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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1BX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jacqueline Stradtman, HFE NE II 07/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 07/11/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 7/19/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/27/2012
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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.

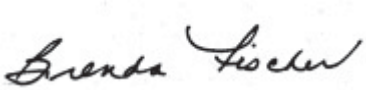
The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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.

Sincerely,



Brenda Fischer, Unit Supervisor
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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	6/21/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0223** Reg. # **483.13(b), 483.13(c)(1)(i)** LSC	Correction Completed **06/11/2012**
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **06/11/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/11/2012**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **06/11/2012**
ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **06/11/2012**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/11/2012**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/sd	07/06/12	21979	06/21/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	6/21/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0287** Reg. # **483.20(f)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/11/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/11/2012**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/11/2012**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **06/11/2012**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/sd	07/06/12	21979	06/21/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/2/2012			

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing 01 - MAIN BUILDING 01	6/25/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	06/11/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	07/06/12	19251	06/25/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/25/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245018	02 - 2007 ADDITION	6/25/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/11/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	07/06/12	19251	06/25/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/25/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1BX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/02/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jacquelin Stradtman, HFE NEII 06/18/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 06/24/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

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

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

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

Crest View
SENIOR COMMUNITIES

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

Talia Aramalay, LNHA
Administrator
Crest View Lutheran Home

6/18/12

JUN 0 5 2012

Crest View
SENIOR COMMUNITIES

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 or763-782-1620 with any questions or concerns. Thank you.

Respectfully submitted,

Talia Aramalay, LNHA
Care Center Administrator

enclosures

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	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the recertification survey, a complaint investigation was also conducted. An investigation of complaint H5018090 was completed and the complaint was substantiated. A deficiency was issued at F223.	F 000	**F000** It is the policy of Crest View Lutheran Home to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction will serve as our credible allegation of compliance but does not constitute an admission of deficient practice.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve a resident grievance in a timely manner for 1 of 3 residents (R 132), in the sample who reported lost clothing items. Findings include:	F 166	**F Tag 166 Grievances** It is the policy of Crest View Lutheran Home to resolve grievances the resident may have promptly, including those about the behavior of other residents. For Resident R132 a missing item report was completed for the missing sweater. The interdisciplinary team will meet with the designated decision maker by 06/11/12 to offer to reimburse the family for the	

6/8/12 HR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia Amalia, LNHA — TITLE: Administrator — (X6) DATE: 6/4/12

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.

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

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F 166	Continued From page 1 R132 had a diagnosis of dementia. The quarterly minimum data set assessment (MDS)dated 2/7/12, 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 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	sweater. Education will be provided for staff members regarding missing item reports by 06/11/12. Resident R132 was discharged on 05/21/12. A review of current concern reports will be completed by the interdisciplinary team in morning meeting by 06/11/12 to ensure that issues were addressed in a timely manner. A meeting will be held with the resident council by 06/11/12 to review grievance practices/protocols, including the prompt response to a grievance. A review of resident council meeting minutes will be completed to confirm that concerns were addressed. The policy and procedure for grievances will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of the revised policies by the Medical Director will be completed to ensure policies meet current standards of practice. Staff members will be trained as it relates to their respective roles and	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 166	Continued From page 2 they all get a notice, look for the item and if not found it is her understanding that the resident gets reimbursed. SSD stated she has had no priority reports and does not know about R132's missing sweater, further stating " it was before my time." During an interview at 10:10 a.m. on 5/1/12, the Administrator (ADM) stated she did not remember the missing clothing item for R132, but would look into it. A follow-up interview at 12:30 p.m. on 5/1/12 the ADM stated she did not have a report regarding the missing clothing. During an interview at 1:20 p.m. on 5/1/12, Receptionist-C (Recep)-C stated she does not remember the report, but then retrieved a folder that contained priority reports and found one that was filled out by (FM)-B dated 2/4/12. (Recep)-C stated that the six designees listed on the bottom of the sheet have check marks next to their titles, so they must have received a copy. She further stated she does not remember if she or someone else made the copies and distributed them. Review of the 2/4/12 priority report noted the sweater was last seen at 1:30 a.m. on 1/17/12 the morning the resident fell. (FM)-B noted he took the sweater out of her dresser to take it home because he thought it was too nice to leave at the facility. (FM)-B then took the resident to the hospital and when he came back at 10:30 a.m. on 1/18/12, the sweater was missing. (FM)-B thought it might have gone to the laundry, but by 2/4/12 he felt it was gone for good. In the report (FM)-B stated " I can ' t believe how people just come into R132 ' s room and take her possessions " . The second section of the report	F 166	responsibilities for the revised policy and procedure by 06/11/12. A review of the resident council meeting minutes will be completed monthly by the Administrator or designee to determine if grievances voiced in this meeting were addressed. A review of grievances and resolution activity will be completed monthly by the Administrator or designee. The results of those reviews will be reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Administrator or designee will be responsible for compliance. Date of Correction: 06/11/12	

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 166	Continued From page 3 " To be completed by staff " was blank. During an interview at 1:35 p.m. on 5/1/12, Licensed Practical Nurse (LPN)-C stated if she was given or filled out a report, she would make copies and put them in all of the boxes of the listed personnel at the bottom of the sheet. (LPN) -C stated they would not likely document anything in progress notes or the chart, stating " you won ' t find it in there " . (LPN)-C further stated she is not sure who is ultimately responsible. Review of the nursing and social worker notes of the medical record for the time period from 1/9/12-2/5/12 revealed no documentation indicating a report of the missing clothing item. Numerous attempts to interview laundry personnel at 9:12 a.m., 9:24 a.m., and 10:05 a.m., on 5/1/12 were unsuccessful. The facility ' s Missing Items Policy dated 3/2010 indicated the following: 1) "when a resident or family member reports a missing item, the person who received the information would fill out a priority report. 2) a copy of the report should be routed to the respective staff listed in the bottom third of the priority report. 3) the report should then be routed back to the unit in which the resident resides for the unit nurse to fill out the second portion, " To be completed by staff". 4) once completed, the unit nurse will return the completed portion to the Director of Social Services. 5) the Director of Social Services will follow-up with the resident and/or family. If the item is found, the word " FOUND " will be written across the form and routed back to those who received the initial report. 6) if the item is not	F 166		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	05/02/2012

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

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F 166	Continued From page 4 found, the Administrator will decide how to proceed on a case-by-case basis". Even though the facility had a policy in place to resolve missing item grievances, they failed to follow the policy so that social services could follow up on the missing items.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident's (R116) in the sample who was observed to self-administer medication. Findings include: The resident had a diagnoses which included chronic obstructive pulmonary disorder, head trauma, and general muscle weakness. R116 clinical record contained physician's orders dated 4/4/12 , which directed the resident receive Albuterol Sulfate 2.5 mg/3ML vial of nebulizer, 1 vial four times daily as needed. An new order dated 4/22/12, noted the nebulizer treatment "should not be left at the bedside for the resident to self administer."	F 176	**F176 Self Administration of Drugs** It is the policy of Crest View Lutheran Home that an individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. For Resident R116 an assessment for self-administration of medication was completed. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. The primary physician was informed of assessment results and a review of the current physician orders was completed. Accommodations for storage and self-administration of drugs have been made. Education/counseling will be provided for staff members regarding self-administration of medication by 06/11/12.	

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F 176	Continued From page 5 On 4/23/12 at 6:18 p.m., the resident was observed in her room holding an operating nebulizer machine to her nose, and turned it off and insisted she was done using it so she could visit. A staff person was not present in the room while the nebulizer machine had been operating. On 4/27/12 at approximately 12:00 p.m., the resident was again observed in her room with the nebulizer mask on her face and an operating nebulizer machine attached to it. There were no staff present in her bedroom. At 2:00 p.m., R116 was interviewed and stated staff were not usually present when she did her nebulizer treatment. On 4/29/12 at 1:45 p.m., registered nurse (RN)-E looked in the clinical record, but was unable to find a self-administration medication (SAM) assessment had been completed for R116. He stated a resident who self-administered any medication, should have an assessment. He stated he had set up her nebulizer machine with the medication that morning, and she did it herself, unattended. On 5/1/12 at 2:48 p.m., licensed practical nurse (LPN)-A was interviewed and verified the physicians order indicated the resident should not do the nebulizer treatment independently. LPN-A was observed in the room with the resident during the nebulizer treatment earlier in the day .	F 176	For other residents who self-administer nebulizer treatments, a self-administration assessment will be completed by 06/11/12. The results will be reported to the interdisciplinary team for review and further action as necessary. The policy and procedure for self-administration of medication will be reviewed and revised by the interdisciplinary team by 06/11/12. The policy and procedure will be reviewed by the Medical Director to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the self-administration policy by 06/11/12. Audits will be completed weekly for4 weeks, monthly for 3 months, then according to the quality control schedule regarding self-administration of medication to ensure continued compliance with results reported to the CQI Committee for review and further recommendations. Upon review system revisions and/or staff education will be implemented if indicated.	
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	F 223		

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F 223	Continued From page 6 The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure residents were free from abusive behaviors exhibited by 3 of 3 residents (R98, R160, R29) reviewed for abuse. The lack of identification, investigation, resident protection, and immediate reporting constituted an immediate jeopardy situation for R98, R160, and R29. The failure to ensure residents were free from abuse/neglect had the potential to affect 34 residents who resided on the Evergreen unit. The administrator and the Director of Nursing (DON) were notified at 4:12 p.m. on 4/26/12 of the immediate jeopardy. 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 at a pattern. Findings Include: R98 displayed aggressive and physically abusive behaviors towards other residents. The facility did not identify and assess these behaviors to determine what interventions could be implemented to protect other vulnerable residents from potential abuse. R98 had diagnoses which included dementia with behavior disturbance, altered mental state, and	F 223	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12 **F223 Staff Treatment of Residents** It is the policy of Crest View Lutheran Home that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. For Resident(s) R98 and R29 a new assessment was completed regarding safety risk. Safety checks and behavior logs were initiated for both residents. Safety checks are then reviewed at morning meeting and the IDT decides when to increase or decrease those checks based on resident behavior. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. The primary physician was informed of the results and a review of the current physician orders was completed. Education will be provided for staff members regarding	

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F 223	Continued From page 7 traumatic brain injury. R98's quarterly minimum data set (MDS) dated 2/11/12, indicated the resident had moderate cognitive impairment, was independent in walking around the facility, and had a history of physical behaviors towards others such as hitting, kicking, pushing, or grabbing. A review of R98's progress notes indicated the following: 6/29/11- "Complaints today that resident has been being angry and mean towards dinner. Observed resident at dinner telling another resident to "be quiet or else." 8/31/11- "Resident got into fight with another resident during dinner tonight. Resident made a point of staring at the other resident all throughout dinner until the other resident got angry. Neither resident would move when asked." 9/4/11- "Receptionist reported to the nurse supervisor that she saw resident attempting to tip (unknown) residents wheelchair by lifting residents wheelchair. No injuries or fall noted. Reported resident- stated "Nothing happened." 10/14/11- R98 and R160 "were engaged in an unwitnessed physical altercation in which R160 sustained some abrasions on his right cheek. Resident (R160) called police but charges were not filed." 12/17/11- "Staff heard noise and went to the scene. Staff saw resident holding onto the shirt of R29, according to him R29 said that he was going to kick him and that annoyed him. No injury	F 223	safety risk and interventions for "at risk behaviors" by 06/11/12. Resident R160 was discharged on 04/20/12. For other residents who may be affected by this practice a record review will be completed by 06/11/12 regarding risk for abuse and safety. Observations of staff interactions with residents and resident to resident interactions will be completed by 06/11/12. Upon this review, system revisions and/or staff education will be implemented if indicated. The policy and procedure for safety risk and abuse prohibition will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of the revised policies by the Medical Director will be completed to ensure that policies meet current standards of practice. Staff members will be trained as it relates to their respective roles and responsibilities regarding safety risk and abuse prohibition by 06/11/12.	

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F 223	Continued From page 8 noted." 3/2/12- "Upset at 1700 (5:00 p.m.) over another (unknown) resident cutting up tiny pieces of napkins and wipes onto dining table. Perpetrator was apparently even coughing up napkins and tossing them out everyone's side of the table. 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	F 223	Safety risk audits will be completed weekly for 4 weeks, monthly for 3 months, then according to the quality control schedule on care plans and resident assessments to determine if staff are assessing 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	

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F 223	Continued From page 9 intervention was to give the resident space and to tell writer if he has any concerns. An attached statement from the receptionist working that evening indicated, "I was working Sunday night at the reception desk and I heard some shouting and swearing between two residents. As I was looking to see what was going on I witnessed R98 was shoving his walker against R3739' wheelchair trying to push him over. I told them to stop it and paged the nurse for assistance and she took over the situation." This was submitted to the state agency and the investigative report indicated the receptionist heard yelling and noted R98 was shaking R3739' wheelchair. The report lacked evidence of interventions put into place at that time. An incident report dated 10/14/11, indicated R98 and R160 had a physical altercation. The receptionist reported that R98 punched R160 on the cheek. R160 called the police but chose not to press charges. The immediate intervention was both residents were separated and staff was advised that both residents are not together in the same area. However, there was no indication on how to keep them apart or how this would be communicated to staff. This report was submitted to the state. The investigative report indicated staff were told to keep the residents apart, however, it was unclear how and when this was communicated to staff. R98 was referred for a psychiatric consult at that time. An incident report dated 12/17/11, indicated R98 was found holding R29's shirt. R29 said he was going to kick him and that annoyed him. The immediate action put into place was staff to make sure both residents were not in close contact.	F 223		

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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 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" there were no interventions implemented to keep R98 and R29 separated. The facility had not identified interventions to reduce 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 presents with a longstanding mentality where	F 223		

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F 223	Continued From page 11 aggression is a viable option, and he is not one to concede. Thus his potential for further altercation with staff and other residents is significant. His cognitive deficits, impaired judgement, etc only adds to this risk potential..." On 12/5/11, R98 had "ongoing aggressive behavior/ verbalization continue reportedly." Treatment plan was "Will remain available to follow resident to facilitate adjustment process, assist with reducing frequency and intensity of volatile behaviors... staff are advised to follow protocol around provision of care to dementia patients (ex approach from front, use names) state your objective, assess mood, if irritable, re-approach, etc." These recommendations were not added to the plan of care. On 12/19/11, R98 was identified as having "anger management issues." R98 was identified as having medium risk and was "capable of growing verbally and physically aggressive quickly." The treatment plan was "Staff are advised to follow safety protocol closely with (R98) with his risk of verbal and physical aggression (ex- keep a safe distance, reading agitation, approach him from the front, make eye contact, use names, and announce what you are there to do). Keep him at a safe distance from other residents when agitated." The treatment plan was not included on the plan of care. On 1/16/12, R98 had an "irritable presentation" although at this time the psychologist indicated R98 risk was low as R98 "has lessened somewhat in terms of risk towards others." No new recommendations were identified at this time. There were no further psychology notes	F 223		

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F 223	Continued From page 12 identified in the record. R98's plan of care dated 2/13/12, indicated the resident had behavioral symptoms of altercations with other residents. The approach's consisted of a checklist including observe for changes in cognitive status, assess for medical reason that may contribute to changes in mentation, inform resident of daily routine, validate feelings of frustration, remind and re-orientate as needed throughout the day, use simple communication, allow for choices throughout the day, encourage fluid intake, and psychology consult. Another focus area of the plan of care included physical aggression with the risk level of altercations with other residents as "low" risk. The approach's included those listed above, as well as 1 to 1's with social worker for support and validation, and remove resident to room or private area for persistent and/ or inappropriate behaviors. Although the facility identified R98 had a history of resident altercations, there were no specific interventions to protect R98 or other residents from confrontation. Also, there was no indication the facility was aware of or had implemented the specific behavioral intervention recommendations the psychologist made. These recommendations had not be included on the plan of care. R98 was observed at 6:05 a.m. on 4/25/12 sitting in the main dayroom/chapel area reading a newspaper. There were no staff in the immediate area and staff were unable to visualize R98 sitting against the wall near the front door. When interviewed at 6:10 a.m. on 4/25/12 registered nurse (RN)- D stated R98 gets up very early in the morning around 4:00 a.m., and sits	F 223		

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F 223	Continued From page 13 out in the main dayroom/ chapel to read his paper. She stated she was not aware of any resident to resident altercations involving R98 and there were no behaviors they needed to be monitoring for R98. When interviewed at 6:20 a.m. on 4/25/12, licensed practical nurse (LPN)- F stated R98 likes to get up very early in the morning. He knew R98 and R160 had previous incidents, and they just tried to keep them apart. He was unaware of any particular behaviors they were to be monitoring for R98. When interviewed at 6:35 a.m. on 4/25/12, trained medication aide (TMA)-A stated he had never seen R98 "cross" with any other residents, but the staff makes sure "no other residents are in his way." When interviewed at 6:50 p.m. on 4/25/12 LPN-E stated she didn't know anything about R98 having any resident to resident altercations with anyone. She did not know of any behaviors staff needed to monitor for R98. When interviewed at 7:15 a.m. on 4/25/12 NA-E stated she was not aware R98 had any previous behaviors and was never instructed to watch him for any behavior or interaction with other residents. When interviewed at 7:25 a.m. on 4/25/12 LPN-G stated she was not aware of any behavior monitoring the staff needed to do with R98. When interviewed at 7:26 a.m. on 4/25/12 TMA-B stated she had heard in the past that R98 and	F 223		

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F 223	Continued From page 14 R160 "don't get along" but was not aware of any special monitoring the staff needed to do. When interviewed at 7:30 a.m. on 4/25/12, LPN-H stated R98 is "pretty quiet" so she was very surprised when she heard about him pushing R160. She was not aware R98 had any behaviors. When interviewed on 4/25/12 at 8:15 a.m., the social service director (SSD) stated she did not know much about R98 as had only been at the facility since 2/13/12. She was not aware R98 had previous altercations with residents and stated the information was not passed on to her when the other social workers left the facility. SSD stated if she had known about R98's previous altercations with other residents she would have ensured interventions were in place to protect R98 and other residents. She stated she had not met with R98 for one on one interventions, but she had met with R160 and he was not a "bully-he's no R98." She stated after the altercation between R98 and R160 on 4/20/12, she called the psychologist to meet with R98. The SSD had not put any new interventions into place for R98 and did not get any recommendations from the psychologist on how to protect other vulnerable adults. The SSD stated she would call the psychologist to get the dictation from that visit and check if he had new recommendations for R98. The facility provided the psychology note which was faxed to the facility on 4/25/12 at 12:42 p.m. It was dated by the psychologist on 4/23/12, and the treatment plan and recommendations were as follows:	F 223		

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F 223	Continued From page 15 "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 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. 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	F 223		

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F 223	Continued From page 16 interventions to prevent further resident to resident altercations. When interviewed on 4/25/12 at 2:00 p.m., the administrator stated R98 is mobile and the facility can't "put up walls to keep him out of public places." She stated R98 can be "provoked" by others; otherwise he keeps to himself. R98 had multiple incidents of abusive behavior towards other residents from 6-29-11 through 4/20/12 which included: verbal abuse, threatening to kick a resident, raising his hands to strike at a resident, caused an abrasion on R160 cheek, attempting to tip a resident out of a wheelchair, and pushing a resident down to the ground resulting in a hip fracture. The facility lacked interventions to protect other residents from R98's behaviors, or protect R98 from potential retaliation from other residents. R160 was not protected from resident to resident abuse although the facility was aware of a history of altercations between R98 and R160. The facility failed to ensure other residents were protected from R160's behaviors, and ensure R160 was free from resident retaliation related to his behaviors. R160 had diagnoses including manic depression, anxiety disorder, dependent personality disorder, gait instability, and history of a stroke. R160 quarterly MDS dated 1-3-12 identified the resident had moderate cognitive impairment, was independent walking around the facility, and had verbal behaviors towards others such as threatening, screaming, or cursing at others 1-3 days in the prior 7 day assessment period.	F 223		

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F 223	Continued From page 17 Review of R160's integrated progress notes identified the following: 10-/4/11, "Residents (R98 and R160) were engaged in an unwitnessed physical altercation in which R160 sustained some abrasions on his right cheek. R160 called police but charges were deferred at this time." 3/9/12, "Resident has been overheard by staff and other residents make inappropriate comments to other residents such as 'maybe you should go get your nipples pierced!" 3/21/12, "Resident in Linden station dining room at 1530 and noted to be yelling at (unknown) resident who is confused and yells out frequently. Resident yelling at resident saying to shut up and being argumentative." 4/20/12, "Resident (R98) pushed (R160) to ground, resident fell on right side, (R160) complained of hip pain." The integrated progress note dated 4/20/12, identified R160's X-ray returned showing a right femur fracture and was admitted into the hospital on 4-20-12. The integrated progress note dated 4/23/12 , identified as a follow up from the incident on 4/20/12, noted "This resident (R160) has had a few other altercations with resident (R98) in the past. This resident has had a habit of seeking out (R98) and repeatedly saying things like "go back to bed...this resident will follow (R98). He has a learning disability and routinely repeats himself when speaking to others."	F 223		

