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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KWZX

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 **9/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Fuerle, HFE NE II 10/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 10/17/2016 (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

MDH
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Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised Letter

CMS Certification Number (CCN): 245018

October 19, 2016

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

Dear Mr. Tobalsky:

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

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

Effective August 31, 2016 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.

Sincerely,

Kamala Fiske-Downing

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

MDH
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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Sincerely,

Kamala Fiske-Downing

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Minnesota Department of Health
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 17, 2016

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

RE: Project Number S5018028 and Complaint Numbers H5018107, H5018108, H5018110

Dear Mr. Tobalsky:

On September 6, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 10, 2016. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 8, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated survey completed on June 8, 2016, and failure to achieve substantial compliance at the recertification survey completed on July 14, 2016 and the abbreviated survey completed on August 18, 2016 where the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections were required.

On September 23, 2016, the Minnesota Departments of Health and the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, as of September 23, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 23, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 8, 2016 be discontinued effective September 23, 2016. (42 CFR 488.417 (b))

- Civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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

As we notified you in our letter of August 5, 2016, 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 September 8, 2016.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245018 Y1	A. Building B. Wing Y2	9/23/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0221	Correction	ID Prefix F0272	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.20(b)(1)	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0276	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(c)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0334	Correction	ID Prefix F0425	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/14/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245018 Y1	A. Building B. Wing Y2	9/23/2016 Y3

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).

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ID Prefix F0157	Correction	ID Prefix F0221	Correction	ID Prefix F0272	Correction
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LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0276	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(c)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix F0334	Correction	ID Prefix F0425	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	10/19/2016	31591	9/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245018 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/25/2016 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0014	08/12/2016	LSC K0015	08/12/2016	LSC K0046	08/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0054	08/12/2016	LSC K0056	08/12/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	10/17/2016	37009	8/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245018 Y1	A. Building 02 - 2007 ADDITION B. Wing Y2	8/25/2016 Y3

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

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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0014	08/12/2016	LSC K0015	08/12/2016	LSC K0054	08/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0056	08/12/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL /kfd	10/17/2016	37009	8/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

MDH
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Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised letter

Please note that the correction date for this facility has changed. This letter has been revised to include this change.

Electronically delivered

October 19, 2016

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

RE: Project Number S5018028 and Complaint Numbers H5018107, H5018108, H5018110

Dear Mr. Tobalsky:

On September 6, 2016, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 10, 2016. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 8, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated survey completed on June 8, 2016, and failure to achieve substantial compliance at the recertification survey completed on July 14, 2016 and the abbreviated survey completed on August 18, 2016 which found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On September 23, 2016, the Minnesota Departments of Health and the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has corrected the deficiencies issued as of August 31, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 31, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 8, 2016 be rescinded. (42 CFR 488.417 (b))

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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

In our letter of Octob, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 8, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 31, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 6, 2016

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This was based on the deficiencies cited by this Department for an abbreviated survey completed on June 8, 2016, and failure to achieve substantial compliance at the recertification survey completed on July 14, 2016 and the abbreviated survey completed on August 18, 2016 where the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections were required.

On September 23, 2016, the Minnesota Departments of Health and the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, as of September 23, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 23, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 8, 2016 be discontinued effective September 23, 2016. (42 CFR 488.417 (b))

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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

As we notified you in our letter of August 5, 2016, 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 September 8, 2016.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered

October 17, 2016

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

Re: Reinspection Results - Project Number S5018028, H5018107

Dear Mr. Tobalsky:

On September 23, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 14, 2016, that included an investigation of complaint number H5018107. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00005 Y1	A. Building B. Wing Y2	9/23/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20265	Correction	ID Prefix	20505	Correction	ID Prefix	20540	Correction
Reg. #	MN Rule 4658.0085	Completed	Reg. #	MN Rule 4658.0300 Subp. 1 A-E	Completed	Reg. #	MN Rule 4658.0400 Subp. 1 & 2	Completed
LSC		08/31/2016	LSC		08/31/2016	LSC		08/31/2016
ID Prefix	20550	Correction	ID Prefix	20565	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0400 Subp. 4	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		08/31/2016	LSC		08/31/2016	LSC		08/31/2016
ID Prefix	20840	Correction	ID Prefix	20860	Correction	ID Prefix	20905	Correction
Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 F.	Completed	Reg. #	MN Rule 4658.0525 Subp. 4	Completed
LSC		08/31/2016	LSC		08/31/2016	LSC		08/31/2016
ID Prefix	20910	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed
LSC		08/31/2016	LSC		08/31/2016	LSC		09/23/2016
ID Prefix	21555	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.1325 Subp. 2	Completed	Reg. #		Completed	Reg. #		Completed
LSC		08/31/2016	LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	10/19/2016	31591	9/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KWZX

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 **07/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Fuerle, HFE NE II 08/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/31/2016 (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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 5, 2016

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

RE: Project Number H5018108, H5018109, S5018028 and H5018107

Dear Mr. Tobalsky:

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

On June 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on June 8, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 14, 2016, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility maintained compliance with federal certification regulations. The most serious deficiencies in your facility at the time of the July 14, 2015 standard survey were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required. In addition, at the time of the July 14, 2016 standard survey an investigation of complaint numbers H5018107 and H5018109 were conducted. Complaint number H5018107 was found to be substantiated at F157 and complaint number H5018109 was found to be unsubstantiated.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective August 10, 2016. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 8, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective, September 8, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 8, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 8, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, 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.

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:

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Gloria.derfus@state.mn.us
Phone: (651) 201-3792 Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

If substantial compliance with the regulations is not verified by September 8, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 8, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	07/14/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition during the recertification survey complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5018107 was completed. The complaint was substantiated at F157. An investigation of complaint H5018109 was completed and the complaint was unsubstantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	F 157		8/31/16

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

Electronically Signed | 08/12/2016

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 _____	07/14/2016

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F 157	Continued From page 1 significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer Vancomycin (a antibiotic) as ordered and failed to notify the physician for the missed antibiotic doses for 1 of 1 resident (R164) reviewed for an infection. Findings include: R164's diagnoses included clostridium difficile diabetes and "s/p [Status Post- after procedure]" heart transplant obtained from the After Discharge Orders dated 2/12/16. R164's After Discharge Orders dated 2/12/16, revealed the following order: -Vancomycin 50 milligram (mg) per milliliter (ml)	F 157	It is the Policy of Crest View Lutheran Home to immediately inform a resident's physician whenever there is a medication error, or if there are missed doses of a prescribed antibiotic for any reason. Resident R164 was discharged from the facility on 2/20/2016, so notification to their physician of missed antibiotic doses cannot occur. The Physician Notification Policy and Procedure, along with the Medication Error Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on	

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 _____	07/14/2016

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F 157	Continued From page 2 take 2.5 ml by mouth 4 times daily for 8 days for clostridium difficile colitis. During review of the February 2016, the Electronic Medication Administration Record (EMAR) was revealed the medication had not been administered on the following days as indicated on the EMAR progress notes: -2/12/16, 8:28 p.m. indicated Vancomycin Hydrochloride (HCL) solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days. New admit medication not here yet and scheduled again at 8pm. -2/18/16, 8:17 a.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days out at leave of absence (LOA) -2/19/16, 9:45 p.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days not available at this time -2/20/16, 8:40 a.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days not available at this time. On 7/14/16, at 1:49 p.m., the consultant pharmacist (CP) indicated R164's medications including the antibiotic had been scanned ready to deliver on 2/12/16, at 8:00 p.m. and thought usually would take approximately an hour to arrive at the facility. CP verified R164 had missed the four o'clock Vancomycin on 2/12/16 and two doses on 2/18/16, at 8:00 a.m. and 12:00 o'clock thought were missed because R164 was out for an appointment. The CP further stated there was no documentation to explain the missed medication doses. At 1:52 p.m. the CP stated she would have expected the staff to call the doctor	F 157	August 10th. The former details all instances in which the physician of a resident needs to be notified. This includes, but is not limited to, medication errors and missed antibiotic doses. The latter describes the procedure of assessing a resident post-medication error, who needs to be notified of the error, and the procedure for filling out the medication error report. All nurses will be re-educated on this policy and procedure by August 25th. Audits for the proper administration of antibiotics will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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F 157	Continued From page 3	F 157		

and let them know about the missed doses depending on the directions of the medication.

On 7/14/16, at 2:20 p.m. the DON stated she would expect the nurse to pass it on report. DON further stated she would not answer, as she was not aware of what had occurred. "I preach staff to call the doctor and let the doctor make the decision."

On 7/14/16, at 2:06 p.m. via telephone the nurse practitioner stated during R164's brief stay at the facility she never saw resident and there was no documentation indicating the facility nurses had notified her office of the missed doses, which would include faxes or phone documentation. The NP stated she would have expected to be informed.

During review of all the progress notes located in R164's medical records from admission on 2/12/16 through the discharge date on 2/20/16, documentation was lacking to indicate the doctor or NP had been updated about the missed antibiotic doses. Review of the medication error forms completed by the facility lacked any mention of R164's missed medication doses.

