
		245018	B, WIN	IG		05/0	2/2012
	PROVIDER OR SUPPLIER	ме		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	1/26/12 included se required total staff a plan of care dated 2 assistance with fee	e. The quarterly MDS dated evere cognitive impairment and easistance with eating. R90's 4/24/12 included total	F 2	241	· · - · · · · · · · · · · · · · · · · ·		- 1 (D)
	10:57 a.m. on 4/24/ for his meal instead his peers ate. Fam his meal.	12 seated at the bed tray table of a dining room table where ily member (FM)-A fed him				-	- Westell Westell - Westell - Westel
· 5.7°	quarterly MDS date cognitive impairmer supervision while ea	ncluded dementia. Her d 3/27/12 included severe nt and required cueing and ating. R167's plan of care ded tray set up was required.				-	
:	seated at an over th	d at 10:57 a.m. on 4/24/12 ne bed tray table in the Willow I of sitting at a dining room ers ate.					
	TMA-C stated there the dining room and have their own space tables instead of a contract.	at 9:22 a.m. on 4/27/12, was no assigned seating in a some residents preferred to be and sit at the bed side tray dining table. She stated R30 rred sitting at the bedside tray					
	supervisor (NS)-A seating in the Willov sat using the bed transpecially R50, R19 explanation as to where the supervisor (NS)-A seating in the will be supervisor (NS)-A seating in the Willow seat using the bed transfer to the will be supervisor (NS)-A seating in the Willow seat using the bed transfer to the will be supervisor (NS)-A seating in the Willow seat using the bed transfer to the will be supervisor (NS)-A seating in the will be s	at 1:50 p.m. on 4/27/12, nurse stated there was no assigned w dining room. Residents who ay tables had behaviors, and R167. She had no hy different residents used the es and at others time they					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Total STATE WILLIAM ST. WA

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02	/2012
	ROVIDER OR SUPPLIER		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH	EAST	
CREST V	TEW LUTHERAN HO	WE	С	OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	Continued From pa	-	F 241			
	indicated they had four-person tables room so everyone room table instead She stated mainter more tables and the residents who use NS-A confirmed the assessed to use of sitting at dining table R19 who had a had been though the free at at tables with the R55, R30, R134, Fover the bed tray the dining room away. The dining room are for 4 of 22 resident in the Willow Dinir	at 2:59 p.m. on 4/30/12, NS-A not thought about getting more like the others in the dining could be seated at a dining of over the bed tray tables. nance may be able to bring in ey could try and place the d tray tables at the new tables. ese residents had not been ver the bed tables rather than bles with their peers except for bit of stealing others liquids. acility allowed most residents to heir peers, R50, R104, R19, R90 and R167 were seated at ables on the outskirts of the from their peers. tmosphere was not respectful ts (R51, R61, R40, and R125) ag Room were directly affected e behavior of another resident				10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (
-	staff intervention f R165's diagnoses Parkinson's disea 3/15/12 included s inattention, disorg	e dining room without adequate for 1 hour and 45 minutes. Included dementia and se. The admission MDS dated severe cognitive impairment, anized thinking, no behaviors others, and behaviors do not				1.1.2 1.1.2 1.1.11
	impact others or or living environm	lo not significantly disrupt care ent. R165 required only set up				

assistance for meals.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	LDING		COMPLE	
		245018	B. Wil	4G —		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	NORTHEAST		
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	OULD BE	(X5) COMPLETION DATE
F 241	Continued From p	page 61	F	241		•	1 - 12
	from 4:45 p.m. to was sitting at a ta across the table finext to her. R166 entered into the cwas pointing and across the table aget out of my hou up, I said shut up care of it" and was cream at R51, thurt my daughter think you better to bad as your son, before I pick her window." R165 trepetitively. TMA medications in the will take care of the beverage. R165 while looking at After TMA-D left "get out of here, not out of my hou want to hear you before I kill her." R51 and R40. R165's right at 5 screaming at him R165 screaming at him R165 screaming respond to R165 her face flushed in her wheel cha R165. R125 did straight ahead, is	ved in the Willow dining room 6:30 p.m. on 4/23/12. R165 ble with R40 to her left, R51 was rom her and R61 was at a table 5 started yelling when she lining room at 4:45 p.m. She shaking her finger at R51 and screaming "get out of here, ise before I call the police. Shut "TMA-D told R165, "I will take liked away. R165 continued to hen directed it to R40 that "she , she has no right to be in here, I eave." Then to R51 "You are as shut up, get her out of my hen pounded her fist on the table 1-D who was passing e dining room again told R165 "I her" and offered R165 a pulled off her clothing protector, R51 but did not strike R51 with it. R165 continued to yell at R51 get out of here" very loudly "your use yet, shut up, I don't even r voice, get her out of here R165 continued to scream at 125 then came and sat down to 102 p.m. and R165 started In also. During the interaction of at her table mates R51 did not but continued to stare at her and R40 would wince and pull back ir with the loudest outbursts from not react to her and just stared gnoring her. R61 who was at a ted to mimicked what R165 was					

	OF DEFICIENCIES OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER: A, BUILDING			(X3) DATE SUR\ COMPLETE	
		245018	B. WING		05/02/2	2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				REET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHI COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE C	(X5) COMPLETION DATE
F 241	Staff made no atter p.m. when a nurse room and removed which was just outs in the day room wit intermittent outburs scream sound and nurse can go to jail R165 then threater holding a glass of vin the day room, no R165 yelling behavintermittent loud so when she was brown Licensed Practical R51 with eating, R but fed self most of attempts to redirect screaming. At 5:50 loud and R51 pulled startled look. At 6:50 to R165 and assist bites R165 yells out help me, I am chold bites of food. R16 disrupt the dining rowas taken out of the During interview at stated they just downen she gets like He was unable to	gh there was staff in the room. Impted to intervene until 5:07 aide-Z came into the dining. R165 to the day room right, side the dining room. R165 sat hout any staff interaction with sts "ahhhh" made into a "nurse, nurse, that damn too," I want water, I said now." and "I will throw this at you" water. There was no one was or did staff attempt to redirect vior. She then was quiet with creechy screams until 5:36 p.m. aight back into the dining room. Nurse (LPN)-A was assisting 165 had occasional outbursts, f meal. Staff made no at R165 when she was 0 p.m. R165 screamed very did away from the table with a 10 p.m. TMA-D sat down next ared her with eating, between at "help me, help me, help me, king." She quieted when fed 5 continued to intermittently oom until 6:30 p.m. when she	F 24			4 (2) (2) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
		at 3:00 p.m., NS-A stated "I n't have a plan if R165 is				

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AND DIAM OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SUF		
		245018	B. WING		05/02/	/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				REET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	IEAST	100
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	nurse (LPN)-I who want her in her ro LPN-I acknowledo disruptive in the d	meal time." Licensed practical b was present stated "we don't bom all the time." NS-A and ged R165 behavior was ining room for other residents.	F 24	1		
F 242 SS=D	for 1 hour and 45 removed at one p heard screaming room in the day room and the day room service inclumeals in a courter 483.15(b) SELF-L	y policy entitled "serving-dining uded "residents shall be served ous and dignified manner." DETERMINATION - RIGHT TO	F 24	2 F242 Self-Determination a	<u>nd</u>	7:7720-12 - 1:70MED- 1:20%-7:391 - 1:17
	schedules, and he her interests, ass interact with mem inside and outside about aspects of are significant to This REQUIREM by: Based on observative the facility (R116) was allow bathing/shower for Findings include: Resident 116's (Findings include)	ENT is not met as evidenced vation, interview, and record failed to ensure 1 of 3 residents ed to make choices about her equency each week.		It is the policy of Crest View Home that each resident had right to choose activities, so and health care consistent her interests, assessments, of care; interact with memory community both inside and the facility; and make choice aspects of his or her life in that are significant to the resident and/or designated maker will be asked about	as the chedules, with his or and plans bers of the doutside ces about the facility esident.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY		
		245018	B. WI	NG		05/02	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421		i Frank
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 242	Continued From page 64 resident's cognition was intact. The plan of care dated 4/12/12 indicated the resident was independent with bathing, and required supervision.		F:	242	bathing/shower preferences new admissions, the Life Enr department will interview th resident regarding bathing/s preferences and relay the re	ichment ie ihower	- 162
	and stated she did about her bathing r asked to have a sh was told it was not	R116 was interviewed on 4/23/12 at 6:28 p.m., and stated she did not feel that she had a choice about her bathing routine. She stated she had asked to have a shower two times a week and was told it was not possible. When interviewed on 4/24/12 at 3:00 p.m., she stated again that she			nursing. A meeting with a response proup will be held by 06/11/ inform residents of their right make decisions about their a schedules, and health care. I resident concerns identified	sident 12 to nt to activities,	- 2-2-2 - 2-2-2 - 2-2-2
-	week, but was told	if they did it for her, they would eryone, and they could not do			following the meeting will be addressed using the concern/complaint procedu	re.	77 (1 <u>7</u> 12 (3 <u>)</u>
	licensed practical r never heard R116	on 4/25/12 at 7:34 a.m., nurse (LPN)-D stated she had ask for more frequent vas not an uncommon request.			The bathing protocols will be reviewed and revised by the interdisciplinary team by 06/ The Medical Director will rev	/11/12.	e e e e e e e e e e e e e e e e e e e
	was asked about h was on Fridays, an prefer to have a sh	on 4/25/12 at 9:30 a.m., R116 er shower day. She stated it d again stated she would ower twice weekly, but was as they would have to do it for esistent request).			policy to ensure it meets the standards of practice. Educabe provided for staff member 06/11/12 regarding resident choose bathing schedules as relates to their respective ro	tion will ers by right to it	* * ****
	When interviewed on 5/1/12 at 9:50 a.m., the facility social worker stated bathing preferences were not something that was discussed on admission, but the question might be addressed by nursing staff. When interviewed on 5/1/12 at 3:15 p.m., the director of nursing stated that any resident could have another bath/shower if they requested it.				responsibilities for the review revised protocols. The bathing protocols will be reviewed and revised by the interdisciplinary team by 06. The Medical Director will repolicy to ensure it meets the	wed and be 6/11/12. eview the	

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STATEMENT	OF DEFICIENCIES
AND DLAN O	F CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

245018

B. WING_

05/02/2012

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

She stated R116 was alert, orientated and 06/11/12 regarding resident right to	
F 242 Continued From page 65 She stated R116 was alert, orientated and of the stated R16 was alert, orientated and of the stated the resident likely had just to of the stated the resident likely had just to of the stated the resident right to of the stated the resident likely had just to of the stated the resident right ri	***
F 242 Continued From page 65 She stated R116 was alert, orientated and of the stated R16 was alert, orientated and of the stated the resident likely had just to of the stated the resident likely had just to of the stated the resident right to of the stated the resident likely had just to of the stated the resident right to of the stated right rig	
She stated R116 was alert, orientated and 06/11/12 regarding resident right to	
lasticking the elected the recident likely ned itist	31 157
reliable. She stated the resident incly had just choose bathing schedules as it	
needed to ask the right person to get the request relates to their respective roles and	
F 244 483.15(c)(6) LISTEN/ACT ON GROUP F 244 responsibilities for the reviewed and	-,-
SS=D GRIEVANCE/RECOMMENDATION revised protocols.	
Public and the completed by	2017 NED
while the views and act upon the checking bath logs weekly for 4	13.9 i
grievances and recommendations of residents weeks, monthly for 3 months, then	
and families concerning proposed policy and	
operational decisions affecting resident care and	
life in the facility. choices are honored with results	
reported to the COI Committee for	
This REQUIREMENT is not met as evidenced review and further	
by: Based on interview and document review, the recommendations. Upon this review,	
facility failed to ensure resident council system revisions and/or staff	1
grievances were addressed timely for 3 of 3 education will be implemented if	•
residents (R22, R130, and R280) who attended resident council and complained about not being indicated.	7.1.5
able to go on outings anymore because there The Director of Nursing or designee	
was no van driver. will be responsible for compliance.	.1 - 22
Findings include:	
Findings include: Date of Correction: 06/11/12	
Review of resident council meeting minutes F244 Participation in Resident and	
indicated the following: Family Groups	150
September 2011- The assistant director of life	C.112
enrichment (ADLE) "explained that with the lt is the policy of Crest View Lutheran	9 7 7 L
addition of more staff the trips to restaurants,	Trie si
shopping, and casinos would hopefully start up again. At this time there is no person qualified to upon the grievances and	.
drive to events." recommendations of residents and	٠.
families concerning proposed policy	
October 2011- "Outings were discussed and	

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		,	A. BUILDING	<i></i>	-	
		245018	B. WING		05/02/2012	<u>.</u>
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME		44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH	EAST	1 0	
CREST	NEW LUTHERAN HO	WE	С	OLUMBIA HEIGHTS, MN 55421		
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				and operational decisions af	fecting	<i>:</i> :
F 244	Continued From pa	1	F 244	resident care and life in the	facility.	
•		e to go to the following places:				• • •
	Perkins Old Coun	Grocery store, museums, ary Buffet, Applebees, Dollar		For Resident R22, R130, and	I	
	store."	,		their concern-regarding the	I	<u> </u>
		NAV		outings was reported to the		
	December 2011-	When will trips off site start plained that at this time there is		Administrator. The outings	i .	
	no one hired to driv	ve the bus for casino,		resumed on 5/21/12 when a		''2012] ('VEO
	shopping, or eating	g out trips."		was available. A plan was in	1	
	January 2042 "Its	was mentioned that a person		by the Life Enrichment Direc		
	was studying the b	us driving manual and		offer at least one outing per	!	
	hopefully outings of	ould be made in the future. "		The new plan for resident or		
	F-5	ADIE "did share that as of		will be discussed with the re	I	· · · · · · · · · · · · · · · · · · ·
	vet no bus driver b	ne ADLE "did share that as of last been found for outside		council by 06/11/12. The Lif	í	٠.٠
•	trips."			Enrichment department has		
	,	t de la companya di sana		employees that will be testi	_	
	March 2012- "No	information has been shared er for outside trips. The life		their bus licenses by 07/1/1	2.	
-	enrichment staff h	as not been given any				44 1000
	information about	when this situation will be		Education will be provided f		
. •	resolved. This is a	a situation which has come up eetings. Questions in the		members on the availability	}	·
•	future should be d	irected to the administrator of		resident outings by 06/11/1	.2.	
	this facility. (The	directions to her office were			1.	
	requested and give	en to the residents)."		For other residents who ma	•	
	During interview a	t 5:50 p.m. on 4-23-12, R22		affected by this practice a n		
	stated she misses	being able to go on outings at		will be offered by 06/11/12		
	the facility and the	y have not been on an outing		resident councils to share ic		1940) 1319
	for "almost a year	" She stated the facility van year ago and the facility keeps		concerns and ensure that is	sues nave	
		ring to get someone who can		been brought to the attenti		
	drive, but hasn't d	one anything about it yet. R22		facility leadership for follow	*	
	stated they have t	alked about this at resident		concerns will be investigate	a with	
	council "many tim	es" but it had not been se there is a big "turnover" in		results reported to the		
	audicased pecaus	oc alore to a big tarrieror in		resident/family council eacl	n month.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A BUILDING

THE PROPERTY OF THE PARTY OF TH

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245018	B. WING		05/02/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 244	Continued From the activity depar	· ·	F 244	The protocols for outings will reviewed and revised by the interdisciplinary team by 06, The Medical Director will rev	/11/12.
	clinic of psycholoresident "did offermany activities the taken outside of know if I could pusee if they could would be willing forward to outing provided by the formal of the could be the forward to outing provided by the formal of the could be the formal of the could be the co	gy dated 8-8-11 indicated r one concern that there are not nese days where residents are the building. She wanted to ut in a good word in to the staff to do that once again. I told her I to do so. She very much looks s on, I assume, the bus that was acility."		policy to ensure it meets the standards of practice. Educa be provided for staff membe regarding outings as it relate respective roles and respons for the reviewed and revised protocols.	current tion will rs s to their 100 miles 100 mile
:	R130 stated they complaining for a anymore and do addressed it. R' saying it is "bein" During interview stated resident of wanting to go on stated the "othe She stated the fasomething about	at 11:00 a.m. on 4-4-24-12, (resident council) have been awhile about not having outings es not feel like the facility has 130 stated the facility just keeps g worked on." at 3:20 p.m. on 5-1-12, R280 ouncil had talked a lot about outings again and the facility r van driver wasn't acceptable." acility said they were going to do it but that was "a long time ago" heard anything since.		Monthly audits will be compensure that resident council are heard and acted upon wiresults reported to the CQI Committee for review and furecommendations. Upon this system revisions and/or stafeducation will be implement indicated. The Director of Life Enrichment in the council of the coun	concerns ith urther s review, f ted if ent or
	4-25-12, he state resident council meeting minutes a turnover in the just have not har the residents. Hanything to reso bring it up often	with ADLE at 7:50 a.m. on ed he assists the residents with meetings and writes up the s. He stated there had been such life enrichment department they d anyone who is able to drive for e stated the facility had not done we this issue and the residents in resident council. He doesn't pond to the resident council		designee will be responsible compliance. Date of Correction: 06/11/1	- 10 Test

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		05/02/2012	
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421			
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F 244	because manager working on getting	age 68 ment keeps saying they are g a driver but it does not get	F 244			
·	facility administrates residents had bro council about outing a driver. She stated river and they may on outings. She in at the assisted living unsure why they is sooner. She states scheduled for out on it. The admini	t 2:55 p.m. on 4-30-12, the or stated she was aware the ught up concerns in residentings but the facility did not have ed the assisted living has a ay use her to bring the residents indicated that driver had worked ing "for along time" but was had not utilized her to drive ed nothing was currently ings and the facility is working strator indicated the new activity g on" getting her bus license.			で (で (で (で (で (で)) (で) (で) (で) (で) (で) (
F 250 SS=D	During interview a director of life enring hired about 4 wees stated she is read license but does appointment sche attempting to take the facility had "ta from the assisted nothing had been 483.15(g)(1) PRORELATED SOCIATION for attain	at 3:50 p.m. on 4-30-12, the ichment stated she had been eks ago as the director. She ling the manual for her bus not have a deadline or eduled for when she will be her license. She also indicated lked" about using the driver living for outings, although scheduled yet. DVISION OF MEDICALLY AL SERVICE Drovide medically-related social or maintain the highest cal, mental, and psychosocial	F 250	F250 Social Services It is the policy of Crest View Home to provide medically social services to attain or rethe highest practicable phymental, and psychosocial wof each resident.	related naintain sical,	

- C (2.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	TO LOTE MILIDIOMINE	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY . COMPLETED
		245018	B. WING		05/02/2012
	ROVIDER OR SUPPLIER	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST
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F 250	Continued From pa This REQUIREME by:	nge 69 NT is not met as evidenced	F 250	For Resident(s) R98 and R16 assessment for safety risk, comood, and behavior will be	ognition,
	Based on interview facility failed to pro services to assure monitoring and im	v and document review the the vide medically related social adequate assessing, plementation of behavioral completed for 3 of 4 residents		completed by 06/11/12. The worker and chaplain met with Resident R161 to discuss the his daughter and provide su	th e loss of pport. A
	(R98, R160, R161) disturbances or de Findings include:	who exhibited behavioral		grief and loss care plan will be initiated for R161. Corresponding updates have been made to plan, care assignment sheet	nding the care
	dementia with beh mental state, and t quarterly minimum	had diagnoses including avior disturbance, altered raumatic brain injury. R98 data set (MDS) dated 2-11-12 ent had moderate cognitive		communicated to the reside and/or designated decision Education will be provided f members regarding behavio	maker. or staff
	impairment, was in the facility, and had towards others suc or grabbing in the	dependent in walking around d a history of physical behavior ch as hitting, kicking, pushing, prior 4-6 days of the 7 day		interventions and depressio management by 06/11/12.	
-	assessment period	f. rogress notes indicated R98		Resident R160 discharged o 04/20/12.	
	had physical or ve residents on 6-29- 12-17-11, 3-2-12,	rbal altercations with other 11, 8-31-11, 9-4-11, 10-14-11, and 4-20-12 which resulted in		For other residents who ma affected by this practice a re	`
	injury to another referred to psycho	esidents, R160. R98's was logy for "anger management hology notes indicated the		review and resident intervieus be completed regarding bet care and depression by 06/2 ensure that medically related	navioral 11/12 to
	and had long stan- management. The prone to anger iss to regard confront	d significant defects in insight ding problems with anger e notes indicated "He has been ues much of his life, and seem ation and aggression as socially isk to others was moderate and		services are being provided resident needs. Upon review concerns are identified they brought to the IDT Team for resolution guidance.	to meet w, if y will be

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		i	(X3) DATE SURVEY COMPLETED	
		245018	B, WING_		05/02/2012
	ROVIDER OR SUPPLIER	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	. ;
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F 250	when agitated. The recommendations—longstanding_ments viable option, and this potential for fur other residents is sideficits, impaired jurisk potential" 12-5-11- R98 had verbalization continglan was "Will remote facilitate adjustment of faci	capable of harming others e treatment plan and were, "He presents with-a — ality where aggression is a ne is not one to concede. Thus ther altercation with staff and significant. His cognitive adgement, etc only adds to this congoing aggressive behavior/ nue reportedly." Treatment ain available to follow resident nent process, assist with and intensity of volatile re advised to follow protocol ff care to dementia patients (ex nt, use names) state your nood, if irritable, reproach, etc." sidentified as having "anger es." R98 was identified as k and was "capable of growing really aggressive quickly." The solly sidentified as k and was "capable of growing really aggressive quickly." The solly with (R98) with his risk of all aggression (ex-keep a safe agitation, approach him from the contact, use names, and are there to do). Keep him at m other residents when	F 250	The policy and procedure for	nd mood by the 11/12. iew the the nood, their iew the the the ses and iew the the nood by the 11/12. iew the the nood, their ibilities iew the nood ibilities i
	1-16-12- R98 had a was identified by th because R98 "has of risk towards othe	an "irritable presentation" but ne psychologist as low risk lessened somewhat in terms ers." No new were made at this time. This		procedures. Cognition, mood, and behavioral will be completed weekly for	or audits