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F 223	Continued From page 18 A resident incident report from 10/14/11, noted R160 stated (R98) "struck him on the cheek for no reason. He was by the bird cage and resident (R98) suddenly got up and punched him with a closed fist." The analysis and interventions indicated, "Isolated incidence involving another resident...Both residents were separated and urged to avoid contact. Staff advised to ensure that both residents are not together in the same area." Although the incident report directed staff to assure residents are not in the same area, there was no indication of how this would be communicated to staff and how to assure they are kept separate. The one psychology note provided by the facility dated 10/31/11, noted R160 was referred for a psychological evaluation "out of concern about boundaries and some presentation of irritability with another resident... his only concern was a male resident that got in his business and hit him. Apparently, this is the altercation that people were concerned about. He gave me the name of the resident and said that he has done everything in his power to stay away from him." The recommendations on the psychology note included: "... I suspect his 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... ." R160's plan of care dated 4/3/12, identified the resident with major depression, anxiety, personality disorder, bipolar, and had a history of previous psychiatric hospital stays. The approach's included to observe for changes in mood or behavior (although it did not identify what	F 223		

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F 223	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. When interviewed on 4/25/12 at 6:20 a.m., LPN-F stated R160 and R98 had a previous incident but staff didn't have any particular direction on the residents behaviors, the staff just tried to "keep them apart." When interviewed on 4/25/12 at 6:35 a.m., TMA-A stated he had never seen R160 have any problems with residents. He stated staff had no particular behavior interventions to do with R160. When interviewed on 4/25/12 at 7:25 a.m., LPN-C stated she knew of a "couple times" R160 and R98 had gotten into altercations. She stated she had not heard of anything special they were suppose to monitor for; she just knew R160 and R98 "did not like each other." 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 or special instructions staff had regarding R160.	F 223		

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F 223	Continued From page 20 When interviewed on 4/25/12 at 8:40 a.m., the social service director (SSD) stated R160 is "a busy body" and can be "annoying to people." She stated R160 was never "malicious, he just gets in people's faces." She stated she was not aware of any previous altercations between R160 and R98 as she just started in February and this information was not passed onto her. SSD stated, "It would have been nice to know; they have a real system problem here." When interviewed on 4/25/12 at 9:55 a.m., with MSA-Z she stated R160 and R98 had a history with each other and did not like each other. She stated she tried to keep them separate in the dining area because they had gotten into a physical alteration in the past. MSA-Z stated she tried to keep an eye on R98 and R160 when they were near each other so there was not an altercation. When interviewed on 4/25/12 at 11:15 a.m., the DON stated R160 had "several" altercations with R98 in the past. She stated R160 will "seek people out" to "get to them" and R160 can be "intrusive." Although the facility was aware R160 had these behaviors, the DON verified none of these were identified on the plan of care or assessed to ensure R160 and other residents safety. R160 was still hospitalized at the time of the exit conference on 5/2/12. R160 had incidents of behaviors towards other residents from 10/4/11 to 4/20/12 which included: intrusiveness, antagonistic behaviors, verbal	F 223		

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F 223	Continued From page 21 abuse, repeated physical altercations with R98 and yelling at confused residents. The facility lacked interventions to protect other residents from R160's behaviors, or protect R160 from potential retaliation from other residents. R29 was identified with aggressive behaviors towards others and the facility lacked interventions to protect other residents from the behaviors, or protect the resident from potential retaliation from other residents. R29 had diagnoses which included: oppositional defiance disorder, mood disorder, and organic brain syndrome. The annual minimum data set assessment (MDS) dated 6/21/11, noted R29's cognition was intact and he had verbal and physical behaviors towards others that significantly disrupted care or living environment. It noted he was not ambulatory, but used a wheelchair and was independent with locomotion on and off the unit. The care area assessment (CAA) completed on 6/22/11 indicated R29 required redirection and reassurance due to inappropriate behaviors. It noted he had a potential behavioral problem that would be addressed in the plan of care to minimize risks and a referral to the house psychologist was warranted. The CAA identified his behavioral disturbances had a pattern and offensive or defensive in nature. It noted R29 would get upset when he needed to be toileted, or when he wanted to be waited on for meals and medication passes. The CAA noted he liked to follow a routine and became aggressive when a routine was not followed.	F 223		

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F 223	Continued From page 22 The quarterly MDS dated 3/21/12, indicated the resident's cognition was still intact and he continued to demonstrate verbal and physical behaviors towards others such as: hitting, kicking, pushing, grabbing, threatening, screaming and cursing. The MDS also noted he had other behaviors not directed toward others. R29 was independent in his wheelchair on and off of his living unit and did not have any impairment with his range of motion. A copy of the resident's current plan of care was provided by the facility on 4/25/12. The care plan identified R29 had a history of aggression and yelled at staff and grabbed staff inappropriately. The care plan included a goal to "not harm self or others" and offered various interventions such as: encourage to express feelings, refer to psychologist, compliment on good mood and behavior, anticipate needs, and use the "behavioral contract". The care plan lacked information to include his history of aggressive acts towards other residents, addressing the aggression towards only staff. When interviewed on 4/27/12 at 12:00 p.m., licensed practical nurse (LPN) -D and R29's nurse practitioner stated R29 once had a behavioral contract, but neither of them could locate it in the chart or elsewhere. Review of the nursing assistant care sheet dated 4/25/12, noted the resident may be verbally and physically abusive, and directed staff to report all behaviors to the nurse immediately and assist with needs as soon as possible to decrease agitation.	F 223		

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F 223	Continued From page 23 The facility incident reports identified the following occurrences: On 5/20/11 at 2:00 p.m., staff observed R29 put his right forearm across R22's neck. The physician and family were notified. An analysis as to the cause of the occurrence was noted by a check mark for "behavior". The review by the interdisciplinary team (IDT) on 5/23/11, noted they encouraged R22 not to make comments to R29 about his behavior. On 12/17/11 at 7:00 p.m., R29 staff heard a noise and observed a R98 holding on to R29's shirt. R98 stated that R29 had threatened to kick him. The physician and family were notified. The section to identify an analysis of the cause was left blank. The IDT reviewed it on 12/19/121, and noted R29's psychotropic medications were changed just before the incident, and that both residents blamed each other. On 2/3/12 at 10:35 p.m., R29 wheeled up behind R16 who was sitting in a wheelchair. R29 began to make a high pitched yell and reached out and squeezed R16's right shoulder near the neck. R29 stated "Yeah I touched her, she was in my way". The nurse practitioner and family were notified. The analysis of occurrence was noted by a check marks for "behavior" and "medications". The incident report noted his psychotropic medications had recently been decreased. The incident was reviewed by the IDT on 2/6/12, and they noted they would have the nurse practitioner review the decrease in medications. On 3/12/12 at 4:00 p.m., R29 punched R3829 in the back of the head. R29 stated " she did not	F 223		

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F 223	Continued From page 24 move out of my way" when asked what happened. The family and nurse practitioner were notified. An analysis as to the cause of the occurrence was noted with a check mark for "behavior". The incident was reviewed by IDT on 3/13/12, and the comments section noted " ask nurse practitioner to check labs". On 3/30/12 at 2:00 p.m., R29 pinched R3913 on his right shoulder. He stated the resident was in his way and he wanted to get through. The nurse practitioner and family were notified. The analysis of the occurrence was identified by a check mark for "behavior". The IDT reviewed the incident on 4/2/12, and noted the nurse practitioner would be updated for suggestions. In addition to the incident reports, the following incidents were noted in the facility Integrated Progress Notes (IPN): On 9/7/11- R29 was verbally aggressive and yelling at his roommate to get out of his room. On 2/23/12, R29 was passing out clothing protectors. He was observed with a raised hand going towards R3913. R29 stated R3913 "did not seem appreciative". The facility pastor intervened and there was no physical contact. When reviewed, the psychology progress notes (PPN) indicated the resident had been receiving services since at least 4/18/11. The notes included the following information: 5/16/12- Altercation with another resident a few days ago. Recommendation: position him facing away from a crowd of people, and place in a	F 223		

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F 223	Continued From page 25 position that allows easy access to leave and go back to his room. 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. 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.,	F 223		

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F 223	Continued From page 26 Resident 116, whom the facility identified as cognitively intact, stated a few weeks ago she witnessed R29 being attacked by R98. She stated R98 was in the face of R29 and had a hold of his arm, and the staff had to break it up. When interviewed on 4/29/12 at 1:24 p.m., RN-E stated R29 had a history of aggression towards others, but he had not had any behaviors for the past few weeks. R29 was observed lying in his bed watching television. When interviewed, he stated he was feeling find and relaxing. On 4/27/12 at 9:23 a.m., trained medication aide (TMA)-A was interviewed and stated R29 had been aggressive in the past toward other residents, but had not been recently. He stated he had a definite routine, and would become disturbed if he could not follow it. On 4/27/12 at 11:55 a.m., R29 was observed lying on his bed and watching television. At 12:00 p.m., R29's nurse practitioner stated the R29's problem was impulse control, not psychoses. She stated he had been aggressive in the past, less so recently. She had been adjusting his medications to decrease his behaviors and he was much better. On 4/30 at 2:30 p.m., R29 was observed seated at a table with 4 other residents playing card bingo. He waved at the surveyor. At 5:45 p.m., R29 was observed seated outside of R157's room, calmly visiting with her. When interviewed on 5/1/12 at 9:39 a.m., the facility social worker stated R29 was on the psychology case load. She verified that his	F 223		

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F 223	Continued From page 27 existing care plan did not contain the warning signs to look for and interventions to implement for his aggressive behaviors towards other residents. She stated R29 was impulsive, impatient, and was cognitively intact. When interviewed on 5/1/12 at 8:15 a.m., the director of nursing stated the R29 had been far more aggressive in the past, but most recently he was better. She stated he did have some incidents of aggression towards others in the prior month, and verified there were several residents in the facility that could not defend themselves if R29 became aggressive. She verified that the care plan lacked specific information about his aggression such as his triggers and his warning signs. She stated R29 had a history of aggressive behavior, the facility was not monitoring R29 behavior to ensure his behaviors would not harm other residents. R29 had multiple incidents of abusive behavior towards other residents from 5-20-11 through 3-30-12 which included: of verbal abuse, having his arm across R22's neck, threatening behavior, pinching, and "punching" R3829 in the head. The facility lacked interventions to protect other residents from these behaviors, or protect R29 from potential retaliation from other residents. The facility initiated an IJ removal plan which included a comprehensive assessment of all three residents (R98, R160, R29) and their behaviors, updating individual care plans to include specific interventions, trained staff on the recognition of resident to resident abuse and behaviors, and increased monitoring and	F 223		

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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 223		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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.	F 225	**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.	

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F 225	Continued From page 29 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review the facility failed to ensure all allegations of potential abuse, neglect, injuries of unknown source and misappropriation of resident property were immediately reported to the administrator and to the state agency, along with conducting a thorough investigation for 10 of 17 residents (R55, R7, R83, R165, R120, R104, R14, R92, R22, R95) in the sample reviewed for alleged abuse, and misappropriation of resident property. Findings include: Resident 55 (R55) had multiple bruises of unknown origin, that were not thoroughly investigated or immediately reported to the state agency and the administrator. R55 had diagnoses which included dementia. The annual MDS dated 1/19/12, noted the resident's cognition was severely impaired. R55 required extensive assistance with mobility, and was dependent on staff for her activities of daily living. The MDS noted the resident demonstrated physical, verbal, and other types of behaviors.	F 225	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. 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 random 20% of current incident reports on file will be audited by 06/11/12 to ensure proper reporting and investigation has taken place. Audit 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 policy and procedure for abuse prohibition and incident reporting and follow up will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policy and procedure	

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	245018	A. BUILDING _____ B. WING _____	05/02/2012

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F 225	Continued From page 30 The care plan dated 1/25/12, noted the resident was resistive to cares. The facility Resident Skin Changes Report (RSCR) form dated 4/2/12, noted R55 was found with new purple bruises. The left arm contained three, 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. The incident report noted R55 was interviewed and yelled "Leave me alone!" The "Immediate Investigation" field (a place to document) on the RSCR was left blank. The report noted the family and physician were notified on 4/2/12; however the administrator and the state agency were not notified. The "Investigation Notes" field was left blank. The RSCR had an attached form titled "Investigation Notes for Injury of Unknown Origin" (INIUO), which contained fields to document identified diagnosis or behaviors prior to the incident and staff interviews for the current shift and prior two shifts. These areas were also left blank. On 4/30/12 at 3:30 p.m., the director of nursing (DON) and administrator (ADM) stated this incident should have been reported to the ADM and state agency because R55 had impaired cognition and the injury was unexplained with multiple bruising noted in the same area. They verified a thorough investigation had not been completed. Although R55 received multiple bruises, a thorough investigation was not completed to include the resident's diagnosis and behaviors prior to the incident and the completion of staff	F 225	to ensure current standards of practice are in place. Facility staff members will be trained as it relates to their respective roles and responsibilities for the revised policies and procedures regarding abuse prohibition and incident report completion by 06/11/12. Audits will be completed weekly for 4 weeks, monthly for 3 months, then according to the quality control schedule to ensure continued compliance with facility protocols. A meeting will be held with a group of residents and or designated decision makers by 06/11/12 to ensure concerns are followed up on by staff members and resolutions are provided. Upon this review, system revisions and/or staff education will be implemented if indicated. The Administrator or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 225	Continued From page 31 interviews of those who discovered the injury, and those who cared for the resident on prior shifts. Resident 7 (R7) had multiple bruises of unknown origin that were not thoroughly investigated or immediately to the state agency. R7 had diagnoses which included dementia. The quarterly MDS dated 3/24/12, noted the resident's cognition was moderately impaired and she was dependent on staff for toileting, dressing and bed mobility. The MDS noted the resident did not demonstrate behaviors. 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 "Immediate Investigation" field noted the resident was on anticoagulant (prevents blood clotting) therapy. The report indicated the administrator and physician were immediately notified, and the family was notified the next day; however the state agency was not notified. The "Investigation Notes" field of the form referenced the resident had slumped into the E-Z stand sling 6 days prior, and the resident's INR was unstable. 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.	F 225		

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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 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	F 225		

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F 225	Continued From page 33 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. Although R83 had a bruise of unknown origin, a thorough investigation was not completed to include the resident's diagnosis and behaviors prior to the incident, and interviewing staff who cared for R83 on prior shifts. Resident 165 (R165) had an abrasion of unknown origin that was not thoroughly investigated or immediately reported to the state agency and the administrator. R165 had diagnoses which included dementia. The admission MDS dated 3/12/12, noted the resident was severely impaired in cognition and required extensive assistance with dressing, hygiene, and mobility. The MDS noted the resident did not demonstrate verbal or physical behaviors, but had other types of behaviors. The care plan dated 3/14/12, did not indicate the resident was resistive to cares. 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. The "Investigation Notes" section on the report completed by a registered nurse on 4/5/12, noted the resident had a fall on 4/1/12, and was found on her left side. The report indicated the administrator (ADM) and the state agency were not notified. On 4/30/12 at 3:30 p.m., the ADM, DON and CEO were all present to review the incident. The ADM stated due to the large size of the injury and	F 225		

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F 225	Continued From page 34 because R165's cognition was impaired and could not explain the injury, it should have been reported to the ADM and the state agency, but it had not. Although R165 had an abrasion of an unknown origin, a thorough investigation was not completed to include the resident's diagnosis and behaviors prior to the incident, nor were staff interviews conducted of those who discovered the injury, and those who cared for the resident two prior shifts. The facility linked it to a fall on 4/1/12, however documentation lacked to indicate that the abrasion was identified at the time of that fall. When interviewed on 5/1/12 at 8:00 a.m., the director of nursing stated the facility did not have documentation to indicate the facility tracked and trended the incidents along with care givers in order to look for potential patterns related to the incidents and staffing. When interviewed on 4/26/12 at 2:55 p.m., the DON, ADM, and CEO all agreed that an injury of unknown origin was one that could not be explained by resident, one that was not observed by anyone, one that was in suspicious location, and if there had been a number of injuries observed at once, or a number of incidents over time. They agreed all incidents should be thoroughly investigated if they met the criteria stated. When interviewed on 4/29/2012 at 12:30 p.m., the ADM and CEO stated although they reviewed and signed the RSCR, the director of nursing was responsible for ensuring the investigations were	F 225		

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F 225	Continued From page 35 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 investigated. When reviewed, the facility submitted a 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 reported R120 had stated 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 and the supervisor was unable to contact the family member 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, but because the resident denied being slapped when asked, they did not. 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 no further 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	F 225		

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F 225	Continued From page 36 surrounding the incident. Resident 104 (R104) was allegedly slapped by staff, and the facility lacked a thorough investigation into the matter. 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, and 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 documented evidence of the staff who were interviewed, and when the interviews occurred. 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 report to the state agency. She stated she could retrieve the information by looking back at the schedules again. The information was not received. Resident 14 (R14) sustained a laceration which was not thoroughly investigated. R14 sustained a 1.5 inch laceration above her right eye on 1/30/12, which required sutures. According to the report submitted to the state agency, on 1/30/12 the resident was found lying on the floor, and had fallen out of her wheelchair. When interviewed on 5/1/12 at 8:00 a.m., the DON stated there had been no further investigation. The investigation lacked an interview with the person/persons reporting the	F 225		

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F 225	Continued From page 37 incident, a review of the resident medical record, and a review of all circumstances surrounding the incident. Although the report to the state agency was timely, the facility was unable to provide evidence they had conducted a thorough investigation to ensure the residents care was provided in accordance with the plan of care and that no neglect had occurred. Resident 92 (R92) was found outside the building during cold weather, and it was not thoroughly investigated. R92 was found outside of the building without a coat 2/12/12. The temperature was 27 degrees Fahrenheit. When interviewed on 5/1/12 at 8:00 a.m., the DON stated there had been no further investigation. Although the incident was reported to the state agency timely and an intervention (wander-guard) was immediately put into place, the facility lacked evidence that a thorough investigation into the matter was conducted to determine things such as: how long the resident had been outside, who was responsible for her well-being at the time, and whether the plan of care was being implemented in order to determine if indeed any neglect had occurred. Resident 22 (R22) reported to the facility staff someone was rough with her during an outside appointment, and she sustained a bruise. The facility did not report the incident to the state agency or conduct a thorough investigation.	F 225		

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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. When interviewed on 4/26/12 at 2:55 p.m., the administrator stated a thorough investigation was not completed, and the incident should have been reported to the state agency. 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	F 225		

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F 225	Continued From page 39 investigation in to the matter. R95 had diagnosis including hypertension. R95's quarterly MDS dated 3/6/12, indicated he is understood and is able to report the day of week and that he is moderately cognitively impaired. The plan of care updated 2/29/12, indicated he has short term memory loss, at times. The care plan did not indicate R95 has any long term memory loss or that he has impaired decision making. The facility Integrated Progress Notes dated 10/12/11, was reviewed and indicated "Resident reported to this writer that somebody robbed him this week. He wanted to speak to the boss and wouldn't tell me anymore about the incident. Supervisor notified of the the residents request". At 9:27 a.m. on 4/27/12, LPN- C stated she was informed by R95 of the missing money and she informed a supervisor but could not remember who she told. At 9:53 a.m. on 4/27/12, R95 stated he was robbed "they took everything in my coin purses. I had 3 of them; it was about $90 in total. I don't keep much money in my purses anymore. The facility did not do anything about it either, that is the problem with this facility; they don't follow through with anything". At 12:29 p.m. on 4/27/12, the administrator and the director of nursing stated they were not aware of R95 reporting of any missing money. They verified they should have been notified and the state agency should have been notified.	F 225		

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F 225	Continued From page 40 The facility lacked a thorough investigation to include a review of the resident's complaint report, interviews with staff members having contact with resident during the period of alleged incident, interviews with family, roommates or visitors. 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 source and misappropriation of property are promptly and thoroughly investigated. The facility's policy directed the investigation would consist of at least the following:	F 225		

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F 225	Continued From page 41 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 incident.....including 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.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to followed their abuse prohibition policy regarding appropriate reporting and thorough investigations of alleged violations of abuse, neglect or injuries of unknown origin for 10 of 17 residents (R55, R7, R83, R165, R22, R95, R120, R104, R14, &	F 226	**F226 Staff Treatment of Residents** It is the policy of Crest View Lutheran Home to develop and implement policies and procedures regarding screening and training employees to prevent, identify, and report abuse, neglect, and mistreatment misappropriation of property. The interpretive guidelines for this F-tag refer to seven key components to be reviewed by surveyors to determine if facility is meeting the intent of F226.	