The facility Administering Medications policy directed:
"3. Medications must be administered in accordance with the orders, including any required time frame.
10. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR is "flagged" with (tags, colored plastic stripes, drinking straws, or paper clips). After completing the medication pass, the nurse returns to the missed resident to administer the

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

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F 157	Continued From page 4 medication..." The policy did not address since the medication record was now electronic how the staff were to be alerted of missed medication. In addition the policy did not address what the staff were supposed to do when a medication had been missed.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of side rails as a potential restraint for 1 of 3 residents (R25) reviewed for accidents. In addition, facility failed to ensure a resident is not restrained for 2 of 4 residents (R53, R62) who had two pillows under the bottom sheets of their beds creating a barrier to getting out of bed. Findings include: R25 was admitted to the facility on 2/1/15. An admission Minimum Data Set (MDS) assessment was completed on 2/8/16, indicated R25 was cognitively intact and required extensive assistive of one staff person for bed mobility. The 2/8/16, MDS assessment further indicated that restraints were not used. A 2/4/16, side rail assessment indicated R25 utilized a right grab bar and was able to safely	F 221	It is the Policy of Crest View Lutheran Home to ensure residents are free from any physical restraints that limit their ability to move, ambulate, or participate in ADLs to their maximum capability. Residents R25, R53, and R62 were re-assessed for their safety risk as well as for side rail use on August 12th. For all other residents this deficient practice may have affected, whole-house side rail assessments were completed for every resident. In addition, a whole-house environmental services audit of the functionality of side rails was completed. Safety Risk assessments, which assess the physical devices utilized for the safety of each resident will be completed quarterly, upon admission, or along with any significant change of the MDS.	8/31/16

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F 221	Continued From page 5 utilize the grab bar. R25's care plan dated 2/16/16, identified the use of safety devices: 1/2 side rails and a right grab bar with side rail cushions. A 5/5/16, Safety Risk Assessment indicated that R25 was independent with bed mobility and utilized a left and right grab bar as a physical device for positioning. On 7/11/16, at 3:38 p.m. R25's bed was observed to have half side rails on the left and right side of the bed. The right side rail was observed to be loose. On 7/12/16, at 2:23 p.m. R25's bed was again observed to have half left and right side rails with the right side rail loose. On 7/12/16, at 2:59 p.m. licensed practical nurse (LPN)-C was asked about R25'S right half side rail and confirmed that the half side rail was loose. LPN-C stated that the facility was in process of a side rail audit. LPN-C stated that she would fill out a maintenance slip to have the loose side rail repaired or replaced. LPN-C stated that maintenance checks the side rails and that they should be tight fitting to the bed. A maintenance slip dated 7/12/16, indicated that R25's "side rails loose and need repair or replace" The maintenance slip indicated under the correction line that this was completed and that the bed and rails were replaced on 7/12/16. On 7/13/16, at 12:53 p.m. R25's bed was observed with both left and right side rails. R25 stated that the loose rail was fixed yesterday	F 221	The Use of Restraints Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy describes the process to create the least restrictive environment for all residents, which includes the prohibition of the use of restraints. The policy also outlines the process for reviewing resident charts periodically by an interdisciplinary team to ensure restraints aren't inadvertently in place. The Side Rail Policy and Procedure of Crest View Lutheran Home was also reviewed and updated by an interdisciplinary team on August 10th. This policy details the process of assessing each resident for the use of side rails in bed, and the environmental services department's responsibility for ensuring side rails are in proper working order. All staff will be re-educated on this policy and procedure by August 25th. Room audits for restraints, along with audits for the appropriateness of side rails and their functionality will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance.	

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F 221	Continued From page 6 (7/12/16). LPN-C was interviewed on 7/13/16, at 1:21 p.m. and stated R25's side rail assessment should indicate the use of two half side rails. LPN-C reviewed the 2/4/16, side rail assessment, the 5/5/16, safety risk assessments and R25's care plan with the surveyor and confirmed R25's assessment and care plan do not identify the use of bilateral (left and right) half side rails, however did indicate the use of a grab bar. LPN-C stated that there should be an assessment for two half side rails. LPN-C then added a nursing order to R25's medical record for a side rail assessment to be completed on the evening shift of 7/13/16. The director of nursing (DON) confirmed on 7/13/16, at 2:08 p.m. that assessments and care plans should match what has been assessed and determined appropriate for the resident's use. A side rail assessment was completed on 7/13/16, at 7:13 p.m. that indicated the use of bilateral half side rails for mobility. On 7/14/16, at 9:11 a.m. R25's bed was observed to have a left half side rail and a right grab bar. -At 9:12 a.m. registered nurse (RN)-C confirmed there was a right grab bar and one half side rail on R25's bed. RN-A stated that she did not know where this (grab bar) came from as yesterday R25 had two half side rails on her bed and that her assessment indicated that two half side rails were being used. -At 9:15 a.m. LPN-C confirmed that there was a right grab bar on R25's bed and not two half side rails as the assessment indicated. -At 9:39 a.m. the administrator confirmed that he was aware R25 had a right grab bar and not two	F 221	Compliance date: 8/31/2016	

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F 221	Continued From page 7	F 221		

half side rails on her bed. The administrator confirmed that two staff were trying to correct what was written on the assessment and care plan. The administrator further stated that maintenance was aware and there would be two side rails put on R25's bed to match what was assessed on 7/13/16. The administrator then confirmed that R25's care plan would also be corrected to reflect what positioning and safety device R25 was utilizing.

A facility policy entitled "Side Bar/Grab Bar Assessment" dated "3/10" indicated that "all residents will be assessed during the admission process and as needed for the use of side rails or grab bars for positioning or increasing self-mobility". The policy further indicated that a nurse would complete the assessment within 7 days of admission and the assessment would be updated annually, with a change in condition or as needed. The policy also indicated the assessment will be reviewed quarterly.

R53's quarterly MDS dated 4/11/16, indicated she was severely cognitively impaired and required assistance for bed mobility, toileting and transfers. The MDS indicated R53 was unsteady but able to stabilize with staff assistance during a surface to surface transfer. A Care Area Assessment (CAA) dated 1/21/16, identified a risk for falls and indicated R53 had difficulty maintaining a standing position and impaired balance during transfers. R53's care plan dated 7/10/16 indicated potential for alteration in safety related cognitive deficits. The care plan directed staff to use a body pillow while in bed.

A review of Crest View Lutheran Home Progress Notes dated 6/1/16, through 7/12/16, indicated

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F 221	Continued From page 8 R53 was found on the floor next to her bed on 6/3/16. A progress noted dated 6/6/16, indicated "body pillow has been applied to resident bed." During an observation on 7/12/16, at 2:38 p.m. R53 was lying in bed on her left side. The left side of her bed was placed against a wall and a pillow approximately four feet in length was placed on her right side. The pillow was placed directly on the mattress with the fitted sheet tucked around it. There was a fall mat on the floor and a pressure alarm placed on the bed. During an observation on 7/14/16, at 7:56 a.m. R53's alarm could be heard sounding from the hallway outside her room. Registered nurse (RN)-B responded to the alarm. RN-B stated R53 was sitting up in her bed when she responded to the alarm. She stated R53 was capable of swinging her legs over the side of the bed and will sit on the side of the bed and attempt to stand. RN-B further stated, R53 can be on the floor, "that's why they have a body pillow." During an interview on 7/13/16, at 8:54 a.m. nursing assistant (NA)-I stated R53's care sheet directed her to use a body pillow in bed. She stated the body pillow goes under the fitted sheet if a resident is a fall risk. During an interview on 7/13/16, at 12:51 p.m., NA- E stated the body pillow keeps R53 from falling out of bed. During an interview on 7/14/16, at 8:08 a.m., RN-F stated, a body pillow was not considered a restraint if the resident was able to adjust it. She stated she was aware the facility was using body pillows as interventions for resident's who fall	F 221		

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F 221	Continued From page 9	F 221		

frequently but was not aware the pillows were being placed under the fitted sheet under the bed. RN-F stated, "If it prevents them from doing something they could do on their own we would call it a restraint." She further stated she was not aware of an assessment specific to restraints.

During an interview on 7/14/16, at 9:41 a.m., NA-J stated he always puts the body pillows under the fitted sheet and stated he was unsure if he was trained to do it that way by anyone specific. He stated that's how I have seen it done."

During an interview on 7/14/16, at 8:39 a.m., the DON stated the facility used body pillows to help define the edge of the bed. She stated tucking the body pillows under the fitted sheet was not the correct application. She stated staff need to be educated that it was not OK to do it that way. R62 was lying in bed with the right side of the bed against the wall and two pillows tucked under the bottom sheet on the left side observed on 7/13/16, at 8:03 a.m. LPN-F removed the two pillows from under the sheet. Once LPN-F removed the pillows R62 sat up on the edge of the bed with feet on floor mat. Alarm under R62's pillow did not sound when R62 sat up. R62 took the medications then laid down. R62 then sat back up and said "I need to use the pot." R62 started to stand up when LPN-F asked R62 to sit down and put on the call light for staff to assist R62. LPN-F acknowledged that the two pillows did not belong under R62's bottom sheet.

During random observation on 7/14/16, at 6:58 a.m. R62 was lying in bed on left side with lights off. There were two pillows under the bottom sheet (one of the pillows was part way out from

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F 221	Continued From page 10 under the sheet). The admission MDS dated 5/2/16, indicated R62 was severely cognitively impaired and required extensive assistive of two staff members for bed mobility. The MDS further indicated restraints were not used. R62's MDS noted R62 diagnoses included generalized weakness, dementia with behaviors, seizure disorder and that R62 was admitted to the facility on 4/25/16. R62's fall CAA dated 5/4/16, indicated R62 was at risk for falls related to a history of falls prior to admission, unsteady balance when moving from seated to standing positions and from bed to wheel chair but did not address the usage of side rails or pillows under the bottom sheet of the bed. R62's fall care plan date 5/16, indicated R62 had fall risk related to weakness, balance impairment, dementia, cardiac disease, and urinary incontinence/urgency. The care plan also indicated R62 crawled out of bed at time, was impulsive and ambulated at time by self. Care plan instructed staff to maintain a clutter free environment, keep call light within reach, 1/2 side rails, sensor alarm in bed and chair. Care plan did not indicate to place pillows under the bottom sheet of the bed on the left side. The Fall Risk Assessment dated 7/12/16, indicated R62 had intermittent confusion, a history of 3 or more falls in the last three months, was chair bound requiring assistance with elimination, had balance problems and decreased muscular coordination. Side Rail Assessment dated 7/13/16, indicated resident did not use grab bars. Restraint	F 221		

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F 221	Continued From page 11 assessment was requested but not provided. The undated Team Sheet indicated R62 was a fall risk, had sensor alarm on bed and wheel chair and required assistance of one staff member for transfers and ambulation. During interview on 7/13/16, at 10:05 a.m. LPN-F stated, "I am not sure why the pillows are tucked under the bottom sheet, but maybe to prevent [R62] from rolling out." LPN-F also stated R62 was able to stand but should have help. LPN-F verified R62 had fallen since admission. LPN-F verified there were no side rails on R62's bed. During interview on 7/14/16, at 7:00 a.m. NA-G stated, "[R62] does attempt to get up out of his bed that is why we put the pillows under the sheet." NA-G verified the pillows were under the bottom sheet. During interview on 7/14/16, at 8:50 a.m. RN-D stated, "I am not sure why the nursing assistants are putting the pillows under the bottom sheet." RN-D said, "I have seen him get up, That is why he has a sensor alarms so I am not sure why they would put the pillows under the sheets." During interview on 7/14/16, at 8:58 a.m. LPN-C stated, the fact staff are putting pillows under the sheets was brought to me by the night nurse downstairs, regarding another resident. LPN-C stated "I did not know about (R62) until I heard you talking to her. Staff are not to put the pillows under the bottom sheet. It would be a restraint if they cannot get over it on their own." When asked if R62 could get over the pillows on own LPN-C stated it depends on the day if R62 could get over it. He has very active days and very sleepy days.	F 221		