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE (X9			COMPLE			
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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HO	ME		444	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	EAST	25.43 1
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F 250 Continued From power was the last psych medical record.	age 71 ology note available in R98's	F 2	50	weeks, monthly for 3 months then according to the quality schedule to ensure that med related social services are pro-	control ically ovided	2 / 50
had behavioral syrother residents. To checklist including cognitive status, a may contribute to resident of daily refrustration, remind throughout the day allow for choices to fluid intake, and perfocus area of the paggression with the other residents as included those list with social worker remove resident to persistent and/or Although the facility of resident alterca interventions to perfrom confrontation the facility was foll recommendations addition, there was social worker was During interview of Social service direct know much about the facility since 2 R98 had previous residents and state passed on to here	mptoms of altercations with he approach's consisted of a observe for changes in ssess for medical reason that changes in mentation, inform butine, validate feelings of and re-orientate as needed y, use simple communication, hroughout the day, encourage sychology consult. Another olan of care included physical re risk level of altercations with "low" risk. The approach's ed above, as well as 1 to 1's for support and validation, and or room or private area for inappropriate behaviors. It is identified R98 had a history tions, there were no specific rotect R98 or other residents in. Also, there was no indication lowing or aware of the sthe psychologist made. In so indication 1 to 1's with the ever offered or implemented. In 4-25-12 at 8:15 a.m. the ector (SSD) stated she does not a R98 as she had "only" been at -13-12. She was not aware altercations with other set the information was not when the other social workers SD stated if she had known			to meet resident needs with reported to the CQI Committer review and further recommendations. Upon this system revisions and/or staff education will be implement indicated. The Director of Social Service designee will be responsible compliance. Date of Correction: 06/11/	results see for s review, ed if es or for	20.000 (20.000) (20.0

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUF COMPLET	
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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOM	1E	4	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DĄTE
residents she would were in place to prof She stated she had one interventions, but She knew R160 was She stated after the between R98 and R psychologist to come R98. SSD had not pplace for R98 and direcommendations from to protect other vulnishe would call the padictation from that vinew recommendation. The facility provided was faxed to the fact The 4-23-12 psychologist to the fact The 4-23-12 psychologist preventive measure this recent incident shawareness of risk fact parties attempting to that do not agree with sitting in view of state can be diverted by some During interview on Director of nursing (and sits out in the matime. She verified Residue)	s altercations with other have ensured interventions tect-R98 and other residents. not met with R98 for one on ut she had met with R160. In not a "bully- he's no [R98]." altercation on 4-20-12 altercation on 4-20-12 altercation on 4-20-12 altercation on 4-20-13 altercation on 4-20-15 and meet with put any new interventions into id not get any rom the psychologist on how erable adults. SSD stated sychologist to get the isit and check if he had any ons for R98 abrupt behavior. If the psychology note which cility on 4-25-12 at 12:42 p.m. ologist note indicated the recommendations for R98 es/ safety planning in light of should involve staff actors, particularly other or engage with (R98) in ways ith him. That (R98) is often ff, it should be something that staff before escalating." 4-25-12 at 11:15 a.m. the (DON) stated R98 is pleasant hain dayroom almost all the R98's plan of care did not rventions to prevent further	F 250			1017 1017 1018 1018 1018 1018 1018 1018

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245018	B, Wil	IG	·	05/0	2/2012
	ROVIDER OR SUPPLIER	WE	•	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORT DLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION · DATE
F 250	Although R98 had a anger managemen altercations with oth failed to implement	ige 73 a well documented history of t issues with multiple ner residents. The social work interventions that were R98 and other residents from	F 2	250			
	altercations, even to prior altercations we R160 had diagnose anxiety disorder, do gait instability, and quarterly MDS date had moderate cognindependent walking	free from resident to resident hough the facility was aware of ith R98. es including manic depression, ependent personality disorder, history of a stroke. R160 ed 1-3-12 identified the resident nitive impairment, was ag around the facility, and had				·	2672 154099D 1537-3384
	threatening, screar days in the prior 7 days in the 160 had altercation with R9 indication that additional altercation. The 10-31-11 psycowas referred for a concern about bout of irritability with an concern was a mal business and hit his altercation that ped	wards others such as ming, or cursing at others 1-3 day assessment period. Integrated progress notes a resident to resident 8 on 10-14-11. There was notional interventions were this incident to prevent ons. Integrated progress notes a resident to resident 8 on 10-14-11. There was notional interventions were this incident to prevent ons. Integrated progress notes a resident to resident to resident 8 on 10-14-11. There was notional interventions were this incident to prevent ons. Integrated progress notes a resident to resident to resident 8 on 10-14-11. There was no it incident to prevent ons. Integrated progress notes a resident 8 on 10-14-11. There was no it incident 8 on					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WIN	G	<u></u>	. 05/0:	2/2012
	ROVIDER OR SUPPLIER	ME		444	ET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421	EAST	7. 7. 4.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
away from him." The programment at the programment		verything in his power to stay he psychologist were"! suspect his	F2	250			. · · · bg
	intellectual functioning is rather low and, therefore, abstract concepts may be difficult for him to understand. Keeping things in simple sentences and in a concrete manner is advised" The facility progress note on 4-20-12 identified R160 and R98 had another resident to resident altercation where R98 pushed R160, which resulted in R160 sustaining a right femur fracture. R160 was sent to the hospital to be admitted.						77 / 2912 1. V " D
							1/40 1/40 1/40 1/40
	which was identified incident on 4-20-12 (R160) has had a fresident (R98) in the a habit of seeking saying things like will follow (R98).	gress note dated 4-23-12 and as a follow up from the 2 identified, "This resident few other altercations with the past. This resident has had out (R98) and repeatedly go back to bedthis resident he has a learning disability and imself when speaking to					7 A.
	had major depress disorder, bipolar, a psychiatric hospita included to observ behavior, offer sup safe environment psychology consul care did not identif exhibited, there was behaviors of reside	e dated 4-3-12 identified R160 sion, anxiety, personality and had a history of previous I stays. The approach's e for changes in mood or apport, validate feelings, provide for resident and others, and t if needed. R160's plan of any what specific behaviors R160 as no monitoring of R160's ent to resident altercations, the staff to separate R160 and R98					

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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WI	۱G _		05/0	2/2012
	ROVIDER OR SUPPLIER	ME :		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421		EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	to ensure they were the plan identify an	e not in the same area, nor did	F:	250			. 152
		assessment dated 4-19-12 had essment to identify behaviors,					32 1 a 2012 1 VEC
	social service direct busy body" and car stated R160 was n people's faces." So any previous alteroas she just started information was no	4-25-12 at 8:40 a.m. the stor (SSD) stated R160 is "a be "annoying to people." She ever "malicious, he just gets in the stated she was not aware of ations between R160 and R98 in February 2012 and this t passed onto her. SSD two been nice to know; they problem here."					
	survey was exited. Although the facility	e hospital on 5-2-12, when the y was aware of the previous t altercations with R160 and					
	R98, the facility fail social services to a monitoring and imp	ed to provide medically related assure adequate assessing, olementation of behavioral implemented to ensure					
	Job Description, id as "developing ca psychosocial well-land to enable resid	d Director of Social Services entified the position summary are plans to meet the being and needs of residents dents to achieve their optimal nee" The Responsibilities					

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

and Plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	·	COMPLE	TED
		245018	B. WIN	√G		05/0	2/2012
	ROVIDER OR SUPPLIER	ИE		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	and duties instruct '	ge 76 'Assess's residents social, emotional status and develops neets the residents needs."	F 2	250	· · · · · · · · · · · · · · · · ·		
:	R161 had a diagnor depression and had immediate family m assessment to dete	nation was provided. sis of depression, indicators of la recent death of an ember, however there was no emine if or what social service needed even though R161 had					7.77 7.77 7.77,0 7.77,531 7.77
	assess mood patter been left blank. R1	S dated 4/13/12 failed to rns, section D (mood) had 61's diagnosis included a recent stroke with ations.					
	indicators was with with an ARD of 12/2 1/17/12. This asset R161 had indicators interest or pleasure day; feeling down, of every day; trouble for	t assessment of mood the previous quarters MDS 28/11 and signed by RN-E on ssment (section D) showed s of depression such as: little in doing things nearly every depressed or hopeless nearly alling or staying asleep, or feeling tired or having little day.				·.	1 (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)
	included "potential a psychosocial well-b to new environment independence." Go in their environment side effects from me	yle plan of care dated 4/9/12 alteration in mood and/or eing r/t depression, adjusting and decline in bal was listed as "Will be safe t" and "Will have little to no eds." Interventions listed as es in mood and/or behavior.					
				- 1			

(X2) MULTIPLE CONSTRUCTION

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245018	B. WING		05/02/2012		
	ROVIDER OR SUPPLIER	ME	STR 44 C	1 / 345 21 / 4 2 / 11 / 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION - DATE	
F 250	Encourage resider frustrations or con- reassurance and e- indicated. Offer 1: needed. Validate as needed. Encou- activities. Provide and others. Admir antidepressant. P R161's physician of indicated R161 has antidepressant) 15 R161 social service indicated the most assessed 12/28/17 depression. It furtible seen by psychology consul R161's medical refrom the facility, but R161's "care confeindicated he had a was showing signs that after the funer lighter and has clo- loss." During interview wat 8:13 a.m. on 4/2 for R161 and verifimonitoring R161 for	nt to express feelings, cerns. Offer support, encouragement as needed and 1 with staff or family as feelings. Involve spiritual care trage socialization and leisure safe environment for resident nister medications as ordered, sychology consult if indicated." order sheets dated 3/30/12 d started on Remeron (an	F 250			1. 17 (2012 1. 17	
	services (SS)-A at	10:15 a.m. on 4/27/12, she				,	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE		
		245018	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	ME		4444 RE	DDRESS, CITY, STATE, ZIP CODE ESERVOIR BOULEVARD NORTH MBIA HEIGHTS, MN 55421	EAST	14.15 1.15 1.16.15 1.16.15
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	stated "what I heardaughter was that I and then felt closur needed to intervention wanted to discharg swallowing problem feeding. She indicated had been assessment had been assessment had be status or depression did not have time to nor had received a the MDS. R161 was interviewed in the most and the would be looking forward to the stated he would be looking forward to the medical difficulties. This depression had	d about him losing his he was sad until the funeral re and did ok, I did not feel I re." Futher stating R161's had e but this was held up due to his and requiring a tube ated family and the facility involved. She verified no seen completed for cognitive on since December 2011. She to complete the assessments my training on how to complete eved at 3:35 p.m. on 5/2/12, he suss his depression or the ter with the surveyor. He	F 2	50			
· ·	description for "Dir provided by the fact summaryDevelop psychosocial well-that and to enable resid level of independent documentation and areas." Under "resincludes under nur	View Lutheran Home job ector of Social Services" cility included under "position bing care plans to meet the being and needs of residents dents to achieve their optimal nee. Responsible for direcord keeping in appropriate sponsibilities and duties" nber 3, "Provide ongoing oblem solving services to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WIN	G		05/02	2/2012
	ROVIDER OR SUPPLIER IEW LUTHERAN HOI	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 252 SS=E	4, "completes social assessment, geriat advanced directives number 5, "assesso psychological, and a plan of care that in Under number 6, "hunderstanding of his sections of the Mini 483.15(h)(1) SAFE/CLEAN/COMENVIRONMENT The facility must promofortable and hothe resident to use to the extent possible. This REQUIREMED by: Based on observative the facility fadining experience of R50, R104, R19, R in the facility's securification. Findings include: On 4/23/12 at 4:45 seating 4 residents person tables were Willow dining room room along the wall	y members." Under number all history, mini mental state ric depression scale and so for residents." Under es resident's social, emotional status and develops meets the residents' needs." has knowledge and ow to complete the assigned mum Data Set." AFORTABLE/HOMELIKE Ovide a safe, clean, melike environment, allowing his or her personal belongings ble. NT is not met as evidenced tion, interview, and record alled to provide a home like or 8 of 22 residents (R55, R30, 134, R90 and R167) who ate ared (Willow) unit. p.m., four large round tables at each and 2 smaller, two observed during dinner in the . On the left side of the dining I, R55 and R30 were each		250	F252 Environment It is the practice of Crest View Lutheran Home to provide a clean, comfortable, and homenvironment, allowing the reto use his or her personal be to the extent possible. For Resident(s) R50, R104, R: R134, and R167 the tray table removed and regular dining were put into place. For Res R90, his spouse uses a tray to set his food on when she visib brunch and assists him with For all other meals R90 will be at a regular dining table. The plan for residents who have members that bring in food were members that the memb	safe, selike esident longings 19, R30, es were tables ident able to its at dining. See placed e care family	
	was lined up agains	n over-the-bed tray table which st the wall. On the right side of 0, R104, and R19 each sat in			updated to reflect family and resident wishes. Correspond		

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		245018	B. WII	1G		05/02	2/2012
	ROVIDER OR SUPPLIER	ME	· ·	44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421		1 - 44 1 - 1 1 - 1 1 - 1 1 - 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 252	front of a over-the-wall. R50, R104, F served their meals residents were not like their peers. During dining obse 4/24/12, there were sitting at the tray to observation, R134 and R19 were aga tables by the wall, regular dining table. During interview w during the meal seknow why he sat a	bed tray tables against that R19, R55, and R30 each were on the-tray tables. These seated at regular dining tables rvation at 10:57 a.m. on e several different residents ables then previous R90, and R167. R55, R50 in observed sitting at the tray R30 and R104 were seated at es during this meal observation. With R50 at 5:19 p.m. on 4/23/12 rvice, he stated he did not ta tray table on the outskirts of d would like to sit with the	F:	2252	updates have been made to plan, care assignment sheet communicated to the reside and/or designated decision reducation will be provided for members regarding dining p by 06/11/12. Resident R55 expired on 05/For other residents who may affected by this practice dining services audits will be completed to 11/12 with results report dining, nursing, or environm services for review and follows:	and nt maker. or staff ractices 26/12. / be ng leted by led to ental	A POST A
:	medication aide (T assigned seating in residents prefer to bed side tray table identified R30 and During interview at supervisor (NS)-A seating in the Willowsit at over the bed behaviors; especia had no explanation used the tray table	9:22 a.m. on 4/27/12 trained MA)-C stated there was no in the dining room but some have their space and sit at the sinstead of a dining table. She R19 who prefer this. 1:50 p.m. on 4/27/12 nurse stated there was no assigned by dining room. Residents who tray tables are due to their ally R50, R19, and R167. She in as to why different residents is at different times.			The policy and procedure for services was reviewed and rethe interdisciplinary team by 06/11/12. The Medical Directive the policy to ensure if the current standards of praceducation was provided for members regarding dining with dignity as it relates to their respective roles and responsibly 06/11/12.	evised by tor will t meets ctice. staff vith	
	stated getting a fer	t 2:59 p.m. on 4/30/12 NS-A w more four-person tables like ining room had not come up			Dining Services audits will be completed weekly for 4 week		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02/2012
	ROVIDER OR SUPPLIER VIEW LUTHERAN HOI	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 252	more tables to try a use tray tables at a these residents had over the bed tables tables like their pee habit of stealing off. The facility did not Willow dining room who ate in the dining tables were given to additional table had	ce may be able to bring in and place the residents who dining table. NS-A-confirmed a not been assessed to use rather than sitting at real ers; except R19 who had a ners liquids. have enough tables in the to accommodate all residents ag room and over the bed tray	F 252	monthly for 3 months, and a to the quality control scheduresults reported to the CQI Committee for review and for recommendations. Upon this system revisions and/or staff education will be implement indicated. The Director of Dining Service designee will be responsible.	ule with urther s review, f ted if uses or uses or
F 272 SS=D	a comprehensive, a reproducible assess functional capacity. A facility must mak assessment of a resident assessment by the State. The aleast the following: Identification and d Customary routine: Cognitive patterns; Communication; Vision; Mood and behavio Psychosocial well-	enduct initially and periodically accurate, standardized sment of each resident's e a comprehensive esident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;	F 272	F272 Resident Assessment It is the policy of Crest View Home to conduct initially an periodically, a comprehensiv accurate, standardized repre assessment of each resident functional capacity. It is the policy of Crest View Home to complete a compre assessment of a resident's ne using the resident assessment instrument (RAI) specified by State. The assessment must at least the following: Identifi and demographic informatio customary routine, cognitive patterns, communication, vis	Lutheran id ve, oducible 's Lutheran chensive eeds, int y the include fication in,

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245018	B. WIN	1G		05/0	2/2012
	ROVIDER OR SUPPLIER	VIE	STREET ADDRESS, CITY, STATE, ZIP COL 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542		444 RESERVOIR BOULEVARD NORTH		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION ; DATE
F 272	Disease diagnosis Dental and nutritior Skin-conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of sthe additional assertingered by Data Set (MDS); ar	and health conditions; nal status; and procedures; summary information regarding esment performed on the care the completion of the Minimum	F:	272	mood and behavior patterns psychological well-being, and physical functioning and struproblems. For Resident R74-a-new-asse was completed for smoking smoking apron was added to of care to help prevent him fourning holes in his clothing himself. For Resident R22 alwisits have been scheduled a attended according to regulater next dental appointment scheduled and the referral winclude her concerns about of	d ssment safety. A his plan rom or I dental nd ation. t is	2
	by: Based on observa review the facility fa comprehensive ass smoking for 1 of 8 observed with burn cigarette smoking; complained of dent residents (R6) who depression. Findings include: R74 had multiple ci jacket and was not	tion, interview and document alled to complete a sessment regarding safe residents (R74) who was holes in his clothing from for 1 of 1 residents (R22) who ure problems and for 1 of 1 had cognitive deficits and assessed to smoke safely.			problems. For Resident R6 a evaluation/assessment was completed regarding cognition mood, and behavior. Corres updates have been made to plan, care assignment sheet communicated to the reside and/or designated decision reducation will be provided to members on smoking safety, care issues, and cognition, mobehavior by 06/11/12. For other residents who smoking assessment will be completed by 06/11/12 to exassessments are in place. Care	on, ponding the care and nt naker. o staff oral ood and oke a	20 (20)

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		245018	B. WING		2/2012		
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) GROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	The admission mir 2/25/12 indicated Fimpairments and wind MDS also identified tobacco. During interview at assistant (NA)-F, so noticed R74 had a tee shirt. NA-F also winters she had not multiple cigarette but to the shirt of	uring interview at 7:17a.m. on 4/25/12, nursing esistant (NA)-F, stated this past winter she officed R74 had a cigarette burn hole on his gray e shirt. NA-F also stated that during this inters she had noticed that R74 also had ultiple cigarette burn hole on his winter jacket. 8:08 a.m on 4/25/12, interview with busekeeping-A stated she had noticed cigarette burn holes on R74's pants but had not noticed by burns on his tee shirts. She stated she ought these burn holes occurred this winter. With R74's permission, housekeeping-A and burveyor observed R74's clothing in his closet. When the partial cotton and others were ade of 100% polyester. R74's pants were in observed and 7 out of 10 pairs had multiple garette burn holes mainly in the thigh area of		272	will be updated for the individual affected. Upon completion of review any concerns will be forwarded to the IDT Team foup. The policy for assessment conwill be reviewed and revised interdisciplinary team by 06/A review of policies by the M Director will be completed to current standards of practice place. Staff members will be as it relates to their respective and responsibilities regarding assessment policy and proce 06/11/12. Audits on resident assessment be completed weekly for 4 we monthly for 3 months, and the	mpletion by the 11/12. edical ensure are in trained re roles dures by onts will reeks, hen	10012 10012 100VED 100V
	dated 1/10/12 and revealed that R74 policy was reviewe smoking policy, ca and lit smoking ma offered a smoking document also rev safe smoking prac plan indicated "res	itled "Smoking Evaluation" reviewed again on 2/7/12 was alert, the facility smoking d with him, R74 follows the n safely utilize lighter/matches aterial, and R74 has been apron but refuses. The ealed that he demonstrates tices with other residents. The ident smokes independently, sues with compliance in other			according to the MDS scheduresults reported to the CQI Committee for review and for recommendations. Upon this system revisions and/or stafeducation will be implement indicated. The Director of Nursing or dowill be responsible for compatte of Correction: 06/11/1	urther s review, f ted if esignee liance.	2 18 2 18 2 19 2 19 2 29 2 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245018		B. WING		05/02/2012		
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 272	1	ge 84 ys followed smoking	F 27	2		, ,	
	licensed practical n completed R74's sr after he moved to the a smoking apron where stated she was not holes on R74's clothes on R74's clothes she would resmoke. Although the facility smoke independen there were 7 out of observed with multiple R22 had diagnoses (kidney) disease. To (MDS) dated 12-22 cognitive impairment assist with personal dental problems. On 4-23-12 at 5:58 and bottom denture well since she got to She stated she just 4-20-12 and they stat times she will we not wear the bottom when I eat or talk; if in!" She also stated	s of weakness and renal The annual minimum data set -11 identified R22 had no nt, was a one person limited I hygiene, and had no oral or p.m., R22 stated she had top es and neither one have fit very hem back in September 2011. I saw the dentist again on till don't fit right. She indicated ear her top dentures, but does on ones because "they fly out t's easier to eat without them and although she had just seen -12, she had to " beg for 3				10/2012 10/10/10/10/10/10/10/10/10/10/10/10/10/1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	:	245018	B. Wil	1G _		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				Y (100)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 272	dated 3-1-12, identi problems" with her	ge 85 on and Initial Care Plan form fied R22 had "no obvious teeth and had upper and is form had an area which	F:	272			
	identified if the residurote in "Do not w There was no furthed determine why R22	dent's dentures "fit." A nurse rear (dentures) per resident." er assessment completed to does not wear the dentures.					7 342 - 510/4 (5 - 510/25)
	dated 12-23-11 ide which were in good missing." There wa	rly Nutrition Assessment form ntified R22 had her own teeth condition but had a "few teeth as no indication that R22 had ntures but had their own teeth.					
·	coordinator register residents have an or she was unable to be stated the dietary to assessment of oral MDS nurses get the MDS. MDS RN-E It assessment form desidents	4-26-12 at 3:40 P.M., MDS red nurse (RN)-E stated all bral screening in their chart but ocate one in R22's chart. She echnicians do the annual health and that's where the eir information to fill out the ooked at the yearly nutrition ated 12-23-11 and stated it incorrect because R22 had					
	dietetic technician (completed R22's yet 12-23-11. She stat wear her dentures it eats but was unsuridentify why the ass maybe R22 was "g	t.m. during interview with DT)-Z she stated she early nutrition assessment on ed she knows R22 does not in the dining room when she e why. DT-Z was unable to sessment was incorrect except groggy" on the day she did the d not tell DT-Z she had				· .	7 7 12 7 7 13 7 13 7 14 7 14 7 14 7 14 7 14 7 14 7 14 7 14