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F 226	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 source and misappropriation of property are	F 226	assessments, care plan updates, training of employees, protection of a resident during an investigation and investigative protocols. For other employees who may have been affected by this practice employee files will be audited for reference checks and completed if necessary by 06/11/12. Screening: An audit will be completed by 06/11/12 for a random sample of employee records to ensure that prescreening was completed. Training: Random interviews of staff members will be conducted by 06/11/12 to ensure their understanding of their roles and responsibilities as it relates to the abuse prohibition/prevention policy and procedures. All staff meetings will be held by 06/11/12 to review the abuse prohibition policy. Prevention: A meeting will be held with individual residents or with a group of residents by 06/11/12 to ensure that allegations of abuse, neglect, misappropriation, or mistreatment have been addressed	

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	245018	A. BUILDING _____ B. WING _____	05/02/2012

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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 incident.....including 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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F 226	Continued From page 44 administrator and the state agency were not notified. The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated, as directed by their policy. On 4/30/12 at 3:30 p.m., the director of nursing (DON) and administrator (ADM) stated this incident should have been reported to the ADM and state agency because it was not explained by the resident and multiple bruises were noted in the same area. They verified a thorough investigation had not been completed. 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	F 226	Reporting/Response: An audit will be completed by 06/11/12 of investigations to ensure reporting timelines were met and investigations completed. 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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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 ADM stated due to the large size of the injury and	F 226	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,	

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F 226	Continued From page 46 because the resident's cognition was impaired and could not explain the injury, it should have been reported to the ADM and the state agency, but it had not. Resident 22 (R22) reported rough treatment at an outside appointment, and the facility did not report this to the state agency or complete a thorough investigation as directed by their facility policy. R22 clinical record contained a progress notes dated 10/21/11 that indicated the author of the note 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, which the resident said had occurred while at an outside appointment due to a nurse being " a little rough when holding her hand." The facility was unable to provide evidence the injury of unknown origin was thoroughly investigated to include all the directives in their policy. When interviewed on 4/26/12 at 2:55 p.m. the administrator stated a thorough investigation was lacking, and it should have been reported to the state agency as directed by the facility abuse prohibition policy. Resident 95 (R95) reported to the facility he was missing personal property and the facility failed to report this to the administrator and the state agency as directed by their facility policy. R95's clinical record contained a progress note dated 10/12/11, which indicated the resident reported to a facility staff person that someone	F 226	Audits will be completed weekly for 4 weeks, monthly for 3 months, and then according the quality control schedule to ensure screening, training, prevention, identification, investigation, and protection is/are in place. The results of those audits will be reported to the CQI Committee for further review and recommendations. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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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 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. 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	F 226		

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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. 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. 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. 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.	F 226		

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F 226	Continued From page 49 R14 sustained a 1.5 inch laceration above her right eye on 1/30/12, which required sutures. According to the report submitted to the state agency, on 1/30/12 the resident was found lying on the floor, and had fallen out of her wheelchair. Although the facility submitted a report the state agency timely, the facility was unable to provide evidence they had conducted a thorough investigation in accordance with their policy to ensure the residents care was provided in accordance with the plan of care and that no neglect had occurred. When interviewed on 5/1/12 at 8:00 a.m., the DON stated there had been no further investigation beside what had been submitted to the state agency. Resident 92 (R92) was found outside the building during cold weather on 2/12/12, and it was not thoroughly investigated as directed by their facility policy. R92 was found outside of the building without a coat 2/12/12. The temperature was 27 degrees Fahrenheit. The incident was reported to the state agency timely, but the facility was unable to provide evidence that a thorough investigation was completed that included all the directives in their policy to determine if indeed any neglect occurred. When interviewed on 5/1/12 at 8:00 a.m., the DON stated there had been no further investigation besides what had been submitted to the state agency for R92. During interview interviewed on 4/26/12 at 2:55	F 226		

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F 226	Continued From page 50 p.m., the DON, ADM, and CEO all agreed that an injuries of unknown origin was one that could not be explained by resident, one that was not observed by anyone, one that was in suspicious location, and if there had been a number of injuries observed at once, or a number of incidents over time. They agreed they should be thoroughly investigated if they met the criteria stated in the policy. When interviewed on 4/29/2012 at 12:30 p.m., the administrator and CEO stated that although they reviewed and signed the incidents, the director of nursing was responsible for ensuring the investigations were thoroughly reviewed and processed. They also stated their facility policy was not implemented as directed. POLICY LANGUAGE The facility's Abuse Prohibition Policy dated 3/10 was reviewed. It was noted to contain directives and language that could be misinterpreted to a reader. This had the potential to affect all 114 residents that resided in the facility. The policy contained the following discrepancies: Page 1, paragraph 5, noted "staff members, volunteers, family members, and others "should be encouraged" to report incidents of abuse... ." When interviewed about the policy on 4/26/12 at 2:55 p.m., the director of nursing (DON), administrator (ADM), and chief executive officer (CEO) all agreed the language would be more clear if it directed staff "must" report, as opposed to "should be encouraged" to report.	F 226		

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F 226	Continued From page 51 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. 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. Procedure 7 noted employees accused of resident abuse shall be barred from any further contact with the "involved resident", rather than all 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	F 226		

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F 226	Continued From page 52 more clear if it directed incidents " must " be reported to the Administrator immediately, and that the accuser would be barred from "all" resident contact, in order to protect the residents. Page 12, procedure 4, of the policy noted "If the accused is an employee of the facility, he/she "may be suspended" until the investigation has been completed...". When interviewed on 4/26/12 at 2:55 p.m., the DON, ADM, and CEO all agreed the language would be more clear if it read the employee "will be" suspended or would not have any direct contact with "all" residents pending the investigation. Page 13, Procedure: External Reporting: directed staff to alert the state agency of any reportable incidents. It lacked a directive to how timely the report needed to be submitted in accordance with state law. When interviewed on 4/29/2012 at 12:30 p.m., the administrator and CEO stated that their policy language needed to be improved, and they were in the process of re-writing it. They verified the directives could be understood differently by various readers of the policy. SCREENING The facility failed to implement their facility's policy for the screening process for of new employees. The facility's Abuse Prohibition Policy dated 3/10, identified screening of employees/volunteers as a component of the policy. It noted the director	F 226		

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F 226	Continued From page 53 hiring the candidate must conduct reference checks of the candidate's prior employment and 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. 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. 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	F 226		

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F 226	Continued From page 54 outlined in their policy. 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.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide meal service in a manner that would promote dignity for 1 of 22 residents (R24) who was not assisted in a timely manner, and for 8 of 22 residents (R50, R104, R19, R55, R30, R134, R90 and R167) who were seated at tray tables instead of dining tables. In addition, the dining room atmosphere was not respectful for 4 of 22 residents (R51, R61, R40, and R125) in the Willow Dining Room were directly affected by the maladaptive behavior of another resident (R165) in the Willow Dining Room. Findings include: R24 was not assisted with her meal for 1 hour and 6 minutes after it was served. R24's diagnosis included Alzheimer's disease.	F 241	**F241 Dignity** It is the policy of Crest View Lutheran Home to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident R24 was served her meal upon notification. For Resident(s) R50, R104, R19, R30, R134, and R167 the tray tables were removed and regular dining tables were put into place. For Resident R90, his spouse uses a tray table to set his food on when she visits at brunch and assists him with dining. For all other meals R90 will be placed at a regular dining table. For Resident(s) R51, R61, R40, and R125 a new behavior plan will be created for R165 to assist with a more positive dining experience. A plan was initiated for R165 to ensure	

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

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F 241	Continued From page 55 The quarterly minimum data set (MDS) dated 1/27/12, identified she was never/rarely understood, had short and long term memory problems, and was totally dependent upon staff for eating. R24 was observed during the evening meal at 4:45 p.m. on 4/23/12 in the Willow dining room. Her meal was placed in front of her at 5:22 p.m. She sat without attempting to feed herself while her two tablemate's were feeding themselves. Nursing assistant (NA)-B was observed passing out desserts, at 5:43 she removed R24's plate that she had without any explanation to R24. When asked, NA-B stated she assigned to feed R24, but she didn't have any time to do this task. NA-B placed R24's plate in the refrigerator and would re-heat it when she had time to assist R24 to eat. R24 continued to sit at the table while her tablemate's ate their meal. R24 sat there with nothing to eat. At 5:51 p.m. registered nurse (RN)-B brought R24 her meal and sat down to assist her. R24 had been sitting at the table for 1 hour and 6 minutes before any staff assisted her to eat, even though her table mates were eating their meals. R50, R104, R19, R55, R30, R134, R90 and R167 were seated at tray tables in the Willow dining room instead of sitting at the dining tables with their peers sat and ate. R50's diagnoses included schizophrenia and stroke. The quarterly MDS dated 3/2/12 included he had moderate cognitive impairment, had no	F 241	she has the ability to leave the meal for calming and so other residents may enjoy mealtime. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. The primary physician was informed of assessment results and a review of the current physician orders will be completed by 06/11/12. Education will be provided for staff members on the policy for dignity and a positive dining experience by 06/11/12. Resident R55 expired on 05/27/12. For other residents who may be affected by this practice, audits will be completed weekly for 4 weeks, monthly for 3 months, and then according to the quality control schedule regarding dining with dignity to ensure residents are being provided with dignity and respect. For other residents who may be affected by this practice, audits will be completed weekly for 4 weeks, monthly for 3 months, and then	

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F 241	Continued From page 56 mood or behavioral problems, and fed himself with set up assistance. R50's plan of care dated 8/21/11, included "Staff to set up tray" and 11/28/11, included "allow choices throughout the day." R50 was observed during the evening meal at 4:45 p.m. on 4/23/12 in the Willow dining room. Even though there were large tables available for residents to sit at, R50 sat on the right side (as you enter the dining room) with his back against the wall. He had an over bed tray table in front of him to place his meal. R50 stated he did not know why he sat at the tray table, and added "I would like to sit at that table with all the men." R50 pointed to a nearby table that seated four men. When asked if a table had been offered to him to eat at, R50 stated "No, I have to sit here." R104's diagnoses included dementia. The significant change MDS dated 3/16/12 identified she had severe cognitive impairment and indicated it was very important for her to do things with groups of people. She was independent eating with staff assistance to set her meal up. R104's plan of care dated 2/5/11 indicated she ate independently with "tray set up" and 3/5/12 was to "encourage socialization and leisure activities." R104 was observed during the evening meal at 4:45 p.m. to 6:30 p.m. on 4/23/12 in the Willow dining room seated at an over the bed tray table, against the wall instead of a dining table where her peers sat and ate. R104 was unable to answer any questions by the surveyor. R19's diagnoses included Alzheimer's disease.	F 241	according to the quality control schedule regarding dining with dignity to ensure residents are being provided with dignity and respect. The policy for dining services will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding dining services policy and procedures and dignity rights by 06/11/12. Audit results will be reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 241	Continued From page 57 The annual MDS dated 3/23/12 identified the resident had severe cognitive impairment and the interview for daily preferences indicated it was somewhat important to do things with groups of people. She required supervision, oversight, encouragement or cueing for meal times. R19 plan of care dated 3/16/12 indicated "sits at separate table to decrease food and liquid stealing and d/t (due to) spastic movements." R19 was observed during the evening meal at 4:45 p.m. to 6:30 p.m. on 4/23/12 in the Willow dining room. She sat at an over the bed tray table with her back to the wall facing out toward the dining room. R19 was given her plate of food at 5:20 p.m. and fed herself with her fingers, including ice cream, hamburger hot dish and green beans. No one assisted or cued R19 to use silverware until a trained medication aide (TMA)-D sat down and attempted to assist R19 to eat at 6:00 p.m., but R19 refused to eat at that time. R19 was not able to answer questions by the surveyor. R55's diagnoses included dementia and malnutrition. The annual MDS dated 2/2/12 identified she had long and short term memory problems, severely impaired decision making skills and required extensive assistance with eating. R55's plan of care dated 4/21/12 included "tray set up" and "assist with part of meal" and "encourage socialization and leisure activities." R55 was observed during the evening meal at 4:45 p.m. to 6:30 p.m. on 4/23/12. R55 sat on the left hand side of the dining room with an over the bed tray table rather to eat her meal instead of a dining room tables that was used by her peers for	F 241		

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F 241	Continued From page 58 their meal. R55 fed herself her meal but was unable to answer questions by the surveyor. R30's diagnoses included dementia. R30's annual MDS dated 1/26/12 identified the resident had severe cognitive impairment and required supervision, oversight, encouragement or cueing for meals. R30's plan of care dated 4/19/12 included she required tray set up and to "encourage socialization and leisure activities." R30 was observed during the evening meal at 4:45 p.m. to 6:30 p.m. on 4/23/12, she sat with an over the bed tray table in the dining room for her meal instead of a dining room table that her peers ate. During the meal R30 would ask passerby's to identify where items the food items were located on her tray. She was not able to answer questions by the surveyor. R134's diagnoses included dementia and psychotic disorder. The quarterly MDS dated 1/11/12 indicated moderate cognitive impairment and required limited assistance with eating. R134's plan of care dated 7/14/11 included he required tray set up. R134 was observed at 10:57 a.m. on 4/24/12 for the brunch meal in the Willow dining room seated with a bed tray table for her meal instead of a dining room table where his peers ate. R134 was independent with his meal. During the evening meal at approximately 5:45 pm on 4-23-12, R134 was observed seated at a dining room table with his peers and did not use the bed tray table as he had on 4-24-12. R90's diagnoses included dementia and	F 241		

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F 241	Continued From page 59 Parkinson's disease. The quarterly MDS dated 1/26/12 included severe cognitive impairment and required total staff assistance with eating. R90's plan of care dated 4/24/12 included total assistance with feeding was required. R90 was observed in the Willow dining room at 10:57 a.m. on 4/24/12 seated at the bed tray table for his meal instead of a dining room table where his peers ate. Family member (FM)-A fed him his meal. R167's diagnoses included dementia. Her quarterly MDS dated 3/27/12 included severe cognitive impairment and required cueing and supervision while eating. R167's plan of care dated 3/30/12 included tray set up was required. R167 was observed at 10:57 a.m. on 4/24/12 seated at an over the bed tray table in the Willow dining room instead of sitting at a dining room table where her peers ate. When interviewed at 9:22 a.m. on 4/27/12, TMA-C stated there was no assigned seating in the dining room and some residents preferred to have their own space and sit at the bed side tray tables instead of a dining table. She stated R30 and R19 both preferred sitting at the bedside tray tables. When interviewed at 1:50 p.m. on 4/27/12, nurse supervisor (NS)-A stated there was no assigned seating in the Willow dining room. Residents who sat using the bed tray tables had behaviors, especially R50, R19 and R167. She had no explanation as to why different residents used the tray tables sometimes and at others time they	F 241		

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F 241	Continued From page 60 used the dining room tables. When interviewed at 2:59 p.m. on 4/30/12, NS-A indicated they had not thought about getting more four-person tables like the others in the dining room so everyone could be seated at a dining room table instead of over the bed tray tables. She stated maintenance may be able to bring in more tables and they could try and place the residents who used tray tables at the new tables. NS-A confirmed these residents had not been assessed to use over the bed tables rather than sitting at dining tables with their peers except for R19 who had a habit of stealing others liquids. Even though the facility allowed most residents to eat at tables with their peers, R50, R104, R19, R55, R30, R134, R90 and R167 were seated at over the bed tray tables on the outskirts of the dining room away from their peers. The dining room atmosphere was not respectful for 4 of 22 residents (R51, R61, R40, and R125) in the Willow Dining Room were directly affected by the maladaptive behavior of another resident (R165). R165 disrupted the dining room without adequate staff intervention for 1 hour and 45 minutes. R165's diagnoses included dementia and Parkinson's disease. The admission MDS dated 3/15/12 included severe cognitive impairment, inattention, disorganized thinking, no behaviors directed towards others, and behaviors do not impact others or do not significantly disrupt care or living environment. R165 required only set up assistance for meals.	F 241		

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F 241	Continued From page 61 Dining was observed in the Willow dining room from 4:45 p.m. to 6:30 p.m. on 4/23/12. R165 was sitting at a table with R40 to her left, R51 was across the table from her and R61 was at a table next to her. R165 started yelling when she entered into the dining room at 4:45 p.m. She was pointing and shaking her finger at R51 across the table and screaming "get out of here, get out of my house before I call the police. Shut up, I said shut up." TMA-D told R165, "I will take care of it" and walked away. R165 continued to scream at R51, then directed it to R40 that "she hurt my daughter, she has no right to be in here, I think you better leave." Then to R51 "You are as bad as your son, shut up, get her out of my house before I pick her up and throw her out of my window." R165 then pounded her fist on the table repetitively. TMA-D who was passing medications in the dining room again told R165 "I will take care of her" and offered R165 a beverage. R165 pulled off her clothing protector, while looking at R51 but did not strike R51 with it. After TMA-D left R165 continued to yell at R51 "get out of here, get out of here" very loudly "your not out of my house yet, shut up, I don't even want to hear your voice, get her out of here before I kill her." R165 continued to scream at R51 and R40. R125 then came and sat down to R165's right at 5:02 p.m. and R165 started screaming at him also. During the interaction of R165 screaming at her table mates R51 did not respond to R165 but continued to stare at her and her face flushed. R40 would wince and pull back in her wheel chair with the loudest outbursts from R165. R125 did not react to her and just stared straight ahead, ignoring her. R61 who was at a nearby table started to mimicked what R165 was	F 241		

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F 241	Continued From page 62 saying. Even though there was staff in the room. Staff made no attempted to intervene until 5:07 p.m. when a nurse aide-Z came into the dining room and removed R165 to the day room right, which was just outside the dining room. R165 sat in the day room without any staff interaction with intermittent outbursts "ahhhh" made into a scream sound and "nurse, nurse, that damn nurse can go to jail too," I want water, I said now." R165 then threatened "I will throw this at you" holding a glass of water. There was no one was in the day room, nor did staff attempt to redirect 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 was taken out of the area. During interview at 6:30 p.m. on 4/23/12 TMA-D stated they just do the best they can with R165 when she gets like this which is most of the time. He was unable to identify a specific plan of how to deal with R165's disruptive behaviors in the dining room. When interviewed at 3:00 p.m., NS-A stated "I guess we really don't have a plan if R165 is	F 241		

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F 241	Continued From page 63 disruptive during meal time." Licensed practical nurse (LPN)-I who was present stated "we don't want her in her room all the time." NS-A and LPN-I acknowledged R165 behavior was disruptive in the dining room for other residents. R165 was allowed to disrupt the dining of others for 1 hour and 45 minutes. Even though she was removed at one point, she was still able to be heard screaming from just outside the dining room in the day room. An undated facility policy entitled "serving-dining room service included "residents shall be served meals in a courteous and dignified manner."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 3 residents (R116) was allowed to make choices about her bathing/shower frequency each week. Findings include: Resident 116's (R116) quarterly minimum data set assessment dated 1/12/12 indicated there	F 242	**F242 Self-Determination and Participating** It is the policy of Crest View Lutheran Home that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. For other current residents who may be affected by this practice, the resident and/or designated decision maker will be asked about	

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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. 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 had asked in the past to have two showers a week, but was told if they did it for her, they would have to do it for everyone, and they could not do that. When interviewed on 4/25/12 at 7:34 a.m., licensed practical nurse (LPN)-D stated she had never heard R116 ask for more frequent showers, but that was not an uncommon request. When interviewed on 4/25/12 at 9:30 a.m., R116 was asked about her shower day. She stated it was on Fridays, and again stated she would prefer to have a shower twice weekly, but was told they could not as they would have to do it for everyone then (consistent request). 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.	F 242	bathing/shower preferences. For new admissions, the Life Enrichment department will interview the resident regarding bathing/shower preferences and relay the request to nursing. A meeting with a resident group will be held by 06/11/12 to inform residents of their right to make decisions about their activities, schedules, and health care. Individual resident concerns identified following the meeting will be addressed using the concern/complaint procedure. The bathing protocols will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policy to ensure it meets the current standards of practice. Education will be provided for staff members by 06/11/12 regarding resident right to choose bathing schedules as it relates to their respective roles and responsibilities for the reviewed and revised protocols. The bathing protocols will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policy to ensure it meets the current	

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F 242	Continued From page 65 She stated R116 was alert, orientated and reliable. She stated the resident likely had just needed to ask the right person to get the request implemented.	F 242	standards of practice. Education will be provided for staff members by 06/11/12 regarding resident right to choose bathing schedules as it relates to their respective roles and responsibilities for the reviewed and revised protocols. Bathing audits will be completed by checking bath logs weekly for 4 weeks, monthly for 3 months, then according the quality control schedule to ensure that resident choices are honored with results reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12 **F244 Participation in Resident and Family Groups** It is the policy of Crest View Lutheran Home to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident council grievances were addressed timely for 3 of 3 residents (R22, R130, and R280) who attended resident council and complained about not being able to go on outings anymore because there was no van driver. Findings include: Review of resident council meeting minutes indicated the following: September 2011- The assistant director of life enrichment (ADLE) "explained that with the addition of more staff the trips to restaurants, shopping, and casinos would hopefully start up again. At this time there is no person qualified to drive to events." October 2011- "Outings were discussed and	F 244		

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F 244	Continued From page 66 residents would like to go to the following places: Walmart, Target, Grocery store, museums, Perkins, Old Country Buffet, Applebees, Dollar store." December 2011- "When will trips off site start again? (ADLE) explained that at this time there is no one hired to drive the bus for casino, shopping, or eating out trips." January 2012- "It was mentioned that a person was studying the bus driving manual and hopefully outings could be made in the future. " February 2012- The ADLE "did share that as of yet no bus driver has been found for outside trips." March 2012- "No information has been shared about the bus driver for outside trips. The life enrichment staff has not been given any information about when this situation will be resolved. This is a situation which has come up at many council meetings. Questions in the future should be directed to the administrator of this facility. (The directions to her office were requested and given to the residents)." During interview at 5:50 p.m. on 4-23-12, R22 stated she misses being able to go on outings at the facility and they have not been on an outing for "almost a year." She stated the facility van driver quit about a year ago and the facility keeps saying they are trying to get someone who can drive, but hasn't done anything about it yet. R22 stated they have talked about this at resident council "many times" but it had not been addressed because there is a big "turnover" in	F 244	and operational decisions affecting resident care and life in the facility. For Resident R22, R130, and R280, their concern regarding the lack of outings was reported to the Administrator. The outings were resumed on 5/21/12 when a driver was available. A plan was initiated by the Life Enrichment Director to offer at least one outing per month. The new plan for resident outings will be discussed with the resident council by 06/11/12. The Life Enrichment department has two employees that will be testing for their bus licenses by 07/1/12. Education will be provided for staff members on the availability of resident outings by 06/11/12. For other residents who may be affected by this practice a meeting will be offered by 06/11/12 to the resident councils to share ideas and concerns and ensure that issues have been brought to the attention of facility leadership for follow up. The concerns will be investigated with results reported to the resident/family council each month.	