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F 221	Continued From page 12 "We started education today on not doing that and will be talking to the night shift." During interview on 7/14/16, at 10:53 a.m. DON said, "Pillows under the bottom sheet is not our practice. It is a restraint." DON stated it does not give them the ability to be free and do what they want. DON stated, "A pillow in bed might be and intervention for comfort or to define edges of bed but we do not direct staff to put it under a sheet." A facility policy entitled Use of Restraints dated 2016, indicated a restraint was classified as anything that prohibited a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews, chart audits and room observations. If an advertent restraint is observed it will be removed immediately by a staff member."	F 221		
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;	F 272		8/31/16

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F 272	Continued From page 13 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; 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 comprehensively and accurately assess for potential restraints for 2 of 4 residents (R25, R62) reviewed for restraints. Findings include: An admission Minimum Data Set (MDS) assessment was completed on 2/8/16, indicated R25 was cognitively intact and required extensive assistive of one staff person for bed mobility. The	F 272	It is the Policy of Crest View Lutheran Home to comprehensively assess each resident's functional ability, and ensure that physical capabilities are not limited due to restraints. Residents R53 and R62 were re-assessed for their safety risk as well as for side rail use on August 12th. For all other residents that this deficient	

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F 272	Continued From page 14 2/8/16, MDS assessment further indicated that restraints were not used and that R25 was admitted to the facility on 2/1/15. A 2/4/16, side rail assessment indicated R25 utilized a right grab bar and was able to safely utilize the grab bar. R25's care plan dated 2/16/16, identified the use of safety devices: 1/2 side rails and a right grab bar with side rail cushions. A 5/5/16, Safety Risk Assessment indicated R25 was independent with bed mobility and utilized a left and right grab bar as a physical device for positioning. On 7/11/16, at 3:38 p.m. R25's bed was observed to have half side rails on the left and right side of the bed. On 7/12/16, at 2:23 p.m. R25's bed was again observed to have half left and right side rails. On 7/13/16, at 12:53 p.m. R25's bed was observed with both left and right side rails. Licensed practical nurse (LPN)-C was interviewed on 7/13/16, at 1:21 p.m. and stated R25's side rail assessment should indicate the use of two half side rails. LPN-C reviewed the 2/4/16, side rail assessment, the 5/5/16, safety risk assessments and R25's care plan with the surveyor and confirmed R25's assessment and care plan did not identify the use of bilateral (left and right) half side rails, however did indicate the use of a grab bar. LPN-C stated that there should be an assessment for two half side rails. LPN-C then added a nursing order to R25's medical	F 272	practice may have affected, whole-house side rail assessments were completed for every resident. In addition, a whole-house environmental services audit of the functionality of side rails was completed. Safety Risk assessments, which assess the physical devices utilized for the safety of each resident will be completed quarterly, upon admission, or along with any significant change of the MDS. The Use of Restraints Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy describes the process to create the least restrictive environment for all residents, which includes the prohibition of the use of restraints. The policy also outlines the process for reviewing resident charts periodically by an interdisciplinary team to ensure restraints aren't inadvertently in place. The Side Rail Policy and Procedure of Crest View Lutheran Home was also reviewed and updated by an interdisciplinary team on August 10th. This policy details the process of assessing each resident for the use of side rails in bed, and the environmental services department's responsibility for ensuring side rails are in proper working order. All staff will be re-educated on this policy and procedure by August 25th. Room audits for restraints, along with audits for the appropriateness of side rails and their functionality will be completed	

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F 272	Continued From page 15 record for a side rail assessment to be completed on the evening shift of 7/13/16. The director of nursing (DON) confirmed on 7/13/16, at 2:08 p.m. that assessments and care plans should match what has been assessed and determined appropriate for the resident's use. A Side Rail assessment was completed on 7/13/16, at 7:13 p.m. and indicated the use of bilateral half side rails for mobility. On 7/14/16, at 9:11 a.m. R25's bed was observed to have a left half side rail and a right grab bar. -At 9:12 a.m. registered nurse (RN)-C confirmed there was a right grab bar and one half side rail on R25's bed. RN-A stated she did not know where that (grab bar) came from, as yesterday R25 had two half side rails on her bed and that her assessment indicated that two half side rails were being used. -At 9:15 a.m. LPN-C confirmed there was a right grab bar on R25's bed and not two half side rails as the assessment indicated. -At 9:39 a.m. the administrator confirmed that he was aware R25 had a right grab bar and not two half side rails on her bed. The administrator confirmed that two staff were trying to correct what was written on the assessment and care plan. The administrator further stated that maintenance was aware and there would be two side rails put on R25's bed to match what was assessed on 7/13/16. The administrator then confirmed R25's care plan would also be corrected to reflect what positioning and safety device R25 was utilizing. A facility policy entitled Side Bar/Grab Bar Assessment dated 3/10 indicated that "all	F 272	weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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F 272	Continued From page 16	F 272		

residents will be assessed during the admission process and as needed for the use of side rails or grab bars for positioning or increasing self-mobility." The policy further indicated that a nurse would complete the assessment within seven days of admission and the assessment would be updated annually, with a change in condition or as needed. The policy also indicated the assessment will be reviewed quarterly.

R62 was lying in bed with the right side of the bed against the wall and two pillows tucked under the bottom sheet on the left side as observed on 7/13/16, at 8:03 a.m. LPN-F removed the two pillows from under the sheet. Once LPN-F removed the pillows R62 sat up on the edge of the bed with feet on floor mat. Alarm under R62's pillow did not sound when R62 sat up. R62 took the medications then laid down. R62 then sat back up and said "I need to use the pot." R62 started to stand up when LPN-F asked R62 to sit down and put on the call light for staff to assist R62. LPN-F acknowledged that the two pillows did not belong under R62's bottom sheet.

During random observation on 7/14/16, at 6:58 a.m. R62 was lying in bed on left side with lights off. There were two pillows under the bottom sheet (one of the pillows was part way out from under the sheet).

R62 was admitted to the facility on 4/25/16. The admission MDS dated 5/2/16, indicated R62 was severely cognitively impaired and required extensive assistive of two staff members for bed mobility. The 5/2/16, MDS further indicated that restraints were not used. R62's MDS indicated R62 diagnoses included generalized weakness, dementia with behaviors, seizure disorder

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F 272	Continued From page 17 R62's fall Care Area Assessment dated 5/4/16, indicated R62 was at risk for falls related to a history of falls prior to admission, unsteady balance when moving from seated to standing positions and from bed to wheel chair but did not address the usage of side rails or pillows under the bottom sheet of the bed. R62's fall care plan date 5/16, indicated R62 had fall risk related to weakness, balance impairment, dementia, cardiac disease, and urinary incontinence/urgency. Care plan also indicated Resident crawls out of bed at time, is impulsive and ambulates at time by self. The care plan instructed staff to maintain a clutter free environment, keep call light within reach, 1/2 side rails, sensor alarm in bed and chair. The care plan did not indicate to place pillows under the bottom sheet of the bed on the left side. The Fall Risk Assessment dated 7/12/16, indicated R62 had intermittent confusion, a history of three or more falls in the last three months, was chair bound requiring assistance with elimination, had balance problems and decreased muscular coordination. The Side Rail Assessment dated 7/13/16, indicated resident did not use grab bars. Restraint assessment was requested but not provided. The undated team sheet indicated R62 was a fall risk, had sensor alarm on bed and wheel chair and required assistance of one staff member for transfers and ambulation. During interview on 7/14/16, at 8:58 a.m. LPN-C said "Staff are not to put the pillows under the	F 272		

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bottom sheet. It would be a restraint if they cannot get over it on their own." When asked if R62 could get over the pillows on own LPN-C said It depends on the day if R62 could get over it. He has very active days and very sleepy days.

During interview on 7/14/16, at 10:53 a.m. DON said, "Pillows under the bottom sheet is not our practice. It is a restraint." DON said it does not give them the ability to be free and do what they want. DON said, "A pillow in bed might be and intervention for comfort or to define edges of bed but we do not direct staff to put it under a sheet." DON said, "We would not have a restraint assessment because we do not use restraints."

The MDS 3.0 manual dated 10/15, defined restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." In addition, the MDS directed the facility to determine if it was a restraint "Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address."

A facility policy entitled Use of Restraints dated 2016, indicated a restraint is classified as anything that prohibits a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated that the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews, chart audits and room observations. If an

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F 272	Continued From page 19 advertent restraint is observed it will be removed immediately by a staff member."	F 272		
F 276 SS=D	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 observation, interview and document review, the facility failed to comprehensively re-assess a potential restraint for 1 of 4 residents (R53) reviewed for restraints. Findings include: R53's quarterly Minimum Data Set (MDS) dated 4/11/16, indicated she was severely cognitively impaired and required assistance for bed mobility, toileting and transfers. A Safety Risk Assessment dated 7/7/16, indicated R53 was at risk for falls. The assessment identified the following physical devices: floor mat, perimeter mattress, low bed, bed alarm/sensor, and bed alarm/tabs. The assessment indicated the purpose of the devices was for positioning. The assessment did not identify the use of a body pillow. R53's care plan dated 7/10/16, indicated potential for alteration in safety related cognitive deficits. The care plan directed staff to use a body pillow while in bed. A review of Crest View Lutheran Home Progress	F 276	It is the Policy of Crest View Lutheran Home to comprehensively assess upon admission, quarterly, or with a significant MDS change, each resident's functional ability, and ensure that physical capabilities are not limited due to restraints. Resident R53 was re-assessed for their safety risk as well as for side rail use on August 12th. For all other residents that this deficient practice may have affected, Safety Risk assessments, which assess the physical devices utilized for the safety of each resident, will be completed quarterly, upon admission, or along with any significant change of the MDS. The Use of Restraints Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy describes the process to create the	8/31/16

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F 276	Continued From page 20 Notes dated 6/1/16 through 7/12/16, indicated R53 was found on the floor next to her bed on 6/3/16. A progress note dated 6/6/16, indicated "body pillow has been applied to resident bed." During an observation on 7/12/16, at 2:38 p.m., R53 was lying in bed on her left side. The left side of her bed was placed against a wall and a pillow approximately four feet in length was placed on her right side. The pillow was placed directly on the mattress with the fitted sheet tucked around it. There was a fall mat on the floor and a pressure alarm placed on the bed. During an observation on 7/14/16, at 7:56 a.m., R53's alarm could be heard sounding from the hallway outside her room. Registered nurse (RN)-B responded to the alarm. RN-B stated R53 was sitting up in her bed when she responded to the alarm. She stated R53 was capable of swinging her legs over the side of the bed and will sit on the side of the bed and attempt to stand. RN-B stated, R53 can be on the floor, "that's why they have a body pillow." During an interview on 7/13/16, at 8:54 a.m., nursing assistant (NA)-I stated R53's care sheet directed her to use a body pillow in bed. She stated the body pillow goes under the fitted sheet if a resident was a fall risk. During an interview on 7/14/16, at 8:08 a.m., RN-F stated, a body pillow was not considered a restraint if the resident was able to adjust it. She stated she was aware the facility was using body pillows as interventions for resident's who fall frequently but was not aware the pillows were being placed under the fitted sheet under the bed. RN-F stated, "If it prevents them from doing	F 276	least restrictive environment for all residents, which includes the prohibition of the use of restraints. The policy also outlines the process for reviewing resident charts periodically by an interdisciplinary team to ensure restraints aren't inadvertently in place. All staff will be re-educated on this policy and procedure by August 25th. Room audits for restraints, along with audits for the appropriateness of side rails and their functionality will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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something they could do on their own we would call it a restraint." She further stated she was not aware of an assessment specific to restraints.