Tree.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245018	B. WING		05/02/2012		
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 272	Continued From pa	_	F 272				
	R6 had_diagnoses schizophrenia.	which included dementia and					
·,	signed by RN-E on completion. Section mental status) iden C0600, C0700, C00 assessed. Section assessment) identi D0350, D0500, D00	vith an ARD of 1/7/12 was 1/21/12 verifying assessment ns C (cognative patterns and tified that C0100, C0200, 800, through C1000 were not D (resident mood fied D0100, D0200, D0300, 800, and D0650 were not and marked as "not-assessed"				12 7. 7. 16/412 7. 18/10 8. 19301	
esd.	1/21/12 included th CAA) identified Alz of care, there was behavioral symtpor	sessments (CAA's) dated e "cognitive loss/dementia cheimer's disease and rejection no analysis of R6's cognition or ns. Even though R6 had a mimers dementia and				1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
	coordinator RN-E a stated the social se responsible for sec MDS. At 9:30 a.m. D had not been col indicated she does	th the facilities MDS at 8:30 a.m. on 4/24/12, she ervice department is tions C, D, E and Q on the , RN-E verified sections C and impleted for this resident, and inot go back and check to vorker codes the sections as					
	-A at 10:15 a.m., o has an area she ca	th social service director (SS) n 4/27/12, she stated the MDS an mark areas as d she does this if she does not					

1.44

1.27

OLITICI	TO TOTT MEDICAL	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	СОМ	(X3) DATE SURVEY COMPLETED
		245018	B. WING		05/02/2012
	ROVIDER OR SUPPLIER	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHI COLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 272 F 276 SS=E	have time to complete the information for R6 for cognitive parequired. She had how to complete the comprehensive or 483.20(c) QUARTILEAST EVERY 3 MA facility must assequarterly review instant approved by Conce every 3 monto. This REQUIREME by: Based on interview facility failed to upon at least quarterly to and mood patterns of 40 (R161, R168 R60) residents reviewed who expelled in addition, the factor residents (R16) retained as to prevent pare a comprehensive in meeds to prevent pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections C (cognitive pare 18161's diagnosis in effects from a strodata set (MDS) will date (ARD) of 3/29/12 verifying a Sections	lete the MDS or can not find coding. She had not assessed tens or for mood indicators as not received any training on the MDS or requirements of the quarterly assessments. ERLY ASSESSMENT AT MONTHS Less a resident using the estrument specified by the State EMS not less frequently than this. In the modern of the MDS for 7 or the facility failed to essess 1 of 3 (R16) residents erienced urinary incontinence. It is included to ensure 1 of 5 viewed for pressure ulcers, had reassessment to determine	F 272		sing the specified by CMS se every 3 R163, shood) re updates splan, sent maker, nformed a cian cation will ers dent at MDS 3.0
				1	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		245018	B, WING		05/02/2012
	ROVIDER OR SUPPLIER	ME	ST	TREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	HEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECTION SEC	OULD BE COMPLETION
F 276	Continued From pa		F 27	Resident R16 expired on 06	/11/12.
	Section D (residen D0100, D022, D03 and D0650 were almarked as "not ass R161's medical red Mental Status (BIM on 12/28/11 indical intact. The assession such as doing things nearly depressed or hope falling or staying as feeling tired or hav day. Although R16 problems with the MDS section D was Review of R161 so indicated on 2/10/1 the PHQ-9 (an ass indicating signs of seen by psych connotes were in R16 consult notes were in R16 consult notes were in the provided. R161's "care conferindicated he had a was showing signs that after the funer	throod assessment) identified throod assessment) identified too, D0350, D0500, D0600, so not completed for R161 and sessed" by the facility. Throod revealed a Brief Interview and the sessed and the sessed and the facility. Throod revealed a Brief Interview and throod and throod assessed and through the facility. Throod revealed a Brief Interview and throod and throod and throod and throod and throod assessed and throod and throod and throod and throod and throod and throod assessed and throod and t		For other residents who may affected by this practice, and quarterly MDS (sections C & be completed by 06/11/12 this review, system revisions staff education will be implificated by 06/11/12. The policy for MDS assessmenter by 06 A reviewed and revised by interdisciplinary team by 06 A review of policies by the Director will be completed current standards of practice. Staff members will as it relates to their respectant responsibilities regard MDS policies and procedur 06/11/12.	n audit on & D) will Upon ns and/or emented nents will the 5/11/12. Medical to ensure ice are in be trained ctive roles ling the
	During interview w	ith the director of social			

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			(X3) DATE SU COMPLE			
		245018	B. WING		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		REET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTI COLUMBIA HEIGHTS, MN 55421	HEAST	10 N 10 10 10 10 10 10 10 10 10 10 10 10 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 276	services (SS)-A at stated "what I hear daughter was that-and then felt closur needed to interven the facility chaplain stated she did not assessments. Even though R161 and his daughter p no further assessment completed to deter required. R168 had diagnost and Wernicke-Kordisorder causing p muscle incoordinated. The quarterly MDS signed by RN-E or completion. The I patterns and ments C0200, C0600, C0 were not assessment) ident D0350, D0500, D0 completed for R16 "not-assessed" by R168's most recer "Folstein mini-ment 10/3/11 showed m R168's most recer	10:15 a.m. on 4/27/12, she d about him losing his he was sad until the funeral re and did ok, I did not feel I - e." She indicated family and had been involved. She have time to complete the had indicators of depression, assed away during the quarter, hent of depression had been mine if further intervention was es which included depression sakoff syndrome (an brain sychosis, memory loss and tion and weakness). With an ARD of 1/7/12 was 1/21/12 verifying assessment MDS section C (cognitive all status) identified that C0100, 700, C0800, through C1000 I. Section D (resident mood iffed D0100, D0200, D0300, 600, and D0650 were also not 8 and were marked as the facility. It cognitive exam entitled that state examination" dated oderate cognitive impairment. It mood indicator exam entitled on scale" dated 10/3/11	F 276	Audits of the MDS assessmeschedule will be completed for 4 weeks, monthly for 3 then according to the MDS to ensure compliance with reported to the CQI Commerciew and further recommendations. Further revision and staff education provided if indicated by autiful be responsible for compate of Correction: 06/11,	d weekly months, Sechedule results nittee for er system will be idits. designee apliance.	20 102 103 103 103 103 103 103 103 103 103 103
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MULT			X3) DATE SURVEY COMPLETED			
		245018	B. WING		05/0	2/2012
	ROVIDER OR SUPPLIER VIEW LUTHERAN HO	ME	S	TREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	ORTHEAST	. , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 276	indicated R168 had medication (Risper daily) on 1/4/12,-du	rder sheets dated 3/28/11 d started an antipsychotic rione 0.25 mg (milligrams)	F 27			26, 7, 162
	depression and W and had started ar facility failed to re-	ernicke-Korsakoff syndrome antipsychotic medications, the assess R168 for depression or assessments had not been				1,000 1,000
	R163's diagnoses depression and re- complications afte	included moderate major ceived hospice care for r a stroke.				
	was signed by RN assessment comp C0200, C0600, C0 D0100, D0200, D0 and D0650 require	IDS with an ARD of 2/16/12 -E on 2/29/12 verifying letion. Sections C0100, 0700, C0800, C0900, C1000, 0300, D0350, D0500, D0600, ed assessment areas were not i3 and were marked as the facility.				
	cognition was on hated 11/30/11 whimpairment and in feeling down or dhaving little energy asleep or sleeping	nt assessment for mood and his significant change MDS hich showed severe cognitive dicators of depression such as epressed, feeling tired or too much, and feeling bad hat you are a failure or have let mily down."				.1.2
	depression, had a	3 had a diagnoses of terminal diagnosis, and at ent had indicators of				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA	MBER:			(X3) DATE SURVEY COMPLETED	
AND PLAN (ORKEUTION	IDENTIFICATION NORDEN.	A. BUILDING	**************************************			
		245018	B, WING		05/02	2/2012	
	ROVIDER OR SUPPLIER	ME	444	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	IEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 276	Continued From pa depression, the fac for cognition or sig	cility failed to re-assess R163	F 276			2 162 21 162	
	heart failure and si services. R16's quarterly ME signed by RN-E or completion. Section C0700, C0800, C0 D0300, D0350, D0 are required assess completed for R16 "not-assessed" by R16's previous ass MDS dated 12/21/impairment and in "Feeling down, defalling or staying a Feeling tired or had or overeating. Feel you are a failure or	luded Alzheimer's disease and ne was receiving hospice OS with an ARD of 3/10/12 was a 3/26/12 verifying assessment ons C0100, C0200, C0600, 1900, C1000, D0100, D0200, 1500, D0600, and D0650 which is ment areas were not and were marked as the facility. Sessment, a significant change 11, indicated severe cognitive dicators of depression such as pressed or hopeless. Trouble sleep, or sleeping too much, ving little energy. Poor appetite eling bad about yourself or that it have let yourself or your family				TO THE STATE OF TH	
	and cognitive impa assessment in De terminal illness, th cognitive status or R15 diagnoses ind depressive disorde ideation.	had indicators of depression airment on the previous cember 2011 and had a e facility failed to re-assess her how her depression was. cluded recurrent major er with psychosis and suicidal DS with an ARD of 2/24/12 was a 3/9/12 verifying assessment				7. 022 7. 240 7. 250 7.	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		e	COMPLE	
		245018	B. WII	1G		05/0	2/2012
	ROVIDER OR SUPPLIER	WE		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTI OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 276	completion. Section C0700, C0800, C0 D0300, D0350, D0 required assessment for R15 and were	nge 92 ns C0100, C0200, C0600, 900, C1000, D0100, D0200, 500, D0600, and D0650	F:	276			
- · .	indicated she was indicators of depre depressed, or hope staying asleep, or	arterly MDS dated 12/9/11 cognitively intact, had ssion such as "Feeling down, eless. Trouble falling or sleeping too much. Trouble hings such as reading the ching television."		and the second s			2012 (2.1.54.0) (2.1.521 (2.1.521
÷	depression and sh on her previous as	diagnoses included major e had indicators of depression sessment 12/9/11, the facility her for changes in cognition rs.					7
	R40 diagnoses inc depression.	luded severe dementia and					
	signed by RN-E or completion. Section C0700, C0800, C0 D0300, D0350, D0 required assessment	OS with an ARD of 1/7/12 was 1/21/12 verifying assessment ons C0100, C0200, C0600, 1900, C1000, D0100, D0200, 1500, D0600, and D0650 ent areas were not completed marked as "not-assessed" by					E-120 10-20 10-20 10-20 10-20
	included she had s problems. Staff as showed R40 had i	arterly MDS dated 10/20/11 short and long term memory ssessment of mood indicators ndicators of depression such as aving little energy. Poor					1. 5. 15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI			
		245018	B. WING		05/0	2/2012
	ROVIDER OR SUPPLIER	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
F 276	bad about self, is a family down. Being	nge 93 Ing. Indicating that she feels failure, or has let self or your g short-tempered, easily	F 276			1.3
7. -	dementia and depr had indicators of de re-assess R40 for de changes.	nad a diagnoses of severe ession as well as previously epression, the facility failed to depression or cognition				- 34 MANY 2 - 34 MANY 2 - 32 FROST
	R60's quarterly MD signed by RN-E on completion. Section C0700, C0800, C0 D0300, D0350, D0 required assessment	PS with an ARD of 4/4/12 was 4/18/12 verifying assessment ons C0100, C0200, C0600, 900, C1000, D0100, D0200, 500, D0600, and D0650 ent areas were not completed marked as "not-assessed" by				7. 7 Supposed 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.
	1/3/12 was signed assessment compl C0200, C0600, C0 D0100, D0200, D0 and D0650 require	terly MDS with an ARD of by RN-E on 1/21/12 verifying letion. Sections C0100, 700, C0800, C0900, C1000, 300, D0350, D0500, D0600, d assessment areas were not and were marked as the facility.				
	MDS dated 10/14/	sessment was her annual 11 showed she had long and problems and did not have epression.				1 / 4/3 13/15
. •	Even though R60 I facility failed to re-	nad Alzheimer's disease, the assess her cognitive status and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			
		245018	B. WING		05/0	2/2012 3/4
	ROVIDER OR SUPPLIER		44	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NOR DLUMBIA HEIGHTS, MN 55421		. 2
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) - COMPLETION DATE
F 276	Continued From her mood since C	_	F 276			
	coordinator, RN-l stated the social responsible for se MDS. At 9:30 a.r D had not been cand indicated she ensure the social required. During interview A at 10:15 a.m. has an area she "not-assessed" a have time to complete information for these residents for indicators as requiraining on how to	with the facilities MDS- E at 8:30 a.m. on 4/24/12 she service department is ections C, D, E and Q on the m. RN-E verified sections C and ompleted for these residents, e does not go back and check to worker codes the sections as with social service director (SS) on 4/27/12, she stated the MDS can mark areas as nd she does this if she does not iplete the MDS or can not find or coding. She had not assessed or cognitive pattens or for mood uired. She had not received any o complete the MDS or he comprehensive or quarterly				100 A
	mood status of R R40 and R60 eve change in menta	to re-assess the cognition or 161, R168, R163, R16, R15, en though each was at risk for a l, emotional and cognitive status lents are a required portion of essment.				A (4)
	comprehensively determine type o R16's diagnoses heart failure, uri	ontinence was not assessed by the facility to fincontinence or voiding pattern. included Alzheimer's disease, nary retention (the inability to er by voiding) and chronic kidney				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. Wil	IG		05/02	2/2012
NAME OF PROVIDER OF		ME	•	444	ET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	EAST	- <u>; ii</u>
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE · · ·
disease (MDS) of cognitive required occasion to ileting significate severe R16's "dated 3 out. The incontine voided p.m. and had voice checked 12:00 and the form contine because R16's "Bladde list style checked "Alzhein (congerenal fate" antiantial diuretical abnormatical contine decays and the form contine because R16's "Bladde list style checked "Alzhein (congerenal fate" antiantial diuretical abnormatical contine decays "antiantiantial diuretical abnormatical contine decays "antiantial diuretical abnormatical diuretical abnormatical contine decays "antiantial diuretical abnormatical diuretical	dated 3/26/ re status.—To extensive enally incomplete i	arterly minimum data set 12 did not assess R16's The MDS identified R16 assistance to toilet, was tinent of urine, but was not on a 's previous assessment, a MDS dated 12/21/11 indicated	F	276			90.77.77.2012 90.77.

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WIN	G		05/02	2/2012
	ROVIDER OR SUPPLIER	OME		4444	r Address, City, State, ZIP CODE RESERVOIR BOULEVARD NORTH UMBIA HEIGHTS, MN 55421	HEAST	9 412 4 13 5 13 13 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 276	status" included "k-hours, incontinent amount each void pattern in last year formed stool every this data. The formed stool every this data. The formed stool every this data. The formed stool every assist, percale wit resident for signs infection, observe meds as ordered. "Resident toileted request, requires transfer at times in seen, continue can R16's assessment address the lack comprehensively use of a diuretic nurgency/frequencuse of narcotic padrowsiness and the patterns of fluid in may irritate the bludetermine if she we retention as she is retention. Further	ds." Under "bladder present bladder frequency every 2-3 with control, medium to large ing, no pain or change to r. Bowel status as continue y day. An LPN had gathered m has a section completed by a anning" and included the r assist every 2-3 hours, needs 2-3 hours, adjust clothing and h assist, staff to observe and symptoms of urinary tract for bowel pattern changes, Under "Assessment" read every 2 hours upon her assist with pericares and to nc (incontinent) but no pattern	F 2	76			
,	During interview v p.m. on 4/26/12, s nurse (RN) to ass	with MDS nurse (MDS)-F at 3:00 she stated there is no registered sess if toileting programs are re residents are not placed on					

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				(X3) DATE SURVEY COMPLETED	
	245018	B. WII	ИG	•	05/0	2/2012	
	ME		44	144 RESERVOIR BOULEVARD NOF	RTHEAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX.	(EACH CORRECTIVE ACTION :	SHOULD BE	(X5) COMPLETION . DATE .	
toileting programs.	An LPN fills out some of the	F	276			: stravija	
at 10:00 a.m. on 4/do a 3 day bowel a is filled out by the r for how often each to the toilet. She do toileting plan due to assess if the plan in the dileting needs are and bladder asses quarterly. She state on the MDS as beithere is not a Regit determine if the curvorking or not. The facility failed to comprehensively a furinary inconting consideration diurnary inconting consideration diurnary inconting enough data to determine position ulcers. R16's quarterly mit 3/26/12 did not as	27/12, she stated usually will and bladder tracking form that hurse aides to determine a plan resident requires assistance loes not place residents on any of there is no RN available to seffective or not. At 2 she stated a residents determined by a 3 day bowel sment that is performed ted no residents are checked ing on a toileting program as stered Nurse assessment to irrent bowel and bladder plan is a sessessed to determine the type ence she had, take into etic use, patterns of fluid intake, ication use, and did not collect termine if R16 had any pattern of or when she was incontinent. The prehensively assessed to hing needs to prevent pressure nimum data set (MDS) dated sess R16's cognitive status.						
R16's MDS identif	ied she required extensive						
	ROVIDER OR SUPPLIER TEW LUTHERAN HO SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From pation to to the toilet of the toilet. She do to the toilet. She do to the toilet of the toilet	TOORRECTION IDENTIFICATION NUMBER: 245018 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 97 toileting programs. An LPN fills out some of the assessment and then an RN does a summary. During interview with MDS coordinator (MDS)-E at 10:00 a.m. on 4/27/12, she stated usually will do a 3 day bowel and bladder tracking form that is filled out by the nurse aides to determine a plan for how often each resident requires assistance to the toilet. She does not place residents on any toileting plan due to there is no RN available to assess if the plan is effective or not. During interview with nurse supervisor (NS)-A at 2:45 p.m. on 5/1/12 she stated a residents toileting needs are determined by a 3 day bowel and bladder assessment that is performed quarterly. She stated no residents are checked on the MDS as being on a toileting program as there is not a Registered Nurse assessment to determine if the current bowel and bladder plan is working or not. The facility failed to ensure R16 was comprehensively assessed to determine the type of urinary incontinence she had, take into consideration diuretic use, patterns of fluid intake, narcotic pain medication use, and did not collect enough data to determine if R16 had any pattern to her need to void or when she was incontinent. R16 was not comprehensively assessed to determine positioning needs to prevent pressure	CONTINUED ROUTE PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 97 toileting programs. An LPN fills out some of the assessment and then an RN does a summary. During interview with MDS coordinator (MDS)-E at 10:00 a.m. on 4/27/12, she stated usually will do a 3 day bowel and bladder tracking form that is filled out by the nurse aides to determine a plan for how often each resident requires assistance to the toilet. She does not place residents on any toileting plan due to there is no RN available to assess if the plan is effective or not. During interview with nurse supervisor (NS)-A at 2:45 p.m. on 5/1/12 she stated a residents toileting needs are determined by a 3 day bowel and bladder assessment that is performed quarterly. She stated no residents are checked on the MDS as being on a toileting program as there is not a Registered Nurse assessment to determine if the current bowel and bladder plan is working or not. 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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	PLE CONSTRUCTION 3	(X3) DATE SUP COMPLETE	
		245018	1			05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIECT OF THE APPROPRIE	OULD BE	(X5) COMPLETION DATE
F 276	no pressure ulcers development of pre- change MDS dated cognitive impairme Alzheimer's diseas R16's care area as 12/13/11 indicated ulcers due to she " move sufficiently to site, confined to be persistently wet, es incontinence, wour	but was at risk for essure ulcers. R16's significant l-12/21/11 indicated severent. R16's diagnoses included e and heart failure. sessment (CAA) dated she was at risk for pressure requires staff assistance to relieve pressure over any one d or chair all or most of time,	F:	276			5.15 5.15 5.15 5.15 5.15 5.15 5.15 5.15
	delirium limits mob nutrition, use of an medications, diabe or heart disease, re daily living, demen The CAA indicated completed to avoid	ility, cognitive loss, poor tianxiety and narcotic tes, chronic or end stage liver ecent decline in activities of tia, terminal illness and pain. care planning would be					
	predicting pressure indicated she had pressure ulcer dev moist-skin is occase extra linen change chair fast-ability to non-existent, cann must be assisted in mobility slightly lim slight changes in bindependently, nut	le assessment form for e sore risk" dated 3/3/312 the following risk factors for elopment: "occasionally sionally moist, requiring an approximately once per day. walk severely limited or ot bear own weight and/or into chair or wheel chair. ited makes frequent though ody or extremity position rition probably inadequateand potential- moves feebly or				:	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPI	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		245018	B. WIN			05/0	2/2012 · ·
	ROVIDER OR SUPPLIER		<u>!</u>	44	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421	EAST	1917 1916 1917 1917
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 276	requires minimum skin probably slide sheets, chairocc	age 99 assistance. During a move s to some extent against asionally slides down." This y a licensed practical nurse	F:	276			:07
	R16's "Crest View comprehensive ev dated 4/21/12 cher R16: scored 3 or bowel, incontinent risk for shear and assist with ADL's (pain. Included on risk factors and int "decreased mobili incont of bladder. red bottom-intact-hours." On the ba "admission/MDS & 4/21/12, this includer and wrote "red" near the comprehension of the ball and wrote "red" near the comprehension of the ball and wrote "red" near the comprehension of the ball and wrote "red" near the comprehension of the comprehension	Lutheran Home aluation of skin risk factors" ck list items were checked for ower in moisture, incontinent of of bladder, nationally at risk, at friction, cognitively impaired, activities of daily living), and this form was a "analysis of terventions" which included ty, impaired cognition and Receives keefor ointment to turned and toileted every 2 tok side of this form included body audit" and was dated ded a drawing of a body and on circled the area of the coccyx ext to it. This area was not dif it was a pressure ulcer.					1.0012 1.
	12/13/11, 3/3/12 a what risk factors is and failed to incluability to endure the adverse effects. If failed to identify if was a pressure ull R16's treatment re 2011 through May prevent pressure	performed by the facility and 4/21/12 failed to identify R16 had that could be modified de an evaluation of R16's skins the effects of pressure without Further, the 4/21/12 assessment the red area on R16's coccyx cer and/or the cause. Becord for each month December of 2012 included "Wound care: ulcers, turning and repositioning and as needed tissue					