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

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F 244	Continued From page 67 the activity department. Review of R22's progress note from associated clinic of psychology dated 8-8-11 indicated resident "did offer one concern that there are not many activities these days where residents are taken outside of the building. She wanted to know if I could put in a good word in to the staff to see if they could do that once again. I told her I would be willing to do so. She very much looks forward to outings on, I assume, the bus that was provided by the facility." During interview at 11:00 a.m. on 4-4-24-12, R130 stated they (resident council) have been complaining for awhile about not having outings anymore and does not feel like the facility has addressed it. R130 stated the facility just keeps saying it is "being worked on." During interview at 3:20 p.m. on 5-1-12, R280 stated resident council had talked a lot about wanting to go on outings again and the facility stated the "other van driver wasn't acceptable." She stated the facility said they were going to do something about it but that was "a long time ago" and they haven't heard anything since. During interview with ADLE at 7:50 a.m. on 4-25-12, he stated he assists the residents with resident council meetings and writes up the meeting minutes. He stated there had been such a turnover in the life enrichment department they just have not had anyone who is able to drive for the residents. He stated the facility had not done anything to resolve this issue and the residents bring it up often in resident council. He doesn't know how to respond to the resident council	F 244	The protocols for outings will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policy to ensure it meets the current standards of practice. Education will be provided for staff members regarding outings as it relates to their respective roles and responsibilities for the reviewed and revised protocols. Monthly audits will be completed to ensure that resident council concerns are heard and acted upon with results reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Life Enrichment or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 244	Continued From page 68 because management keeps saying they are working on getting a driver but it does not get resolved. During interview at 2:55 p.m. on 4-30-12, the facility administrator stated she was aware the residents had brought up concerns in resident council about outings but the facility did not have a driver. She stated the assisted living has a driver and they may use her to bring the residents on outings. She indicated that driver had worked at the assisted living "for along time" but was unsure why they had not utilized her to drive sooner. She stated nothing was currently scheduled for outings and the facility is working on it. The administrator indicated the new activity director is "working on" getting her bus license. During interview at 3:50 p.m. on 4-30-12, the director of life enrichment stated she had been hired about 4 weeks ago as the director. She stated she is reading the manual for her bus license but does not have a deadline or appointment scheduled for when she will be attempting to take her license. She also indicated the facility had "talked" about using the driver from the assisted living for outings, although nothing had been scheduled yet.	F 244		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	**F250 Social Services** It is the policy of Crest View Lutheran Home to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	

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F 250	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on interview and document review the the facility failed to provide medically related social services to assure adequate assessing, monitoring and implementation of behavioral interventions were completed for 3 of 4 residents (R98, R160, R161) who exhibited behavioral disturbances or depression. Findings include: Resident 98 (R98) had diagnoses including dementia with behavior disturbance, altered mental state, and traumatic brain injury. R98 quarterly minimum data set (MDS) dated 2-11-12 identified the resident had moderate cognitive impairment, was independent in walking around the facility, and had a history of physical behavior towards others such as hitting, kicking, pushing, or grabbing in the prior 4-6 days of the 7 day assessment period. Review of R98's progress notes indicated R98 had physical or verbal altercations with other residents on 6-29-11, 8-31-11, 9-4-11, 10-14-11, 12-17-11, 3-2-12, and 4-20-12 which resulted in injury to another residents, R160. R98's was referred to psychology for "anger management issues." The psychology notes indicated the following: 11-21-11- R98 had significant defects in insight and had long standing problems with anger management. The notes 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	F 250	For Resident(s) R98 and R161 a new assessment for safety risk, cognition, mood, and behavior will be completed by 06/11/12. The social worker and chaplain met with Resident R161 to discuss the loss of his daughter and provide support. A grief and loss care plan will be initiated for R161. 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 behavioral interventions and depression management by 06/11/12. Resident R160 discharged on 04/20/12. For other residents who may be affected by this practice a record review and resident interviews will be completed regarding behavioral care and depression by 06/11/12 to ensure that medically related social services are being provided to meet resident needs. Upon review, if concerns are identified they will be brought to the IDT Team for resolution guidance.	

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F 250	Continued From page 70 seemed physically capable of harming others when agitated. The treatment plan and recommendations were, "He presents with a longstanding mentality where aggression is a viable option, and he is not one to concede. Thus his potential for further altercation with staff and other residents is significant. His cognitive deficits, impaired judgement, etc only adds to this risk potential..." 12-5-11- R98 had "ongoing aggressive behavior/ verbalization continue reportedly." Treatment plan was "Will remain available to follow resident to facilitate adjustment process, assist with reducing frequency and intensity of volatile behaviors... staff are advised to follow protocol around provision of care to dementia patients (ex approach from front, use names) state your objective, assess mood, if irritable, reproach, etc." 12-19-12- R98 was identified as having "anger management issues." R98 was identified as having medium risk and was "capable of growing verbally and physically aggressive quickly." The treatment plan was "Staff are advised to follow safety protocol closely with (R98) with his risk of verbal and physical aggression (ex- keep a safe distance, reading agitation, approach him from the front, make eye contact, use names, and announce what you are there to do). Keep him at a safe distance from other residents when agitated." 1-16-12- R98 had an "irritable presentation" but was identified by the psychologist as low risk because R98 "has lessened somewhat in terms of risk towards others." No new recommendations were made at this time. This	F 250	The policy and procedure for behavioral care, cognition, and mood will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policies to ensure they meet the current standards of practice. Education will be provided for staff members regarding cognition, mood, and behavior as it relates to their respective roles and responsibilities for the behavioral care policies and procedures. The policy and procedure for behavioral care, cognition, and mood will be reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policies to ensure they meet the current standards of practice. Education will be provided for staff members regarding cognition, mood, and behavior as it relates to their respective roles and responsibilities for the behavioral care policies and procedures. Cognition, mood, and behavior audits will be completed weekly for 4	

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F 250	Continued From page 71 was the last psychology note available in R98's medical record. R98's plan of care dated 2-13-12 indicated R98 had behavioral symptoms of altercations with other residents. The approach's consisted of a checklist including observe for changes in cognitive status, assess for medical reason that may contribute to changes in mentation, inform resident of daily routine, validate feelings of frustration, remind and re-orientate as needed throughout the day, use simple communication, allow for choices throughout the day, encourage fluid intake, and psychology consult. Another focus area of the plan of care included physical aggression with the risk level of altercations with other residents as "low" risk. The approach's included those listed above, as well as 1 to 1's with social worker for support and validation, and remove resident to room or private area for persistent and/ or inappropriate behaviors. Although the facility identified R98 had a history of resident altercations, there were no specific interventions to protect R98 or other residents from confrontation. Also, there was no indication the facility was following or aware of the recommendations the psychologist made. In addition, there was no indication 1 to 1's with the social worker was ever offered or implemented. During interview on 4-25-12 at 8:15 a.m. the Social service director (SSD) stated she does not know much about R98 as she had "only" been at the facility since 2-13-12. She was not aware R98 had previous altercations with other residents and stated the information was not passed on to her when the other social workers left the facility. SSD stated if she had known	F 250	weeks, monthly for 3 months, and then according to the quality control schedule to ensure that medically related social services are provided to meet resident needs with results reported to the CQI Committee for review and further 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	

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F 250	Continued From page 72 about R98's previous altercations with other residents she would have ensured interventions were in place to protect R98 and other residents. She stated she had not met with R98 for one on one interventions, but she had met with R160. She knew R160 was not a "bully- he's no [R98]." She stated after the altercation on 4-20-12 between R98 and R160 she called the psychologist to come to the facility and meet with R98. SSD had not put any new interventions into place for R98 and did not get any recommendations from the psychologist on how to protect other vulnerable adults. SSD stated she would call the psychologist to get the dictation from that visit and check if he had any new recommendations for R98 abrupt behavior. The facility provided the psychology note which was faxed to the facility on 4-25-12 at 12:42 p.m. The 4-23-12 psychologist note indicated the treatment plan and recommendations for R98 were as follows: "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, it should be something that can be diverted by staff before escalating." During interview on 4-25-12 at 11:15 a.m. the Director of nursing (DON) stated R98 is pleasant and sits out in the main dayroom almost all the time. She verified R98's plan of care did not include specific interventions to prevent further resident to resident altercations.	F 250		

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F 250	Continued From page 73 Although R98 had a well documented history of anger management issues with multiple altercations with other residents. The social work failed to implement interventions that were identified to protect R98 and other residents from potential injury. No further information was provided. R160 was not kept free from resident to resident altercations, even though the facility was aware of prior altercations with R98. R160 had diagnoses including manic depression, anxiety disorder, dependent personality disorder, gait instability, and history of a stroke. R160 quarterly MDS dated 1-3-12 identified the resident had moderate cognitive impairment, was independent walking around the facility, and had verbal behaviors towards others such as threatening, screaming, or cursing at others 1-3 days in the prior 7 day assessment period. Review of R160's integrated progress notes identified R160 had a resident to resident altercation with R98 on 10-14-11. There was no indication that additional interventions were implemented after this incident to prevent additional altercations. The 10-31-11 psychology note identified R160 was referred for a psychological evaluation "out of concern about boundaries and some presentation of irritability with another resident... his only concern was a male resident that got in his business and hit him. Apparently, this is the altercation that people were concerned about. He gave me the name of the resident and said	F 250		

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F 250	Continued From page 74 that he has done everything in his power to stay away from him." The psychologist recommendations were "... I suspect his 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. The integrated progress note dated 4-23-12 which was identified as a follow up from the incident on 4-20-12 identified, "This resident (R160) has had a few other altercations with resident (R98) in the past. This resident has had a habit of seeking out (R98) and repeatedly saying things like "go back to bed...this resident will follow (R98). He has a learning disability and routinely repeats himself when speaking to others." R160's plan of care dated 4-3-12 identified R160 had major depression, anxiety, personality disorder, bipolar, and had a history of previous psychiatric hospital stays. The approach's included to observe for changes in mood or behavior, offer support, validate feelings, provide safe environment for resident and others, and psychology consult if needed. R160's plan of care did not identify what specific behaviors R160 exhibited, there was no monitoring of R160's behaviors of resident to resident altercations, the plan did not direct staff to separate R160 and R98	F 250		

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F 250	Continued From page 75 to ensure they were not in the same area, nor did the plan identify any of the psychology recommendations to decrease or eliminate R160's behaviors. R160's safety risk assessment dated 4-19-12 had an area on the assessment to identify behaviors, this was left blank. During interview on 4-25-12 at 8:40 a.m. the social service director (SSD) stated R160 is "a busy body" and can be "annoying to people." She stated R160 was never "malicious, he just gets in people's faces." She stated she was not aware of any previous altercations between R160 and R98 as she just started in February 2012 and this information was not passed onto her. SSD stated, "It would have been nice to know; they have a real system problem here." R160 was still in the hospital on 5-2-12, when the survey was exited. Although the facility was aware of the previous resident to resident altercations with R160 and R98, the facility failed to provide medically related social services to assure adequate assessing, monitoring and implementation of behavioral interventions were implemented to ensure resident safety. The facility undated Director of Social Services Job Description, identified the position summary as "...developing care plans to meet the psychosocial well-being and needs of residents and to enable residents to achieve their optimal level of independence..." The Responsibilities	F 250		

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F 250	Continued From page 76 and duties instruct "Assess's residents social, psychological, and emotional status and develops a plan of care that meets the residents needs."	F 250		

No additional information was provided.

R161 had a diagnosis of depression, indicators of depression and had a recent death of an immediate family member, however there was no assessment to determine if or what social service interventions were needed even though R161 had these risk factors.

R161 quarterly MDS dated 4/13/12 failed to assess mood patterns, section D (mood) had been left blank. R161's diagnosis included depression and had a recent stroke with swallowing complications.

R161's most recent assessment of mood indicators was with the previous quarters MDS with an ARD of 12/28/11 and signed by RN-E on 1/17/12. This assessment (section D) showed R161 had indicators of depression such as: little interest or pleasure in doing things nearly every day; feeling down, depressed or hopeless nearly every day; trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy nearly every day.

R161's check list style plan of care dated 4/9/12 included "potential alteration in mood and/or psychosocial well-being r/t depression, adjusting to new environment and decline in independence." Goal was listed as "Will be safe in their environment" and "Will have little to no side effects from meds." Interventions listed as "observe for changes in mood and/or behavior.

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F 250	Continued From page 77 Encourage resident to express feelings, frustrations or concerns. Offer support, 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. Psychology consult if indicated." R161's physician order sheets dated 3/30/12 indicated R161 had started on Remeron (an antidepressant) 15 mg on 1/12/12. R161 social service progress notes dated 2/10/12 indicated the most recent BIMS and PHQ-9 were assessed 12/28/11 and indicated signs of depression. It further indicated "he continues to be seen by psych consult." No further social service notes were in R161's medical record. Psychology consult notes were not found in R161's medical record, they were requested from the facility, but were not provided. R161's "care conference summary" dated 4/5/12 indicated he had a "recent death in family, (name) was showing signs of depression-wife reported that after the funeral for the daughter he seems lighter and has closure, was able to deal with the loss." During interview with nursing supervisor (NS)-D at 8:13 a.m. on 4/27/12, she reviewed information for R161 and verified the facility had not been monitoring R161 for mood indicators. During interview with the director of social services (SS)-A at 10:15 a.m. on 4/27/12, she	F 250		

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F 250	Continued From page 78 stated "what I heard about him losing his daughter was that he was sad until the funeral and then felt closure and did ok, I did not feel I needed to intervene." Futher stating R161's had wanted to discharge but this was held up due to swallowing problems and requiring a tube feeding. She indicated family and the facility chaplain had been involved. She verified no assessment had been completed for cognitive status or depression since December 2011. She did not have time to complete the assessments nor had received any training on how to complete the MDS. R161 was interviewed at 3:35 p.m. on 5/2/12, he did not wish to discuss his depression or the death of his daughter with the surveyor. He stated he would be discharging soon and was looking forward to going home. R161 had indicators of depression in December 2011, his daughter passed away during the quarter, and his discharge had been delayed by medical difficulties. However, no assessment of his depression had been completed to determine if further intervention was required for R161. An undated Crest View Lutheran Home job description for "Director of Social Services" provided by the facility included under "position summary...Developing care plans to meet the psychosocial well-being and needs of residents and to enable residents to achieve their optimal level of independence. Responsible for documentation and record keeping in appropriate areas." Under "responsibilities and duties" includes under number 3, "Provide ongoing counseling and problem solving services to	F 250		

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F 250	Continued From page 79 residents and family members." Under number 4, "completes social history, mini mental state assessment, geriatric depression scale and advanced directives for residents." Under number 5, "assesses resident's social, psychological, and emotional status and develops a plan of care that meets the residents' needs." Under number 6, "has knowledge and understanding of how to complete the assigned sections of the Minimum Data Set."	F 250		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide a home like dining experience for 8 of 22 residents (R55, R30, R50, R104, R19, R134, R90 and R167) who ate in the facility's secured (Willow) unit. Findings include: On 4/23/12 at 4:45 p.m., four large round tables seating 4 residents at each and 2 smaller, two person tables were observed during dinner in the Willow dining room. On the left side of the dining room along the wall, R55 and R30 were each seated in front of an over-the-bed tray table which was lined up against the wall. On the right side of the dining room R50, R104, and R19 each sat in	F 252	**F252 Environment** It is the practice of Crest View Lutheran Home to provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. For Resident(s) R50, R104, R19, R30, R134, and R167 the tray tables were removed and regular dining tables were put into place. For Resident R90, his spouse uses a tray table to set his food on when she visits at brunch and assists him with dining. For all other meals R90 will be placed at a regular dining table. The care plan for residents who have family members that bring in food will be updated to reflect family and resident wishes. Corresponding	

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F 252	Continued From page 80 front of a over-the-bed tray tables against that wall. R50, R104, R19, R55, and R30 each were served their meals on the tray tables. These residents were not seated at regular dining tables like their peers. During dining observation at 10:57 a.m. on 4/24/12, there were several different residents sitting at the tray tables then previous observation, R134, R90, and R167. R55, R50 and R19 were again observed sitting at the tray tables by the wall. R30 and R104 were seated at regular dining tables during this meal observation. During interview with R50 at 5:19 p.m. on 4/23/12 during the meal service, he stated he did not know why he sat at a tray table on the outskirts of the dining room and would like to sit with the other 4 men at the table nearby. During interview at 9:22 a.m. on 4/27/12 trained medication aide (TMA)-C stated there was no assigned seating in the dining room but some residents prefer to have their space and sit at the bed side tray tables instead of a dining table. She identified R30 and R19 who prefer this. During interview at 1:50 p.m. on 4/27/12 nurse supervisor (NS)-A stated there was no assigned seating in the Willow dining room. Residents who sit at over the bed tray tables are due to their behaviors; especially R50, R19, and R167. She had no explanation as to why different residents used the tray tables at different times. During interview at 2:59 p.m. on 4/30/12 NS-A stated getting a few more four-person tables like the others in the dining room had not come up	F 252	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 dining practices by 06/11/12. Resident R55 expired on 05/26/12. For other residents who may be affected by this practice dining services audits will be completed by 06/11/12 with results reported to dining, nursing, or environmental services for review and follow up. The policy and procedure for dining services was reviewed and revised by the interdisciplinary team by 06/11/12. The Medical Director will review the policy to ensure it meets the current standards of practice. Education was provided for staff members regarding dining with dignity as it relates to their respective roles and responsibilities by 06/11/12. Dining Services audits will be completed weekly for 4 weeks,	

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F 252	Continued From page 81 before. Maintenance may be able to bring in more tables to try and place the residents who use tray tables at a dining table. NS-A confirmed these residents had not been assessed to use over the bed tables rather than sitting at real tables like their peers; except R19 who had a habit of stealing others liquids. The facility did not have enough tables in the Willow dining room to accommodate all residents who ate in the dining room and over the bed tray tables were given to 5-6 residents. During observation on 5/1/12 at 10:00 a.m., an additional table had been provided for the residents.	F 252	monthly for 3 months, and according to the quality control schedule with results reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Dining Services or designee will be responsible. Date of Correction: 06/11/12	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272	**F272 Resident Assessment** It is the policy of Crest View Lutheran Home to conduct initially and periodically, a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. It is the policy of Crest View Lutheran Home to complete a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information, customary routine, cognitive patterns, communication, vision,	

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F 272	Continued From page 82 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete a comprehensive assessment regarding safe smoking for 1 of 8 residents (R74) who was observed with burn holes in his clothing from cigarette smoking; for 1 of 1 residents (R22) who complained of denture problems and for 1 of 1 residents (R6) who had cognitive deficits and depression. Findings include: R74 had multiple cigarette burns on his pants and jacket and was not assessed to smoke safely. R74 had diagnoses of diabetes mellitus, peripheral vascular disease and schizophrenia.	F 272	mood and behavior patterns, psychological well-being, and physical functioning and structural problems. For Resident R74 a new assessment was completed for smoking safety. A smoking apron was added to his plan of care to help prevent him from burning holes in his clothing or himself. For Resident R22 all dental visits have been scheduled and attended according to regulation. Her next dental appointment is scheduled and the referral will include her concerns about denture problems. For Resident R6 a new evaluation/assessment was completed regarding cognition, mood, and behavior. 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 to staff members on smoking safety, oral care issues, and cognition, mood and behavior by 06/11/12. For other residents who smoke a smoking assessment will be completed by 06/11/12 to ensure assessments are in place. Care plans	

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F 272	Continued From page 83 The admission minimum data set (MDS) dated 2/25/12 indicated R74 had no memory impairments and was cognitively intact. The MDS also identified that he currently uses tobacco. During interview at 7:17a.m. on 4/25/12, nursing assistant (NA)-F, stated this past winter she noticed R74 had a cigarette burn hole on his gray tee shirt. NA-F also stated that during this winters she had noticed that R74 also had multiple cigarette burn hole on his winter jacket. At 8:08 a.m.. on 4/25/12, interview with housekeeping-A stated she had noticed cigarette burn holes on R74's pants but had not noticed any burns on his tee shirts. She stated she thought these burn holes occurred this winter. With R74's permission, housekeeping-A and surveyor observed R74's clothing in his closet. R74 had 10 pairs of athletic pants in his closet, some made of partial cotton and others were made of 100% polyester. R74's pants were in observed and 7 out of 10 pairs had multiple cigarette burn holes mainly in the thigh area of these pants. Document review titled "Smoking Evaluation" dated 1/10/12 and reviewed again on 2/7/12 revealed that R74 was alert, the facility smoking policy was reviewed with him, R74 follows the smoking policy, can safely utilize lighter/matches and lit smoking material, and R74 has been offered a smoking apron but refuses. The document also revealed that he demonstrates safe smoking practices with other residents. The plan indicated "resident smokes independently, cognition intact (issues with compliance in other	F 272	will be updated for the individuals affected. Upon completion of the review any concerns will be forwarded to the IDT Team for follow up. The policy for assessment completion will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding assessment policy and procedures by 06/11/12. Audits on resident assessments will be completed weekly for 4 weeks, monthly for 3 months, and then according to the MDS schedule with results reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 272	Continued From page 84 areas but has always followed smoking regulation)."	F 272		
	During interview at 8:54 a.m.. on 4/25/12, licensed practical nurse (LPN)-C stated she completed R74's smoking assessment on 2/7/12 after he moved to the Aspen unit. They offer him a smoking apron which he refuses but felt R74 was safe to smoke independently. LPN-C then stated she was not aware of any cigarette burn holes on R74's clothing and if he had burns on his clothes she would not feel he would be safe to smoke. Although the facilty assessed R74 was safe to smoke independently on 1/10/12 and 2/17/12, there were 7 out of 10 pair of R74's pants observed with multiple cigarette burns. R22 had diagnoses of weakness and renal (kidney) disease. The annual minimum data set (MDS) dated 12-22-11 identified R22 had no cognitive impairment, was a one person limited assist with personal hygiene, and had no oral or dental problems. On 4-23-12 at 5:58 p.m., R22 stated she had top and bottom dentures and neither one have fit very well since she got them back in September 2011. She stated she just saw the dentist again on 4-20-12 and they still don't fit right. She indicated at times she will wear her top dentures, but does not wear the bottom ones because "they fly out when I eat or talk; it's easier to eat without them in!" She also stated although she had just seen the dentist on 4-20-12, she had to " beg for 3 months to get in to see the dentist!"			