During an interview on 7/14/16, at 8:39 a.m., the director of nursing (DON) stated the facility used body pillows to help define the edge of the bed. She stated tucking the body pillows under the fitted sheet was not the correct application. She stated staff need to be educated that it was not OK to do it that way. She the DON further stated the body pillow was not assessed as a restraint.

The MDS 3.0 manual dated 10/15, defined restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." In addition, the MDS directed the facility to determine if it was a restraint "Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address."

A facility policy entitled Use of Restraints dated 2016, indicated a restraint is classified as anything that prohibits a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated that the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews, chart audits and room observations. If an advertent restraint is observed it will be removed immediately by a staff member."

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F 282	Continued From page 22	F 282		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to follow the plan of care for 1 of 1 residents (R140) reviewed for non-pressure skin conditions observed with bruises of unknown cause. In addition the facility failed to ensure the plan of care was implemented for timely toileting and repositioning for 2 of 2 residents (R45, R122) reviewed for toileting and repositioning and failed to provide to nail care for 1 of 1 resident (R47) reviewed for activities of daily living. Findings include: Non-pressure skin: R140 was observed on 7/11/16, at 4:15 p.m. The resident was observed seated in the day room and was observed with two purple bruises on the left and right hand. On 7/13/16, at 9:26 a.m. R140 observed resident standing outside the activity office in the hallway. R140's bruises visible from standing at the nursing station approximately two feet. The bruise on the left hand appeared dark purple. On 7/14/16, at 7:30 a.m. R140 observed seated at the dining room table eating breakfast. The	F 282	It is the Policy of Crest View Lutheran Home to provide services by qualified staff in accordance with each resident's written plan of care. For Resident R140, a risk management incident report was completed on July 14th for bruises observed during the annual survey. Her written plan of care was updated by qualified staff at that time to note her potential risk for bruising, as well as interventions to prevent future bruises. This incident was reviewed by an interdisciplinary team on July 15th. For residents R45 and R122, toileting and turning and repositioning assessments were initiated by August 12th. Resident R47's nails were checked on August 11th, in addition to her scheduled bath day to ensure her nails were clipped and clean, per her plan of care. Her nail care will be assessed weekly in addition to her scheduled bath day. The Resident Incident and Skin Changes Investigation, Incontinence Policy and	8/31/16

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F 282	Continued From page 23 bruises were visible and several staff observed go by resident none acknowledged the bruises which were visible. On 7/14/16, at 8:40 to 8:49 a.m. nursing assistants (NA)-D and NA-E were observed walk down the hallway with R140 both holding each hand went to room. Both assisted R140 with toileting. During the observation, none of the NA's has acknowledged the visible bruises. At 8:51 a.m., NA-E even brought R140 to the bathroom and assisted resident to wash hands. R140's pressure ulcer Care Area Assessment (CAA) dated 10/16/15, indicated resident had advanced dementia and needed more assistance. CAA indicated skin would remain intact and directed staff to monitor skin with cares. R140's skin care plan dated 10/15 also, indicated resident had potential for skin alteration related to incontinence and directed staff to monitor skin with cares. R140's quarterly Minimum Dadta Set (MDS) dated 4/5/16, indicated resident had a diagnosis of dementia. In addition, the MDS indicated resident had severely impaired cognition and wandered. R140's Physician's Orders dated 6/27/16, directed staff to complete "Skin Check/Nail Trim on Bath Day every day shift every Wednesday." During review of July 2016, Treatment Administration Record, it was revealed a nurse had signed off the skin check had been completed however during review of the Weekly Body Audit dated 7/6/16, and 7/13/16, no skin concerns were identified in the assessment.	F 282	Procedure, the Turning and Repositioning Policy and Procedure, and the Nail Care Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy describes the processes by staff to report and documents incidents such as bruises, as well as to assess resident needs for incontinence, skin breakdown, repositioning, and nail care, respectively. For all other residents that these deficient practices may affect, all staff will be re-educated on these policies and procedures by August 25th. In addition, staff were re-educated on the proper use of the INTERACT tool, the STOP AND WATCH form. This tool is used to best communicate changes in condition such as bruise, redness, skin breakdown, etc. This education was completed by August 25th. Audits for peri-care, turning/repositioning, and nail care will all be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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On 7/14/16, at 2:01 p.m. registered nurse (RN)-B stated she would have expected staff to report skin changes to the nurse to investigate and staff was to follow the plan of care.

On 7/14/16, at 2:03 p.m., NA-E stated she had completed R140's shower on Wednesday 7/13/16, and she had reported to licensed practical nurse (LPN)-E who was orientating in the unit and he had thought the bruise looked old. NA-E stated the bruises on the hands were not new.
-At 2:07 p.m. RN-B stated she was shocked the nurse did not document the bruises.

On 2/14/16, at 2:29 p.m. the direct of nursing (DON) she would expect staff to report any skin concerns and to follow the care plan.

The facility Care Plan Policy and Procedure revised 9/14, indicated the care plan was to ensure the resident received the appropriate care required to maintain or attain the resident's highest level of practicable function possible.

Toileting and Repositioning:
R45 was observed on 7/13/16, at 7:09 a.m. for morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes."

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Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45.

On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact.

During interview on 7/13/16, at 12:14 p.m. R45 stated, "I do not use the toilet. I just have my diaper changed. R45 stated I had not been changed since got up and I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being offered to be checked and/or changed for incontinence nor was R45 repositioned.

R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning. R45's urinary incontinence CAA worksheet dated 7/27/15, indicated R45 was always incontinent of urine related to neurogenic bladder (a lack of bladder sensation and control, due to damage to nerves through injury or disease) and multiple sclerosis and needed assistance with all toileting needs.

R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and

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toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the lower body including legs), and depression.

R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to turn and reposition R45 every two hours and use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, have a foam cushion in wheelchair, provide peri care after incontinent episodes and apply barrier cream per doctor's order.

R45's bowel and bladder care plan dated 7/2016, instructed staff R45 had an alteration in continence related to neurogenic bladder with urinary retention, multiple sclerosis and staff were to toilet R45 every two hours, assist to toilet per resident request, check and change every two hours and as needed. Post void residuals are checked on the first and 15th of each month. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, provide peri care after incontinent episodes and apply barrier cream per doctor's order.

Undated Linden Team # team Card indicated R45 was to be checked and changed every two hours and as needed and barrier cream applied to

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

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buttocks. It also indicated R45 was to be turned and repositioned every two hours.

The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed.

During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change and reposition R45 out of the wheel chair during the day shift NA-H responded "two times, that's it."

During interview on 7/13/16, at 1:29 p.m. RN-E said (R45) was to be changed every two hours and as needed. R45 likes to sit up so, when (R45) was changed was when (R45) was repositioned.

During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. LPN-C said if changed at 7 a.m., "I would have expected them to do a change (R45) about 9:00 a.m. and 11:00 a.m."

During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect residents to be checked and changed according to the care plan and if the residents refuses, the nursing assistants should at least tell the nurse." DON said, "I would expect them to follow the care plan for repositioning." R122 was continuously observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be

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incontinent of urine. After morning cares were completed R122 was wheeled into the hallway and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel.

Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went for three hours and 16 minutes without being offered the use of a bathroom or repostioned according to the care plan.

R122's activity of daily living (ADL) CAA worksheet dated 12/1/15, indicated R122 required extensive assistance with toileting and repositioning.

R122's care plan, dated December 2015, indicated toileting and repositioning was to be done every two hours.

R122's quarterly MDS dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. R122 had severe cognitive impairment.

R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive.

When interviewed on 7/13/16, at 9:53 a.m. NA-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours. NA-A confirmed R122 had not been repositioned since getting out of bed early in the day.

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F 282	Continued From page 29 On 7/13/16, at 10:36 a.m. NA-A was asked to take R122 to the bathroom. R122's brief was dry and shook her head "no" when asked if she wanted to use the toilet. R122 stood during this time. When interviewed on 7/13/16, at 1:15 p.m. LPN-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting and repositioning. The LPN-B was interviewed on 7/13/16, at 1:22 p.m. and confirmed R122's care plan indicated "toilet every two hours to meet her needs." LPN-B was unable to locate the last three day data collection tool used to document bowel and bladder habits. LPN-B stated bowel and bladder three day collection tool was done quarterly and with significant changes. On 7/13/16, at 1:59 p.m. the DON was interviewed and stated the care plan was to be followed. Nail Care R47 was observed on 7/12/16, at 8:17 a.m. to have dark debris under eight out of 10 finger nails. On 7/12/16, at 3:19 p.m. and again on 7/13/16, at 1:00 p.m. R47's nails continued to have dark debris under eight of the ten nails. R47's ADL CAA worksheet dated 2/26/16, indicated that R47 had an ADL deficit related to dementia and required extensive assistance with personal hygiene. R47's care plan, dated March 2016, indicated weekly diabetic nail care to be	F 282		