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION	(X3) DATE S	URVEY
		245018	B. WING		05/0	2/2012
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		17.5
CREST V	IEW LUTHERAN HO	ME		4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	THEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 276	"Keegans cream-aperi-area q (every substitution of the control of	ncluded staring 12/1/11 was oply to red area on coccyx and shift) and prn (as needed)." 8:00 a.m. on 4/24/12 NA-I aware if R16 should be loaded at any time intervals. Il often say when she needs to has bad days when she doesn't and staff will assist her to bed if the LPN-A at 12:00 p.m. on on aware if R16 was on any cositioning; she thought it huple hours or so. She stated ould assist R16 with rected on their worksheets. In R16 ever had a reddened she gets the Keegens cream at 12:03 p.m. on 4/24/12 NA-C hally say when she needs to lie in has days where she can't	F 276			
·	During interview at nurse (MDS)-F sta done quarterly or a in determining pos unable to find any been admitted to the During interview at coordinator (MDS) does an admission	ng cognition status. 3:00 p.m. on 4/26/12 the MDS ated a tissue tolerance test is annually by the facility to assist itioning needs. She was testing done since R16 had he facility. 1:10:00 a.m. on 4/27/12 MDS -E stated the facility normally and annual tissue tolerance sident. She was unable to				

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During interview at 2:45 p.m. on 5/1/12=nurse supervisor (NS)-A stated R16 never had a pressure ulcer and thought the red area on her coccyx on the 4/21/12 assessment may have been a rash. She had not assessed this area after it was documented on 4/21/12. When NS-A reviewed R16's plan of care she stated R16 should be repositioned every 2 hours, when reviewing the treatment record, she stated "every 1-2 hours to prevent pressure ulcers." She was not sure why the treatment record indicated R16 had a "red area on coccyx," and indicated she did not recall R16 ever having a pressure ulcer. A "Crest View Lutheran Home turning and repositioning observation" with tissue tolerance testing dated 5/2/11 was provided after the survey. "Crest View Lutheran Home Skin and pressure ulcer policy and procedure" dated 2/08 included: under "procedures" "tissue tolerance-admit, re-admit, significant change, and annually." Under "prevention of skin breakdown" included B.3 "frequency of position changes is titrated for the individual resident." Even though the facility assessed R16 as being at risk for pressure ulcers, the facility falled to	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	JITIPLE CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME CAUSID (EACH DEPICE PROTECTION IN THE PRICE DEPOSITION OF PROPERTY AND PROPERTY			245018			05/0	2/2012
F276 Continued From page 101 locate any testing for R16. During interview at 2:45 p.m. on 5/1/12-nurse supervisor (NS)-A stated R16 never had a pressure ulcer and thought the red area on her coocyx on the 4/21/12 assessment may have been a rash. She had not assessed this area after it was documented on 4/21/12. When NS-A reviewed R16's plan of care she stated R16 should be repositioned every 2 hours, when reviewing the treatment record, she stated "every 1-2 hours to prevent pressure ulcers," She was not sure why the treatment record indicated R16 had a "red area on occcyx," and indicated she did not recall R16 ever hawing a pressure ulcer. A "Crest View Lutheran Home turning and repositioning observation" with tissue tolerance testing dated 5/2/11 was provided after the survey. "Crest View Lutheran Home Skin and pressure ulcer policy and procedure" dated 2/208 included: under "procedures" "lissue tolerance-admit, re-admit, significant change, and annually." Under "prevention of skin breakdown" included B.3 "frequency of position changes is titrated for the individual resident." Even though the facility assessed R16 as being at risk for pressure ulcers, the facility falled to ensure R16 had an individualized comprehensive assessment to include tissue tolerance testing, and failed to indicate what risk factors could be modified to assist in prevention of pressure ulcers.				1	4444 RESERVOIR BOULEVAR	IP CODE D NORTHEAST	
locate any testing for R16. During interview at 2:45 p.m. on 5/1/12 nurse supervisor (NS)-A stated R16 never had a pressure ulcer and thought the red area on her coccyx on the 4/2/1/2 assessment may have been a rash. She had not assessed this area after it was documented on 4/2/1/12. When NS-A reviewed R16's plan of care she stated R16 should be repositioned every 2 hours, when reviewing the treatment record indicated R16 had a "red area on coccyx," and indicated R16 had a "red area on coccyx," and indicated R16 had a "red area on coccyx," and indicated she did not recall R16 ever having a pressure ulcer. A "Crest View Lutheran Home turning and repositioning observation" with tissue tolerance testing dated 5/2/11 was provided after the survey. "Crest View Lutheran Home Skin and pressure ulcer policy and procedure" dated 2/08 included: under "procedures" "lissue tolerance-admit, re-admit, significant change, and annually." Under "prevention of skin breakdown" included B.3 "frequency of position changes is titrated for the individual resident." Even though the facility assessed R16 as being at risk for pressure ulcers, the facility failed to ensure R16 had an individualized comprehensive assessment to include tissue tolerance testing, and failed to indicate what risk factors could be modified to assist in prevention of pressure ulcers.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETION
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		supervisor (NS)-A pressure ulcer and coccyx on the 4/2 been a rash. She after it was docum reviewed R16's plus should be repositive reviewing the treative wing the treative will be treative with the treative will be tre	distated R16 never had a distance of thought the red area on her 1/12 assessment may have had not assessed this area hented on 4/21/12. When NS-A an of care she stated R16 oned every 2 hours, when timent record, she stated "every ent pressure ulcers." She was reatment record indicated R16 in coccyx," and indicated she did er having a pressure ulcer. Theran Home turning and ervation" with tissue tolerance 11 was provided after the eran Home Skin and pressure rocedure" dated 2/08 included: still still still be read annually." In of skin breakdown" included position changes is titrated for dent." Tacility assessed R16 as being at alcers, the facility failed to an individualized comprehensive clude tissue tolerance testing, that what risk factors could be an in prevention of pressure				2012 C.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLET	
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		245018	B. WING 05/02				/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278 SS=E	The assessment m	ESSMENT RDINATION/CERTIFIED Just accurately reflect the	F	278	F278 Accuracy of Assessmen It is the policy of Crest View Home to ensure that the ass	Lutheran	
	A registered nurse each assessment of participation of hea				accurately reflect the resider status. For Resident(s) R161, R168,	nt's	1.02 B
	A registered nurse must sign and certify that the assessment is completed.				R15, R6, R40, and R60 a new assessment was completed to cognition, mood, and behavior	for	
		o completes a portion of the sign and certify the accuracy of assessment.			R95 a new assessment was completed for fall risk. Corresponding updates have		
	willfully and knowing false statement in subject to a civil me	and Medicaid, an individual who wingly certifies a material and in a resident assessment is money penalty of not more than			made to the care plan, care assignment sheets, and communicated to the reside	nt	1.50
	\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.				and/or designated decision of Education will be provided for members regarding cognition behavior care, and fall risk by 06/11/12.	or staff n, mood,	
	Clinical disagreem material and false	ent does not constitute a statement.			Resident R16 expired on 05/ For other residents who may	y be	
	by: Based on intervie failed to ensure a cutilizing the resider	NT is not met as evidenced we and record review the facility comprehensive assessment in assessment instrument was me of the quarterly or annual lude cognitive and mood and			affected by this practice, an cognition, mood, behavior, a will be completed by 06/11/this review, system revisions staff education will be imple if indicated by 06/11/12.	and falls 12. Upon and/or	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	IULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. Wil	NG	· · · · · · · · · · · · · · · · · · ·	05/02	2/2012
	E OF PROVIDER OR SUPPLIER EST VIEW LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421						
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ix [PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Continued From pa	From page 103 patterns for 8 of 41 residents (R161,		278	The policy for assessment co	mpletion	
1 210	'			1 210	will be reviewed and revised	by the	
		R15, R6, R40, and R60)			interdisciplinary team by 06/	11/12. A	
	-reviewed for asses	sment completion			review of policies by the Me	dical	
	Furthermore the as	ssessment-did-not-accurately	, ,		Director will be completed to	o-ensure-	
reflect fall status for identified falls.		or 1 of 3 residents (R95) with			current standards of practice	e are in	
	lucitilled falls.				place. Staff members will be	trained	-7 -3712
Fi	Findings included:				as it relates to their respecti		1 1 1 1
P161's augretarh		inimum data aat (MDS) with			and responsibilities regardin		기사이관점
•	an assessment ref	ninimum data set (MDS) with erence date (ARD) of 3/29/12			cognition, mood, behavior c		
	was signed as con	as signed as completed by the registered nurse,			fall risk by 06/11/12.		
		RN)-E on 4/13/12. The MDS			Audits on cognition, mood,	hehavior	
		e patterns and mental status) 00, C0200, C0600, C0700,			care and fall risk will be con		1
	C0800. through C	1000 were not assessed.			weekly for 4 weeks, monthl		
	Section D (residen	t mood assessment) identified			months, then according to		· .
		300, D0350, D0500, D0600,			quality control schedule to		
		ot completed for R161 and sessed" by the facility.			compliance with results rep		
	marked as moreas	by the identy.			the CQI Committee for revi		
					further recommendations.		
	R168's quarterly M	1DS with an ARD of 1/7/12 was			system revision and staff ed		
	signed by Kin-E or	n 1/21/12 verifying assessment MDS section C (cognitive					
		al status) identified that C0100,			will be provided if indicated	ı by	
		700, C0800, through C1000			audits.		
	were not assessed	d. Section D (resident mood ified D0100, D0200, D0300,			The Division of Nursing or	docionao	, - ,-
	D0350 D0500 D0	0600, and D0650 were not	}		The Director of Nursing or		
	completed for R16	88 and marked as			will be responsible for com	hiialice.	12
	"not-assessed" by	the facility.			Data of Commentions OC/22	112	
	R163's quarterly M	IDS with an ARD of 2/16/12			Date of Correction: 06/11/	77	
	was signed by RN	-E on 2/29/12 verifying					
	assessment comp	letion. The MDS section C					.
		and mental status) identified					
	that C0100, C0200	D, C0600, C0700, C0800,			+		

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WI			05/0:	2/2012
	ROVIDER OR SUPPLIER		1	44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421		1.95
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
(resident mood ass D0200; D0300, D0 D0650 were not co		re not assessed. Section D sessment) identified D0100, 350, D0500, D0600, and	F	278			M N 167
-	D0650 were not completed-for-R163 and marked as "not-assessed" by the facility. R16's quarterly MDS with an ARD of 3/10/12 was signed by RN-E on 3/26/12 verifying assessment completion. The MDS section C (cognitive patterns and mental status) identified that C0100, C0200, C0600, C0700, C0800, through C1000 were not assessed. Section D (resident mood assessment) identified D0100, D0200, D0300, D0350, D0500, D0600, and D0650 were not completed for R16 and marked as "not-assessed" by the facility.						CONTRACTOR OF THE PROPERTY OF
· .	signed by RN-E on completion. The M patterns and ments C0200, C0600, C0 were not assessed assessment) ident D0350, D0500, D0	OS with an ARD of 2/24/12 was 3/9/12 verifying assessment 1/1DS section C (cognitive al status) identified that C0100, 700, C0800, through C1000 l. Section D (resident mood iffed D0100, D0200, D0300, 600, and D0650 were not and marked as "not-assessed"					3 152
:	signed by RN-E or completion. The M patterns and ment C0200, C0600, C0 were not assessed assessment) ident D0350, D0500, D0	with an ARD of 1/7/12 was 1/21/12 verifying assessment IDS section C (cognitive al status) identified that C0100, 1/700, C0800, through C1000 I. Section D (resident mood ified D0100, D0200, D0300, 1/600, and D0650 were not and marked as "not-assessed"					

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		245018	B. WING		05/02	/2012
	ROVIDER OR SUPPLIER	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	signed by RN-E-on completion. The M patterns and ments C0200, C0600, C0 were not assessed assessment) ident D0350, D0500, D0 completed for R40 "not-assessed" by R60's quarterly ME signed by RN-E or completion. The M patterns and ment C0200, C0600, C0 were not assessed assessment) ident D0350, D0500, D0 completed for R60 "not-assessed" by R95 had a fall that on his MDS.	OS with an ARD of 1/7/12 was 1/21/12-verifying assessment IDS section C (cognitive al status) identified that C0100, 700, C0800, through C1000 I. Section D (resident mood ified D0100, D0200, D0300, 600, and D0650 were not and were marked as the facility. OS with an ARD of 4/4/12 was 1/4/18/12 verifying assessment I/IDS section C (cognitive al status) identified that C0100, 1/700, C0800, through C1000 I. Section D (resident mood ified D0100, D0200, D0300, 1/200, and D0650 were not 0 and were marked as the facility. It was not accurately assessed as that included hypertension.	F 278			1 10 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	independent with the MDS also did not admission or the pure when reviewed, a	S dated 9/7/11 indicated he was transfers and mobility. The indicate he had any falls since prior assessment. I form titled "Resident Incident 10/11, revealed that R95 had				33 (15) 18 18 (16) 18 (15) 19 (15)
	fallen in his bathro					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IG	COMPLE	
		245018	B. Wil	NG _		05/0	2/2012
	ROVIDER OR SUPPLIER TIEW LUTHERAN HO	ME		4	REET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	IEAST	10 10 17 10 17 13 10 17 10 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 278		his last quarterly MDS was she should have coded the	F	278			
	R161, R168, R163 and R95 MDS. Th stated the social se responsible for sec MDS. At 9:30 a.m. D had not been co and indicated she	on 4/24/12 at 8:30 a.m., about, R16, R15, R6, R40, R60, e MDS coordinator RN-E ervice department was stions C, D, E and Q on the RN-E verified sections C and impleted for these residents does not go back and check to worker codes the sections as					12002 112002 122000 1220000 1220000 1220000 1220000 1220000 1220000 1220000 1220000 1220000 1220000 12200 1220000 122000 122000 122000 122000 122000 122000 122000 122000 1220000 122000 122000 122000 122000 122000 122000 122000 122000 1220000 122000 122000 122000 122000 122000 122000 122000 122000 1220000 120000 120000 120000 120000 120000 120000 120000 120000 1200
	social service direct an area she can mand she does this complete the MDS for coding. She has residents for cognitindicators as required training on how to	on 4/27/12 at 10:15 a.m., the ctor (SS)-A stated the MDS has ark areas as "not-assessed" if she does not have time to or can not find the information ad not assessed these tive pattens or for mood red. She had not received any complete the MDS or what is apprehensive or quarterly idents.					
٠	Minnesota Departr submission coordi placed a dash in th	on 4/30/12 at 12:00 p.m., the ment of Health's MDS hator verified the facility had nese areas for these residents indicated the area was not mation.					Sind Sind Sind Sind Sind Sind Sind Sind
	, 	ž.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		245018	B. WIN	iG_		05/02	/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST	3 % **** - 13 ** - 15 ***
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	The facility failed to R161, R168, R163 -R158 and R95 wer include the residen	ensure the assessments for R16, R15, R6, R40, R60, e correctly documented to———t's medical, functional and	F :	278			. 0.1 61 182
F 279 SS=D	maintain or improve abilities, and psych facility failed to ens	k)(1) DEVELOP	F;	279	F279 Comprehensive Care P	lan <u>s</u>	. Azmy 19 101
	to develop, review comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, a needs that are idented assessment. The care plan must to be furnished to a highest practicable psychosocial well-to \$483.25; and any see the required under the due to the residente.	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial atified in the comprehensive that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment			It is the policy of Crest View Home to utilize the results of assessment to develop, revier revise the resident's compreplan of care. For Resident(s) R98 and R29 plan was reviewed and revise Corresponding updates have made to care assignment show communicated to the reside and/or designated decision in Safety checks were initiated notification from the survey Safety checks are reviewed a meetings daily. The primary was informed and a review of current physician orders was	f the ew and hensive the care ed. e been eets and nt maker. upon team. at IDT physician of the	Company (Company) (Company
•	by:	NT is not met as evidenced wand document review, the			completed. Education will be provided for staff members	e	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		245018	B. WING_		05/02/2012	
*** ****	ROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CONTRACTORY)	D BE COMPLETION	
F 279	facility failed to ensign R160, and R29) waggression towards interventions included care to ensure their vulnerable adults in Findings Include: R98 diagnoses incomplete disturbance, alterest brain injury. R98's (MDS) dated 2-11-moderate cognitive in walking around in physical behavior to kicking, pushing, or day assessment provided in injury to the resident had physical various residents of 10-14-11, 12-17-1 resulted in injury to Review of R98's problem of R98	sure 3 of 3 residents (R98, those behaviors and known so other-residents, had————————————————————————————————————	F 279	comprehensive care planning 06/11/12. Resident R160 discharged on 04/20/12. For other residents who may be affected by this practice, an accare plans will be completed by 06/11/12. Upon this review, or plan revisions and/or staff educed will be implemented if indicate 06/11/12. The policy for comprehensive plans will be reviewed and reverthe interdisciplinary team by 06/11/12. A review of policies Medical Director will be computed to ensure current standards or practice are in place. Staff me will be trained as it relates to the respective roles and responsible regarding the comprehensive planning policy and procedure 06/11/12.	care vised by the leted f mbers cheir vilities care	
1	12-5-11- R98 had "ongoing aggressive behavior/		I	1		

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OLIVILI	to r oit medicinte	S	AND THE TIPLE CONCEDITION (Y2) DATE CUPIES		NEL BATE GUELEN
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245018	B. WING _		05/02/2012
	ROVIDER OR SUPPLIER	ME	4	REET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	IEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
F 279	verbalization continuity plan was "staff are around-provision of approach from from objective, assess in 12-19-12- R98 was management issue and physically aggreplan was "Staff are protocol closely with and physical aggredistance, reading a the front, make eye announce what you a safe distance from a safe distance from a checklist including cognitive status, as may contribute to cresident of daily row frustration, remind throughout the day allow for choices the fluid intake, and perfocus area of the paggression with the other residents as included those lists with social worker.	re advised to follow protocol feare to dementia patients (exit, use names) state your mood, if irritable, reproach, etc." sidentified as having "anger escapable of growing verbally ressive quickly." The treatment advised to follow safety h (R98) with his risk of verbal ssion (ex- keep a safe gitation, approach him from e contact, use names, and a are there to do). Keep him at mother residents when dated 2-13-12 indicated the vioral symptoms of altercations s. The approach's consisted of g observe for changes in sesss for medical reason that changes in mentation, informutine, validate feelings of and re-orientate as needed y use simple communication, moughout the day, encourage sychology consult. Another alan of care included physical erisk level of altercations with "low" risk. The approach's ed above, as well as 1 to 1's for support and validation, and	F 279	Care plan audits will be comweekly for 4 weeks, monthly months, then according to control-schedule to ensure compliance with results repithe CQI Committee for reviet further recommendations. System revision and staff edwill be provided if indicated audits. The Director of Nursing or comill be responsible for committee for	y for 3 quality orted to ew and Further ducation I by designee pliance.
	persistent and/ or i	room or private area for nappropriate behaviors.			
	Although the facilit	y identified R98 had a history			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
B + Per		245018	B. WING		05/0	2/2012	
	ROVIDER OR SUPPLIER	ME		TREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	of resident altercation interventions to profrom confrontation was no indication to R98's care plan. During interview or Director of nursing and sits out in the time. She verified	ions, there were no specific beect R98 or other residents in the care plan.—Also, there—he facility was following or had endations of the psychologist for his explosive behaviors. 1.4-25-12 at 11:15 a.m. the (DON) stated R98 is pleasant main dayroom almost all the R98's plan of care did not erventions to prevent further	F 279	Э		: 14.2	
	with other resident	known physical aggression s, the plan of care did not ntions or triggers staff should				Table Ship	
	triggers related to behaviors and resi R160 diagnoses in anxiety disorder, d gait instability, and quarterly MDS date had moderate cog	re lacked interventions and the previous history of dent to resident altercations. Included manic depression, ependent personality disorder, history of a stroke. R160 and 1-3-12 identified the resident nitive impairment, was any around the facility, and had		-			
	verbal behaviors to threatening, screar days in the 7 day a Review of R160's identified R160 ha altercation with R9	owards others such as ming, or cursing at others 1-3 assessment period. integrated progress notes d a resident to resident 1-8 on 10-14-11. A note on "Resident (R98) pushed (R160)					