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F 272	Continued From page 85 The facility Evaluation and Initial Care Plan form dated 3-1-12, identified R22 had "no obvious problems" with her teeth and had upper and lower dentures. This form had an area which identified if the resident's dentures "fit." A nurse wrote in " Do not wear (dentures) per resident." There was no further assessment completed to determine why R22 does not wear the dentures. Review of the Yearly Nutrition Assessment form dated 12-23-11 identified R22 had her own teeth which were in good condition but had a "few teeth missing." There was no indication that R22 had upper and lower dentures but had their own teeth. During interview on 4-26-12 at 3:40 P.M., MDS coordinator registered nurse (RN)-E stated all residents have an oral screening in their chart but she was unable to locate one in R22's chart. She stated the dietary technicians do the annual assessment of oral health and that's where the MDS nurses get their information to fill out the MDS. MDS RN-E looked at the yearly nutrition assessment form dated 12-23-11 and stated it looked like it was incorrect because R22 had dentures. On 5-1-12 at 9:30 a.m. during interview with dietetic technician (DT)-Z she stated she completed R22's yearly nutrition assessment on 12-23-11. She stated she knows R22 does not wear her dentures in the dining room when she eats but was unsure why. DT-Z was unable to identify why the assessment was incorrect except maybe R22 was "groggy" on the day she did the assessment and did not tell DT-Z she had dentures.	F 272		

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F 272	Continued From page 86 No further information was provided. R6 had diagnoses which included dementia and schizophrenia. R6's annual MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 verifying assessment completion. Sections C (cognative 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 R6 and marked as "not-assessed" by the facility. R6's Care Area Assessments (CAA's) dated 1/21/12 included the "cognitive loss/dementia CAA) identified Alzheimer's disease and rejection of care, there was no analysis of R6's cognition or behavioral symtpoms. Even though R6 had a diagnoses of Alzhemimers dementia and schizophrenia. During interview with the facilities MDS coordinator RN-E at 8:30 a.m. on 4/24/12, she stated the social service department is responsible for sections C, D, E and Q on the MDS. At 9:30 a.m., RN-E verified sections C and D had not been completed for this resident, and indicated she does not go back and check to ensure the social worker codes the sections as required. During interview with social service director (SS) -A at 10:15 a.m., on 4/27/12, she stated the MDS has an area she can mark areas as "not-assessed" and she does this if she does not	F 272		

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F 272	Continued From page 87 have time to complete the MDS or can not find the information for coding. She had not assessed R6 for cognitive pattens or for mood indicators as required. She had not received any training on how to complete the MDS or requirements of the comprehensive or quarterly assessments.	F 272		
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update each resident assessment at least quarterly to include cognitive (section C) and mood patterns (section D) of the MDS for 7 of 40 (R161, R168, R163, R16, R15, R40, and R60) residents reviewed for assessment completion. Further, the facility failed to comprehensively assess 1 of 3 (R16) residents reviewed who experienced urinary incontinence. In addition, the facility failed to ensure 1 of 5 residents (R16) reviewed for pressure ulcers, had a comprehensive reassessment to determine needs to prevent pressure ulcers. R161's diagnosis included depression and late effects from a stroke. His quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/29/12 was signed by RN-E on 3/29/12 verifying assessment completion. Sections C (cognitive patterns and mental status) identified that C0100, C0200, C0600, C0700,	F 276	**F276 Resident Assessment (Quarterly)** It is the policy of Crest View Lutheran Home to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. For Resident(s) R161, R168, R163, R15, R40, and R60 Section C (cognition) and Section D (mood) assessments/interviews were completed. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. The primary physician was informed of the assessment results and a review of the current physician orders was completed. Education will be provided for staff members regarding assessing the resident at least quarterly according to MDS 3.0 guidelines and CMS by 06/11/12.	

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F 276	Continued From page 88 C0800 through C1000 were not assessed. Section D (resident mood assessment) identified D0100, D022, D0300, D0350, D0500, D0600, and D0650 were also not completed for R161 and marked as "not assessed" by the facility. R161's medical record revealed a Brief Interview Mental Status (BIMS) score was last completed on 12/28/11 indicating R161 was cognitively intact. The assessment (section D-mood assessment) showed R161 had indicators of depression such as: little interest or pleasure in doing things nearly every day; feeling down, depressed or hopeless nearly every day; trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy nearly every day. Although R161 had identified mood disorder problems with the 12-28-11 MDS, the 4-13-12 MDS section D was mark as "not assessed." Review of R161 social service progress notes indicated on 2/10/12 indicated "Scored a 12 on the PHQ-9 (an assessment for depression) indicating signs of depression, he continues to be seen by psych consult." No further social service notes were in R161's medical record. Psychology consult notes were not found in R161's medical record, they were requested from the facility, but not provided. R161's "care conference summary" dated 4/5/12 indicated he had a "recent death in family, (name) was showing signs of depression-wife reported that after the funeral for the daughter he seems lighter and has closure, was able to deal with the loss." During interview with the director of social	F 276	Resident R16 expired on 06/11/12. For other residents who may be affected by this practice, an audit on quarterly MDS (sections C & D) will be completed by 06/11/12. Upon this review, system revisions and/or staff education will be implemented if indicated by 06/11/12. The policy for MDS assessments will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the MDS policies and procedures by 06/11/12.	

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F 276	Continued From page 89 services (SS)-A at 10:15 a.m. on 4/27/12, she stated "what I heard about him losing his daughter was that he was sad until the funeral and then felt closure and did ok, I did not feel I needed to intervene." She indicated family and the facility chaplain had been involved. She stated she did not have time to complete the assessments. Even though R161 had indicators of depression, and his daughter passed away during the quarter, no further assessment of depression had been completed to determine if further intervention was required. R168 had diagnoses which included depression and Wernicke-Korsakoff syndrome (an brain disorder causing psychosis, memory loss and muscle incoordination and weakness). The quarterly MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 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 also not completed for R168 and were marked as "not-assessed" by the facility. R168's most recent cognitive exam entitled "Folstein mini-mental state examination" dated 10/3/11 showed moderate cognitive impairment. R168's most recent mood indicator exam entitled "geriatric depression scale" dated 10/3/11 showed it was "normal."	F 276	Audits of the MDS assessment schedule will be completed weekly for 4 weeks, monthly for 3 months, then according to the MDS schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 276	Continued From page 90 R168's physician order sheets dated 3/28/11 indicated R168 had started an antipsychotic medication (Risperione 0.25 mg (milligrams) daily) on 1/4/12, during the assessment period. Even though R168 had a diagnoses of depression and Wernicke-Korsakoff syndrome and had started an antipsychotic medications, the facility failed to re-assess R168 for depression or cognition. These assessments had not been completed since 10/3/11. R163's diagnoses included moderate major depression and received hospice care for complications after a stroke. R163's quarterly MDS with an ARD of 2/16/12 was signed by RN-E on 2/29/12 verifying assessment completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 required assessment areas were not completed for R163 and were marked as "not-assessed" by the facility. R163's most recent assessment for mood and cognition was on his significant change MDS dated 11/30/11 which showed severe cognitive impairment and indicators of depression such as "feeling down or depressed, feeling tired or having little energy, trouble falling or staying asleep or sleeping too much, and feeling bad about yourself-or that you are a failure or have let yourself or your family down." Even though R163 had a diagnoses of depression, had a terminal diagnosis, and at previous assessment had indicators of	F 276		

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F 276	Continued From page 91 depression, the facility failed to re-assess R163 for cognition or signs of depression. R16 diagnoses included Alzheimer's disease and heart failure and she was receiving hospice services. R16's quarterly MDS with an ARD of 3/10/12 was signed by RN-E on 3/26/12 verifying assessment completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 which are required assessment areas were not completed for R16 and were marked as "not-assessed" by the facility. R16's previous assessment, a significant change MDS dated 12/21/11, indicated severe cognitive impairment and indicators of depression such as "Feeling down, depressed or hopeless. Trouble falling or staying asleep, or sleeping too much, Feeling tired or having little energy. Poor appetite or overeating. Feeling bad about yourself or that you are a failure or have let yourself or your family down." Even though R16 had indicators of depression and cognitive impairment on the previous assessment in December 2011 and had a terminal illness, the facility failed to re-assess her cognitive status or how her depression was. R15 diagnoses included recurrent major depressive disorder with psychosis and suicidal ideation. R15's quarterly MDS with an ARD of 2/24/12 was signed by RN-E on 3/9/12 verifying assessment	F 276		

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F 276	Continued From page 92 completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 required assessment areas were not completed for R15 and were marked as "not-assessed" by the facility. R15's previous quarterly MDS dated 12/9/11 indicated she was cognitively intact, had indicators of depression such as "Feeling down, depressed, or hopeless. Trouble falling or staying asleep, or sleeping too much. Trouble concentrating on things such as reading the newspaper or watching television." Even though R15 diagnoses included major depression and she had indicators of depression on her previous assessment 12/9/11, the facility failed to re-assess her for changes in cognition and mood indicators. R40 diagnoses included severe dementia and depression. R40's quarterly MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 verifying assessment completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 required assessment areas were not completed for R40 and were marked as "not-assessed" by the facility. R40's previous quarterly MDS dated 10/20/11 included she had short and long term memory problems. Staff assessment of mood indicators showed R40 had indicators of depression such as "Feeling tired or having little energy. Poor	F 276		

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F 276	Continued From page 93 appetite or overeating. Indicating that she feels bad about self, is a failure, or has let self or your family down. Being short-tempered, easily annoyed." Even though R40 had a diagnoses of severe dementia and depression as well as previously had indicators of depression, the facility failed to re-assess R40 for depression or cognition changes. R60 diagnoses included Alzheimer's disease. R60's quarterly MDS with an ARD of 4/4/12 was signed by RN-E on 4/18/12 verifying assessment completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 required assessment areas were not completed for R60 and were marked as "not-assessed" by the facility. R60 previous quarterly MDS with an ARD of 1/3/12 was signed by RN-E on 1/21/12 verifying assessment completion. Sections C0100, C0200, C0600, C0700, C0800, C0900, C1000, D0100, D0200, D0300, D0350, D0500, D0600, and D0650 required assessment areas were not completed for R60 and were marked as "not-assessed" by the facility. R60's next prior assessment was her annual MDS dated 10/14/11 showed she had long and short term memory problems and did not have any indicators of depression. Even though R60 had Alzheimer's disease, the facility failed to re-assess her cognitive status and	F 276		

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F 276	Continued From page 94 her mood since October of 2011. During interview with the facilities MDS coordinator, RN-E at 8:30 a.m. on 4/24/12 she stated the social service department is responsible for sections C, D, E and Q on the MDS. At 9:30 a.m. RN-E verified sections C and D had not been completed for these residents, and indicated she does not go back and check to ensure the social worker codes the sections as required. During interview with social service director (SS) -A at 10:15 a.m. on 4/27/12, she stated the MDS has an area she can mark areas as "not-assessed" and she does this if she does not have time to complete the MDS or can not find the information for coding. She had not assessed these residents for cognitive pattens or for mood indicators as required. She had not received any training on how to complete the MDS or requirements of the comprehensive or quarterly assessments. The facility failed to re-assess the cognition or mood status of R161, R168, R163, R16, R15, R40 and R60 even though each was at risk for a change in mental, emotional and cognitive status and the assessments are a required portion of the quarterly assessment. R16's urinary incontinence was not comprehensively assessed by the facility to determine type of incontinence or voiding pattern. R16's diagnoses included Alzheimer's disease, heart failure, urinary retention (the inability to empty the bladder by voiding) and chronic kidney	F 276		

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F 276	Continued From page 95 disease. R16's quarterly minimum data set (MDS) dated 3/26/12 did not assess R16's cognitive status. The MDS identified R16 required extensive assistance to toilet, was occasionally incontinent of urine, but was not on a toileting plan. R16's previous assessment, a significant change MDS dated 12/21/11 indicated severe cognitive impairment. 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 date 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 assessed to determine a pattern. On 3/6/12 date the assessment form showed R16 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 because much of the form had not been filled in. 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 "antianxiety, antihypertensives, antipsychotics, diuretics and narcotics." No peri-rectal abnormalities were noted. Under "additional data" included fluid intake at meals, diet assist of	F 276		

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F 276	Continued From page 96 1 and relates needs." Under "bladder present status" included "bladder frequency every 2-3 hours, incontinent with control, medium to large amount each voiding, no pain or change to pattern in last year. Bowel status as continue formed stool every day. An LPN had gathered this data. The form has a section completed by a RN under "care planning" and included the following: calls for assist every 2-3 hours, needs anticipated every 2-3 hours, adjust clothing and assist, percale with assist, staff to observe resident for signs and symptoms of urinary tract infection, observe for bowel pattern changes, meds as ordered. Under "Assessment" read "Resident toileted every 2 hours upon her request, requires assist with pericares and to transfer at times inc (incontinent) but no pattern seen, continue care plan. R16's assessment done on 3/7/12 failed to address the lack of data collected to comprehensively assess voiding patterns, R16's use of a diuretic medication that can cause urgency/frequency shortly after administration, use of narcotic pain medication that may cause drowsiness and therefor functional incontinence, patterns of fluid intake, if utilizes any caffeine that may irritate the bladder, or any testing for R16 to determine if she was currently having any urinary retention as she had a diagnosis of urinary retention. Further, the facility failed to identify the type of urinary incontinence R16 had such as urge, stress, mixed, overflow, or functional. During interview with MDS nurse (MDS)-F at 3:00 p.m. on 4/26/12, she stated there is no registered nurse (RN) to assess if toileting programs are effective, therefore residents are not placed on	F 276		

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F 276	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 ulcers. R16's quarterly minimum data set (MDS) dated 3/26/12 did not assess R16's cognitive status. R16's MDS identified she required extensive assistance with bed mobility and transfers, had	F 276		

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F 276	Continued From page 98 no pressure ulcers but was at risk for development of pressure ulcers. R16's significant change MDS dated 12/21/11 indicated severe cognitive impairment. R16's diagnoses included Alzheimer's disease and heart failure. R16's care area assessment (CAA) dated 12/13/11 indicated she was at risk for pressure ulcers due to she "requires staff assistance to move sufficiently to relieve pressure over any one site, confined to bed or chair all or most of time, persistently wet, especially from fecal incontinence, wound drainage of perspiration, immobility, incontinent, altered mental status, delirium limits mobility, cognitive loss, poor nutrition, use of antianxiety and narcotic medications, diabetes, chronic or end stage liver or heart disease, recent decline in activities of daily living, dementia, terminal illness and pain. The CAA indicated care planning would be completed to avoid complications. A significant change "nutrition assessment form" dated 12/10/11 indicated R16's coccyx was red. R16's "Braden scale assessment form for predicting pressure sore risk" dated 3/3/312 indicated she had the following risk factors for pressure ulcer development: "occasionally moist-skin is occasionally moist, requiring an extra linen change approximately once per day. chair fast-ability to walk severely limited or non-existent, cannot bear own weight and/or must be assisted into chair or wheel chair. mobility slightly limited makes frequent though slight changes in body or extremity position independently, nutrition probably inadequate...and friction and shear potential- moves feebly or	F 276		

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F 276	Continued From page 99 requires minimum assistance. During a move skin probably slides to some extent against sheets, chair...occasionally slides down." This form was signed by a licensed practical nurse (LPN). R16's "Crest View Lutheran Home comprehensive evaluation of skin risk factors" dated 4/21/12 check list items were checked for R16: scored 3 or lower in moisture, incontinent of bowel, incontinent of bladder, nationally at risk, at risk for shear and friction, cognitively impaired, assist with ADL's (activities of daily living), and pain. Included on this form was a "analysis of risk factors and interventions" which included "decreased mobility, impaired cognition and incont of bladder. Receives keefor ointment to red bottom-intact-turned and toileted every 2 hours." On the back side of this form included "admission/MDS body audit" and was dated 4/21/12, this included a drawing of a body and on drawing staff had circled the area of the coccyx and wrote "red" next to it. This area was not staged or identified if it was a pressure ulcer. The assessments performed by the facility 12/13/11, 3/3/12 and 4/21/12 failed to identify what risk factors R16 had that could be modified and failed to include an evaluation of R16's skins ability to endure the effects of pressure without adverse effects. Further, the 4/21/12 assessment failed to identify if the red area on R16's coccyx was a pressure ulcer and/or the cause. R16's treatment record for each month December 2011 through May 2012 included "Wound care: prevent pressure ulcers, turning and repositioning every 1-2 hours and as needed tissue	F 276		

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F 276	Continued From page 100 tolerance..." Also included staring 12/1/11 was "Keegans cream-apply to red area on coccyx and peri-area q (every shift) and prn (as needed)." During interview at 8:00 a.m. on 4/24/12 NA-I stated she was not aware if R16 should be repositioned or off-loaded at any time intervals. She stated R16 will often say when she needs to lie down, but she has bad days when she doesn't indicate this need and staff will assist her to bed if she is sleepy. During interview with LPN-A at 12:00 p.m. on 4/24/12 she was not aware if R16 was on any time frames for repositioning; she thought it should be every couple hours or so. She stated the nurse aides should assist R16 with repositioning as directed on their worksheets. She was not aware R16 ever had a reddened coccyx, she stated she gets the Keegens cream to prevent rash. During interview at 12:03 p.m. on 4/24/12 NA-C stated R16 will usually say when she needs to lie down, although she has days where she can't related to her varying cognition status. During interview at 3:00 p.m. on 4/26/12 the MDS nurse (MDS)-F stated a tissue tolerance test is done quarterly or annually by the facility to assist in determining positioning needs. She was unable to find any testing done since R16 had been admitted to the facility. During interview at 10:00 a.m. on 4/27/12 MDS coordinator (MDS)-E stated the facility normally does an admission and annual tissue tolerance testing for each resident. She was unable to	F 276		

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F 276	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 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 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. No further information was provided.	F 276		

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F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a comprehensive assessment utilizing the resident assessment instrument was completed at the time of the quarterly or annual assessment to include cognitive and mood and	F 278	**F278 Accuracy of Assessment** It is the policy of Crest View Lutheran Home to ensure that the assessment accurately reflect the resident's status. For Resident(s) R161, R168, R163, R15, R6, R40, and R60 a new assessment was completed for cognition, mood, and behavior. For R95 a new assessment was completed for fall risk. Corresponding updates have been made to the care plan, care assignment sheets, and communicated to the resident and/or designated decision maker. Education will be provided for staff members regarding cognition, mood, behavior care, and fall risk by 06/11/12. Resident R16 expired on 05/27/12. For other residents who may be affected by this practice, an audit of cognition, mood, behavior, and falls will be completed by 06/11/12. Upon this review, system revisions and/or staff education will be implemented if indicated by 06/11/12.	