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F 282	Continued From page 30 done by nursing. R47's quarterly MDS dated 5/26/16, indicated R47 required extensive assistance with personal hygiene. R47 had moderate cognitive impairment. R47's Admission Record printed 7/14/16, indicated R47's diagnosis included vascular dementia, diabetes mellitus type two and depression. When interviewed on 7/13/16, at 1:09 p.m. LPN-A stated the nurses provide nail care and they are checked on R47's bathed. LPN-A stated that everything with nail care should be done by the nurses. LPN-A confirmed the dark debris under R47's fingernails. The DON was interviewed on 7/14/16, at 9:19 a.m. The DON stated "the expectation is that nails are to be maintained, clean and short. If their diabetic, the nurse needs to cut but the nursing assistants can clean under the nails." The facility provided an undated policy and procedure titled Grooming and Nail Care. The policy indicated, "Proper grooming and nail care is to be performed in a dignified manner for all residents in need of assistance. Under the procedure section, line five reads "Nurses will be responsible for nail care for all diabetic residents."	F 282		
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	F 309		8/31/16

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F 309	Continued From page 31 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services related to fluid restrictions for 1 of 1 resident (R114) reviewed for dialysis. In addition, the facility failed to identify non-pressure related skin conditions for 1 of 1 resident (R140) with observed bruising. Findings include: Dialysis R114's diagnosis include end stage renal disease (ESRD), hypertension, atrial fibrillation, type II diabetes and dementia obtained from the annual Minimum Data Set (MDS) dated 6/10/16. In addition the MDS indicated R114 had moderately impaired cognition. On 7/12/16, at 2:26 p.m. observed resident lying in her bed. When asked how dialysis was going, and the facility coordination with dialysis place, resident stated was going well as she smiled at this surveyor. When asked about her diet and fluid restriction resident stated the facility staff took care of all her food/fluid needs. A pink water pitcher with straw was observed on top of the dresser on the edge to the left and was half way filled. When asked about where the access site was resident point to her right upper shoulder as she left her shirt. When asked who changed the dressing indicated the staff changed it but was not sure which if it was at dialysis or at the facility.	F 309	It is the Policy of Crest View Lutheran Home to provide services to attain or maintain the highest practicable mental, physical or psychosocial well-being for all residents, in accordance with their written plan of care. For Resident R114, her ordered fluid restriction was communicated to all staff that work on her nursing unit. In consultation with her registered dietician, an education was given and signed by each staff member on her nursing unit, which described her fluid restriction, how to monitor her intake, and how future residents with an order for fluid restrictions will be identified on the team care sheets. For all other residents that this deficient practice may have affected, all residents with orders for fluid restrictions will be identified on the team care sheet by the front line staff, and fluid documentation will be set up in their electronic health record. For Resident R140, a risk management incident report was completed on July 14th for bruises observed during the annual survey. Her written plan of care was updated by qualified staff at that time to note her potential risk for bruising, as	

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F 309	Continued From page 32 Resident indicated she was going to take a nap and would visit with surveyor later. On 7/12/16, at 3:27 p.m. the consultant registered dietician (CRD) stated the dietary tech would write the care plan for nutrition and she was in the process of revising her care plan and intakes as resident husband was indicating he had noticed since he was at the facility mostly during meals that resident needed two ounces of milk approximately for cereal and was asking for eight ounces of juice at the two meals, as on non-dialysis days she had continental breakfast and supper and dialysis days brunch and supper. CRD stated resident did not like the Nepro (supplement) and extra fluids between the meals however had 60-90 milliliters (ml) with meds. RD stated resident had been started on a fluid restriction on 7/11/16, and was in the process of revising the fluid intake allotting for the meals. On 7/12/16, at 3:44 p.m. resident was observed up seated on wheelchair at the door to room. The water pitcher was still observed on top of dresser. When asked if she would drink out of the pitcher at times, resident stated, "Yes honey I do when my mouth is dry." When asked if she knew what her fluid restriction was resident stated she did not know as she smiled. On 7/12/16, at 3:56 p.m. licensed practical nurse (LPN)-D stated she thought resident was in a fluid restriction always however, the CRD at the nursing desk corrected LPN-D that resident weights had been stable and was not on a fluid restriction until 7/11/16. LPN-D stated resident intake and output were being monitored and this was at each shift. When asked where the nursing assistants were informed resident fluid restriction	F 309	well as interventions to prevent future bruises. This incident was reviewed by an interdisciplinary team on July 15th. For all other residents that these deficient practices may affect, all staff will be re-educated on these policies and procedures by August 25th. In addition, staff were re-educated on the proper use of the INTERACT tool, the STOP AND WATCH form. This tool is used to best communicate changes in condition such as bruise, redness, skin breakdown, etc. This education was completed by August 25th. The Fluid Restriction Policy and Procedure and Resident Incident and Skin Changes Investigation Policy and Procedure for Crest View Lutheran Home were reviewed and updated by an interdisciplinary team on August 10th. These policies describe the processes of managing and documenting fluid restrictions for residents, as well as the steps to take in order to report and document incidents, such as bruises. Audits for fluid restriction protocols will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance.	

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F 309	Continued From page 33 she stated would be in the assignment sheet however when she reviewed it, the sheet did not address the fluid restriction. LPN-D also showed surveyor the intake binder which did not mention the fluid restriction. On 7/12/16, at 4:03 a.m. nursing assistant (NA)-C stated he was not sure what R114's fluid restriction was and directed the surveyor to review the meal ticket for all the dietary and fluid information. When asked if he had been, informed resident was on a fluid restriction as he was assigned to resident NA-C stated he did not know. NA-C stated resident had been given a water pitcher during the shift. On 7/12/16, at 4:06 p.m., CRD and surveyor went to R114's room and from standing at the door; CRD verified R114 had a water pitcher in the room. CRD stated because R114 was on a fluid restriction, she was not supposed to have a water pitcher in the room. When surveyor indicated R114 had reported she took sips out of the pitcher CRD acknowledged the facility did not have an accurate system of monitoring resident fluid intake. On 7/12/16, at 4:07 p.m. trained medication aide (TMA)-B stated he did not know R114 was on a fluid restriction and the only thing he knew was R114 received Nepro supplement which was being recorded in the electronic medication record (EMAR). TMA-B stated he had not been informed R114 was on a fluid restriction now. On 7/12/16, at 4:08 p.m. CRD provided a copy of the updated assignment sheet after concern was brought to facility attention regarding staff not knowing R114 was on a fluid restriction and the	F 309	Compliance date: 8/31/2016	

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water pitcher was removed from the room.

On 7/12/16, at 4:11 p.m. LPN-C unit supervisor was approached she acknowledged the nursing assignment sheet had not been updated to reflect the fluid restriction R114 was on. LPN-C stated she had just done it.

On 7/13/16, at 2:37 p.m. via telephone spoke with dialysis registered nurse who indicated, usually with a new order for R114 a nurse from the center would call the facility, would write orders on the facility communication sheet sent each time and the dialysis center staff sent the pre and post run sheet to the facility on dialysis days. When asked about the fluid restriction RN stated R114 had a new order for fluid restriction and had noted during the run for today 7/13/16, she had noticed R114 was "high by 2.8 kilograms from the previous post run weight on Monday 7/11/16." When asked what would attribute to the weight gain RN stated would be mostly not following the fluid restriction and R114 had been put on a fluid restriction because R114's high blood pressures were difficult to manage.

On 7/14/16, at 12:18 p.m. LPN-C stated when asked who was responsible for letting the staff know of the fluid restriction there was a break down between. LPN-C stated dietary was notified, and the floor nurse was supposed to let the staff know. LPN-C indicated when she received the order she never went to the room to check to make sure the water pitcher was not in the room. LPN-C stated the supervisor was supposed to update the assignment sheet.

On 7/14/16, at 2:14 p.m. the director of nursing (DON) stated she would have expected the staff

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to know about the fluid restriction if there was no breakdown. Would have expected the water pitcher not to be in the room at the time as resident was on a fluid restriction. In addition stated she would have expected the dialysis care plan to be up to date with all the changes.

The physician's order dated 7/11/16, noted R 114 was on dialysis and was on 1000 milliliter (ml/cc) fluid restrictions.

Care plan dated 6/10/16, indicated resident had actual alteration in nutrition related to dementia, type II diabetes and ESRD. Care plan indicated resident had weight fluctuation anticipated related to dialysis/fluid. Care plan directed to monitor the changes in weights, monitor intakes per facility policy, resident was on a renal diet and was on 1000 ml fluid restriction, was to take two ounces (oz) milk and four ounces apple juice (breakfast), four ounces apple juice at lunch and four ounces of apple juice supper. Also indicated resident was receiving Nepro eight oz twice daily. Care plan indicated nursing was to make up 100 cc.

Care plan dated 12/15, for dialysis indicated resident had potential for complications with hemodialysis, had ESRD, had renal failure. Care plan approaches- protect shunt from injury, avoid constriction on arm, shut care daily, listen to bruit in the internal fistula, check shunt for infection or leakage , days for dialysis Monday, Wednesday and Friday, emergency protocol.

R114's nutrition Care Area Assessment (CAA) dated 6/10/16, indicated R114 had a diagnoses of end stage renal disease and diabetes, received dialysis, had memory problems and had dementia.

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F 309	Continued From page 36 The facility Dialysis Care policy revised 9/10, indicated it was the policy of Crest View Corporation to maintain communication with and coordinate services with outside dialysis providers for the people the facility serves. The policy directed staff to: "5. Nursing will monitor the referrals to/from the dialysis center to ensure that information regarding the resident's health status are communicated between the facility and the dialysis center. 10. Follow orders from dialysis and doctor as warranted..." Skin condition R140's quarterly MDS dated 4/5/16, indicated resident had a diagnosis of dementia. In addition, the MDS indicated resident had severely impaired cognition and wandered. On 7/11/16, at 4:15 p.m. resident was observed seated in the day room and was observed with two purple bruises on the left and right hand. On 7/13/16, at 9:26 a.m. R140 observed resident standing outside the activity office in the hallway. R140's bruises visible from standing at the nursing station approximately two feet. The bruise on the left hand appeared dark purple. On 7/14/16, at 7:30 a.m. R140 observed seated at the dining room table eating breakfast. The bruises were visible and several staff observed go by resident none acknowledged the bruises which were visible. On 7/14/16, at 8:40 to 8:49 a.m. nursing	F 309		

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assistants (NA)-D and NA-E were observed walk down the hallway with R140 both holding each hand went to room. Both assisted R140 with toileting. During the observation, none of the NA's has acknowledged the visible bruises. At 8:51 a.m., NA-E even brought R140 to the bathroom and assisted resident to wash hands.

On 7/14/16, at 2:01 p.m. registered nurse (RN)-B stated she would have expected staff to report skin changes to the nurse to investigate. RN-B reviewed the Weekly Body Audit dated 7/13/16, and the nursing notes indicated she did not see any documentation of the bruises.