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLE	1ED
		245018	B. WING			05/0	2/2012
	ROVIDER OR SUPPLIER /IEW LUTHERAN HO!	ИЕ	S	4444 R	ADDRESS, CITY, STATE, ZIP CODE ESERVOIR BOULEVARD NORTHE MBIA HEIGHTS, MN 55421	AST	. 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	to ground, resident complained of hip p the hospital with a f	fell on right side, (R160) pain." R160 was later sent to ractured right femur.	F 27		•		1.41.583
	resident had major personality disorder previous psychiatric approach's included mood or behavior (a that behavior was), feelings, provide sa and others (it did not psychology consult care did not identify regarding resident to	dated 4-3-12 identified the depression, anxiety, to bipolar, and had a history of thospital stays. The disto observe for changes in although it did not identify what offer support, validate fe environment for resident of clarify what that meant), and if needed. R160's plan of monitoring R160's behaviors to resident altercations or e R160 and R98 were not in					7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.
	DON stated R160 h R98 in the past. Sh people out" to "get "intrusive." Althoug had these behavior these were listed or	4-25-12 at 11:15 a.m. the had "several" altercations with he stated R160 will "seek to them" and R160 can be with the facility was aware R160 s, the DON verified non of the residents plan of care.					6.3
	R29 had diagnoses defiance disorder, r brain syndrome. Th 3/21/12, indicated t intact and he demo behaviors towards	s not developed to address his other residents in the facility. which included: oppositional mood disorder, and organic the quarterly MDS dated the resident's cognition was instrated verbal and physical others such as: hitting, kicking, threatening, screaming and					1.194.5

(X2) MULTIPLE CONSTRUCTION

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	LDING		COMPLE	
		245018	B. Wii	VG		05/0	2/2012
- "	ROVIDER OR SUPPLIER			44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTI OLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	6/22/11-indicated-had a pattern and nature. It noted R needed to be toile waited on for mea CAA noted he like became aggressive followed, and a re was warranted. When reviewed, the second of the like became aggressive at the like became aggressive acts to 2/3/12, 3/12/12 ar squeezed, punche when they were in	sessment (CAA) completed on R29's behavioral-disturbances offensive or defensive in 29 would get upset when he ted, or when he wanted to be als and medication passes. The dot follow a routine and we when a routine was not ferral to the house psychologist the psychology progress note for a few days ago. The dot follow a routine was not ferral to the house psychologist the psychology progress note for a few days ago. This was to position him facing dof people, and place in a seasy access to leave and go are an another resident and the care for the following season and 3/30/12 in which he either fed, or pinched other residents in his way.	F	279			0.00 (2002) 0.00 (
	period of 1/3/12 to the resident's agg time period. The r conference, and t making threats to their help. The no been any discuss fellow residents.	ence Summary note for the time of 4/24/12 lacked any mention of ressive behaviors during that note indicated R29 attended the he staff talked to him about not the staff while he waited for ted did not indicate there had ion about his aggression to dent's current plan of care was					
		and a series of the series (1990)					1.77

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	OF DESIGNATION AND		(Y2) 1/	illi Tic	PLE CONSTRUCTION	(X3) DATE SU	IRVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI			COMPLE	
		245018	B. WI	1G		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	resident had a histo- staff-and-grabbed s plan was not devel- aggressive acts to	ige 113 ility on 4/25/12, and noted the ory of aggression and yelled at staff-inappropriately. The care-oped to-include his history of vards other residents inspite of story of such actions.	F:	279			
F 280 SS=D	facility social worked psychology case look existing care pland signs to look for an for his aggressive residents. She state impatient, and was 483.20(d)(3), 483.		F	280	F280 Comprehensive Care Pl (Timeliness)	ans	11/2012 A MACOVED CO.12-0391 A MACOVED A MACOV
	incompetent or oth incapacitated under participate in plant changes in care at A comprehensive within 7 days after comprehensive as interdisciplinary temphysician, a register for the resident, and disciplines as determed and, to the extent the resident, the relegal representative	er the laws of the State, to aing care and treatment or and treatment. care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in rmined by the resident's needs, practicable, the participation of esident's family or the resident's e; and periodically reviewed eam of qualified persons after			It is the policy of Crest View I Home to develop a comprehe care plan within seven days a completion of the comprehe assessment. For Resident(s) R95 his fall riplan and for R165 his behaviplan will be reviewed and rethe interdisciplinary team by 06/11/12. Corresponding up have been made to care assis sheets and communicated to resident and/or designated of maker. The primary physicial informed of results and a rev	ensive after the nsive sk care or care vised by dates gnment o the decision in was	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		245018	B. WIN	1G		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280			F:	280	the current physician orders completed. Education will be provided for staff members r care plan revision by 06/11/1	egarding	426.
	by: Based on observa review the facility for was revised for 1 or interventions regar residents (R165) which behaviors during of Findings include. R95 had diagnosis lower back pain. For updated on 2/24/12 impairment, cardia use. Staff were diagnosis to the diagnosis lower back pain. For updated on 2/24/12 impairment, cardia use. Staff were diagnosis free environment, lassist with activitie need and per requigait, balance, judg strength. Notify Miside rails, ensure pare locked on bed transfers, keep eye occurs, and follow Review of the door Report dated 8/10 fallen in his bathro document titled "In Prevent Reoccurre instructed to ask for referral had been in The document also	of hypertension, leg pain and R95 's current plan of care 2 indicated he had balance c disease, pain and narcotic rected to: maintain a clutter keep call light within reach, s of daily living per resident est, observe for changes in ment, coordination and 0, family and physical therapy, proper footwear, ensure brakes and wheelchair during ewear within reach, if fall			For other residents who may affected by this practice, an a care plans will be completed 06/11/12. Upon this review, plan revisions and/or staff edwill be implemented if indica 06/11/12. The policy for comprehensive plans will be reviewed and rethe interdisciplinary team by 06/11/12. A review of policic Medical Director will be comto ensure current standards practice are in place. Staff mill be trained as it relates to respective roles and respons regarding comprehensive carplanning by 06/11/12.	be audit of by care lucation ted by e care evised by es by the pleted of embers o their ibilities	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WI	NG_		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	····	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	Review of the docu Report dated 3/17/- forward-onto-the flot the right-side-of-his the document titled Prevent Reoccurre resident from falling Review of the curre not identify either of 8/10/11 incident re evaluate R95 nor v 3/17/12 incident re falling asleep while to the list of interve care plan. During interview at Director of Nursing interventions should care plan.	Iment titled Resident Incident 12, revealed that R95 fell for out of his wheelchair hitting head. Under the section of "Immediate Action Taken to nce" indicated discourage g asleep in his wheelchair. ent falls care plan 2-24-12 did of the interventions from the port for occupational therapy to vas the intervention from port to discourage R95 from in his wheelchair were added entions to prevent falls in the 1:15p.m. on 4/27/12, the (DON) verified that the fall id have been added to R95's	F:	280	Care plan audits will be com weekly for 4 weeks, monthly months, then according the control schedule to ensure compliance with results reported the CQI Committee for revies further recommendations. It system revision and staff edwill be provided if indicated. The Director of Nursing or dwill be responsible for composite of Correction: 06/11/1	for 3 quality orted to w and Further ucation by audit. esignee	24
-	depression and ex room. The facility	es that included dementia, hibited behaviors in the dining failed to revise R165 plan of aff on how to intervene with					
,	3/15/12 indicated sinattention, and dis no hallucinations, symptoms not diredid not significantly environment. She	minimum data set (MDS) dated severe cognitive deficit, sorganized thinking. She had but had other behavior cted toward others. Behaviors a disrupt care or living required total staff assistance attensive assistance with all					

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	: & MFDICAID SERVICES			ONID NO. 0000-000
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	B, WII	NG	05/02/2012
NAME OF BROVIDED OR SURPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•

NAME OF PROVIDER OR SUPPLIER

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

CKEST	ALTA FOLIERWIA LIQUIC		COLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 116 activities of daily living (ADL's) except could feed self with set up. Care area assessments (CAA's) dated 3/15/12 indicated she had delirium possibly due to urinary tract infection and "resident will yell out at staff at times." No referrals had been made, but decision to proceed to care plan was indicated. R165's plan of care last updated 4/5/12 identified "actual alteration in mood R/T (related to) cognitive impairment, depression, insomnia, hx (history) psychosis, flat affect and hx psych hosp." Approaches included items on a check list including "Observe for changes in mood/and or behavior. Encourage resident to express feelings, frustrations or concerns. Offer support,	F 28		
	reassurance and encouragement as needed and indicated. Offer 1:1 with staff or family as needed. Validate feelings. Involve spiritual care as needed. Encourage socialization and leisure activities. Provide safe environment for resident and others. Administer medications as ordered, antidepressant, antipathetic. Psychology consult if indicated. AIMS (abnormal involuntary movement scale) per protocol. Orthostatic blood pressure every month. Monitor sleep pattern x 3 nights every month."			
	A review of R165's progress notes from 3/12/12 to 4/30/12 indicated R165 would often become agitated, yell out at others, and disrupt dining.			2002 2009 2009 2009 2009
	During interview with licensed practical nurse (LPN)-I at 2:59 p.m. on 4/30/12 she stated some times it helps R165 to whisper to her to get her to	·		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETI	
		245018	B. WI	IG		05/02/	2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 287 SS=B	loudly again. She interventions that he interventions that he with her distress with decrease this distributed in the with her distress with decrease this distributed in the with her distress with a sum of care failed staff to follow wher facility was not mousual behavior mogeneric intervention. Even though R165 of yelling out and of care failed to ide direct staff on how distress. 483.20(f) ENCODI RESIDENT ASSE (1) Encoding Data completes a residemust encode the fresident in the fact (i) Admission assection (ii) Annual assessiciii) Significant characteristic (v) A subset of iter reentry, discharge	soon as stop, R165 will yell was not aware of any and been placed to assist R165-hen she is yelling or to aption to others. Ith nurse supervisor (NS)-A at 12 she acknowledged R165's to include any interventions to a R165 yells out. Further, the nitoring this behavior on their nitoring sheets that has some ans listed on it. I started displaying the behavior disrupting others, R165's plan entify this behavior and failed to to intervene to assist with her ING/TRANSMITTING SSMENT Within 7 days after a facility ent's assessment, a facility collowing information for each ility: essment. I ment updates. Inge in status assessments. I was assessments.		280	F287 Automated Data Proce Requirement It is the policy of Crest View Home to encode resident days after completing a reassessment for admission assessment, annual assessment updates, significant change assessments, quarterly reviews assessments, a subset of ite a resident's transfer, reentredischarge, and death; and background information if the service of the se	Lutheran ata within esident nent in status ew ems upon y,	1. (160) 2. (16
	(2) Transmitting d	ata. Within 7 days after a facility			admission assessment.		2.2.2 (1.2.2) 2

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING B. WING	<u> </u>	
		245018	D. WING _		05/02/2012
· · · · · · · · · · · · · · · · · · ·	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME	4	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	EAST
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 287	must be capable of System information the MDS in a format record layouts and passes standardize the State. (3) Transmittal req a facility completes facility must electroaccurate, and com System, including (i) Admission asse (ii) Annual assessi (iii) Significant con (v) Significant con (v) Significant corrassessment. (vi) Quarterly revied (vii) A subset of ite reentry, discharge (viii) Background (initial transmission does not have an incomplete the format specified by CMS. This REQUIREME	ent's assessment, a facility of transmitting to the CMS of for each resident contained in at that conforms to standard data dictionaries, and that ed edits defined by CMS and uirements. Within 14 days after a resident's assessment, a polically transmit encoded, plete MDS data to the CMS the following: ssment. ment. ment. mege in status assessment. rection of prior full assessment. rection of prior quarterly w. ms upon a resident's transfer,	F 287	For all residents listed the RA documents were encoded an submitted as they were com A new Social Services Directed been hired and assessments up to date by 06/11/12. Corresponding updates have made to the RAI policies and procedures and communicate the interdisciplinary team. It will be provided for staff meregarding the RAI process an expectations for timely com 06/11/12. For other residents who man affected by this practice, an Casper/submission reports to complete by 06/11/12. Up review, departments responsany late or incomplete assess will be counseled. The policy for completing the process will be reviewed an by the interdisciplinary team 06/11/12. The submission will be reviewed weekly by	pleted. or has will be e been debeen deducation embers and pletion y be audit of will be bon this asible for ssments ne RAI d revised m by reports
	facility failed to co	ent review and interview, the mplete assessments timely, assessments timely, develop			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLE	
		245018	B. WI	۱G		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		4	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHI COLUMBIA HEIGHTS, MN 55421		V: 3:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 287	care plans timely, edata set (MDS) datedata set (MD	encode or transmit minimum a to the Center for (CMS) system timely for 139 messments reviewed between and April 30, 2012. multiple MDS's were pleted late and care plans were timely manner as identified by "MN (Minnesota) MDS 3.0 cs by facility" from 11/1/11 to e facility had submitted 708 and records to the CMS data "MN MDS 3.0 assessments showed the following facility between 11/1/11 to 4/30/12: The: care plan completed late: assessment the CAA (care process date is more than 13 te. 35 resident admission nitted by the facility were late in e area assessments.	F:	287	Administrator or designee to timeliness and accuracy. A repolicies by the Medical Direct be completed to ensure currestandards of practice are in Staff members will be trained relates to their respective repossibilities regarding the policies and procedures by Control Chart audits regarding RAI documents will be completed for 4 weeks, monthly for 3 of their according to the quality schedule to ensure compliance results reported to the CQI Committee for review and recommendations. Further revision and staff education provided if indicated by audition to the provided if indicated by audition to the complete for review and recommendations. Further revision and staff education provided if indicated by audition to the provided if indicated by audition to the complete for complete	eview of ctor will rent place. d as it oles and e RAI 06/11/12. ed weekly months, by control nce with further r system of will be dits. designee pliance.	100 ASU (5)
	for this admission a is more than 13 day	ac: assessment completed late assessment, completion date ys after entry date. 34 resident ments submitted by the facility te.			Date of corrections soft and		7557 777.57 777.57
		c: care plan completed late. completed more than 7 days					1.55

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTI	RUCTION	(X3) DATE S	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING		00////	
		245018	B. WING	9		05/0	02/2012
	ROVIDER OR SUPPLIER	ME		4444 RESER	ESS, CITY, STATE, ZIP COI RVOIR BOULEVARD NOI A HEIGHTS, MN 5542	RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF COR CH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 287		ature. This error was	F 2	87	-		·
	CAA signature date	b: care plan completed late: e is more than 14 days after ference date. This error was by the facility.					0 - V612
	late, assessment of	Pa: assessment completed completion date is more than 14 ment reference date. This error					10.0001
	submission date is	De: record submitted late. The more than 14 days after the a modified/inactivated record.	}				
	submission date is	Od: record submitted late. The smore than 14 days after the a new resident record. This mes.					
- - -	submission date is	Oc: record submitted late. The more than 14 days after prehensive assessments. This mes.					
	submission date is	0a: record submitted late. The smore than 14 days after y tracking records. This error	7				
	quarterly assessm	0: a comprehensive or nent was not completed within evious record. This error					
1				1			

· · : 1

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02/201	2
	ROVIDER OR SUPPLIER	ME		REET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	HEAST	*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	X5) LETION ATE
F 287	assessment had no	age 121 b: a comprehensive ot been completed within 366 us-record:—This-error-occurred	F 28	7		of 135
F 309 SS=D	During phone inter of nursing (DON) a stated the MDS received a stated the MDS received a stated the MDS received a coordinate are often held up to department being Error reports from herself and the ad. The facility failed to were performed as base within the received and plantime frames required 483.25 PROVIDE HIGHEST WELL I. Each resident must provide the necession of nursidents and plantime frames required to the state of th	o ensure the required MDS's and submitted to the CMS data quired time frame. Further, the sure assessment of the soft care were in place in the red. CARE/SERVICES FOR BEING St receive and the facility must sary care and services to attain	F 30	F309 Quality of Care It is the policy of Crest View Home to provide each resi		(1012) (1012) (1013) (1
	mental, and psych accordance with the and plan of care.	thest practicable physical, osocial well-being, in ne comprehensive assessment		necessary care and service or maintain the highest prophysical, mental, and psychological well-being, in accordance comprehensive assessment of care.	acticable hosocial with the	28 18 28 1

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL		LDIN	G	COMPLE	
		245018		√G_		05/02/2012	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			1.17
CREST VIEW LUTHERAN HOME				4444 RESERVOIR BOULEVARD NORTHEAST			-
01001 1121 2011210111				COLUMBIA HEIGHTS, MN 55421			•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
					For Resident R116 a referral v	vas	,
F 309	, •		F:	309	made to a pain clinic for her and she		. 1 19 352
		ion, interview and document			initially refused the appointm	ent. A	* ****
	review, the facility failed to provide the necessary care and services that addressed pain issues for				second offer of a pain clinic re	eferral _	· · · · · · · · · · · · · · · · · · ·
	1 of 4 residents (R116) who was not referred to a			will be given to R116 to see if			· · ·
	pain clinic when recommended, and for 1 of 2 residents (R165) who demonstrated maladaptive behaviors during dining.				now willing to attend the		, ,, , ,
					appointment. The primary care		
					physician/NP for R116 provided new		
	Findings include:				orders for assisting with pain		
					management. For R165 a new		: : : : : :
		6) had diagnoses which			assessment was completed for	or	
	included: chronic pain syndrome, lupus, and degenerative arthritis, opiate dependence and anxiety.				cognition, mood, and behavio	or.	
					Behavior logs and safety chec	cks were	;
	The average of the second	www.data.aat.aaaaamant			initiated for R165 to ensure h	ner	
	The quarterly minimum data set assessment (MDS) dated 1/2/12 noted R116 cognition was intact, and received scheduled pain medications.				safety and the safety of others. A		•
					calming plan was initiated for R165		
-		R116 rated her pain as			to assist with her behaviors.	:	,1 + 1 ₂₂ 1%
worst pain and 1 be		e of 8 out of 10 (10 being the			Corresponding updates have	been	
•	worst pain and 1 being mind pain).				made to care plans, care assi	gnment	e e e e e e e e e e e e e e e e e e e
,		essment (CAA) dated 4/12/12			sheets and communicated to	the	· .0152
	identified R116 had pain, and when interviewed, stated the pain was at a level 8 on a scale from 1				resident and/or designated o	lecision	~
	to 10. She identified				makers. The primary physicia	ans were	·
	experiencing was "	almost constantly" over the			informed of the assessment	results	
	last 5 days and that she limited her day to day activities due to the pain. The CAA noted that the pain adversely affected her mood as well.				and a review of the current p	-	. ,;;
					orders was completed. Educa	ation will	
	pail adversely alle	Sted Her HIOOG as Well.			be provided for staff membe	ers	1.2
	The plan of care dated 4/12/12 noted the resident had actual pain that caused her discomfort. It included a check list of pain relief interventions such as analgesics, diversion, activities, music therapy, warm blanket, repositioning etc.				regarding pain management	and	٠.۵
					behavior care by 06/11/12.		
					For other residents who may	/ be	
					affected by this practice, an	audit	
		•			regarding pain management	and	
•	vvnen interviewed (on 4/23/12 at 6:45 p.m., R116			behavior care will be comple		
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D1BX11 Fac 06/11/12. Upon thi						care	ge 123 of 162

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY	
		245018	B. WIN	lG		05/0	2/2012
	ROVIDER OR SUPPLIER		•	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- (PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F.309	Clinic to reduce hemedications and toping and pain it would likely mitigate pain was a significant environment. Shwith locomotion, activities of daily self with set up.	er dependency on pain o empower her with effective nanagement strategies. It noted gate her anxiety over time, as unificant culprit in her struggles note dated 4/12/11 indicated not been seen by the pain clinic nued to take Oxycontin twice. If on 5/1/12 at 3:15 p.m., the g (DON) not think R116 went to nich was the psychologist on 4-11-11, over one year agoualth information stated she had file for further information. Inable to provide evidence to not to the pain clinic to assist her anxiety and pain issues. If we we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we will not to the pain clinic to assist her anxiety and pain issues. If we we we we we we will not the pain clinic to assist her anxiety and pain issues. If we we we we we we we will not the pain clinic to assist her anxiety and pain issues. If we we we we we we we we we will not the pain clinic to assist her anxiety and pain issues. If we will not the pain clinic to assist her anxiety and pain issues. If we		309			
		pression. Care area AA's) dated 3/15/12 indicated					

	to roll medicing	1			VOLDATE OU	OVEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02	/2012
	PROVIDER OR SUPPLIER	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTI DLUMBIA HEIGHTS, MN 55421	HEAST	
						-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
						1
F 309	9 Continued From page 125 she had delirium possibly due to urinary tract infection and "resident will yell out at staff at		F 309			
		Is_had_been_made,_but_decision_				
		plan-was-indicated on this				·
	CAA.					***
	Dining was observ	ed in the Willow dining room				11,77032
	from 4:45 p.m. to	6:30 p.m. on 4/23/12. R165			į.	11 May 12 - 1
,		le with R40 to her left, R51 was	ľ			31.11
•		om her and R61 was at a table	1		}	
•	next to her. K100	started yelling when she ning room at 4:45 p.m. She			[
	was pointing and s	shaking her finger at R51			İ	
	across the table ar	nd screaming "get out of here,			ŀ	•
	get out of my hous	se before I call the police. Shut	1		-	
•	up, I said shut up."	' TMA-D told R165, "I will take			}	
		ked away. R165 continued to en directed it to R40 that "she	-			as to Ex france
		she has no right to be in here, I				
	think you better lea	ave." Then to R51 "You are as	1		ļ	1.4
	bad as your son, s	shut up, get her out of my house				ء . شپعد د جمع د د ر
		p and throw her out of my				1 . 15.
		en pounded her fist on the table			ļ	
	medications in the	D who was passing dining room again told R165 "I			j	
		er" and offered R165 a	•			
		oulled off her clothing protector,				
	while looking at R	51 but did not strike R51 with it.				
		R165 continued to yell at R51				:
		et out of here" very loudly "your				1441
		se yet, shut up, I don't even voice, get her out of here				17111
		R165 continued to scream at				1.0
		25 then came and sat down to				
	R165's right at 5:0	2 p.m. and R165 started				
	screaming at him	also. During the interaction of				
		at her table mates R51 did not				
	respond to R165 b	out continued to stare at her and				

D: 05/17/2012 M APPROVED O. 0938-0391

(X5) COMPLETION DATE

WHICH A W.	indephillerinessin value.	\$\$\$\$\$\$\$4\$*\$\$\$\$\$\$\$\$\$\$\$\$*************					
DEPART	TMENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED FORM OMB NO	APPRO
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLI	URVEY ETED
		245018	B. Wil	NG _		05/0	2/2012
	PROVIDER OR SUPPLIER	ME		4	REET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTI COLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPL DA
F 309	her face flushed. In her wheel chair R165. R125 did no straight ahead, ign nearby table started saying. Even thou Staff made no atternoom and removed which was just out in the day room with intermittent outbur scream sound and nurse can go to ja R165 then threate	age 126 R40 would wince and pull back with the loudest outbursts from of react to her and just stared oring her. R61 who was at a d to mimicked what R165 was gh there was staff in the room, mpted to intervene until 5:07 aide-Z came into the dining the R165 to the day room right, side the dining room. R165 sat thout any staff interaction with sts "ahhhh" made into a I "nurse, nurse, that damn if too," I want water, I said now." ned "I will throw this at you" water. There was no one was	F	309		-	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)

was taken out of the area.