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F 278	Continued From page 103 behavior patterns for 8 of 41 residents (R161, R168, R163, R16, R15, R6, R40, and R60) reviewed for assessment completion. Furthermore the assessment did not accurately reflect fall status for 1 of 3 residents (R95) with identified falls. Findings included: R161's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/29/12 was signed as completed by the registered nurse, MDS coordinator (RN)-E on 4/13/12. 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 R161 and marked as "not-assessed" by the facility. R168's quarterly MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 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 R168 and marked as "not-assessed" by the facility. R163's quarterly MDS with an ARD of 2/16/12 was signed by RN-E on 2/29/12 verifying assessment completion. The MDS section C (cognitive patterns and mental status) identified that C0100, C0200, C0600, C0700, C0800,	F 278	The policy for assessment completion will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the cognition, mood, behavior care, and fall risk by 06/11/12. Audits on cognition, mood, behavior care and fall risk will be completed weekly for 4 weeks, monthly for 3 months, then according to the quality control schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 278	Continued From page 104 through C1000 were not assessed. Section D (resident mood assessment) identified D0100, D0200, D0300, D0350, D0500, D0600, and 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. R15's quarterly MDS with an ARD of 2/24/12 was signed by RN-E on 3/9/12 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 R15 and marked as "not-assessed" by the facility. R6's annual MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 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 R6 and marked as "not-assessed"	F 278		

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F 278	Continued From page 105 by the facility. R40's quarterly MDS with an ARD of 1/7/12 was signed by RN-E on 1/21/12 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 R40 and were marked as "not-assessed" by the facility. R60's quarterly MDS with an ARD of 4/4/12 was signed by RN-E on 4/18/12 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 R60 and were marked as "not-assessed" by the facility. R95 had a fall that was not accurately assessed on his MDS. R95 had diagnoses that included hypertension. The quarterly MDS dated 9/7/11 indicated he was independent with transfers and mobility. The MDS also did not indicate he had any falls since admission or the prior assessment. When reviewed, a form titled " Resident Incident Report " dated 8/10/11, revealed that R95 had fallen in his bathroom. At 12:14p.m. on 4/27/12, interview with the MDS	F 278		

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F 278	Continued From page 106 coordinator stated his last quarterly MDS was dated 8/25/11, and she should have coded the fall that had occurred on 8/10/11. When interviewed on 4/24/12 at 8:30 a.m., about R161, R168, R163, R16, R15, R6, R40, R60, and R95 MDS. The MDS coordinator RN-E stated the social service department was responsible for sections C, D, E and Q on the MDS. At 9:30 a.m. RN-E verified sections C and D had not been completed for these residents and indicated she does not go back and check to ensure the social worker codes the sections as required. When interviewed on 4/27/12 at 10:15 a.m., the social service director (SS)-A stated the MDS has an area she can mark areas as "not-assessed" and she does this if she does not have time to complete the MDS or can not find the information for coding. She had not assessed these residents for cognitive pattens or for mood indicators as required. She had not received any training on how to complete the MDS or what is required in the comprehensive or quarterly assessment of residents. When interviewed on 4/30/12 at 12:00 p.m., the Minnesota Department of Health's MDS submission coordinator verified the facility had placed a dash in these areas for these residents on the MDS, which indicated the area was not assessed/ no information.	F 278		

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F 278	Continued From page 107 The facility failed to ensure the assessments for R161, R168, R163, R16, R15, R6, R40, R60, R158 and R95 were correctly documented to include the resident's medical, functional and psychosocial problems and identify strengths to maintain or improve medical status, functional abilities, and psychosocial status. Further, the facility failed to ensure an RN conducted or coordinated each resident assessment to ensure completion and accuracy.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 279	**F279 Comprehensive Care Plans** It is the policy of Crest View Lutheran Home to utilize the results of the assessment to develop, review and revise the resident's comprehensive plan of care. For Resident(s) R98 and R29 the care plan was reviewed and revised. Corresponding updates have been made to care assignment sheets and communicated to the resident and/or designated decision maker. Safety checks were initiated upon notification from the survey team. Safety checks are reviewed at IDT meetings daily. The primary physician was informed and a review of the current physician orders was completed. Education will be provided for staff members regarding	

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F 279	Continued From page 108 facility failed to ensure 3 of 3 residents (R98, R160, and R29) whose behaviors and known aggression towards other residents, had interventions included on their individual plan of care to ensure their safety and the safety of other vulnerable adults in the facility. Findings include: R98 diagnoses included dementia with behavior disturbance, altered mental state, and traumatic brain injury. R98's quarterly minimum data set (MDS) dated 2-11-12 identified R98 had moderate cognitive impairment, was independent in walking around the facility, and had a history of physical behavior towards others such as hitting, kicking, pushing, or grabbing 4-6 days of the 7 day assessment period. Review of R98's progress notes indicated the resident had physical or verbal altercations with various residents on 6-29-11, 8-31-11, 9-4-11, 10-14-11, 12-17-11, 3-2-12, and 4-20-12 which resulted in injury to another resident, R160. Review of R98's psychology reports indicated the following: 11-21-11- R98 had significant defects in insight and had long standing problems with anger management. His risk to others was moderate and seemed physically capable of harming others when agitated. The treatment plan and recommendations were, "He presents with a longstanding mentality where aggression is a viable option, and he is not one to concede..." 12-5-11- R98 had "ongoing aggressive behavior/	F 279	comprehensive care planning by 06/11/12. Resident R160 discharged on 04/20/12. For other residents who may be affected by this practice, an audit of care plans will be completed by 06/11/12. Upon this review, care plan revisions and/or staff education will be implemented if indicated by 06/11/12. The policy for comprehensive care plans will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the comprehensive care planning policy and procedures by 06/11/12.	

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F 279	Continued From page 109 verbalization continue reportedly." Treatment plan was "...staff are advised to follow protocol around provision of care to dementia patients (ex- approach from front, use names) state your objective, assess mood, if irritable, reproach, etc." 12-19-12- R98 was identified as having "anger management issues...capable of growing verbally and physically aggressive quickly." The treatment plan was "Staff are advised to follow safety protocol closely with (R98) with his risk of verbal and physical aggression (ex- keep a safe distance, reading agitation, approach him from the front, make eye contact, use names, and announce what you are there to do). Keep him at a safe distance from other residents when agitated." R98's plan of care dated 2-13-12 indicated the resident had behavioral symptoms of altercations with other residents. .The approach's consisted of a checklist including observe for changes in cognitive status, assess for medical reason that may contribute to changes in mentation, inform resident of daily routine, validate feelings of frustration, remind and re-orientate as needed throughout the day, use simple communication, allow for choices throughout the day, encourage fluid intake, and psychology consult. Another focus area of the plan of care included physical aggression with the risk level of altercations with other residents as "low" risk. The approach's included those listed above, as well as 1 to 1's with social worker for support and validation, and remove resident to room or private area for persistent and/ or inappropriate behaviors. Although the facility identified R98 had a history	F 279	Care plan audits will be completed weekly for 4 weeks, monthly for 3 months, then according to quality control schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 279	Continued From page 110 of resident altercations, there were no specific interventions to protect R98 or other residents from confrontation in the care plan. Also, there was no indication the facility was following or had added the recommendations of the psychologist to R98's care plan for his explosive behaviors. During interview on 4-25-12 at 11:15 a.m. the Director of nursing (DON) stated R98 is pleasant and sits out in the main dayroom almost all the time. She verified R98's plan of care did not include specific interventions to prevent further resident to resident altercations. Although R98 had known physical aggression with other residents, the plan of care did not include any interventions or triggers staff should be aware of. R160's plan of care lacked interventions and triggers related to the previous history of behaviors and resident to resident altercations. R160 diagnoses included manic depression, anxiety disorder, dependent personality disorder, gait instability, and history of a stroke. R160 quarterly MDS dated 1-3-12 identified the resident had moderate cognitive impairment, was independent walking around the facility, and had verbal behaviors towards others such as threatening, screaming, or cursing at others 1-3 days in the 7 day assessment period. Review of R160's integrated progress notes identified R160 had a resident to resident altercation with R98 on 10-14-11. A note on 4-20-12 indicated "Resident (R98) pushed (R160)	F 279		

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F 279	Continued From page 111 to ground, resident fell on right side, (R160) complained of hip pain." R160 was later sent to the hospital with a fractured right femur. R160's plan of care dated 4-3-12 identified the resident had major depression, anxiety, personality disorder, bipolar, and had a history of previous psychiatric hospital stays. The approach's included to observe for changes in mood or behavior (although it did not identify what 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 did not identify monitoring R160's behaviors regarding resident to resident altercations or direct staff to ensure R160 and R98 were not in the same area. During interview on 4-25-12 at 11:15 a.m. the DON stated R160 had "several" altercations with R98 in the past. She stated R160 will "seek people out" to "get to them" and R160 can be "intrusive." Although the facility was aware R160 had these behaviors, the DON verified non of these were listed on the residents plan of care. R29's care plan was not developed to address his aggression towards other residents in the facility. R29 had diagnoses which included: oppositional defiance disorder, mood disorder, and organic brain syndrome. The quarterly MDS dated 3/21/12, indicated the resident's cognition was intact and he demonstrated verbal and physical behaviors towards others such as: hitting, kicking, pushing, grabbing, threatening, screaming and cursing.	F 279		

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F 279	Continued From page 112 The care area assessment (CAA) completed on 6/22/11 indicated R29's behavioral disturbances had a pattern and offensive or defensive in nature. It noted R29 would get upset when he needed to be toileted, or when he wanted to be waited on for meals and medication passes. The CAA noted he liked to follow a routine and became aggressive when a routine was not followed, and a referral to the house psychologist was warranted. When reviewed, the psychology progress note (PPN) dated 5/16/12 noted the resident had an altercation with another resident a few days ago. The recommendation was to position him facing away from a crowd of people, and place in a position that allows easy access to leave and go back to his room. This was not added to the care plan. Facility incident reports indicated that R29 had aggressive acts towards other residents on 2/3/12, 3/12/12 and 3/30/12 in which he either squeezed, punched, or pinched other residents when they were in his way. 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 noted did not indicate there had been any discussion about his aggression to fellow residents. A copy of the resident's current plan of care was	F 279		

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F 279	Continued From page 113 provided by the facility on 4/25/12, and noted the resident had a history of aggression and yelled at staff and grabbed staff inappropriately. The care plan was not developed to include his history of aggressive acts towards other residents inspite of the documented history of such actions. When interviewed on 5/1/12 at 9:39 a.m., the facility social worker stated R29 was on the psychology case load. She verified that his existing care plan did not contain the warning signs to look for and interventions to implement for his aggressive behaviors towards other residents. She stated R29 was impulsive, impatient, and was cognitively intact.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F280 Comprehensive Care Plans (Timeliness)** It is the policy of Crest View Lutheran Home to develop a comprehensive care plan within seven days after the completion of the comprehensive assessment. For Resident(s) R95 his fall risk care plan and for R165 his behavior care plan will be reviewed and revised by the interdisciplinary team by 06/11/12. Corresponding updates have been made to care assignment sheets and communicated to the resident and/or designated decision maker. The primary physician was informed of results and a review of	

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F 280	Continued From page 114 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the plan of care was revised for 1 of 4 residents (R95) to include interventions regarding falls, and for 1of 1 residents (R165) who demonstrated maladaptive behaviors during dining. Findings include. R95 had diagnosis of hypertension, leg pain and lower back pain. R95 ' s current plan of care updated on 2/24/12 indicated he had balance impairment, cardiac disease, pain and narcotic use. Staff were directed to: maintain a clutter free environment, keep call light within reach, assist with activities of daily living per resident need and per request, observe for changes in gait, balance, judgment, coordination and strength. Notify MD, family and physical therapy, side rails, ensure proper footwear, ensure brakes are locked on bed and wheelchair during transfers, keep eyewear within reach, if fall occurs, and follow facility policy. Review of the document titled, Resident Incident Report dated 8/10/11, revealed that R95 had fallen in his bathroom. Under the section of the document titled "Immediate Action Taken to Prevent Reoccurrence" indicated that R95 was instructed to ask for help when transferring and a referral had been made to occupational therapy. The document also indicated a referral was made to occupational therapy to look at wheelchair.	F 280	the current physician orders will be completed. Education will be provided for staff members regarding care plan revision by 06/11/12 For other residents who may be affected by this practice, an audit of care plans will be completed by 06/11/12. Upon this review, care plan revisions and/or staff education will be implemented if indicated by 06/11/12. The policy for comprehensive care plans will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding comprehensive care planning by 06/11/12.	

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F 280	Continued From page 115 Review of the document titled Resident Incident Report dated 3/17/12, revealed that R95 fell forward onto the floor out of his wheelchair hitting the right side of his head. Under the section of the document titled "Immediate Action Taken to Prevent Reoccurrence" indicated discourage resident from falling asleep in his wheelchair. Review of the current falls care plan 2-24-12 did not identify either of the interventions from the 8/10/11 incident report for occupational therapy to evaluate R95 nor was the intervention from 3/17/12 incident report to discourage R95 from falling asleep while in his wheelchair were added to the list of interventions to prevent falls in the care plan. During interview at 1:15p.m. on 4/27/12, the Director of Nursing (DON) verified that the fall interventions should have been added to R95's care plan. R165 had diagnoses that included dementia, depression and exhibited behaviors in the dining room. The facility failed to revise R165 plan of care to directed staff on how to intervene with these behaviors. R165's admission minimum data set (MDS) dated 3/15/12 indicated severe cognitive deficit, inattention, and disorganized thinking. She had no hallucinations, but had other behavior symptoms not directed toward others. Behaviors did not significantly disrupt care or living environment. She required total staff assistance with locomotion, extensive assistance with all	F 280	Care plan audits will be completed weekly for 4 weeks, monthly for 3 months, then according the quality control schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audit. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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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, 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. 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	F 280		

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

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F 280	Continued From page 117 talk quietly, but as soon as stop, R165 will yell loudly again. She was not aware of any interventions that had been placed to assist R165 with her distress when she is yelling or to decrease this disruption to others. During interview with nurse supervisor (NS)-A at 3:00 p.m. on 4/30/12 she acknowledged R165's plan of care failed to include any interventions to staff to follow when R165 yells out. Further, the facility was not monitoring this behavior on their usual behavior monitoring sheets that has some generic interventions listed on it. Even though R165 started displaying the behavior of yelling out and disrupting others, R165's plan of care failed to identify this behavior and failed to direct staff on how to intervene to assist with her distress.	F 280		
F 287 SS=B	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility	F 287	**F287 Automated Data Processing Requirement** It is the policy of Crest View Lutheran Home to encode resident data within 7 days after completing a resident assessment for admission assessment, annual assessment updates, significant change in status assessments, quarterly review assessments, a subset of items upon a resident's transfer, reentry, discharge, and death; and background information if there is no admission assessment.	

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F 287	Continued From page 118 completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete assessments timely, perform care area assessments timely, develop	F 287	For all residents listed the RAI documents were encoded and submitted as they were completed. A new Social Services Director has been hired and assessments will be up to date by 06/11/12. Corresponding updates have been made to the RAI policies and procedures and communicated to the interdisciplinary team. Education will be provided for staff members regarding the RAI process and expectations for timely completion 06/11/12. For other residents who may be affected by this practice, an audit of Casper/submission reports will be completed by 06/11/12. Upon this review, departments responsible for any late or incomplete assessments will be counseled. The policy for completing the RAI process will be reviewed and revised by the interdisciplinary team by 06/11/12. The submission reports will be reviewed weekly by the	

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F 287	Continued From page 119 care plans timely, encode or transmit minimum data set (MDS) data to the Center for Medicare/Medicaid (CMS) system timely for 139 of 708 resident assessments reviewed between November 1, 2011 and April 30, 2012. Findings include: During the survey, multiple MDS's were incomplete or completed late and care plans were not completed in a timely manner as identified by the following: A CASPER report "MN (Minnesota) MDS 3.0 Submission statistics by facility" from 11/1/11 to 4/30/12 showed the facility had submitted 708 resident assessment records to the CMS data base. A CASPER report "MN MDS 3.0 assessments with error..." report showed the following facility submission errors between 11/1/11 to 4/30/12: Error number 3749e: care plan completed late: For this admission assessment the CAA (care area assessment) process date is more than 13 days after entry date. 35 resident admission assessments submitted by the facility were late in addressing the care area assessments. Error number 3749d: assessment completed late for this admission assessment, completion date is more than 13 days after entry date. 34 resident admission assessments submitted by the facility were completed late. Error number 3749c: care plan completed late. The care plan was completed more than 7 days	F 287	Administrator or designee to ensure timeliness and accuracy. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the RAI policies and procedures by 06/11/12. Chart audits regarding RAI documents will be completed weekly for 4 weeks, monthly for 3 months, then according to the quality control schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 287	Continued From page 120 after the CAA signature. This error was performed 1 time by the facility. Error number 3749b: care plan completed late: CAA signature date is more than 14 days after the assessment reference date. This error was performed 7 times by the facility. Error number 3749a: assessment completed late, assessment completion date is more than 14 days after assessment reference date. This error occurred 46 times. Error number 3810e: record submitted late. The submission date is more than 14 days after the attestation date on a modified/inactivated record. This occurred 1 time. Error number 3810d: record submitted late. The submission date is more than 14 days after the signature date for a new resident record. This error occurred 2 times. Error number 3810c: record submitted late. The submission date is more than 14 days after completion of comprehensive assessments. This error occurred 2 times. Error number 3810a: record submitted late. The submission date is more than 14 days after admission for entry tracking records. This error occurred 4 times. Error number 1040: a comprehensive or quarterly assessment was not completed within 92 days of the previous record. This error occurred 1 time.	F 287		

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F 287	Continued From page 121 Error number 1038: a comprehensive assessment had not been completed within 366 days of the previous record. This error occurred 6 times. Six resident records that were submitted, were completely rejected due to facility errors. During phone interview with the facilities director of nursing (DON) at 9:30 a.m. on 5/2/12 she stated the MDS registered nurse (RN)-E was responsible for completion and the medical records coordinator submits them, however, they are often held up by the social service department being late with their assessments. Error reports from CMS are routinely reviewed by herself and the administrator. The facility failed to ensure the required MDS's were performed and submitted to the CMS data base within the required time frame. Further, the facility failed to ensure assessment of the residents and plans of care were in place in the time frames required.	F 287		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	**F309 Quality of Care** It is the policy of Crest View Lutheran Home to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 122 Based on observation, interview and document review, the facility failed to provide the necessary care and services that addressed pain issues for 1 of 4 residents (R116) who was not referred to a pain clinic when recommended, and for 1 of 2 residents (R165) who demonstrated maladaptive behaviors during dining. Findings include: Resident 116 (R116) had diagnoses which included: chronic pain syndrome, lupus, and degenerative arthritis, opiate dependence and anxiety. The quarterly minimum data set assessment (MDS) dated 1/2/12 noted R116 cognition was intact, and received scheduled pain medications. The MDS also noted R116 rated her pain as constant, on a scale of 8 out of 10 (10 being the worst pain and 1 being mild pain). The Care Area Assessment (CAA) dated 4/12/12 identified R116 had pain, and when interviewed, stated the pain was at a level 8 on a scale from 1 to 10. She identified the pain she was experiencing was "almost constantly" over the 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. 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. When interviewed on 4/23/12 at 6:45 p.m., R116	F 309	For Resident R116 a referral was made to a pain clinic for her and she initially refused the appointment. A second offer of a pain clinic referral will be given to R116 to see if she is now willing to attend the appointment. The primary care physician/NP for R116 provided new orders for assisting with pain management. For R165 a new assessment was completed for cognition, mood, and behavior. Behavior logs and safety checks were initiated for R165 to ensure her safety and the safety of others. A calming plan was initiated for R165 to assist with her behaviors. Corresponding updates have been made to care plans, care assignment sheets and communicated to the resident and/or designated decision makers. The primary physicians were informed of the assessment results and a review of the current physician orders was completed. Education will be provided for staff members regarding pain management and behavior care by 06/11/12. For other residents who may be affected by this practice, an audit regarding pain management and behavior care will be completed by 06/11/12. Upon this review, care	

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F 309	Continued From page 123 stated she had pain in her right side that was just "kind of there" and never really went away. When interviewed on 4/25/12 at 11:43 a.m., and asked about pain status, R116 stated she was alright at the present time, because she had received a pain pill right before brunch. She said the pain never completely goes away, but would lighten up. The physician's orders dated 4/4/12 indicated the resident received multiple medications for pain which included: Oxycodone C2 (narcotic pain medication) 5 mg tablet every 6 hours PRN (as needed) for breakthrough pain, Tylenol Extra-Strength (analgesic) 1000 mg four times a day for pain, Oxycontin CR C2 10 mg slow release every 12 hours for pain, and Neurontin (used for nerve pain) 100 mg three times a day for neuralgia. The facility comprehensive pain assessments dated 1/10/12 and 4/7/12 continued to be on the same medications without any changes. Also, there was no indication that other interventions were attempted to reduce or alleviate R116 pain. According to the April Medication Administration Record, the resident requested and received the PRN Oxycodone medication on 41 occasions, from 4/1/12 to 4/24/12. A Diagnostic Assessment Report completed by a Doctor of Psychology on 4/11/11, indicated R116 was referred for the psychological consult for ongoing anxiety, pain issues and subsequent dependence on narcotics. The recommendation from the assessment indicated the resident was a reasonable candidate for a Pain Management	F 309	plan revisions and/or staff education will be implemented if indicated by 06/11/12. The policy for pain management and behavior care will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding pain management and behavior care by 06/11/12. Behavior and pain management audits will be completed weekly for 4 weeks, monthly for 3 months, then according to the quality control schedule to ensure compliance with results reported to the CQI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 309	Continued From page 124 Clinic to reduce her dependency on pain medications and to empower her with effective coping and pain management strategies. It noted it would likely mitigate her anxiety over time, as the pain was a significant culprit in her struggles with anxiety. A physician's visit note dated 4/12/11 indicated the resident had not been seen by the pain clinic yet, and she continued to take Oxycontin twice daily. When interviewed on 5/1/12 at 3:15 p.m., the director of nursing (DON) not think R116 went to the pain clinic, which was the psychologist recommendation on 4-11-11, over one year ago. The director of health information stated she would check the old file for further information. The facility was unable to provide evidence to indicate R116 went to the pain clinic to assist her with her ongoing anxiety and pain issues. R165 had multiple behaviors of yelling out which interrupted the environment for others. R165's admission minimum data set (MDS) dated 3/15/12 (an assessment reference date (ARD) of 3/12/12) indicated severe cognitive deficit, inattention, and disorganized thinking. She had no hallucinations, but had other behavior symptoms not directed toward others. Behaviors did not significantly disrupt care or living environment. She required total staff assistance with locomotion, extensive assistance with all activities of daily living (ADL's) except could feed self with set up. R165's diagnoses included dementia and depression. Care area assessments (CAA's) dated 3/15/12 indicated	F 309		