On 7/14/16, at 2:03 p.m., NA-E stated she had completed R140's shower on Wednesday 7/13/16, and she had reported to LPN-E who was orientating in the unit and he had thought the bruise looked old. NA-E stated the bruises on the hands were not new.
-At 2:07 p.m. RN-B stated she was shocked the nurse did not document the bruises.

On 2/14/16, at 2:29 p.m. DON stated she would have expected the nurse to document any skin concerns that had been identified and investigate immediately the cause. DON further stated she would expect staff to report any skin concerns and to follow the care plan.

R140's pressure ulcer Care Area Assessment (CAA) dated 10/16/15, indicated resident had advanced dementia and needed more assistance. CAA indicated skin would remain intact and directed staff to monitor skin with cares. R140's skin care plan dated 10/15; also, indicated resident had potential for skin alteration related to incontinence and directed staff to

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F 309	Continued From page 38 monitor skin with cares. R140's physician orders dated 6/27/16, directed staff to complete "Skin Check/Nail Trim on Bath Day every day shift every Wednesday." During review of July 2016, Treatment Administration Record, it was revealed a nurse had signed off the skin check had been completed however during review of the Weekly Body Audit dated 7/6/16, and 7/13/16, no skin concerns were identified in the assessment. On 7/14/16, at 2:00 p.m. the facility skin policy was requested however, was not provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for nail care for 1 of 1 resident (R47) reviewed for activities of daily living. In addition facility failed to ensure the care plan was followed to provide incontinence care for 1 of 1 resident (R45) who went five hours between check and changes. Findings include:	F 312	It is the Policy of Crest View Lutheran Home assess and provide necessary assistance with activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. Resident R47's nails were checked on August 11th, in addition to her scheduled bath day to ensure her nails were clipped and clean, per her plan of care. Her nail care will be assessed weekly along with	8/31/16

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F 312	Continued From page 39 R47 was observed on 7/12/16, and 7/13/16. Three observations were made and R47 had dark debris under eight out of ten fingernails. R47's activity of daily living (ADL) Care Area Assessment (CAA) worksheet dated 2/26/16, indicated that R47 had an ADL deficit related to dementia and required extensive assistance with personal hygiene. R47's care plan, dated March 2016, identified, an "alteration in self care" and an "alteration in health maintenance related to diabetes." R47's care plan revealed "diabetic nail care every week." R47's care plan did not specify what discipline was responsible for the nail care. R47's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 5/26/16, indicated R47 required extensive assistance with personal hygiene. R47's MDS indicated R47 had moderate cognitive impairment. R47's diagnoses included vascular dementia, diabetes mellitus type two and depression. When interviewed on 7/13/16, at 1:09 p.m., licensed practical nurse (LPN)-A stated the nurses provide nail care and the nails are checked on R47's bath day. LPN-A stated everything with nail care should be done by the nurses. LPN-A confirmed the dark debris under R47's fingernails. The director of nursing (DON) was interviewed on 7/14/16, at 9:19 a.m. The DON stated, "The expectation is that nails are to be maintained, clean and short. If they are diabetic, the nurse needs to cut the nails but the nursing assistants can clean under the nails."	F 312	her scheduled bath day on a scheduled basis. For resident R45, a new toileting assessment was initiated by August 12th. For all other residents that this deficient practice may have affected, ADL assessments and Incontinence assessments will be completed upon admission, quarterly, and with any significant change to the MDS. The Nail Care Policy and Procedure, and the Incontinence Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. These policies describe the process of how to provide good nail and grooming care for all residents, and how to best provide incontinence care based on the Incontinence Assessment. All staff will be re-educated on this policies and procedures by August 25th. Audits for proper nail care and incontinence care will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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The facility provided an undated policy and procedure titled Grooming and Nail Care. The policy indicated, "Proper grooming and nail care is to be performed in a dignified manner for all residents in need of assistance." Under the procedure section, line five read "Nurses will be responsible for nail care for all diabetic residents." R45 was observed on 7/13/16, at 7:09 a.m. for morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45.

On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact.

During interview on 7/13/16, at 12:14 p.m. R45 stated, "I do not use the toilet. I just have my diaper changed. R45 stated I had not been changed since got up and I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being offered

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F 312	Continued From page 41 to be checked and/or changed for incontinence. R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning. R45's urinary incontinence CAA worksheet dated 7/27/15, indicated R45 was always incontinent of urine related to neurogenic bladder (a lack of bladder sensation and control, due to damage to nerves through injury or disease) and multiple sclerosis and needed assistance with all toileting needs. R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the lower body including legs), and depression. R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to turn and reposition R45 every two hours and use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan indicated R45 was to be provided peri care after incontinent episodes and apply barrier cream per doctor's order. R45's bowel and bladder care plan dated 7/2016,	F 312		

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instructed staff R45 had an alteration in continence related to neurogenic bladder with urinary retention, multiple sclerosis and staff were to toilet R45 every two hours, assist to toilet per resident request, check and change every two hours and as needed. Post void residuals are checked on the first and 15th of each month. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, provide peri care after incontinent episodes and apply barrier cream per doctor's order.

Undated Linden Team # team Card indicated R45 was to be checked and changed every two hours and as needed and barrier cream applied to buttocks.

The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed.

During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change R45 during the day shift, NA-H responded "two times, that's it."

During interview on 7/13/16, at 1:29 p.m. RN-E said (R45) was to be changed every two hours and as needed.

During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. LPN-C said if changed at 7 a.m., "I would

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F 312	Continued From page 43 have expected them to do a change (R45) about 9:00 a.m. and 11:00 a.m." During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect residents to be checked and changed according to the care plan and if the residents refuses, the nursing assistants should at least tell the nurse." Toileting policy requested but not provided.	F 312		
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 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 provide timely repositioning for 2 of 2 residents (R122, R45) who were reviewed for pressure ulcers. Findings include: R122 was continuously observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be incontinent of urine. After morning cares were completed R122 was wheeled into the hallway	F 314	It is the Policy of Crest View Lutheran Home to assess and ensure that a resident who enters the facility without pressure sores does not develop them unless their clinical condition demonstrates that they are unavoidable. For residents R122 and R45, new turning and repositioning assessments, as well as incontinence assessments were initiated by August 12th.	8/31/16

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F 314	Continued From page 44 and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel. Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went for three hours and 16 minutes without being offered the use of a bathroom or repostioned according to the care plan. R122's activity of daily living (ADL) CAA worksheet dated 12/1/15, indicated R122 required extensive assistance with toileting and repositioning. R122's care plan, dated December 2015, indicated toileting and repositioning was to be done every two hours. R122's quarterly MDS dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. R122 had severe cognitive impairment. R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive. When interviewed on 7/13/16, at 9:53 a.m. NA-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours. NA-A confirmed R122 had not been repositioned since getting out of bed early in the day. On 7/13/16, at 10:36 a.m. NA-A was asked to take R122 to the bathroom. R122's brief was dry	F 314	For all other residents that this deficient practice may have affected, turning and repositioning assessments, and incontinent assessments will be completed upon admission, quarterly, and with any significant change to the MDS. The Turning and Repositioning Policy and Procedure, as well as the Incontinence Policy and Procedure for Crest View Lutheran Home were reviewed and updated by an interdisciplinary team on August 10th. These policies describe the process of assessing each resident's individual risk of skin breakdown and incontinence needs. They also describe the procedure of assisting with repositioning and peri-care. All staff will be re-educated on these policies and procedures by August 25th. Audits for proper turning and repositioning, incontinence care, and peri-care will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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and shook her head "no" when asked if she wanted to use the toilet. R122 stood during this time.

When interviewed on 7/13/16, at 1:15 p.m. LPN-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting and repositioning.

The LPN-B was interviewed on 7/13/16, at 1:22 p.m. and confirmed R122's care plan indicated "toilet every two hours to meet her needs." LPN-B was unable to locate the last three day data collection tool used to document bowel and bladder habits. LPN-B stated bowel and bladder three day collection tool was done quarterly and with significant changes.

On 7/13/16, at 1:59 p.m. the DON was interviewed and stated R122 should have offered toileting every two hours.
R45 was observed on 7/13/16, at 7:09 a.m. for morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri

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rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45.

On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact.

During interview on 7/13/16, at 12:14 p.m. R45 stated, "I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being repositioned.

R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning. R45's urinary incontinence CAA worksheet dated 7/27/15, indicated R45 was always incontinent of urine related to neurogenic bladder (a lack of bladder sensation and control, due to damage to nerves through injury or disease) and multiple sclerosis and needed assistance with all toileting needs.

R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the

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F 314	Continued From page 47 lower body including legs), and depression. R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, have a foam cushion in wheelchair, provide peri care after incontinent episodes and apply barrier cream per doctor's order. R45's potential for alteration in skin integrity care plan dated 7/2016, indicated R45 was to be repositioned according to tissue tolerance assessment, provide peri care after incontinent episodes and apply barrier cream per doctor's order. Undated Linden Team # team Card indicated R45 was to be turned and repositioned every two hours. The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed. During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change and reposition R45 out of the wheel chair during the day shift NA-H responded "two times, that's it."	F 314		

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F 314	Continued From page 48 During interview on 7/13/16, at 1:29 p.m. RN-E said (R45) was to be changed every two hours and as needed. R45 likes to sit up so, when (R45) was changed was when (R45) was repositioned. During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. LPN-C said if changed at 7 a.m., "I would have expected them to do a change (R45) about 9:00 a.m. and 11:00 a.m." During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect residents to be repositioned according to the care plan and if the residents refuses, the nursing assistants should at least tell the nurse." Turning and Repositioning Order Policy and Procedures revised 6/2012, instructed staff that, "Tuning [sic] and Repositioning observation form is to be completed on admit, readmit, annually and with significant change." Policy also instructed staff, "evaluation will include skin observation of sacrum, coccyx,buttock and any other pressure points at 1-hour after being in the same position. To be done in the sitting and lying down positions. If redness occurs at the 1-hour interval the resident needs to be turned and repositioned every one hour. If no redness is present a 2 hours then resident must be turned and repositioned every 2 hrs [hours]."	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	F 315		8/31/16