R165 yelling behavior. She then was quiet with intermittent loud screechy screams until 5:36 p.m. when she was brought back into the dining room. Licensed Practical Nurse (LPN)-A was assisting R51 with eating, R165 had occasional outbursts, but fed self most of meal. Staff made no attempts to redirect R165 when she was screaming. At 5:50 p.m. R165 screamed very loud and R51 pulled away from the table with a startled look. At 6:10 p.m. TMA-D sat down next to R165 and assisted her with eating, between bites R165 yells out "help me, help me, help me, help me, I am choking." She quieted when fed bites of food. R165 continued to intermittently disrupt the dining room until 6:30 p.m. when she

There was no indication that R165 had any yelling behaviors prior to the 3-12-12 MDS assessment reference date. The facility integrated progress notes identified the following: 3/12/12 "Resident

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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WI	1G		05/	02/2012
	ROVIDER OR SUPPLIER	ME		444	ET ADDRESS, CITY, STATE, ZIP COE 4 RESERVOIR BOULEVARD NOF LUMBIA HEIGHTS, MN 5542	RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	She was redirectal 3/19/12 "Resident	ing dinner, yelling out for staff. ole if staff stayed near her." is very agitated on shift with	F	309			: 162
	hallucinations-that members and then father" 3/20/12 "	she is talking to family talks back to herself as her some agitation this a.m.,					
	yelling and swearing agitated and yelling home now! Were to go!" Res yelling at talking to people were assure research you!" Staff monito agitated on p.m. shand having convertoom. Resident can given some towels is aware of agitatic this shift. Yellowed room. Once put in	ng" 3/21/12 "Res (resident) g out in dining room. "Go hrough," "Lets go, lets go, lets to other residents and staff and who aren't there, attempts to t always successful, "no, not ring." 3/21/12 "Resident very hift, yelling out swear words sations with people not in the almed down a little bit when to fold. NP (nurse practitioner on." 3/24/12 "Resident agitated dour curse words in the dining hed resident quieted down 2 "NP called back and changed					(20.2 (20.2) (20
	the Risperdal (an a orderNP was not secure unit until fa Social services wh family and come u "Resident kept yell "Transferred from Willow (secured un "Resident was call disruptive to other "continued to call apparent reason. when redirected." screams" 4/6/12 Res talks to herse me, help me, "stop	antipsychotic medication) t ready to send resident to amily members were involved. To were going to contact the p with a plan." 3/27/12 ling this shift" 3/29/12 Linden station to room 49B- nit) station" 3/30/12 ling outshe was a little residents" 4/1/12 Il out "help help" for no yelling and screaming at times 4/5/12 "resident continuously 2 "res was yelling out this a.m. elf saying things such as "help p yelling,"they stole my her"Oh shut up"This					

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(X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02/2012		
	ROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	conversation went through out the a.r "residentscream 4/20/12"continu	on with herself off and on n. shift." 4/16/12 ing-and-talking to self" ed to scream "shut up" and	F	309			
	"help me" and whe here." and she wa voiceagitating of yelling intermittent would yell out, no tell herself to shut not help." 4/28/12 people who are no supper. Staff offe food and reassura 4/30/12 "While at yelling cont. (conti	en staff intervened"get out of s yelling at top of her her res" 4/28/12 "Res was ly all through out brunch. Res a word or phrase, just yell then upres given 1:1 but his did "Res was yelling and talking to ot there before, during and after red BRP (bathroom privileges), ince without any effect" brunch res was screaming, nuously) staff whispered while d res mirrored writer, this only					
	"actual alteration i cognitive impairme (history) psychosis hosp." Approache including "Observe behavior. Encour feelings, frustratio reassurance and indicated. Offer 1 needed. Validate as needed. Enco activities. Provide and others. Admi antidepressant, at if indicated. AIMS movement scale)	re last updated 4/5/12 identified in mood R/T (related to) ent, depression, insomnia, hx is, flat affect and hx psych es included items on a check list er for changes in mood/and or age resident to express in sor concerns. Offer support, encouragement as needed and 11 with staff or family as feelings. Involve spiritual care urage socialization and leisure er safe environment for resident inister medications as ordered, intipathetic. Psychology consult is (abnormal involuntary per protocol. Orthostatic blood onth. Monitor sleep pattern x 3 ith."					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/02/2	2012
	PLAN OF CORRECTION DENTIFICATION NUMBER: 245018 ME OF PROVIDER OR SUPPLIER REST VIEW LUTHERAN HOME (4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ME	STRE 44 CO	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE C	(X6) COMPLETION DATE
F 309	Continued From pa	age 129	F 309			2 602
	stated they just do when she gets like He was unable to i deal with R165's di	the best they can with R165 this which is most of the time. dentify a specific plan of how to				1.02012 1.02012 1.02012
•	practical nurse (LP helps to whisper to but as soon as you again. LPN-I was interventions to he	N)-I stated that at times it R165 to get her to talk quietly, I stop, R165 will yell loudly unaware of any specific Ip decrease R165 behaviors of		·		NEW YORK
	supervisor (NS)-A care failed to inclu- follow when R165 was no indication I being inappropriate	acknowledged R165's plan of de any interventions to staff to yells out. Furthermore, there R165's behaviors of yelling and e with other residents were				- 14-18/2
F 314 SS=D	out and disrupting not assessed, mor which intervention decrease or elimin 483.25(c) TREATI	others, R165's behavior was nitored or tracked to determine s needed to be implemented to late these behaviors.	F 314	F314 Pressure Sores	-	1. 1000 1. 1000 1. 1000 1. 1000
	resident, the facilit	prehensive assessment of a y must ensure that a resident cility without pressure sores		It is the policy of Crest View Home to ensure that based comprehensive assessment	on the	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING		J JOHN EE	
		245018	B. WING			05/02	/2012
	ROVIDER OR SUPPLIER	МЕ		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	does not develop p individual's clinical they were unavoidad pressure sores receservices to promote prevent new sores. This REQUIREMED by: Based on observative, the facility of (R16 and R100) received the care as prevent pressure under the comprehence of the	ressure sores unless the condition demonstrates that able; and a resident having gives necessary treatment and be healing, prevent infection and	F:	314	resident, a resident who entifacility without pressure sores the individual's clinical condition demonstrates that they were unavoidable; and a resident pressure sores receives nect treatment and services to phealing, prevent infection a prevent new sores from deventable. All staff members responsible prevention of pressure sore educated on the policies and procedures by 06/11/12. Resident R16 expired on 05 Resident R100 expired on 05 Resident R100 expired on 05 review of residents who may affected by this practice and review of residents at risk for breakdown will be completed 06/11/12. After review, up be made as appropriate.	res does unless lition re having essary romote nd veloping. ole for es will be d /27/12. esybe record for skin eed by	200.000 (200.000) (200.000
		e of her room. She was					, , , , , , , , , , , , , , , , , , , ,

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 $\varphi_{\mathbf{f}_{\mathbf{i}}} = \varphi_{\mathbf{f}_{\mathbf{i}}} + \varphi_{\mathbf{f}_{\mathbf$

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G	COMPLETED		
		245018	B. WING _		05/02/2012	. 11
	ROVIDER OR SUPPLIER	ME	4	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉT	TION :
F 314	observed sitting the	ige 131 ere until 8:05 p.m., from asked quietly multiple times to or to-go-to-bed. At-7:30 p.m.	F 314	& repositioning and preven pressure sores will be revie	tion of wed and	
3.	she had a strong fe p.m. nurse aide (N. bathroom, her pad soiled with loose st taken R16 to the batto supper. She sta repositioning plan,	ecal odor around her. At 8:05 A)-I assisted R16 to the was slightly wet and was ool. NA-I stated she had athroom last at 4:30 p.m. prior		revised by the interdisciplir by 06/11/12. A review of per the Medical Director will be completed to ensure curre standards of practice are in Staff members will be train relates to their respective r responsibilities regarding th	olicies by ent place. ed as it	93.0
	12:06 p.m. on 4/24 in her chair. R16 of 9:00 a.m. and then the chapel area an a.m. when she was and placed at a tab practical nurse (LP dining room prior to administered her not 11:40 a.m. R16 room table, she rel 11:40 a.m. when a from the table and shop. At 12:00 p.r not been repositions she would locate F	observation from 8:00 a.m. to /12 R16 was not repositioned was at breakfast from 8:00 - brought out to hall outside of d remained there until 10:20 brought to the dining room ole. At 10:30 a.m. licensed N)-A retrieved R16 from the other being served brunch and nedications to her at 10:37 a.m. was brought back to the dining mained in the dining room until family member removed her brought her to the beauty n. LPN-A was notified R16 had ned for 4 hours. LPN-A stated t16 and have her assisted to		responsibilities regarding the policies and practices by 06, Skin risk audits will be compweekly for4 weeks, monthly months, and then according quality control schedule to compliance. The results repthe CQI Committee for review further recommendation. Ureview, system revisions an education will be implement indicated. The Director of Nursing or compositions and control of the c	vileted vifor 3 vito the ensure orted to ew and Jpon this d/or staff ited if	
	had been brought gone at least 4 hot assisting her to the During continuous 9:00 a.m. on 4/2/1	I2:06 a.m. LPN-A stated R16 putside by family. R16 had urs and 6 minutes without staff bathroom. observation from 6:25 a.m. to 2, R16 was not repositioned. her back with the head of her		will be responsible for comp	oliance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1' '	ULTIPE LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WII	NG		05/0	2/2012
	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME		444	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	IORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5). COMPLETION DATE
F 314	bed slightly elevate assisted her with n This was 2 hours 3 was unusual for R on her back and b	ed until nurse aide (NA)-C norning cares at 9:00 a.m. 85 minutes: NA-C stated this 16 to sleep so late. R16's skin uttocks was observed to be	F 	314	·		я ей
	free from redness R16's care area as 12/13/11 indicated ulcers due to she " move sufficiently to site, confined to be persistently wet, es incontinence, wous immobility, incontin delirium limits mob nutrition, use of an medications, diabe or heart disease, r	at this time. ssessment (CAA) dated she was at risk for pressure frequires staff assistance to or relieve pressure over any one ed or chair all or most of time, specially from fecal and drainage of perspiration, anent, altered mental status, bility, cognitive loss, poor tianxiety and narcotic etes, chronic or end stage liver ecent decline in activities of					2012 2012 2016 2016 2016 2016 2016 2016
	The CAA indicated completed to avoid	tia, terminal illness and pain. I care planning would be I complications. ge "nutrition assessment form" licated R16's coccyx was red.		3000			
·	predicting pressur indicated she had pressure ulcer developments. It is occaextra linen change chair fast-ability to non-existent, can must e assisted in slightly limited machanges in body of	ale assessment form for e sore risk" dated 3/3/312 the following risk factors for velopment: "occasionally sionally moist, requiring an approximately once per day. walk severely limited or not bear own weight and/or to chair or wheel chair. mobility kes frequent though slight or extremity position trition probably inadequateand					

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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WII	1G		05/0	2/2012
	ROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	requires minimum a skin probably slides sheets, chairocca form was signed by	ge 133 otential- moves feebly or assistance. During a move to some extent against asionally slides down." This a licensed practical nurse	F:	314			. 1 6 162
.: `. .:	dated 4/21/12 check R16: scored 3 or key bowel, incontinent or risk for shear and for assist with ADL's (a pain. Included on the risk factors and interpretation of bladder. Incont of b	Lutheran Home aluation of skin risk factors" ak list items were checked for ower in moisture, incontinent of of bladder, nationally at risk, at riction, cognitively impaired, activities of daily living), and his form was a "analysis of erventions" which included or, impaired cognition and Receives Keefor ointment to urned and toileted every 2 ack side of this form included ody audit" and was dated ed a drawing of a body and on ad circled the area of the red" next to it. This area was ified if it was a pressure ulcer					NOT HOUSE NOT HOUSE NOT THE STATE NOT THE ST
•	"Alteration in mobil and reposition ever in skin integrity" into list included "Reposassessment. Low w/c gel. Elevate he care after incontine and wrinkle free. I prevent shearing.	dated 3/12/12 included ity" and directed staff to "turn y 2 hours." Under "Alteration erventions checked off a check sition per tissue tolerance air loss mattress. cushion in eels off mattress. Provide perient episodes. Keep linen clean ift, do not slide resident to Monitor skin with cares.					

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STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		05/0)2/2012:
	NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			REET ADDRESS, CITY, STATE, ZIP COD 444 RESERVOIR BOULEVARD NOF COLUMBIA HEIGHTS, MN 55421	RTHEAST	. a 42.
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	RECTION SHOULD BE	(X5) COMPLETION DATE
F 314	Continued From pa open area or skin o supplements as or fluid intake:"	age 134 changes. Nutritional dered. Encourage food and	F 314			. * &
	12/13/11, 3/3/12 at what risk factors R and failed to include ability to endure the adverse effects. F identify if the red a	performed by the facility and 4/21/12 failed to identify 16 had that could be modified le an evaluation of R16's skins e effects of pressure without further, the 4/21/12 failed to rea on R16's coccyx was a what it's cause was.				
	A nurse aide work R16 was to be rep "heel lift boots in b	sheet dated 5/1/12 indicated ositioned every 2 hours and ed."				1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1
	2011 through May prevent pressure to every 1-2 hours are tolerance" Also "Keegans cream-a	ecord for each month December 2012 included "Wound care: alcers, turning and repositioning and as needed tissue included staring 12/1/11 was apply to red area on coccyx and shift) and prn (as needed)."				
	she stated she wa repositioned or off she stated R16 w lie down, but she	t 8:00 a.m. on 4/24/12 with NA-I is not aware if R16 should be f-loaded at any time intervals, will often say when she needs to has bad days when she doesn't and staff will assist her to bed if			1	0.15 0.15 0.15 0.15 0.15
	4/24/12 she was r time frames for re couple hours or se	with LPN-A at 12:00 p.m. on not aware if R16 was on any spositioning, should be every by She stated nurse aides with repositioning as directed				

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(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B, WIN	G		05/0	2/2012
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	on their workshee	oage 135 ts. She was not aware R16 ned coccyx, she stated she gets m-to prevent rash;	F 3	- Louis Transport			
~:	4/24/12 he stated she needs to lie do though. Upon rev stated R16 should upon review of the "every 1-2 hour re prevent pressure aids should follow She was not sure indicated R16 had	with NA-C at 12:03 p.m. on R16 will usually say she when own, has days where she can't riew of R16's plan of care she do be repositioned every 2 hours, a treatment record she stated epositioning is on there to ulcers." She state the nurse what is on their worksheets. Why the treatment sheets do a "red area on coccyx" stating She had not assessed the					. 7:14
	p.m. on 4/26/12, s test is done quarte assist in determin	with MDS nurse (MDS)-F at 3:00 she stated a tissue tolerance erly or annually by the facility to ing positioning needs, she was testing done since R16 had					Section of the sectio
	at 10:00 a.m. on 4 normally does an	with MDS coordinator (MDS)-E 4/27/12, she stated the facility admission and annual tissue for each resident, she was any for R16.					
	2:45 p.m. on 5/1/1 say when she nee had not had a pre area on her coccy	with nurse supervisor (NS)-A at 12 she stated R16 will usually eds to lie down. She stated R16 essure ulcer and thought the red ex on the 4/21/12 assessment rash. She had not assessed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245018	B. WING		05/02/2012			
	NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 314	risk for pressure ul- ensure R16-had an assessment to incle and failed to indica modified to assist in ulcers. Further, the was repositioned the care (every 2 hours) (every 1-2 hours) a in her wheel chair f	cility assessed R16 as being at cers, the facility failed to individualized comprehensive ude tissue tolerance testing, te what risk factors could be in prevention of pressure facility failed to ensure R16 mely as directed by her plan of s) or by her treatment records and allowed her to stay seated for 3 hours 35 minutes, 4 hours ours 35 minutes without	F 314			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
·	Resident 100 (R10 dementia and imparaminimum data set identified R100 had was an extensive a living (ADL 's), and pressure ulcers. R100 's plan of castaff to toilet every reposition every 2 also identified R10 skin integrity relate incontinence, eden vascular disease). R100 's bowel and 2-14-12 identified to two hours." The pressure ulcers day which identified the developing pressure Analysis of risk factorism and imparamentations.	0) had diagnoses including aired mobility. The quarterly (MDS) dated 11-15-11 disevere cognitive impairment, assist with all activities of daily disease at risk for developing are dated 2-17-12 instructed 1½ hours and to turn and hours. R100's plan of care 0 had a potential alteration in diseased mobility, na, and PVD (pulmonary diseases bladder assessment dated to "offer toileting every one to Braden scaled for predicting ted 3-14-12 was scored a 15, are resident is at mild risk for refucers. A body audit "stors and interventions" dated R100 is "at risk for skin						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		05/02/2012	
, ,, ,,,,	ROVIDER OR SUPPLIER IEW LUTHERAN HO	ME	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	the dining room-loc Aspen unit at 8:10 constant observation dining area without 9:10 a.m. when the (LEA)-C pushed the main dayroom/ cha		F 314			102 102 103 103 103 103 103 103 103 103 103 103
	During constant of the dining room un brought back to the Linden and Aspen (NA)-M. She still repositioned after NA-M walked awar At 11:48 a.m. on 4 by surveyor and as R100 was toileted stated R100 was shours and right aft was unsure last tir bathroom but the rinterrupt activities bathroom. NA-L at that time. Although R100 was the plan of care in reposition resident was not toileted or 35 minutes.	oservation R100 remained in till 11:42 a.m. until she was e dining room located between unit by an nursing assistant had not been toileted or 3 hours and 35 minutes, and y. -24-12 NA-L was approached sked if she was aware when or repositioned last. NA-L supposed to be toileted every 2 er she is done eating. NA-L he R100 was assisted to the hursing assistants do not to take a resident to the assisted R100 to the bathroom as at risk for pressure areas and structed staff to toilet and the every 1 ½ hours, the resident repositioned for 3 hours and				
	ulcer policy and prunder "procedures	ran Home Skin and pressure rocedure" dated 2/08 included: ""tissue tolerance-admit, nt change, and annually."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED		
		245018	B. WING 0			05/02	/2012	
	ROVIDER OR SUPPLIER			44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314		n of skin breakdown" included position changes is titrated for	F:	314			11,7	
F 315 SS=D	repositioning obsetesting dated 5/2/survey. 483.25(d) NO CA RESTORE BLAD Based on the restassessment, the resident who enterindwelling catheter resident's clinical catheterization was who is incontinent treatment and seinfections and to function as possil	ident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless the condition demonstrates that as necessary; and a resident t of bladder receives appropriate rvices to prevent urinary tract restore as much normal bladder	F	315	It is the policy of Crest View Home that based on the resi comprehensive assessment, resident who enters the faci without an indwelling catheterized unless the residunical condition demonstrated the catheterization was necessal resident who is incontinent bladder receives appropriate treatment and services to preservices.	dent's a lity ter is not dent's ites that ry; and a of	1 (2010) 1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	
•	by: Based on observative, the facility (R16) reviewed for the services need level of continent assess incontined assistance to the care. Findings include: R16's quarterly makes as a services assistance.	vation, interview and document y failed to ensure 1 of 3 residents or urinary incontinence received essary to maintain or attain here, failed to comprehensively not status and failed to provide toilet as directed by her plan of			urinary tract infections and as much normal bladder fun possible. Resident R16 expired on 05, For other residents who ma affected by this practice a review of residents with uri incontinence and appropria justification for catheters w completed by 06/11/12. After	to restore action as /27/12. y be ecord nary te ill be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			X3) DATE SURVEY . COMPLETED	
		245018	B. WING		05/02	2/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	The MDS identified assistance to toile	d R16 required extensive	F 315	review, updates will be ma appropriate for each reside identified.	1	29 1 15 2	
	toileting plan. R16's previous as MDS dated 12/21 impairment. R16	sessment, a significant change /11 indicated severe cognitive s diagnoses included se and heart failure.		The policy and procedure fincontinence assessments of the incontinent resident reviewed and updated by the continent received and updated by the continent reviewed and updated by the c	and care will be the	(2) (2) (3) (4) (4) (4) (4) (4)	
·	was brought from the hallway outsic observed sitting to 6:30-7:30 p.m. sh	on at 6:15 p.m. on 4/23/12 R16 the dining room and placed in the of her room. She was there until 8:05 p.m., from the asked quietly multiple times to the or to go to bed. At 7:30 p.m.		interdisciplinary team by 0 A review of policies by the Director will be completed current standards of practi place. Staff members will be	Medical to ensure ice are in be trained		
	she had a strong 8:05 p.m. nurse a bathroom, her pa soiled with loose taken R16 to the	fecal odor surrounding her. At lide (NA)-I assisted R16 to the d was slightly wet and was stool. NA-I stated she had bathroom last at 4:30 p.m. prior		as it relates to their respect and responsibilities regard incontinence management assessment by 06/11/12.	ing	The state of the s	
	R16 will say wher	tated R16 is not on a toilet plan, n she needs to use the vas not toileted for 3 hours and		Toileting and incontinent a audits will be completed o for 4 weeks, monthly for 3	n weekly months,	17.00	
	12:06 p.m. on 4/2 the bathroom. R 9:00 a.m. and the the chapel area a	s observation from 8:00 a.m. to 24/12 R16 was not assisted to 16 was at breakfast from 8:00 - 20 brought out to hall outside of and remained there until 10:20 as brought to the dining room		and then according to the control schedule to ensure compliance with results repthe CQI Committee for revifurther recommendation.	continued ported to lew and		
	and placed at a topractical nurse (Lidining room prior administered her At 10:42 a.m. R1 room table, she is	able. At 10:30 a.m. licensed .PN)-A retrieved R16 from the to her being served brunch and medications to her at 10:37 a.m. 6 was brought back to the dining remained in the dining room until a family member removed her		review, system revisions ar education will be implement indicated by a prescribed a	nted if		