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	245018	A. BUILDING _____ B. WING _____	05/02/2012

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F 309	Continued From page 125 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 on this CAA. Dining was observed in the Willow dining room from 4:45 p.m. to 6:30 p.m. on 4/23/12. R165 was sitting at a table with R40 to her left, R51 was across the table from her and R61 was at a table next to her. R165 started yelling when she entered into the dining room at 4:45 p.m. She was pointing and shaking her finger at R51 across the table and screaming "get out of here, get out of my house before I call the police. Shut up, I said shut up." TMA-D told R165, "I will take care of it" and walked away. R165 continued to scream at R51, then directed it to R40 that "she hurt my daughter, she has no right to be in here, I think you better leave." Then to R51 "You are as bad as your son, shut up, get her out of my house before I pick her up and throw her out of my window." R165 then pounded her fist on the table repetitively. TMA-D who was passing medications in the dining room again told R165 "I will take care of her" and offered R165 a beverage. R165 pulled off her clothing protector, while looking at R51 but did not strike R51 with it. After TMA-D left R165 continued to yell at R51 "get out of here, get out of here" very loudly "your not out of my house yet, shut up, I don't even want to hear your voice, get her out of here before I kill her." R165 continued to scream at R51 and R40. R125 then came and sat down to R165's right at 5:02 p.m. and R165 started screaming at him also. During the interaction of R165 screaming at her table mates R51 did not respond to R165 but continued to stare at her and	F 309		

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

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F 309	Continued From page 126 her face flushed. R40 would wince and pull back in her wheel chair with the loudest outbursts from R165. R125 did not react to her and just stared straight ahead, ignoring her. R61 who was at a nearby table started to mimicked what R165 was saying. Even though there was staff in the room. Staff made no attempted to intervene until 5:07 p.m. when a nurse aide-Z came into the dining room and removed R165 to the day room right, which was just outside the dining room. R165 sat in the day room without any staff interaction with intermittent outbursts "ahhhh" made into a scream sound and "nurse, nurse, that damn nurse can go to jail too," I want water, I said now." R165 then threatened "I will throw this at you" holding a glass of water. There was no one was in the day room, nor did staff attempt to redirect 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 was taken out of the area. 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	F 309		

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F 309	Continued From page 127 was paginated during dinner, yelling out for staff. She was redirectable if staff stayed near her." 3/19/12 "Resident is very agitated on shift with hallucinations that she is talking to family members and then talks back to herself as her father..." 3/20/12 "...some agitation this a.m., yelling and swearing..." 3/21/12 "Res (resident) agitated and yelling out in dining room. "Go home now! Were through," "Lets go, lets go, lets go!" Res yelling at other residents and staff and talking to people who aren't there, attempts to reassure res aren't always successful, "no, not you!" Staff monitoring." 3/21/12 "Resident very agitated on p.m. shift, yelling out swear words and having conversations with people not in the room. Resident calmed down a little bit when given some towels to fold. NP (nurse practitioner is aware of agitation." 3/24/12 "Resident agitated this shift. Yellowed our curse words in the dining room. Once put in bed resident quieted down and slept." 3/26/12 "NP called back and changed the Risperdal (an antipsychotic medication) order...NP was not ready to send resident to secure unit until family members were involved. Social services who were going to contact the family and come up with a plan." 3/27/12 "Resident kept yelling this shift...." 3/29/12 "Transferred from Linden station to room 49B-Willow (secured unit) station..." 3/30/12 "Resident was calling out...she was a little disruptive to other residents..." 4/1/12 "...continued to call out "help help" for no apparent reason. yelling and screaming at times when redirected." 4/5/12 "resident continuously screams..." 4/6/12 "res was yelling out this a.m. Res talks to herself saying things such as "help me, help me, "stop yelling,.."they stole my daughter and mother"...Oh shut up"...This	F 309		

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F 309	Continued From page 128 conversation went on with herself off and on through out the a.m. shift." 4/16/12 "resident...screaming and talking to self..." 4/20/12 "...continued to scream "shut up" and "help me" and when staff intervened..."get out of here." and she was yelling at top of her voice...agitating other res..." 4/28/12 "Res was yelling intermittently all through out brunch. Res would yell out, no a word or phrase, just yell then tell herself to shut up...res given 1:1 but his did not help." 4/28/12 "Res was yelling and talking to people who are not there before, during and after supper. Staff offered BRP (bathroom privileges), food and reassurance without any effect..." 4/30/12 "While at brunch res was screaming, yelling cont. (continuously) staff whispered while talking and res and res mirrored writer, this only lasted several minutes..." 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, 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."	F 309		

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F 309	Continued From page 129 During interview at 6:30 p.m. on 4/23/12 TMA-D stated they just do the best they can with R165 when she gets like this which is most of the time. He was unable to identify a specific plan of how to deal with R165's disruptive behaviors in the dining room. During interview at 2:59 p.m. on 4/30/12 licensed practical nurse (LPN)-I stated that at times it helps to whisper to R165 to get her to talk quietly, but as soon as you stop, R165 will yell loudly again. LPN-I was unaware of any specific interventions to help decrease R165 behaviors of yelling, and disrupting others. During interview at 3:00 p.m. on 4/30/12 nurse supervisor (NS)-A acknowledged R165's plan of care failed to include any interventions to staff to follow when R165 yells out. Furthermore, there was no indication R165's behaviors of yelling and being inappropriate with other residents were being monitored by the facility. Even though R165 displayed behaviors of yelling out and disrupting others, R165's behavior was not assessed, monitored or tracked to determine which interventions needed to be implemented to decrease or eliminate these behaviors.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	**F314 Pressure Sores** It is the policy of Crest View Lutheran Home to ensure that based on the comprehensive assessment of a	

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F 314	Continued From page 130 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 5 residents (R16 and R100) reviewed for pressure ulcers, received the care and services necessary to prevent pressure ulcers from occurring. Findings include: Resident 16 (R16) was not repositioned timely and according to her plan of care, further, R16 was not comprehensively assessed to determine how often she required assistance with repositioning to prevent pressure ulcer occurrence. R16's quarterly minimum data set (MDS) dated 3/26/12 did not assess R16's cognitive status. R16's MDS showed she required extensive assistance with bed mobility and transfers, she did not have any pressure ulcers, but she was at risk for development of pressure ulcers. R16's significant change MDS dated 12/21/11 indicated severe cognitive impairment. R16's diagnoses included Alzheimer's disease and heart failure. During observation at 6:15 p.m. on 4/23/12 R16 was brought from the dining room and placed in the hallway outside of her room. She was	F 314	resident, a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. All staff members responsible for prevention of pressure sores will be educated on the policies and procedures by 06/11/12. Resident R16 expired on 05/27/12. Resident R100 expired on 05/04/12. For other residents who may be affected by this practice a record review of residents at risk for skin breakdown will be completed by 06/11/12. After review, updates will be made as appropriate.	

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F 314	Continued From page 131 observed sitting there until 8:05 p.m., from 6:30-7:30 p.m. she asked quietly multiple times to go to the bathroom or to go to bed. At 7:30 p.m. she had a strong fecal odor around her. At 8:05 p.m. nurse aide (NA)-I assisted R16 to the bathroom, her pad was slightly wet and was soiled with loose stool. NA-I stated she had taken R16 to the bathroom last at 4:30 p.m. prior to supper. She stated R16 is not on a repositioning plan, she will say when wants to lie down. R16 was not repositioned for 3 hours and 35 minutes. During continuous observation from 8:00 a.m. to 12:06 p.m. on 4/24/12 R16 was not repositioned in her chair. R16 was at breakfast from 8:00 - 9:00 a.m. and then brought out to hall outside of the chapel area and remained there until 10:20 a.m. when she was brought to the dining room and placed at a table. At 10:30 a.m. licensed practical nurse (LPN)-A retrieved R16 from the dining room prior to her being served brunch and administered her medications to her at 10:37 a.m. At 10:42 a.m. R16 was brought back to the dining room table, she remained in the dining room until 11:40 a.m. when a family member removed her from the table and brought her to the beauty shop. At 12:00 p.m. LPN-A was notified R16 had not been 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. During continuous observation from 6:25 a.m. to 9:00 a.m. on 4/2/12, R16 was not repositioned. R16 was in bed on her back with the head of her	F 314	The policy and procedure for turning & repositioning and prevention of pressure sores will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the skin risk policies and practices by 06/11/12. Skin risk audits will be completed weekly for4 weeks, monthly for 3 months, and then according to the quality control schedule to ensure compliance. The results reported to the CQI Committee for review and further recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 314	Continued From page 132 bed slightly elevated until nurse aide (NA)-C assisted her with morning cares at 9:00 a.m. This was 2 hours 35 minutes. NA-C stated this was unusual for R16 to sleep so late. R16's skin on her back and buttocks was observed to be free from redness at this time. R16's care area assessment (CAA) dated 12/13/11 indicated she was at risk for pressure ulcers due to she "requires staff assistance to move sufficiently to relieve pressure over any one site, confined to bed or chair all or most of time, persistently wet, especially from fecal incontinence, wound drainage of perspiration, immobility, incontinent, altered mental status, delirium limits mobility, cognitive loss, poor nutrition, use of antianxiety and narcotic medications, diabetes, chronic or end stage liver or heart disease, recent decline in activities of daily living, dementia, terminal illness and pain. The CAA indicated care planning would be completed to avoid complications. A significant change "nutrition assessment form" dated 12/10/11 indicated R16's coccyx was red. R16's "Braden scale assessment form for predicting pressure sore risk" dated 3/3/312 indicated she had the following risk factors for pressure ulcer development: "occasionally moist-skin is occasionally moist, requiring an extra linen change approximately once per day. chair fast-ability to walk severely limited or non-existent, cannot bear own weight and/or must e assisted into chair or wheel chair. mobility slightly limited makes frequent though slight changes in body or extremity position independently, nutrition probably inadequate...and	F 314		

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F 314	Continued From page 133 friction and shear potential- moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair...occasionally slides down." This form was signed by a licensed practical nurse (LPN). R16's "Crest View Lutheran Home comprehensive evaluation of skin risk factors" dated 4/21/12 check list items were checked for R16: scored 3 or lower in moisture, incontinent of bowel, incontinent of bladder, nationally at risk, at risk for shear and friction, cognitively impaired, assist with ADL's (activities of daily living), and pain. Included on this form was a "analysis of risk factors and interventions" which included "decreased mobility, impaired cognition and incont of bladder. Receives Keefor ointment to red bottom-intact-turned and toileted every 2 hours." On the back side of this form included "admission/MDS body audit" and was dated 4/21/12, this included a drawing of a body and on the drawing staff had circled the area of the coccyx and wrote "red" next to it. This area was not staged or identified if it was a pressure ulcer or not. R16's plan of care dated 3/12/12 included "Alteration in mobility" and directed staff to "turn and reposition every 2 hours." Under "Alteration in skin integrity" interventions checked off a check list included "Reposition per tissue tolerance assessment. Low air loss mattress. cushion in w/c gel. Elevate heels off mattress. Provide peri care after incontinent episodes. Keep linen clean and wrinkle free. Lift, do not slide resident to prevent shearing. Monitor skin with cares. Treatments per MD order. Notify dietary with any	F 314		

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F 314	Continued From page 134 open area or skin changes. Nutritional supplements as ordered. Encourage food and fluid intake." The assessments performed by the facility 12/13/11, 3/3/12 and 4/21/12 failed to identify what risk factors R16 had that could be modified and failed to include an evaluation of R16's skins ability to endure the effects of pressure without adverse effects. Further, the 4/21/12 failed to identify if the red area on R16's coccyx was a pressure ulcer or what it's cause was. A nurse aide worksheet dated 5/1/12 indicated R16 was to be repositioned every 2 hours and "heel lift boots in bed." R16's treatment record for each month December 2011 through May 2012 included "Wound care: prevent pressure ulcers, turning and repositioning every 1-2 hours and as needed tissue tolerance..." Also included staring 12/1/11 was "Keegans cream-apply to red area on coccyx and peri-area q (every shift) and prn (as needed)." During interview at 8:00 a.m. on 4/24/12 with NA-I she stated she was not aware if R16 should be repositioned or off-loaded at any time intervals, she stated R16 will often say when she needs to lie down, but she has bad days when she doesn't indicate this need and staff will assist her to bed if she is sleepy. During interview with LPN-A at 12:00 p.m. on 4/24/12 she was not aware if R16 was on any time frames for repositioning, should be every couple hours or so. She stated nurse aides should assist R16 with repositioning as directed	F 314		

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F 314	Continued From page 135 on their worksheets. She was not aware R16 ever had a reddened coccyx, she stated she gets the Keegens cream to prevent rash. During interview with NA-C at 12:03 p.m. on 4/24/12 he stated R16 will usually say she when she needs to lie down, has days where she can't though. Upon review of R16's plan of care she stated R16 should be repositioned every 2 hours, upon review of the treatment record she stated "every 1-2 hour repositioning is on there to prevent pressure ulcers." She state the nurse aids should follow what is on their worksheets. She was not sure why the treatment sheets indicated R16 had a "red area on coccyx" stating it could be a rash. She had not assessed the area for pressure. During interview with MDS nurse (MDS)-F at 3:00 p.m. on 4/26/12, she stated a tissue tolerance test is done quarterly or annually by the facility to assist in determining positioning needs, she was unable to find any testing done since R16 had been admitted. During interview with MDS coordinator (MDS)-E at 10:00 a.m. on 4/27/12, she stated the facility normally does an admission and annual tissue tolerance testing for each resident, she was unable to locate any for R16. During interview with nurse supervisor (NS)-A at 2:45 p.m. on 5/1/12 she stated R16 will usually say when she needs to lie down. She stated R16 had not 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 the "red" area.	F 314		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 136 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. Further, the facility failed to ensure R16 was repositioned timely as directed by her plan of care (every 2 hours) or by her treatment records (every 1-2 hours) and allowed her to stay seated in her wheel chair for 3 hours 35 minutes, 4 hours 6 minutes and 2 hours 35 minutes without repositioning her. Resident 100 (R100) had diagnoses including dementia and impaired mobility. The quarterly minimum data set (MDS) dated 11-15-11 identified R100 had severe cognitive impairment, was an extensive assist with all activities of daily living (ADL ' s), and was at risk for developing pressure ulcers. R100 ' s plan of care dated 2-17-12 instructed staff to toilet every 1 ½ hours and to turn and reposition every 2 hours. R100's plan of care also identified R100 had a potential alteration in skin integrity related to decreased mobility, incontinence, edema, and PVD (pulmonary vascular disease). R100 ' s bowel and bladder assessment dated 2-14-12 identified to " offer toileting every one to two hours. " The Braden scaled for predicting pressure ulcers dated 3-14-12 was scored a 15, which identified the resident is at mild risk for developing pressure ulcers. A body audit " Analysis of risk factors and interventions " dated 3-14-12 identified R100 is " at risk for skin	F 314		

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F 314	Continued From page 137 breakdown as a result of immobility. " R100 was observed sitting in her wheelchair in the dining room located between Linden and Aspen unit at 8:10 a.m. on 4-24-12. During constant observation the resident remained in the dining area without toileting or repositioning until 9:10 a.m. when the Life enrichment assistant (LEA)-C pushed the resident into an activity in the main dayroom/ chapel area. R100 remained in the activity until 10:20 a.m. when the LEA-C brought R100 to the main dining area for brunch. During constant observation R100 remained in the dining room until 11:42 a.m. until she was brought back to the dining room located between Linden and Aspen unit by an nursing assistant (NA)-M. She still had not been toileted or repositioned after 3 hours and 35 minutes, and NA-M walked away. At 11:48 a.m. on 4-24-12 NA-L was approached by surveyor and asked if she was aware when R100 was toileted or repositioned last. NA-L stated R100 was supposed to be toileted every 2 hours and right after she is done eating. NA-L was unsure last time R100 was assisted to the bathroom but the nursing assistants do not interrupt activities to take a resident to the bathroom. NA-L assisted R100 to the bathroom at that time. Although R100 was at risk for pressure areas and the plan of care instructed staff to toilet and reposition resident every 1 ½ hours, the resident was not toileted or repositioned for 3 hours and 35 minutes. "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."	F 314		

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F 314	Continued From page 138 Under "prevention of skin breakdown" included B.3 "frequency of position changes is titrated for the individual resident." A "Crest View Lutheran Home turning and repositioning observation" with tissue tolerance testing dated 5/2/11 was provided after the survey.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R16) reviewed for urinary incontinence received the services necessary to maintain or attain her level of continence, failed to comprehensively assess incontinent status and failed to provide assistance to the toilet as directed by her plan of care. Findings include: R16's quarterly minimum data set (MDS) dated 3/26/12 did not assess R16's cognitive status.	F 315	**F315 Urinary Incontinence** It is the policy of Crest View Lutheran Home that based on the resident's comprehensive assessment, a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident R16 expired on 05/27/12. For other residents who may be affected by this practice a record review of residents with urinary incontinence and appropriate justification for catheters will be completed by 06/11/12. After	

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F 315	Continued From page 139 The MDS identified R16 required extensive assistance to toilet, was occasionally incontinent of urine, continent of stool but was not on a toileting plan. R16's previous assessment, a significant change MDS dated 12/21/11 indicated severe cognitive impairment. R16's diagnoses included Alzheimer's disease and heart failure. During observation at 6:15 p.m. on 4/23/12 R16 was brought from the dining room and placed in the hallway outside of her room. She was observed sitting there until 8:05 p.m., from 6:30-7:30 p.m. she asked quietly multiple times to go to the bathroom or to go to bed. At 7:30 p.m. she had a strong fecal odor surrounding her. At 8:05 p.m. nurse aide (NA)-I assisted R16 to the bathroom, her pad was slightly wet and was soiled with loose stool. NA-I stated she had taken R16 to the bathroom last at 4:30 p.m. prior to supper. She stated R16 is not on a toilet plan, R16 will say when she needs to use the bathroom. R16 was not toileted for 3 hours and 35 minutes. During continuous observation from 8:00 a.m. to 12:06 p.m. on 4/24/12 R16 was not assisted to the bathroom. R16 was at breakfast from 8:00 - 9:00 a.m. and then brought out to hall outside of the chapel area and remained there until 10:20 a.m. when she was brought to the dining room and placed at a table. At 10:30 a.m. licensed practical nurse (LPN)-A retrieved R16 from the dining room prior to her being served brunch and administered her medications to her at 10:37 a.m. At 10:42 a.m. R16 was brought back to the dining room table, she remained in the dining room until 11:40 a.m. when a family member removed her	F 315	review, updates will be made as appropriate for each resident identified. The policy and procedure for urinary incontinence assessments and care of the incontinent resident will be reviewed and updated by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding incontinence management and assessment by 06/11/12. Toileting and incontinent assessment audits will be completed on weekly for 4 weeks, monthly for 3 months, and then according to the quality control schedule to ensure continued compliance with results reported to the CQI Committee for review and further recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.	

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F 315	Continued From page 140 from the table and brought her to the beauty shop. At 12:00 p.m. LPN-A was notified R16 had 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	F 315	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 315	Continued From page 141 "antianxiety, antihypertensives, antipsychotics, diuretics and narcotics." No peri-rectal abnormalities were noted. Under "additional data" included fluid intake at meals, diet assist of 1 and relates needs." Under "bladder present status" included "bladder frequency every 2-3 hours, incontinent with control, medium to large amount each voiding, no pain or change to pattern in last year. Bowel status as continue formed stool every day. An LPN had gathered this data. The form has a section completed by a RN under "care planning" and included the following: calls for assist every 2-3 hours, needs anticipated every 2-3 hours, adjust clothing and assist, percale with assist, staff to observe resident for signs and symptoms of urinary tract infection, observe for bowel pattern changes, meds as ordered. Under "Assessment" read "Resident toileted every 2 hours upon her request, requires assist with pericares and to transfer at times inc (incontinent) but no pattern seen, continue care plan. R16's assessment performed by the facility on 3/7/12 failed to address the lack of data collected to comprehensively assess voiding patterns, R16's use of a diuretic medication that can cause urgency/frequency shortly after administration, use of narcotic pain medication that may cause drowsiness and therefor functional incontinence, patterns of fluid intake, if utilizes any caffeine that may irritate the bladder, or any testing for R16 to determine if she was currently having any urinary retention as she had a diagnosis of urinary retention. Further, the facility failed to identify the type of urinary incontinence R16 had such as urge, stress, mixed, overflow, , or functional. Therefore, identifying appropriate toileting	F 315		

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F 315	Continued From page 142 program or interventions had not been completed.	F 315		
	R16's plan of care dated 3/12/12 included "Actual alteration in bowel and bladder function R/T" (related to) and the following items are checked on a check list "cognitive impairment, impaired mobility, inability to control urge, disease of the bladder/prostate, renal failure, endocrine disease, use of diuretic, Foley (indwelling) catheter/urostomy, incontinent less than 1 x day; incontinent at least 1 time day bowel, diarrhea." The goal is listed as "Will have no skin breakdown due to incontinence." The approaches for R16 have the following items checked "complete bowel and bladder assessment, toilet every 2-3 hours to meet resident needs, provide assist of 2 for toileting, observe for non-verbal signs for toileting needs, provide adequate fluids at and between meals, monitor bowel status every shift, administer meds a ordered, notify MD (doctor) for needs of bulk forming laxatives and/or stool softener prn (as needed), catheter care per protocol, monitor Foley output q (every) shift, assist to toilet per resident request, check and change every 2 hours and prn, see skin care plan. The plan of care directs staff to perform indwelling catheter care and she does not have an indwelling catheter. Further, it directs staff to take to toilet per resident request, check and change her incontinent product every 2 hours and as needed, assist to toilet every 2-3 hours. During interview at 8:00 a.m. on 4/24/12 with NA-I she stated she was not aware if R16 should be assisted to the toilet at any intervals, she stated			

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F 315	Continued From page 143 R16 will often say when she needs to use the bathroom, but she has bad days when she doesn't indicate this need and staff will take her every 2-3 hours or just change her incontinent pad. During interview with LPN-A at 12:00 p.m. on 4/24/12 she was not aware if R16 was on any time frames for being assisted to the toilet, should be every couple hours or so. She stated nurse aides should assist R16 with toileting as directed on their worksheets. During interview with NA-C at 12:03 p.m. on 4/24/12 he stated R16 will usually say she when she needs to go to the bathroom, has days where she can't though. During interview with MDS nurse (MDS)-F at 3:00 p.m. on 4/26/12, she stated there is no registered nurse (RN) to assess if toileting programs are effective, therefore residents are not placed on toileting programs and can not be coded as such on the MDS. 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	F 315		

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F 315	Continued From page 144 quarterly, but NS-A could not locate this in R16's medical record. 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. She further stated the nurse aides are to assist residents to the bathroom as directed on their worksheets. When reviewing the plan of care, NS-A stated the plan "covers all the bases" and agreed it was not individualized for R16. A nurse aide worksheet dated 5/1/12 indicated R16 was incontinent of bowel and bladder, but did not direct staff on how often to toilet her. 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. Further, the facility failed to ensure R16 was actually assisted to the toilet as was directed on the plan of care. No attempt had been made to assist R16 with regaining continence or maintaining her current level of continence. Even though staff stated the nurse aides needed to follow their worksheets, the worksheets failed to direct them on R16's toileting needs. A facility policy for urinary assessment was requested, but not provided.	F 315		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	**F323 Accidents** It is the policy of Crest View Lutheran Home that each resident receives adequate supervision and assistance to prevent accidents.	