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F 315	Continued From page 49 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 services were implemented for timely toileting for 1 of 1 resident (R122) reviewed for toileting. Findings include: R122 was continuoulys observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be incontinent of urine. After morning cares were completed R122 was wheeled into the hallway and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel. Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went three hours and 16 minutes without being offered the use of a bathroom according to the care plan. R122's quarterly Minimum Data Set dated 5/24/16, indicated resident required extensive assistance with actives of daily living. R122's pressure ulcer Care Area Assessment (CAA) dated 12/1/15, indicated frequent	F 315	It is the Policy of Crest View Lutheran Home to assess and ensure that each resident who is incontinent receives appropriate incontinence care in accordance with their needs. For resident R122 a new incontinence assessment was initiated by August 12th. For all other residents that this deficient practice may have affected, incontinent assessments will be completed upon admission, quarterly, and with any significant change to the MDS. The Incontinence Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy describes the process of assessing each resident's incontinence needs, and providing the necessary care in accordance with those needs. All staff will be re-educated on these policies and procedures by August 25th. Audits for incontinence care will be completed weekly for four weeks, 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 315	Continued From page 50 incontinence of bowel and bladder related to dementia and limited mobility. R122's CAA indicated R122 required assistance with toileting and staff to provide peri-care as needed. The care plan dated 12/2015 indicated R122 was to be toileted every two hours. When interviewed on 7/13/16, at 1:00 p.m. nursing assistant (NA)-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours. When interviewed on 7/13/16, at 1:15 p.m. licensed practical nurse (LPN)-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting. LPN-B was interviewed on 7/13/16 at 1:22 p.m. and confirmed R122's toileting plan was "toilet every two hours to meet her needs." LPN-B stated, "I would expect there would attempt to toilet her, bring her into the bathroom, depending on her willingness, see if she will void." On July 13, 2016, at 1:59 p.m., the director of nursing was interviewed and stated the care plan was to be followed. Toileting policy requested but not provided.	F 315	then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		8/31/16

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F 334	Continued From page 51 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 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	F 334		

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F 334	Continued From page 52 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 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 pneumococcal vaccines were offered to 2 of 5 residents (R56, R173) whose immunization records were reviewed. In addition, the facility failed to develop guidelines for Pneumococcal PCV (Pneumococcal Conjugate Vaccine)-13 as recommended by the Centers for Disease Control (CDC). Finding include: R56 was 83 years old, and was admitted to the facility on 1/18/16. Immunization records revealed	F 334	It is the Policy of Crest View Lutheran Home to offer, gain consent, and administer the appropriate pneumococcal immunizations, per current CDC guidelines, for the residents we serve. For residents R56 and R173, consent to administer the pneumococcal vaccines was obtained and administration was scheduled by August 12th. For all other residents that this deficient practice may have affected, a	

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F 334	Continued From page 53 the resident had received pneumococcal polysaccharide vaccination (PPV-23) on 11/13/98. There was no indication the PCV-13 had been offered to R56. R173 was 67 years old, and was admitted to the facility on 3/24/16. Immunization records revealed received a PPV-23 on 5/10/06, which was repeated again on 5/19/15, however, the medical record lacked evidence the resident was also offered the PCV-13 vaccination as recommended by the CDC. On 7/14/16, at 11:35 a.m. a registered nurse (RN)-A who was responsible for the facility's infection control program acknowledged the facility had not implemented the use of PCV-13, nor was it reflected in their pneumococcal policy. The director of nursing stated on 7/14/16, at 11:54 a.m. "I really do not know anything about the pneumovax guideline changes. It is new to me." On 7/14/16, at 12:17 p.m. during a follow up interview with RN-A, she confirmed R173 had received PPV-23 vaccinations on 5/10/06 and 5/19/15, but there was no record the resident had also received the PCV-13 vaccination. RN-A verified R56 had previously declined PPV-23 when hospitalized prior to admission, but there was no record the resident was offered vaccination once she was admitted to the facility. The facility's 8/13, Pneumococcal Vaccination policy directed staff as follows: "Each resident will be offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized." The	F 334	whole-house audit was conducted to determine which residents had and had not received the vaccination(s). For those who hadn't, consent forms were given to their responsible parties. In addition, the standing house orders for pneumococcal vaccinations were ordered in order to be up-to-date with current CDC guidelines. Letters were then sent to all residents' physicians detailing the updated standing house orders, and to request previous immunization records for their patients residing in our facility. The Pneumococcal Vaccination Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy includes the current CDC guidelines and administration recommendations. All staff responsible for pneumococcal administration, consent, or tracking, will be re-educated on these policies and procedures by August 25th. Audits for pneumococcal vaccination administration will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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F 334	Continued From page 54 policy, however, did not incorporate the new CDC guidelines to ensure residents were offered timely immunization.	F 334		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe and accurate administration of a prescribed medication for 1 of 2 residents (R122) observed during observation of morning cares.. Findings include:	F 425	It is the Policy of Crest View Lutheran Home to administer necessary medications and treatments, by a licensed nurse, to all residents. For resident R122, all medications and treatments will be administered by a licensed nurse. This includes her	8/31/16

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F 425	Continued From page 55 R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive. R122's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. A Brief Interview of Mental Status (BIMS) was done on 6/2/16. R122 scored five out of 15 that indicated severe cognitive impairment. During observation on 7/13/16, at 7:14 a.m., nursing assistant (NA)-A was observed to have a paper medication cup with white cream in it. NA-A stated that it was medication to apply to the red bumps on R122's face. NA-A stated that the nurse gives the cream to the nursing assistants to apply. NA-A was observed to apply the white cream to R122's to red bumps on her face. R122's Physician Orders dated 4/26/16, read: hydrocortisone 1% (percent) apply lightly to reddened areas on face one time daily until resolved When interviewed on 7/13/16, at 1:59 p.m. the director of nursing (DON) stated that she expects a nurse to apply the hydrocortisone cream to R122's face. The DON also stated it was unacceptable for it to be applied by NA. When interviewed on 7/14/16, at 12:27 p.m., the consulting pharmacist (Rph) stated that the hydrocortisone should be applied by an nurse. The Rph had written a recommendation to the primary physician regarding the long-term use of the hydrocortisone cream	F 425	prescribed hydrocortisone 1% cream. The Application of Prescription Topical Ointments Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on August 10th. This policy states that all medications and treatments will be administered by a licensed nurse. For all other residents this deficient practice may affect, all staff will be re-educated on this policy and procedure by August 25th. Audits for staff knowledge on medication and treatment administration will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		8/31/16

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F 441 SS=F	Continued From page 56 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop the infection control program to include surveillance for infection, ongoing tracking and analysis, and tracking of antibiotic resistance to prevent the spread of infection. This deficient practice had the potential to affect all 112 residents who resided in the facility. In addition the facility failed to ensure hand hygiene was completed in 1 of 4 dining rooms. This had the potential to affect 8 residents who received room trays. Furthermore facility failed to ensure appropriate hand hygiene and glove usage for 1 of 1 resident (R45) observed for urinary incontinence, The facility failed to have a system to track, trend and analyze illness to determine if the cases had developed within the facility, or from an exposure of a resident admitted with an infection. It was unclear from facility documentation the number and types of infections, if they were developed in the facility, and for example if the 2, wounds on a unit were on one or two residents. Findings include: The facility's infection control logs from 1/16 to 6/16, were reviewed. The log included total numbers of residents with various infection diseases, such as urinary tract infection, pneumonia, cellulitis (skin infection), wounds. Total number of residents per unit each month were recorded. The log, however, lacked enough information to determine an analysis. The logs lacked resident name and room number, date of onset of infection, symptoms, reoccurance, and resolution dates, as well as other pertinent	F 441	It is the Policy of Crest View Lutheran Home to establish and maintain an Infection Control Program that is designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of diseases and infections by both residents and employees. It is also the Policy and Procedure of Crest View Lutheran Home to practice appropriate hand washing and glove changing, per current CDC guidelines. For all residents that the deficient infection control program may have affected, a new tracking log for all resident and employee infections was created and implemented. This log will be used to monitor and analyze infections and their potential trends throughout the facility. Outcomes from the infection control program will be communicated during all future quarterly QA committee meetings. For resident R45, proper handwashing and glove use will be used by all staff members that perform her care. For all other residents that the deficient handwashing and glove changing practice may have affected, Handwashing Policy and Procedure, along with the Glove Use Policy and Procedure for Crest View Lutheran Home were reviewed and updated by an interdisciplinary team on	

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F 441	Continued From page 58 information. One resident on Linden was identified as having a wound/incision that read, "1 on-going w/ [with] no stop date." On Evergreen one resident had "elevated temp" with no additional information, and another resident "groin" with no additional information. Information regarding residents with pneumonia did not reflect the type of pneumonia such as aspiration, bacterial, viral, etc. During an interview on 7/14/16, at 9:20 a.m. a registered nurse (RN)-A the July 2016 infection control logs were reviewed. The logs indicated the facility four cases of pneumonia on one unit. One resident was admitted with pneumonia and the rest were acquired in-house. RN-A could not say if the one resident came in with it and the the other resident acquired from that one resident. The logs lacked evidence of dates or any other information to determine the cause of the three in-house acquired pneumonia. RN-A stated she could not state that from looking at her surveillance system if they had an in-house spread of the pnemonia. During an interview on 7/14/16, at 9:20 a.m. a RN-A explained the facility's general infection control program. RN-A stated she was primarily responsible for the overall program, with assistance from a licensed practical nurse (LPN)-B and the director of nursing (DON). RN-A explained she received the data from the supervisors, recorded it on her own form, and then transferred the monthly data to the Infection Control Log. She looked for new infections and for trends. If trends were noted, she informed the DON and gave her the log information. The DON then took the information to the quality committee for review. If further action was needed, the medical director was informed. RN-A stated, "I	F 441	August 10th. These policies describe the correct procedures for washing hands and changing gloves by all staff members. All staff will be re-educated on these policies and procedures by August 25th. Audits for handwashing, glove use, and peri-care will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next quarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	

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F 441	Continued From page 59	F 441		

kind of keep track and if I notice an increase in amount of urinary tract infections, I educate staff and ask the charge nurse to educate any female residents about pericare." She also looked at nursing reports to determine if symptoms were resolving. "I do not track at all for anyone not on an antibiotic--I just look at trends." RN-A verified the logs did not specify resident names and pertinent information such as the actual organism/illness, whether it was aquired at the facility, when symptoms started or resolved, whether antibiotics were effective or were changed, etc.

The DON explained in an interivew on 7/14/16, at 12:32 p.m. that after she received the data from the infection control nurse she took the information to quality improvement (QI) committee for review. The QI committee reviewed the information and looked for patterns and then gave it to the medical director for review.