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CENTERS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ILDING	(X3) DATE SURVEY COMPLETED
	240010			1 00102/2012
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

ONLOT	ALLA COTTICIONE	1 0	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)	(X6) COMPLETION DATE				
F 315	Continued From page 140	F 315	The Director of Nursing or designee					
	from the table and brought her to the beauty shop. At 12:00 p.m. LPN-A was notified R16 had		will be responsible for compliance.					
	not been toileted or repositioned for 4-hours. LPN-A stated she would locate R16 and have her assisted to the bathroom. At 12:06 a.m. LPN-A stated R16 had been brought outside by family. R16 had gone at least 4 hours and 6 minutes without staff assisting her to the bathroom. R16's "3 day bowel and bladder assessment" dated 3/4/12, 3/5/12 and 3/6/12 was partially filled out. The 3/4/12 showed R16 was incontinent of urine at 3 p.m. and 9 p.m. and had voided in the toilet at 5 a.m., 11 a.m., 2 p.m., 4 p.m. and 7 p.m. The 3/5/12 date showed R16 had voided in the toilet at 2 a.m. and had been checked and her incontinent product was dry at 12:00 a.m. and 4 a.m. the rest of the day had not been filled in to determine a pattern. On 3/6/12 date the form showed R16 had voided in the toilet at 2 a.m. 10:00 p.m. and 11:00 p.m. Her incontinent product was checked and dry at 12:00 a.m., 3 a.m., 5 a.m. and 5 p.m., the rest of the form was blank. No pattern of urinary continence or needs was able to be determined as much of the form had not been filled in. R16's care area assessment (CAA) dated 12/13/11 indicated she had an indwelling Foley catheter, (this had since been discontinued). R16's "Crest View Lutheran Home Bowel and Bladder Assessment" dated 3/7/12 was a check list style assessment with the following areas checked: under "pertinent diagnosis" included "Alzheimer's Disease/dementia, CHEF (congestive heart failure), diabetes, end stage renal failure." Under "Medications" included		Date of Correction: 06/11/12————					
	Tenarranure. Origer Wedications included			<u> </u>				

CENTER	RS FOR MEDICARE	A MEDICAID SERVICES				(V2) DATE S	IIDVCV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLE	
		245018	B. WIN				2/2012
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 4 RESERVOIR BOULEVARD NORT		
CREST V	CREST VIEW LUTHERAN HOME				LUMBIA HEIGHTS, MN 55421		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	diuretics and narco- abnormalities were data"-included-fluid 1 and relates need status" included "b hours, incontinent amount each voidi pattern in last year formed stool every this data. The forr RN under "care pla following: calls for anticipated every 2 assist, percale with resident for signs a infection, observe meds as ordered. "Resident toileted request, requires a	pertensives, antipsychotics, btics." No peri-rectal e-noted.—Under "additional tintake-at meals, diet assist of s." Under "bladder present ladder frequency every 2-3 with control, medium to largeing, no pain or change to the Bowel status as continue and an Antiperior and included the cassist every 2-3 hours, needs 2-3 hours, adjust clothing and an assist, staff to observe and symptoms of urinary tract for bowel pattern changes, Under "Assessment" read every 2 hours upon her assist with pericares and to	F	315			10 - 20 - 20 - 20 - 20 - 20 - 20 - 20 -
	R16's assessmen 3/7/12 failed to ad to comprehensive R16's use of a did urgency/frequency use of narcotic padrowsiness and the patterns of fluid in may irritate the bladetermine if she was retention as she have retention. Further type of urinary incourge, stress, mixed	t performed by the facility on dress the lack of data collected ly assess voiding patterns, aretic medication that can cause y shortly after administration, in medication that may cause perefor functional incontinence, take, if utilizes any caffeine that adder, or any testing for R16 to was currently having any urinary and a diagnosis of urinary report that the facility failed to identify the continence R16 had such as ed, overflow, , or functional.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING	B. WING		2/2012
	ROVIDER OR SUPPLIER	ME		REET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	ORTHEAST	1. h.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	Continued From pa program or interve completed.	age 142 ntions had not been	F 31	5		:: ::: :::::::::::::::::::::::::::::::
	alteration in bowel (related to) and the on a check list "cog mobility, inability to bladder/prostate, ruse of diuretic, Fol catheter/urostomy, incontinent at least The goal is listed a breakdown due to approaches for R1 checked "complete assessment, toilet resident needs, probserve for non-very provide adequate if monitor bowel stat a ordered, notify M forming laxatives a needed), catheter Foley output q (eversident request, chours and prn, see The plan of care d indwelling catheter an indwelling catheter an indwelling catheter change her inconting as needed, assist During interview at she stated she was	incontinent less than 1 x day; 1 time day bowel, diarrhea." Is "Will have no skin incontinence." The 6 have the following items be bowel and bladder every 2-3 hours to meet ovide assist of 2 for toileting, bribal signs for toileting needs, fluids at and between meals, us every shift, administer meds ID (doctor) for needs of bulk and/or stool softener prn (as care per protocol, monitor ery) shift, assist to toilet per theck and change every 2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	if CORRECTION	IDENTIFICATION NOTICE	A. BUI				
		245018	B. Wi	łG		05/02/2012	
	ROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	bathroom, but she	age 143 when she needs to use the has bad days when she is need and staff will take her just change her incontinent	F	315	·		
	4/24/12 she was n time frames for be be every couple ho	oith LPN-A at 12:00 p.m. on ot aware if R16 was on any sing assisted to the toilet, should burs or so. She stated nurse at R16 with toileting as directed ts.		100			77012 ************************************
	4/24/12 he stated	vith NA-C at 12:03 p.m. on R16 will usually say she when o the bathroom, has days where		į			
	p.m. on 4/26/12, s nurse (RN) to assi effective, therefore	with MDS nurse (MDS)-F at 3:00 the stated there is no registered ess if toileting programs are e residents are not placed on and can not be coded as such					
·	at 10:00 a.m. on 4 do a 3 day bowel a is filled out by the for how often each to the toilet. She toileting plan due	with MDS coordinator (MDS)-E 4/27/12, she stated usually will and bladder tracking form that nurse aides to determine a plan h resident requires assistance does not place residents on any to there is no RN available to is effective or not.					
	2:45 p.m. on 5/1/1 toileting needs are	with nurse supervisor (NS)-A at 12 she stated a residents e determined by a 3 day bowel ssment that is performed					

13/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		05/02/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	medical record. Stachecked on the ME program as there is assessment to detect bladder plan is worthe nurse aides are bathroom as direct reviewing the plan "covers all the base individualized for R. A nurse aide works R16 was incontine not direct staff on the facility failed to comprehensively a of urinary incontine consideration diure narcotic pain medical enough data to detect to her need to void Further, the facility actually assisted to	a could not locate this in R16's ne stated no residents are DS as being on a toileting on a toileting on a toileting on a toileting or not a Registered Nurse ermine if the current bowel and king or not. She further stated to assist residents to the ed on their worksheets. When of care, NS-A stated the plan es" and agreed it was not on the ed on their worksheets. When of care, NS-A stated the plan es" and agreed it was not on the ed	F 315			100 (200 (200 (200 (200 (200 (200 (200 (
	assist R16 with reg maintaining her cu though staff stated	lo attempt had been made to gaining continence or rrent level of continence. Even the nurse aides needed to eets, the worksheets failed to S's toileting needs.				11 22	
F 323 SS=J	requested, but not 483.25(h) FREE C HAZARDS/SUPER		F 323	F323 Accidents It is the policy of Crest View Home that each resident red adequate supervision and a	ceives		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING			05/02/2012	
	ROVIDER OR SUPPLIER	ME	\$	44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULĎ BE	(X5) COMPLETION DATE
F 323		m page 145 emains as free of accident hazards and each resident receives		23	For Resident R74 a new asse for smoking and safety risk w completed. R74 now wears	vas a	:
		on and assistance devices to	· -		smoking apron while out on breaks and has a covered mu hot beverages. For R158 a ne smoking assessment was cor	ig for ew	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 1 of 8 residents (R74) who				and water was added to the receptacles, the ash receptacles be emptied three times per o	ash cles will	7 (100 P) 7 (100 P) 7 (100 P)
					she wears a smoking apron f smoking. Corresponding upd have been made to the care	lates	and the same
	consumption of hol (R74) who sustained	n the facility, and for the safe beverages for 1 of 1 residents and a burn from handling a hot lity's failure to provide			care assignment sheets and communicated to the reside and/or designated decision r		
	supervision and a spotential burns from and hot beverages	safe environment to prevent n unsafe smoking practices constituted an immediate n addition to the resident in			Staff members responsible we educated on safe smoking por and procedures by 06/11/12	olicies	
	immediate jeopard safety interventions risk of a burn injury	y, the facility failed to ensure s were in place to minimize the for 1 of 1 residents (R158)			Resident R16 expired on 05/	27/12.	157
	who was observed digging in ashtrays for lit cigarettes, and for 1 of 1 residents (R16) observed whose electrical power strip was being used in an unsafe fashion.				For other residents who may affected by this practice a re residents who smoke will be	view of	
	chief executive offi immediate jeopard p.m The immedia 5/01/12 at 1:25 p.n remained at the sc	director of nursing (DON) and cer (CEO) were notified of the y for R74 on 4/26/12 at 4:12 te jeopardy was removed on but non-compliance ope and severity of no actual ntial for no more than minimal			completed by 06/11/12. An a was completed of all residen and power strips were replace hospital grade surge protects where appropriate. After revupdates will be made as app for each resident identified.	t rooms ced with ors riew	

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RS FOR MEDICARE	& MEDICAID SERVICES				1	
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE SUI COMPLET	
	245018	B. Wil	NG_		05/02	/2012
ROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE		s ** ,
	LAC		44	444 RESERVOIR BOULEVARD NORTHE	EAST	*****
TEW LUTHERAN HO	WIE		С	COLUMBIA HEIGHTS, MN 55421		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X6) COMPLETION DATE
Continued From pa	age 146	F	323	The policy and procedure for		ं तं छ
Containaca i Tom pe	1			1110 harral min branching 121		
				_		-
Findings-include:					· .	
D74 was observed	with multiple cigarette hurn			interdisciplinary team by our	11/12.7	•,
holes on his pants	and jacket during a tour of the			review of policies by the Med	dical	
facility on 4/23/12.	The facility did not identify this					17.7000
or other safety con	cerns related to the resident					- 19 1 THE
independently smo	oking unsupervised.					
R74 had diagnose	s which included: diabetes					
mellitus, periphera	l vascular disease and					
schizophrenia. Th	ne most current minimum data			smoking policy and procedu	res by	
memory impairme	nts and was cognitively intact.			06/11/12.	\$	***
transfers, dressing	, set up assist with eating and			Audits on smoking behavior	will be	
that he uses a who	eelchair for mobility. The					
current plan of car	e updated 2/13/12, indicated					- 30x
R74 was independ	dent with smoking.					
When interviewed	on 4/25/12 at 7:17 a.m.,					
nursing assistant ((NA)-F, stated over the past)
winter she noticed	E also stated she noticed a					
cigarette burn hole	e in his winter jacket.					٠ .
On 4/25/12 at 8:08	3 a.m., housekeeper-A stated					
sne noticed cigare	tee-shirts. She indicated she					
					,	
recent winter. Wi	th R74's permission,	Į		prescribed action plans		'
housekeeper-A ar	nd surveyor observed R74	1		The Director of Nursing or o	lesignee	
clothing during thi	s time. K/4 had 10 pairs of					
cotton and others	were made of 100% polyester.			will be responsible for comp	אמווהבי	
The following was pants:	observed for 7 of 10 pair of			Date of Correction: 06/11/	12	: - :
	ROVIDER OR SUPPLIER TEW LUTHERAN HO SUMMARY STA (EACH DEFICIENC' REGULATORY OR I Continued From pa Findings-include: R74 was observed holes on his pants facility on 4/23/12. or other safety con independently smo R74 had diagnose mellitus, periphera schizophrenia. The MDS also inditransfers, dressing that he uses a who current plan of car R74 was independently winderes and but not con his thought the cigaret recent winter. Withousekeeper-A arclothing during thi athletic pants in hicotton and others The following was	ROVIDER OR SUPPLIER TIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 146 Findings-include: R74 was observed with multiple cigarette burn holes on his pants and jacket during a tour of the facility on 4/23/12. The facility did not identify this or other safety concerns related to the resident independently smoking unsupervised. R74 had diagnoses which included: diabetes mellitus, peripheral vascular disease and schizophrenia. The most current minimum data set (MDS) dated 2/25/12, indicated R74 had no memory impairments and was cognitively intact. The MDS also indicated R74 needs assist with transfers, dressing, set up assist with eating and that he uses a wheelchair for mobility. The current plan of care updated 2/13/12, indicated R74 was independent with smoking. When interviewed on 4/25/12 at 7:17 a.m., nursing assistant (NA)-F, stated over the past winter she noticed cigarette burn holes on R74's gray tee shirt. NA-F also stated she noticed a cigarette burn hole in his winter jacket. On 4/25/12 at 8:08 a.m, housekeeper-A stated she noticed cigarette burn holes on R74's pants and but not on his tee-shirts. She indicated she thought the cigarette burns occurred over the recent winter. With R74's permission, housekeeper-A and surveyor observed R74 clothing during this time. R74 had 10 pairs of athletic pants in his closet, some made of partial cotton and others were made of 100% polyester. The following was observed for 7 of 10 pair of	A BU 245018 ROVIDER OR SUPPLIER TEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 146 Findings-include: R74 was observed with multiple cigarette burn holes on his pants and jacket during a tour of the facility on 4/23/12. The facility did not identify this or other safety concerns related to the resident independently smoking unsupervised. R74 had diagnoses which included: diabetes mellitus, peripheral vascular disease and schizophrenia. The most current minimum data set (MDS) dated 2/25/12, indicated R74 had no memory impairments and was cognitively intact. The MDS also indicated R74 needs assist with transfers, dressing, set up assist with eating and that he uses a wheelchair for mobility. 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The following was observed for 7 of 10 pair of	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLA DENTIFICATION NUMBER: 245018 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 146 F 323 Findings-include: R74 was observed with multiple cigarette burn holes on his pants and jacket during a tour of the facility on 4/23/12. The facility did not identify this or other safety concerns related to the resident independently smoking unsupervised. R74 had diagnoses which included: diabetes mellitus, peripheral vascular disease and schizophrenia. The most current minimum data set (MDS) dated 2/25/12, indicated R74 had no memory impairments and was cognitively intact. The MDS also indicated R74 needs assist with transfers, dressing, set up assist with eating and that he uses a wheelchair for mobility. 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(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	ME	4444 RESERVOIR BOULEVAR		EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	RD NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 147	F	323			+ 152
		cotton pants with 2 cigarette ight.leg.approximately_1/4"_to					
	holes on the right k 3rd pair- Pants ma cigarette burn hole 4th pair- Black pan burn hole on the rig 5th pair- Blue pants the front and the ba 6th pair- Pants with on front thigh area. 7th pair- Gray cotto inch cigarette burn the thigh area. The remaining 3 pa burn holes. During observation a.m. R74's coat ha the right chest area would let his cigare and stated "I know stated he never bu and the holes in his ashes that dropped Record review ider "Smoking Evaluatio again on 2/7/12, de noted the facility sr	ide of 100% polyester, 5 is on the upper thigh area. Its 100% polyester, cigarette ght stomach area of pants. Its, 5 cigarette burn holes on ack of the upper thigh area. In multiple cigarette burn holes on pants with an approximate 1 on the right side of his pants in airs of pants had no cigarette of R74 on 4/25/12 at 8:20 and 3 cigarette burn holes on a of his coat. R74 stated he ette rest on his coat while lit, I shouldn't do that". R74 rned his skin from smoking is clothes were from cigarette					1012 1012 1013 101,000 101 101 101 101 101 101 101 101
	and lit smoking ma offered a smoking	n safely utilize lighter/matches terial, the resident has been apron and refuses". The 74 demonstrates safe smoking					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLI	
		245018	B. WI	1G _	, grant plants de particular de la compansa de la c	05/0	2/2012
	ROVIDER OR SUPPLIER	ME		4	EET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	"resident smokes i	r residents. The plan indicated ndependently, cognition intact ance in other areas but has	F	323			10,3
	(LPN)-C was interviously completed R74's safter he moved to to offered him a smoland they felt he was without the use of the was not aware of a clothing and if R74	a.m., licensed practical nurse riewed and stated she moking assessment on 2/7/12, the Aspen unit and they king apron, however he refused is safe to smoke independently the apron. LPN-C stated she any cigarette burn holes on his had cigarette burn holes on ould not consider that resident ependently.					1 11 + 30 + 2 + 00 + 0 - 11 + 90 + 0 - 11 + 12 + 13 - 11 + 14 + 14 - 12 + 14 + 14
	lighting his cigarett the window of the in his hands were shad cigarette. The mean present, and stated On 4/25/12 at 7:19 stated she comple	a.m., R74 was observed to on the patio located outside main dinning room. Both of aky while he was lit the all service assistant-H was dinner. The shakes all time.	144100			•	1.00
	independently. She Evergreen unit who assessment and self the was safe. Self the assessment, self the assessment, self the assessment as on at	e was able to smoke e stated he was on the en she completed this he could see him smoke, and She stated when she conducts he looks at the clothing the the time, and she was not cigarette burn holes on his					TO ATTACK TO ATTACK TO A DO
	On 4/25/12 at 7:21	a.m., R74 was observed	:				

PRINTED: 05/17/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 245018 05/02/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST **CREST VIEW LUTHERAN HOME** COLUMBIA HEIGHTS, MN 55421 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) Continued From page 149 F 323 F 323 outside smoking on the patio with a 1/2 inch long ash at the end of his cigarette. He extended his right arm and flicked the ash onto the patio floor. Licensed practical nurse- K (also the facility wound nurse) was interviewed at this time and verified R74 has not received any cigarette burns on his skin. NO On 4/25/12 at 7:22 a.m., the director of nursing (DON) was interviewed and stated R74 smoked independently and she was aware of the surveyor findings of cigarette burn holes on his clothes. She stated "we offered him a smoking apron and he refused to wear it." The DON stated she had not discussed the risks and benefits of refusing the apron with R74. On 4/25/12, at 7:24 a.m., R74 stated the facility had offered him an apron about a year and a half

he did not wear it.

On 4/27/12 at 12:00 p.m., NA-H stated R74 "has so many (cigarette burn holes in his clothing) it is difficult to know when he gets new cigarette burn

ago. He stated he was not informed of the risks and benefits of not wearing one until last night, when a staff person told him he "could burn up" if

On 4/27/12 at 12:22 p.m., a family member (FM) -A was interviewed via phone and stated he was aware of the number of cigarette burn holes in R74's clothing. FM-A stated he purchased seven new pair of pants in February 2012 (2 months ago), which now have new cigarette burn holes. FM-A stated R74 used to live with a family, and they found cigarette burn holes on his clothing too, at times he would fall asleep while

Facility ID: 00005

If continuation sheet Page 150 of:162

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holes".