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F 323	Continued From page 145 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 1 of 8 residents (R74) who currently smoked in the facility, and for the safe consumption of hot beverages for 1 of 1 residents (R74) who sustained a burn from handling a hot beverage. The facility's failure to provide supervision and a safe environment to prevent potential burns from unsafe smoking practices and hot beverages constituted an immediate jeopardy for R74. In addition to the resident in immediate jeopardy, the facility failed to ensure safety interventions were in place to minimize the risk of a burn injury for 1 of 1 residents (R158) 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. The administrator, director of nursing (DON) and chief executive officer (CEO) were notified of the immediate jeopardy for R74 on 4/26/12 at 4:12 p.m.. The immediate jeopardy was removed on 5/01/12 at 1:25 p.m. but non-compliance remained at the scope and severity of no actual harm with the potential for no more than minimal harm at a pattern..	F 323	For Resident R74 a new assessment for smoking and safety risk was completed. R74 now wears a smoking apron while out on smoke breaks and has a covered mug for hot beverages. For R158 a new smoking assessment was completed and water was added to the ash receptacles, the ash receptacles will be emptied three times per day, and she wears a smoking apron for safe smoking. Corresponding updates have been made to the care plans, care assignment sheets and communicated to the resident and/or designated decision makers. Staff members responsible will be educated on safe smoking policies and procedures by 06/11/12. Resident R16 expired on 05/27/12. For other residents who may be affected by this practice a review of residents who smoke will be completed by 06/11/12. An audit was completed of all resident rooms and power strips were replaced with hospital grade surge protectors where appropriate. After review updates will be made as appropriate for each resident identified.	

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

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F 323	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 pants:	F 323	The policy and procedure for smoking and environmental safety will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the smoking policy and procedures by 06/11/12. Audits on smoking behavior will be completed weekly for 4 weeks, monthly for 3 months, and then according to the quality control schedule to ensure continued compliance. The results will be reported to the CQI Committee for review and further recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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F 323	Continued From page 147 1st pair- Dark blue cotton pants with 2 cigarette burn holes on the right leg approximately 1/4" to 1/2" in size. 2nd pair- Dark blue pants with 2 cigarette burn holes on the right knee. 3rd pair- Pants made of 100% polyester, 5 cigarette burn holes on the upper thigh area. 4th pair- Black pants 100% polyester, cigarette burn hole on the right stomach area of pants. 5th pair- Blue pants, 5 cigarette burn holes on the front and the back of the upper thigh area. 6th pair- Pants with multiple cigarette burn holes on front thigh area. 7th pair- Gray cotton pants with an approximate 1 inch cigarette burn on the right side of his pants in the thigh area. The remaining 3 pairs of pants had no cigarette burn holes. During observation of R74 on 4/25/12 at 8:20 a.m. R74's coat had 3 cigarette burn holes on the right chest area of his coat. R74 stated he would let his cigarette rest on his coat while lit, and stated "I know I shouldn't do that". R74 stated he never burned his skin from smoking and the holes in his clothes were from cigarette ashes that dropped onto his pants. Record review identified a facility form titled "Smoking Evaluation" dated 1/10/12, and updated again on 2/7/12, described R74 as alert and noted the facility smoking policy was reviewed with him. It went on to say R74 "...follows the smoking policy, can safely utilize lighter/matches and lit smoking material, the resident has been offered a smoking apron and refuses". The document noted R74 demonstrates safe smoking	F 323		

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F 323	Continued From page 148 practices with other residents. The plan indicated "resident smokes independently, cognition intact (issues with compliance in other areas but has always followed smoking regulation)". On 4/25/12 at 8:54 a.m., licensed practical nurse (LPN)-C was interviewed and stated she completed R74's smoking assessment on 2/7/12, after he moved to the Aspen unit and they offered him a smoking apron, however he refused and they felt he was safe to smoke independently without the use of the apron. LPN-C stated she was not aware of any cigarette burn holes on his clothing and if R74 had cigarette burn holes on his clothes, she would not consider that resident safe to smoke independently. On 4/25/12 at 7:17 a.m., R74 was observed lighting his cigarette on the patio located outside the window of the main dinning room . Both of his hands were shaky while he was lit the cigarette. The meal service assistant-H was present, and stated "he shakes all time". On 4/25/12 at 7:19 a.m., nurse supervisor-A stated she completed a smoking assessment on 1/10/12, and felt he was able to smoke independently. She stated he was on the Evergreen unit when she completed this assessment and she could see him smoke, and felt he was safe. She stated when she conducts the assessment, she looks at the clothing the resident has on at the time, and she was not aware he had any cigarette burn holes on his clothing. On 4/25/12 at 7:21 a.m., R74 was observed	F 323		

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F 323	Continued From page 149 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. 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 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 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 holes". 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	F 323		

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

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F 323	Continued From page 150 smoking. FM-A verified R74's hands were also shaky when R74 smokes his cigarettes. The facility smoking policy updated 1/2012, was reviewed. The policy noted the following: residents or family members that smoke must provide their own smoking materials, Crest View employees may not give residents smoking materials or buy smoking materials for them, residents may be assisted to designated smoking areas and must dispose of smoking materials appropriately. Residents smoking policy will be reviewed with all new residents upon admission, residents smoking materials may be held by nursing staff and given to residents according to resident compliance and/or resident's ability to smoke appropriately, a smoking apron is available adjacent to the smoking area, a smoking evaluation is completed on admission for those residents who wish to smoke. The evaluation will be reviewed quarterly and as necessary for any changes. Although the facility staff were aware of R74's hand tremors and the multiple burn holes on his clothing from cigarette ashes, they continued to allow R74 to smoke independently without supervision and failed to assess and implement additional interventions to ensure R74 remained safe while smoking. R74 also sustained a burn from hot liquids. The facility failed to assess R74's ability to safely handle hot liquids and to provide supervision and interventions to prevent further burns from hot liquids.. A facility document titled "Resident Skin	F 323		

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F 323	Continued From page 151	F 323		

Changes Report" (incident report) dated 1/5/12, noted R74 had a 8.0 cm X by 2.0 (centimeter) intact blister intact on his left inner thigh. The incident report noted R74 stated he spilled hot cocoa on himself. The interventions included a tegaderm skin protectant was to be used over the burn. The incident report indicated the Interdisciplinary Team (IDT) interventions and notes indicated the injury was "self inflicted". There were no other interventions identified to prevent R74 from additional burns with hot liquids. The current plan of care updated 2/28/12, indicated R74 had a burn to his left inner thigh which healed on 2/28/12. The care plan lacked interventions related to handling hot liquids, even though R74 sustained a burn from spilling hot liquids on himself.

Document review of the IDT notes dated 1/6/12 noted "reviewed hot chocolate spill of 1/5/12, resident self inflicted injury".

On 4/25/12 at 3:33 p.m., the DON was interviewed and stated they did not put any interventions in place after R74's burn from the hot liquid. She stated he was independent with his food and fluids and did not feel they needed to add any interventions.

At 12:41 p.m., Cook-A was interviewed and stated she was not aware that R74 had received a burn from his hot cocoa, and he did not use a cup with a lid to prevent potential burns. She stated there were no residents that have burned themselves, and if a resident needed a lid to contain hot liquids, they had them available.

On 4/25/12 at 7:17 a.m., R74 was observed

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F 323	Continued From page 152 lighting his cigarette on the patio located outside the window of the main dinning room . Both of his hands were shaky while he was lit the cigarette. The meal service assistant-H was present, and stated "he shakes all time". Although the facility staff were aware of R74's hand tremors and that he had received a burn on his skin from a hot beverage, the facility failed to assess R74's ability to safely handle hot beverage or implement any interventions to ensure R74 remained safe while consuming hot beverages. The facility initiated an IJ removal plan which included implementing the use of smoking aprons for residents who smoked and were at risk of dropping cigarettes/ashes, revision of the facility smoking policy, training all staff about new smoking policy, and reassessment of R74's ability to smoke and /handle hot beverages safely and safety interventions implemented for R74. Direct care and licensed nursing staff were interviewed on 4/29/12 at 1:00 p.m., and on 5/01/12 between 11:05 a.m. and 11:36 a.m., and were able to explain their responsibility of the facility smoking policy and the interventions in place for R74. R74 was also provided with a covered lid beverage container to prevent further burns. Audits were being conducted of safety intervention implementation. The immediacy was removed at 5/01/12 at 1:25 p.m., and non-compliance remained at the scope and severity level of no actual harm with a potential for no more than minimal harm at a pattern. R158 had behaviors of digging into used ashtrays for lit cigarette butts and struck out at other residents who were smoking in an attempt to take	F 323		

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F 323	Continued From page 153 a cigarette from those residents. R158's behavior placed her at risk of being burned, injuring other residents or being injured by other residents. The facility failed to have interventions, including supervision when out on the smoking patio, in place to prevent potential accident hazards for R158 and other residents. R158's had diagnoses that included dementia, depression, chemical dependency history, tobacco use disorder and panic disorder. R158's quarterly minimum data set (MDS) dated 3/6/12 indicated she had moderate cognitive impairment, had no behavioral issues and was independent with most ADL's (activities of daily living). R158 was observed at 1:18 p.m. on 4/29/12 coming out to the facilities outdoor resident smoking patio. As soon as she opened the door leading out onto the outside patio 3 other residents R168, R174 and R44 who were out smoking started to yell at R158. "You get away from here, you get out." "Get out of here." Over and over, R158 did not react to the other residents yelling at her and dug into the used ashtray in an attempt to find a lit cigarette, but no lit cigarettes were found. She then walked over to R168 and tried to grab an unlit cigarette and lighter from R168's hand. R158 did not speak and had a flat facial affect, while she was attempting to get the cigarette from R168 hand. R168 pulled her hand away and yelled at R158 to "get out of here." R158 raised her right hand and swung at R168's face. R168 pulled away without being hit by R168. R158 started aimlessly wandering around the smoking patio. Nursing assistant (NA)-A came out to the patio and stated	F 323		

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F 323	Continued From page 154 "good everyone has on their smoking aprons." NA-A was informed by the surveyor that R158 swung at R168 and missed when R158 tried to take her cigarette. NA-A stated she would report the incident to the nurse and escorted R158 back into the building. At 1:29 p.m. R158 again came out to the smoking patio again, and the same 3 residents, R168, R174 and R44, began to yell at R158 telling her to "get out." R158 remained with a flat facial affect and did not speak, she tried to get into an ash can which contained used cigarette that measured 4.5 inches across the top, and 4 inches tall. R158 stuck her entire hand into this ash can and pulled out a lit cigarette and preceded to smoke it. NA-A again came out to the patio and escorted R158 inside when she finished the cigarette. After R158 was escorted into the building by NA-A. R168 stated "Thank you for telling them (R158's name) tried to hit me, she does it all the time, she is always trying to take our cigarettes and if you won't give her one, she will hit you. I didn't think anyone would believe me, but now I have witnesses." R174, R44 and R158 all verified that R158 comes to the smoking area multiple times a day digs into the used ash can for a lit cigarette and also try's to take their cigarettes. R158's "safety risk assessment" dated 9/16/11 indicated "aggressive, physically abusive, agitation, aggression, withdrawn, pacing." There was no plan identified as to how staff should intervene, and to help reduce or eliminate these behaviors displayed by R158. A psychology note for R158 dated 5/23/11 indicated under "risk to others: Moderately capable of physical/emotional aggression," and	F 323		

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F 323	Continued From page 155 "anger/irritability: frequent, perhaps even constant," and "further assessment/monitoring warranted."	F 323		

R158's follow up psychology note dated 6/6/11 indicated "She continues to exhibit continuous behaviors, particularly around smoking privileges, verbally demanding, aggressive, heightened by confusion, impaired insight and judgement."

A submitted Office of Health Facility Complaints (OHFC) form dated 6/21/11 indicated R158 had called a resident a bastard and slapped him in the face when he wouldn't give R158 a cigarette. The facility investigation report indicated the residents were separated and "encouraged not to redirect other residents or call names." An "interdisciplinary team review" noted "depakote (an antisiezure drug often used for behavior manifestation) increased and labs ordered."

A facility incident report dated 6/24/11 indicated R158 had asked for a cigarette from another resident and R158 struck her in the arm. The "interdisciplinary team review" indicated "will continue to look for other placement."

A facility resident incident report dated 8/19/11 indicated R158 hit another residents shoulder when she came to get a cigarette. An "interdisciplinary team review" dated 8/23/11 indicated "will continue to redirect as needed."

A submitted OHFC form dated 8/19/11 indicated R158 had "punched" another resident in the shoulder twice as he had refused to give R158 a cigarette. A "interdisciplinary team review dated 6/27/12 indicated "encourage to keep her

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F 323	Continued From page 156 distance." An intervention was listed as "(resident name) was told to stay away...staff continue to observe (name) so she doesn't bother others." Another psychology note for R158 dated 8/29/11 indicted "...ongoing issue related to her tobacco use, she receives 1 cigarette every 2 hours (what she can afford) but spends the rest of the time asking anyone and everyone for a cigarette and also digging old cig butts out of the trash/ash trays." The suggestion was made for a secured unit. The psychologist did not identify any interventions, or recommendations the facility could implement to decrease or eliminate these behaviors from occurring even though the psychologist was aware of these concerns. R158's "behavior/intervention monthly flow records" for January 2012, February 2012 and March 2012 included monitoring for "delusional statements, restlessness, withdrawn from activities, continuous pacing, uncooperative, agitation and insomnia" only. The facility did not address R158 behaviors of digging into the ash cans that contained used cigarette butts trying to find a lit cigarette, attempting to hit and grab other residents cigarettes if she was unable to find any in the used cigarette can. R158's plan of care dated 2/24/12 included "Actual alteration in mood and/or psychosocial well-being r/t (related to): and the following items are checked: "depression, anxiety/panic disorder, adjusting to new environment, dementia with behaviors, OCD (obsessive compulsive disorder), delusions, and flat affect." Approaches included check list items such as "psychology consult if indicated, administer medications as ordered and	F 323		

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F 323	Continued From page 157 validate feelings." A hand written notation was added, "allow to independently smoke one cigarette every 2 hours. Nursing staff to distribute cigs. She does go out and smoke cigarette butts of others between her own cigarettes despite continuous redirection." R158's plan of care did not address any safety issues with R158 placing her hand into an ash can to get out used lit cigarettes, nor did it address R158 attempting to obtain cigarettes from others, including striking others, and did not direct staff on how to provide supervision and how to handle these behaviors and safety issues. During interview with the facilities director of nursing (DON) at 2:00 p.m. on 4/29/12, she acknowledged R158's plan of care did not include any interventions to keep R158 safe from being burned by digging into the ash can for lit cigarettes, did not include information on how to prevent R158 from being yelled at by her peers and did not address how staff should handle R158's aggressive behaviors toward her peers. Even though psychology and nursing staff identified R158 looked for extra cigarettes continuously, including digging into ash cans for lit cigarettes, attempting to get them from others, striking others at times, they failed to address this behavior for R158. This placed R158 at risk for burns, being yelled at by her peers, hitting others or being hit due to her behavior. R16 had medical equipment plugged into a power strip creating a potential accident hazard. During observation at 9:42 a.m. on 4/24/12, R16	F 323		

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F 323	Continued From page 158 had a nebulizer machine (a machine that delivers medication by aerosol) plugged into a power strip. The power strip was draped over the top of the dresser, then draped partially over the back of a reclining chair plugged into the wall behind the dresser. During interview with registered nurse (RN)-E at 2:10 p.m. on 4/27/12, she stated she was not aware that medical equipment should not be plugged into power strips. She unplugged the nebulizer and found a wall outlet for it. During interview with the facilities director of nursing (DON) at 12:30 p.m. on 5/1/12, she stated medical equipment should not be plugged into power strips. A policy was requested, but not provided.	F 323		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	**F334 Influenza and Pneumococcal Immunizations** It is the policy of Crest View Lutheran Home that all residents are offered the Influenza and pneumococcal immunizations when appropriate according to the federal guidelines and the CDC. For residents on Aspen the immunization information was filed in the residents' clinical records. A review will be completed all residents for the identification of immunization status by 06/11/12.	

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F 334	Continued From page 159 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334	Residents who had refused the immunization or had it completed elsewhere was documented. Education/counseling will be provided for staff members regarding immunization policies by 06/11/12. For other residents who may be affected by this practice a record review was completed regarding immunization education/consents by 06/11/12. After review, consent will be obtained, refusal will be documented, and/or immunization forms will be updated updates will be made as appropriate. The process will be ongoing for new admissions throughout the flu season. The policy and procedure for immunizations will be reviewed and revised by the interdisciplinary team by 06/11/12. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place with results reported to the CQI Committee for further review and	

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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 334	Continued From page 160 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each residents medical record included documentation the resident or their legal representative was provided education regarding the benefits and potential side effects on the influenza immunization for 30 of 114 residents who resided in the facility. Findings include: Upon review of influenza vaccines in the facility at 10:30 a.m. on 5/1/12, it was noted all 30 resident records on the Aspen unit did not contain the required education of the resident or their representative of the benefits and potential side effects of the influenza vaccine for the 2011-2012 influenza season. When interviewed on 5/1/12 at 11:00 a.m.,the director of nursing stated the facility kept a binder for their Aspen unit, that contained the required documentation for 30 of their residents, but these had not been filed in the resident records yet. The other units had been filed. She stated they all should have been filed into the resident records.	F 334	recommendations. Staff members will be trained as it relates to their respective roles and responsibilities regarding the immunization policies and procedures by 06/11/12. Audits will be completed during the influenza season weekly for 3 months to ensure continued compliance with results reported to the CQI Committee for review and further recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 06/11/12	

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	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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F 334	Continued From page 161 An undated influenza vaccine facility policy did not include the need to ensure this education was placed in the medical record.	F 334		

Crest View
SENIOR COMMUNITIES

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

enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY	K 000	RECEIVED JUN - 5 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 06-11-2012

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

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

EXIT: 05.02.2012

POC ok
PS 6-18-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sala Thomalay LNHA	Administrator	6/4/12

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

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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. Crestview Lutheran Home Building 1 is a 2-story building with a partial basement. Original year of construction 1964, with an addition in 1968, both buildings are type II(111).The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and building was constructed in 2008 and surveyed in accordance with LSC Chapter 18. Both building have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in each resident room that is monitored for fire	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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

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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.	K 000		
K 050 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as 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 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 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	K 050	K050 Fire Drills It is the policy of Crest View Lutheran Home to provide periodic fire drills according to Life Safety Code. 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	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2012

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K 050	Continued From page 3 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		

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

F5018023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 02 - 2007 ADDITION B. WING _____	04/25/2012

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

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K 000	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: MR. PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR ST., SUITE 145 ST. PAUL, MN 55101-5145 E-MAIL: pat.sheehan@state.mn.us	K 000	POC ok PS 6-18-12 RECEIVED JUN 18 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Isabel Mercedes LNHA — TITLE: Administrator — (X6) DATE: 6/18/12

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

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K 000	Continued From page 1 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. 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. The requirement at 42 CFR, Subpart 483.70(a) is NOT met by evidenced by:	K 000		
K 050 SS=F	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.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 02 - 2007 ADDITION B. WING _____	04/25/2012

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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	