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S COMPLI	
		245018	B. WING_		05/0	02/2012
	ROVIDER OR SUPPLIER	ME		REET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 5	NORTHEAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From p smoking. FM-A ve shaky when R74 s	age 150 erified R74's hands were also mokes his cigarettes.	F 323	3		25 m 102
	reviewed. The poresidents or family provide their own employees may not materials or buy so residents may be areas and must diappropriately. Retreviewed with all residents smoking nursing staff and resident compliant smoke appropriate available adjacent smoking evaluation for those resident evaluation will be necessary for any Although the facil hand tremors and clothing from cigal allow R74 to smosupervision and fadditional interves afe while smoking R74 also sustained facility failed to as handle hot liquids	ity staff were aware of R74's If the multiple burn holes on his arette ashes, they continued to ke independently without ailed to assess and implement ntions to ensure R74 remained				7/312 7/30 7/30 7/30 7/30 7/30 7/30 7/30 7/30
	liquids	ent titled "Resident Skin				

1000-00

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDING		OOM EL	
		245018	B. Wil	lG		05/02	2/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	IEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Changes Report" (noted R74 had a 8 intact-blister-intact- incident report note cocoa on himself. tegaderm skin prot burn. The incident Interdisciplinary Te notes indicated the There were no oth prevent R74 from a liquids. The currer indicated R74 had which healed on 2a interventions related	age 151 incident report) dated 1/5/12, .0 cm X by 2.0 (centimeter) on-his-left-inner-thigh: The ed R74 stated he spilled hot The interventions included a sectant was to be used over the report indicated the eam (IDT) interventions and e injury was "self inflicted". er interventions identified to additional burns with hot at plan of care updated 2/28/12, a burn to his left inner thigh 1/28/12. The care plan lacked ed to handling hot liquids, even med a burn from spilling hot	F	3323			United States of the States of
	noted "reviewed he resident self inflicted on 4/25/12 at 3:33 interviewed and strict interventions in play hot liquid. She stated in the state of th	s p.m., the DON was ated they did not put any ace after R74's burn from the ted he was independent with and did not feel they needed to					
			1				::.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ₩ A. BU		G	COMPL	
		245018	B. WII	NG		05/0	02/2012
	ROVIDER OR SUPPLIER	ME		4	EEET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	IEAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	XI	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	lighting his cigaret the window of the	age 152 te on the patio located outside main dinning room . Both of aky-while he was lit the	F	323			
3	cigarette. The mean present, and state Although the facilinand tremors and his skin from a housess R74's abiling implement any	al service assistant-H was d'he shakes all time". ty staff were aware of R74's that he had received a burn on the beverage, the facility failed to to to safely handle hot beverage interventions to ensure R74 ile consuming hot beverages.					17.4 E018
÷:	The facility initiate included impleme for residents who dropping cigarette smoking policy, at to smoke and /ha safety intervention care and licensed on 4/29/12 at 1:00 11:05 a.m. and 1 explain their respipolicy and the intervention container to prevent to prevent the second container the	d an IJ removal plan which ning the use of smoking aprons smoked and were at risk of es/ashes, revision of the facility aining all staff about new and reassessment of R74's ability ndle hot beverages safely and as implemented for R74. Direct nursing staff were interviewed 0 p.m., and on 5/01/12 between 1:36 a.m., and were able to consibility of the facility smoking erventions in place for R74. R74 with a covered lid beverage ent further burns. Audits were of safety intervention The immediacy was removed at m., and non-compliance cope and severity level of no a potential for no more than					
	for lit cigarette bu	ors of digging into used ashtrays tts and struck out at other ere smoking in an attempt to take					1.17 1.17

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP	PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
		245018	B, Wil			05/0	2/2012
	ROVIDER OR SUPPLIER		. 	44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTH OLUMBIA HEIGHTS, MN 55421	IEAST	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XI.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 323	placed her at risk of residents or being facility failed to have supervision when or place to prevent por R158 and other research to bacco use disord quarterly minimum indicated she had impairment, had n	ose residents. R158's behavior of being burned, injuring other injured-by-other-residents.—The re interventions, including out on the smoking patio, in otential accident hazards for	F	323			A CONTROL OF THE CONT
	coming out to the smoking patio. As leading out onto the residents R168, R smoking started to from here, you get and over, R158 discresidents yelling a ashtray in an atter lit cigarettes were to R168 and tried lighter from R168 and had a flat faci attempting to get R168 pulled her hunget out of here." swung at R168's to being hit by R168 wandering around	facilities outdoor resident soon as she opened the door ne outside patio 3 other 174 and R44 who were out o yell at R158. "You get away tout." "Get out of here." Over d not react to the other ther and dug into the used mpt to find a lit cigarette, but no found. She then walked over to grab an unlit cigarette and shand. R158 did not speak al affect, while she was the cigarette from R168 hand. and away and yelled at R158 to R158 raised her right hand and face. R168 pulled away without. R158 started aimlessly d the smoking patio. Nursing came out to the patio and stated					12,0

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER /IEW LUTHERAN HO	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421	EAST	. :
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) . COMPLETION DATE
F 323	NA-A was informed swung at R-168-and take her cigaretter the incident to the into the building. A out to the smoking residents, R168, R158 telling her to a flat facial affect aget into an ash car cigarette that meatop, and 4 inches thand into this ash cigarette and preceame out to the pawhen she finished escorted into the build believe me, R174, R44 and Rato the smoking are	s on their smoking aprons." d by the surveyor that R158 d-missed-when R158 tried to NA-A stated she would report nurse and escorted R158 back at 1:29 p.m. R158 again came patio again, and the same 3 174 and R44, began to yell at "get out." R158 remained with and did not speak, she tried to n which contained used sured 4.5 inches across the rall. R158 stuck her entire can and pulled out a lit eded to smoke it. NA-A again atio and escorted R158 inside the cigarette. After R158 was building by NA-A. R168 stated ing them (R158's name) tried to all the time, she is always cigarettes and if you won't give it you. I didn't think anyone but now I have witnesses." I58 all verified that R158 comes are multiple times a day digs into for a lit cigarette and also try's	F	323			
	indicated "aggress agitation, aggress was no plan ident	k assessment" dated 9/16/11 sive, physically abusive, ion, withdrawn, pacing." There ified as to how staff should help reduce or eliminate these and by R158.					10. 10. 10. 10. 10. 10.
··	indicated under "r	e for R158 dated 5/23/11 isk to others: Moderately al/emotional aggression," and					

1.00

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPI ILDING	LE CONSTRUCTION	COMPLI	ETED
		245018	B. WII	NG		05/0	2/2012
	ROVIDER OR SUPPLIER VIEW LUTHERAN HO			44	ET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTI DLUMBIA HEIGHTS, MN 55421	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From p "anger/irritability: fi constant," and "fu warranted.".	requent, perhaps even irther assessment/monitoring	F	323			
	indicated "She cor behaviors, particul verbally demandin	osychology note dated 6/6/11 ntinues to exhibit continuous larly around smoking privileges, ag, aggressive, heightened by ed insight and judgement."					- 72012 - 72012 - 71,0750 - 71,0751
	(OHFC) form date called a resident a face when he wou The facility investi residents were se redirect other residents ciplinary to (an antisiezure dru	e of Health Facility Complaints and 6/21/11 indicated R158 had a bastard and slapped him in the aldn't give R158 a cigarette. gation report indicated the parated and "encouraged not to dents or call names." An eam review" noted "depakote ug often used for behavior reased and labs ordered."					1 N N N N N N N N N N N N N N N N N N N
	R158 had asked f resident and R158 "interdisciplinary to	report dated 6/24/11 indicated for a cigarette from another struck her in the arm. The eam review" indicated "will or other placement."					
	indicated R158 hi when she came to "interdisciplinary t	incident report dated 8/19/11 t another residents shoulder o get a cigarette. An eam review" dated 8/23/11 ttinue to redirect as needed."					1673 1873 151440 1513440
	R158 had "punch shoulder twice as cigarette. A "inter	C form dated 8/19/11 indicated ed" another resident in the he had refused to give R158 a rdisciplinary team review dated "encourage to keep her					

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	,	245018	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	ME		444	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION.SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	name) was told to	age 156 rvention was listed as "(resident stay awaystaff continue to she doesn't bother others."	, F:	323			.1,52
	Another psychologindicted "ongoing use, she receives she can afford) but asking anyone and also digging old citrays." The sugge unit. The psychologist was a could implement to behaviors from occupy the psychologist was a R158's "behavior/records" for Janual March 2012 include statements, restle activities, continue agitation and inso address R158 behaviors that contained find a lit cigarette, residents cigarette in the used cigarette in the used cigarette in the used cigarette activities, continued alteration well-being r/t (related and pushing to new elemants) and flaterations,	gy note for R158 dated 8/29/11 g issue related to her tobacco 1 cigarette every 2 hours (what it spends the rest of the time d everyone for a cigarette and g butts out of the trash/ash estion was made for a secured ogist did not identify any ecommendations the facility of decrease or eliminate these courring even though the aware of these concerns. Intervention monthly flow ary 2012, February 2012 and ded monitoring for "delusional assness, withdrawn from bus pacing, uncooperative, mnia" only. The facility did not naviors of digging into the ashed used cigarette butts trying to attempting to hit and grab other es if she was unable to find any					17.7112 12.7112 12.7110 12.7112 17.7112 17.7112 17.7112 17.7112 17.7112 17.7112

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(X3) DATE SURVEY

STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245018	B. WIN			05/0:	2/2012
	VIDER OR SUPPLIER			44	EET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHI DLUMBIA HEIGHTS, MN 55421		311 3211 3111
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
a ci	dded, "allow to in igarette every 2-h igs. She does go f others between	A hand written notation was dependently smoke one ours. Nursing staff to distribute out and smoke cigarette butts her own cigarettes despite	F	323			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
R is c a fi	ssues with R158 p an to get out use ddress R158 atte om others, includ irect staff on how	e did not address any safety placing her hand into an ash dit cigarettes, nor did it impting to obtain cigarettes ling striking others, and did not to provide supervision and se behaviors and safety issues.	-				#7.12 \$28.00 \$2.00
n a a b	pursing (DON) at 2 acknowledged R1 any interventions to purned by digging agarettes, did not prevent R158 from and did not addresses.	rith the facilities director of 2:00 p.m. on 4/29/12, she 58's plan of care did not include to keep R158 safe from being into the ash can for lit include information on how to being yelled at by her peers so how staff should handle be behaviors toward her peers.					The second secon
i C S k k	dentified R158 loc continuously, incluit it cigarettes, atter striking others at to behavior for R158	hology and nursing staff obked for extra cigarettes ading digging into ash cans for npting to get them from others, imes, they failed to address this . This placed R158 at risk for d at by her peers, hitting others behavior.					
	strip creating a po	equipment plugged into a power stential accident hazard. n at 9:42 a.m. on 4/24/12, R16					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP ILDING	LE CONSTRUCTION	COMPLET	
		245018	B. Wil	4G		05/02	/2012
, ,	ME OF PROVIDER OR SUPPLIER REST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	medication by aer	achine (a machine that delivers osol) plugged into a power strip. as draped over the top of the	F	323			62
F 334	dresser, then dray reclining chair plu dresser. During interview v 2:10 p.m. on 4/27 aware that medical plugged into power nebulizer and four nursing (DON) at stated medical ed into power strips. A policy was required the state of the st	with registered nurse (RN)-E at /12, she stated she was not al equipment should not be er strips. She unplugged the nd a wall outlet for it. with the facilities director of 12:30 p.m. on 5/1/12, she juipment should not be plugged ested, but not provided.	F	334	F334 Influenza and Pneumo	coccal	100 May 100 Ma
SS=B	IMMUNIZATIONS The facility must that ensure that - (i) Before offering each resident, or representative rebenefits and pote immunization; (ii) Each resident immunization Octanually, unless contraindicated or immunized during (iii) The resident representative has immunization; and	develop policies and procedures the influenza immunization, the resident's legal ceives education regarding the ntial side effects of the is offered an influenza tober 1 through March 31 the immunization is medically or the resident has already been go this time period; or the resident's legal as the opportunity to refuse			It is the policy of Crest View Home that all residents are of the Influenza and pneumocol immunizations when appropria according to the federal guid and the CDC. For residents on Aspen the immunization information wi in the residents' clinical recol review will be completed all residents for the identification immunization status by 06/2	offered occal oriate delines was filed ords. A	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		245018	B. WIN			05/02	/2012
	ROVIDER OR SUPPLIER	-		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHI OLUMBIA HEIGHTS, MN 55421		1.00 A160 1.00 1.00 1.00
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334	documentation tha	t indicates, at a minimum, the	F:	334	Residents who had refused the immunization or had it completely elsewhere was documented.		7.6
	representative was the benefits and po immunization; and	ent or-resident's legal provided education regarding otential side effects of influenza lent either received the			Education/counseling will be provided for staff members re immunization policies by 06/		. A
	influenza immuniza	ation or did not receive the ation due to medical			For other residents who may affected by this practice a recreview was completed regard	cord	100 (2000) 100 (2000) 100 (2000)
	that ensure that (i) Before offering immunization, eac legal representative the benefits and poimmunization; (ii) Each resident immunization, unleading contrains already been immunication.	h resident, or the resident's e receives education regarding otential side effects of the s offered a pneumococcal ess the immunization is dicated or the resident has unized;			immunization education/con 06/11/12. After review, cons be obtained, refusal will be documented, and/or immuniforms will be updated update made as appropriate. The privill be ongoing for new admithroughout the flu season.	isents by ent will ization es will be ocess	
·	(iii) The resident or epresentative has immunization; and (iv) The resident's documentation that following: (A) That the resident's and presentative was the benefits and preumococcal impresentative was the preumococcal impreumococcal impreumococcal impresentation of (v) As an alternation	r the resident's legal s the opportunity to refuse medical record includes at indicated, at a minimum, the dent or resident's legal s provided education regarding otential side effects of munization; and dent either received the munization or did not receive I immunization due to medical			The policy and procedure for immunizations will be review revised by the interdisciplina by 06/11/12. A review of pothe Medical Director will be completed to ensure current standards of practice are in with results reported to the Committee for further review	ved and ary team olicies by t place CQI	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
AND PLAN O	FCORRECTION	IDENTIFICATION TO THE PARTY OF	A. BU B. WII		3		
		245018	D. VVII			05/02	/2012
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334	pneumococcal imm years following the immunization; unle	nunization may be given after 5 first pneumococcal ss medically contraindicated or- resident's legal representative	F	334	recommendations. Staff men will be trained as it relates to respective roles and respons regarding the immunization and procedures by 06/11/12	their ibilities policies	
	by: Based on interview facility failed to ensure record included do their legal represer regarding the beneon the influenza impresidents who residents who residents who residents who residents who residents are united in the influenza impressentative of the influenza impressentative impressentative of the influenza impressentative	NT is not met as evidenced v and document review, the sure each residents medical cumentation the resident or ntative was provided education of the sand potential side effects imunization for 30 of 114 ded in the facility. The same vaccines in the facility at 12, it was noted all 30 resident pen unit did not contain the facility of the resident or their the benefits and potential side enza vaccine for the 2011-2012			Audits will be completed durinfluenza season weekly for to ensure continued compliaresults reported to the CQI Committee for review and for recommendation. Upon this system revisions and/or staff education will be implement indicated. The Director of Nursing or dwill be responsible for complete of Correction: 06/11/1	3 months ance with wrther review, if ted if lesignee bliance.	
	director of nursing for their Aspen uni documentation for had not been filed The other units ha	on 5/1/12 at 11:00 a.m.,the stated the facility kept a binder t, that contained the required 30 of their residents, but these in the resident records yet. d been filed. She stated they en filed into the resident					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		G	COMPLI	
		245018	B. Wi	۱G	and the second s	05/0	2/2012
	ROVIDER OR SUPPLIER	ME	<u>, , , , , , , , , , , , , , , , , , , </u>	4	REET ADDRESS, CITY, STATE, ZIP COD 444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	E RTHEAST	
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F 334	An undated influent	za vaccine facility policy did d to ensure this education was	F	334			37.
							1/2012 1/



4444 RESERVOIR BLVD NE COLUMBIA HEIGHTS, MN 55421 763.782.1611 FAX 782.0857 WWW.CRESTVIEWCARES.ORG

June 4, 2012

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshall Division 444 Cedar Street, Suite 145 Saint Paul, MN 55101-5145

Re: Crest View Lutheran Home

Dear Mr. Sheehan:

Please accept this plan of correction for Crest View Lutheran Home as our credible allegation of compliance. You can reach me at (763) 782-1620 or taramalay@crestviewcare.org with any questions or concerns. Thank you.

Respectfully submitted,

Talia Aramalay, LNHA
Care Center Administrator

enclosurés

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 5018023 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A. BUILDING B. WING 04/25/2012 245018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST CREST VIEW LUTHERAN HOME COLUMBIA HEIGHTS, MN 55421 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE MN DEPT, OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION 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 prcok 1861812 AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Crestview Lutheran Home Building 1 was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@state.mn.us (X6) DATE LABORATORY DIRECTOR'S OR PROVIDED SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE minist Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

PRINTED: 05/23/2012

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	JLTIPL	E CONSTRUCTION	(X3) DATE SUI	
AND PLAN O	F CORRECTION	IDENTIFICATION NONDEX.	A. BUIL	DING	01 - MAIN BUILDING 01		
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K 000	THE PLAN OF CODEFICIENCY MUSTOLLOWING INFO 1. A description of to correct the defice 2. The actual, or possible for correvent a reoccurror Crestview Lutheral building with a par construction 1964 buildings are type sprinkler protected fire alarm system corridors and space monitored for autonotification. This facility was subuildings because construction. Build to March 1, 2003. accordance with Least was constructed in accordance with Least possible providers and area system that consicorridors and area corridors and area corrections.	PRRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to rence of the deficiency. In Home Building 1 is a 2-story tial basement. Original year of with an addition in 1968, both II(111). The building is fully fire if throughout. The facility has a with smoke detection in ces open to the corridors that is omatic fire department urveyed as two separate of different dates of different dates of ding one was constructed prior Therefore, it was surveyed in SC Chapter 19 and building in 2008 and surveyed in	KC	000			

PRINTED: 05/23/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING 04/25/2012 245018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST **CREST VIEW LUTHERAN HOME** COLUMBIA HEIGHTS, MN 55421 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 | Continued From page 2 department notification. the facility has a capacity of 122 and census at the time of this survey was 118-The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 050 K050 Fire Drills K 050 SS=F Fire drills are held at unexpected times under It is the policy of Crest View Lutheran varying conditions, at least quarterly on each shift. Home to provide periodic fire drills The staff is familiar with procedures and is aware according to Life Safety Code. that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are The fire drill times will be changed to qualified to exercise leadership. Where drills are ensure that fire drills will be done at conducted between 9 PM and 6 AM a coded alternating times during each shift. announcement may be used instead of audible 19.7.1.2 alarms. The policy and procedure for fire drills will be reviewed and revised by the interdisciplinary team by 06/11/12. The This STANDARD is not met as evidenced by: staff was educated on the policy and Based on review of reports and records, it was procedure for fire drills. Periodic audits determined that the facility failed to vary the times for the required number of fire drills for each shift will be completed to ensure compliance in the last 12-month period in accordance with with results reported to the CQI NFPA 101 LSC (00) Section 19.7.1.2. This Committee for further review and deficient practice could affect how staff react in recommendation. The Director of the event of a fire. Improper reaction by staff would affect the safety of all 118 residents, Environmental Services or his designee will be responsible for compliance. Date visitors and staff. of Correction: 06/11/12 Findings include: On facility tour between 9:00 AM and 12:30 PM on 4/25/2012, 1. A review of the available fire drill reports

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION O 1 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		245018	B. WIN	IG		04/2	5/2012
	ROVIDER OR SUPPLIER	ME		44	EET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTI OLUMBIA HEIGHTS, MN 55421	HEAST	
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K 050	revealed that the fa 2012 and 2011 we hours of 12:05 AM 11:15 PM not at va Section 19.7.1.2 and	acility's Night-shift fire drills in re conducted between the , 11:15 PM, 11:30 PM, and aried times as required by and, sed an Evening-shift fire drill in	K	050			
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Printed: 04/30/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

02 - 2007 ADDITION

(X3) DATE SURVEY COMPLETED

245018

B. WING __

04/25/2012

NAME OF PROVIDER OR SUPPLIER **CREST VIEW LUTHERAN HOME** STREET ADDRESS, CITY, STATE, ZIP CODE

4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
INITIAL COMMENTS	K 000		
Surveyor: 19251 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.		POC ok	
in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: MR. PATRICK SHEEHAN		JUN 1 8 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	The state of the s
	INITIAL COMMENTS Surveyor: 19251 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A LIFE Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crestview Lutheran Home (bldg. #2) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:	Surveyor: 19251 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crestview Lutheran Home (bldg. #2) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: MR. PATRICK SHEEHAN	INITIAL COMMENTS Surveyor: 19251 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2587 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, At the time of this survey Crestview Lutheran Home (bldg, #2) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: MR. PATRICK SHEEHAN

E-MAIL: pat.sheehan@state.mn.us PLIER REPRESENTATIVE'S, SIGNATURE LABORATORY DIRECTORYS OR

STATE FIRE MARSHAL DIVISION 444 CEDAR ST., SUITE 145 ST. PAUL, MN 55101-5145

Any deliciency 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

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245018

A. BUILDING 02 - 2007 ADDITION
B. WING

04/25/2012

NAME OF PROVIDER OR SUPPLIER
CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

	COLUR	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)	COMPLETION DATE				
K 000	Continued From page 1 FAX: 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION; 1. A description of what has been, or will be, done to correct the deficiency. 2 The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	K 000						
	Crestview Lutheran Home Building 2 is a 1 story building with a full basement, type II(111) construction. The building was constructed in 2007 and is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in corridors, spaces open to the corridors and sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 122 beds and had a census of 118 at the time of the survey.							
K 050 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT met by evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050	K050 Fire Drills It is the policy of Crest View Lutheran Home to provide periodic fire drills according to Life Safety Code.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

ONSTRUCTION (X3) DATE SURVEY

02 - 2007 ADDITION (X3) DATE SURVEY

245018

A. BUILDING B. WING

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OU ADDITION

04/25/2012

NAME OF PROVIDER OR SUPPLIER
CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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K 050	Continued From page 2 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This Standard is not met as evidenced by: Surveyor: 19251 Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 118 residents, visitors and staff. Findings include: On facility tour between 9:00 AM and 12:30 PM on 4/25/2012, 1. A review of the available fire drill reports revealed that the facility's Night-shift fire drills in 2012 and 2011 were conducted between the hours of 12:05 AM, 11:15 PM, 11:30 PM, and 11:15 PM not at varied times as required by Section 19.7.1.2 and, 2. The facility missed an Evening-shift fire drill in the 2nd quarter of 2011.	K 050	The fire drill times will be changed to ensure that fire drills will be done at alternating times during each shift. The policy and procedure for fire drills will be reviewed and revised by the interdisciplinary team by 06/11/12. The staff was educated on the policy and procedure for fire drills. Periodic audits will be completed to ensure compliance with results reported to the CQI Committee for further review and recommendation. The Director of Environmental Services or his designee will be responsible for compliance. Date of Correction: 06/11/12	