The facility's 7/11/16, Infection Prevention Guidelines indicated the purpose was "To provide cares and an environment which prevents infections in our residents...Surveillance of resident infections including review of antibiotics, documentation of infections and analysis of data and Surveillance of the environment...preventative and control measures shall be as recommended per the Center for Disease Control [CDC)] the MN [Minnesota] Department of Health [MDH] evidence based nursing practice. "

Linden Unit

On 7/11/16, at 4:52 p.m. the dietary supervisor looked on the floor and noted a puddle of water after a resident had wheeled off the area and asked nursing assistant (NA)-F to get a towel.

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F 441	Continued From page 60 NA-F was observed go into the linen closet by the dinning area and came out with two wash towels and laid both on the puddle. Then NA-A was asked by R78 to pick a napkin she had dropped right next to the wheelchair for her. NA-F was observed bend over and with bare hands picked the napkin which was soiled with brown sputum off the floor took it to the garbage can by the window. NA-F used both hands to push the lip inward tossed the napkin then and returned to the food rack and observed proceed to get food from the steam table and set the room trays without washing his hands. As NA-F set the trays was observed touch the drinking glass covers stacked on the cart by the nursing desk; touched the rims of the four ounce drinking glasses went over to the juice machine and obtained juice still holding the rims of the glasses with the soiled hands. -At 4:56 p.m. when NA-F was picking one of the trays off the rack to bring to the room, surveyor intervened. NA-F acknowledged he had not washed his hands after picking the soiled napkin off the floor. -At 5:00 p.m. after washing his hands NA-F came back to the trays he had set up with the soiled hands and attempted to bring the trays to the room at this time surveyors intervened again. NA-F stated he had only touched the covers and had gotten different covers and was just going to use the same tray of food set up. At this point the dietary supervisor was observed set different trays and asked NA-F to leaved the contaminated trays alone. On 7/11/16, at 5:10 p.m. the DON stated she appreciated the surveyors intervening. When asked what her expectation was DON stated she would expect staff to have washed hands. R45:	F 441		

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F 441	Continued From page 61 On 7/13/16 at 7:09 a.m. morning cares were observed for R45. NA-H washed hands put on gloves and removed R45's gown and washed upper body. NA-H removed gloves put on new gloves without washing or sanitizing hands. NA-H dressed R45's upper body. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to perirectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45. NA-H put ted hose, pants and shoes on R45. R45's Quarterly Minimum Data Set (MDS) dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction resulting in physical, mental and sometimes psychiatric problems) , paraplegia (paralysis of the lower body including legs), and depression.	F 441		

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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 441	Continued From page 62 During interview on 7/13/16, at 12:37 p.m. NA-H said, "I normally wash my hands when I remove my gloves." NA-H acknowledged only washed hands when startted and was done. NA-H denied using sanitizer. NA-H acknowledged used the same glove to apply barrier cream to R45's bottom and then to R45's front, including peri area. During interview on 7/14/16, at 9:47 a.m. RN-A stated expected staff to wash hands; before contact with a resident, after contact, when removing gloves, if handling trash, if staff has been to the bathroom. When asked are staff to change gloves and wash or sanitize their hands after cleaning up stool? RN-A responded, Staff are allowed to put incontinence product on then change gloves and wash or sanitize hands before touching anything else. RN-A said the staff cannot apply barrier cream with a glove hand to the rectal area and then use the same gloved hand to apply barrier cream to the perineal area. RN-A said staff "have to go front to back always, do not go to the rear until they are done with the front." During interview on 7/14/16, at10:56 a.m. DON said staff are to wash or sanitize hands before and after cares and any time staff change gloves, or any time they touch someting dirty. DON said she expects staff when applying barrier cream to go from clean to dirty; from the peri area to the rectal area. The undated Incontinent Care Policy instructs staff to explain to resident what they are going to do and provide privacy for resident. It further instructs them: "6. Wash hands and apply gloves.	F 441		

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 _____	07/14/2016

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 441	Continued From page 63 7. Remove soiled diaper and place in diaper pail , at bed side. 8. Wet disposable washcloth with warm water. Apply soap or use peri-wash spray 9. Wash genital area, washing from urethral meatus back toward anal area. Separate labia with fingers to cleanse area well. 10. Wash entire buttock area and any additional body part that is soiled. 11. Using same disposable wshcloth, rinse residents's skin thoroughly. 12. Dry the skin well with the second clean disposable washcloth. 13. Apply clean diaper and other linen as needed. 14. Assist in redressing resident in clean clothing, as necessary. 15. Change necessary bed linen and place soiled linen in hamper. 16. Prompt and thorough cleansing of any floors, chairs, mattress, etc., which might have been soiled. 17. Remove supplies and leave unit in order. 18. Document provision of care on the form in the NA/R book." Policy lacked direction for staff on when to change gloves or perform hand washing or sanitizing when providing incontinence cares. Hand Washing Policy and Proceedures dated 2/08, instructed staff, "Hand washing/ Hand Sanitizing must be done: a. Before performing invasive procedures. b. Before contact with particularly susceptible residents c. Before touching food or medications to be given to residents. d. Before and after touching wounds of any kind. e. Before and after providing personal cares for a resident.	F 441		

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 _____	07/14/2016

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 441	Continued From page 64 f. After removing gloves g. After touching anything that may have been contaminated with blood or bodily fluids. h. After caring for a resident with an active infection. i. After going to the bathroom, nose blowing, covering a sneeze and coughing. j. Before eating and before going home at the end of the shift."	F 441		

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 _____	**07/14/2016**

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 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 14, 2016. At the time of this survey Crest View Lutheran Home, Building 1 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 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 TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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.

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 _____	**07/14/2016**

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	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction typed is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 014 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation.	K 014		8/12/16

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 _____	**07/14/2016**

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 014	Continued From page 2 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 This STANDARD is not met as evidenced by: Documentation review and staff interview revealed that facility did not maintain documentation of flame spread ratings for interior finishes in egress ways in accordance with NFPA 101 (LSC) 19.3.3.1, 19.3.3.2 This deficient practice could effect all 110 residents. Findings Include: On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that there was no documentation of the flame spread ratings for finishes in egress passageways. This deficient practice was verified by the Administrator at the time of inspection.	K 014	It is the policy of Crest View Lutheran Home to have documented flame spread ratings for all interior finish for means of egress, including exposed interior surfaces of buildings such as fixed movable walls, partitions, columns, and ceilings at a rating of Class A or Class B. All interior finish, for means of egress, flame spread ratings were obtained from the manufacturers and contractors that Crest View uses. All of these flame spread ratings are now located in the Fire Safety book, maintained by the Director of Environmental Services. This was achieved by August 12th 2016. For all additional finishes that are brought into the building in the future, a checklist has been created to ensure these flame spread ratings are captured and documented. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16.	
K 015 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit	K 015		8/12/16

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 _____	**07/14/2016**

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K 015	Continued From page 3 access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Documentation review and staff interview revealed that facility did not maintain documentation of flame spread ratings for interior finishes in areas not used as exit passageways in accordance with NFPA 101 (LSC) 19.3.3.1, 19.3.3.2. This deficient practice could effect all 110 residents. Findings Include: On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that there was no documentation of the flame spread ratings for finishes in corridors.. This deficient practice was verified by the Administrator at the time of inspection.	K 015	It is the policy of Crest View Lutheran Home to have documented flame spread ratings for all interior finish for rooms and spaces. All interior finish flame spread ratings were obtained from the manufacturers and contractors that Crest View uses. All of these flame spread ratings are now located in the Fire Safety book, maintained by the Director of Environmental Services. This was achieved by August 12th 2016. For all additional finishes that are brought into the building in the future, a checklist has been created to ensure these flame spread ratings are captured and documented. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide adequate emergency lighting in accordance with LSC (00) 19.2.8. This deficient practice can effect all 110 residents. Findings include: On a facility tour between 09:00 AM and 01:00	K 046	It is the policy of Crest View Lutheran Home to provide effective and safe, lighting. The battery operated emergency lighting was removed and capped off. All lights are backed up by a generator, and the battery operated emergency lighting was	8/12/16

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	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2016**

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K 046	Continued From page 4 PM on July 14, 2016, observation revealed that there was no documentation of a 90 minute annual test for battery operated emergency egress lighting. This deficient practice was verified by the Administrator at the time of inspection.	K 046	not necessary. Therefore, no emergency light testing will need to occur in the futre. This was achieved by August 12th 2016. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 110 residents. Findings include: On a facility tour between 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that the facility could not documentation for a current smoke detector sensitivity test. This deficient practice was verified by the Administrator at the time of inspection.	K 054	It is the policy of Crest View Lutheran Home to conduct sensitivity testing on all smoke detectors on the fire alarm system. Smoke detector sensitivity testing was completed by Mayer Electric on July 18th, and will be completed annually by their company for Crest View Lutheran Home. These sensitivities are archived in the Fire Safety Book by the Director of Life Enrichment. Audits will be completed yearly to ensure that these sensitivities are being tested and documented. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16.	8/12/16
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an	K 056		8/12/16

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K 056	Continued From page 5 approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 110 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that the current annual automatic sprinkler inspection does not indicate that a five year internal pipe inspection was performed on the system or that the guages were replaced or calibrated. This deficient practice was verified by the Administrator at the time of inspection .	K 056	It is the policy of Crest View Lutheran Home that the automatic sprinkler system is maintained in accordance with NAPA 13 the Standard for the Sprinkler Systems 1999 edition. Current annual automatic sprinkler system inspections now include a five-year internal pipe inspection. In addition, gauges were replaced. This work was completed by Mayer Electric on 7/26/16. An audit has been created to track the five-year internal sprinkler pipe inspections at Crest View Lutheran Home. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16	

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	245018	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**07/14/2016**

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K 000	INITIAL COMMENTS	K 000		

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 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 14, 2016. At the time of this survey Crest View Lutheran Home, Building 1 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 2000 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:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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.

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 _____	**07/14/2016**

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction typed is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 014 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 This STANDARD is not met as evidenced by:	K 014		8/12/16

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 _____	**07/14/2016**

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K 014	Continued From page 2 Documentation review and staff interview revealed that facility did not maintain documentation of flame spread ratings for interior finishes in egress ways in accordance with NFPA 101 (LSC) 18.3.3.1, 18.3.3.2 This deficient practice could effect all 110 residents. Findings Include: On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that there was no documentation of the flame spread ratings for finishes in egress passageways. This deficient practice was verified by the Administrator at the time of inspection.	K 014	CORRECTED	
K 015 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. This STANDARD is not met as evidenced by: Documentation review and staff interview revealed that facility did not maintain documentation of flame spread ratings for interior finishes in areas not used as exit passageways in accordance with NFPA 101 (LSC) 18.3.3.1, 18.3.3.2. This deficient practice could effect all 110 residents. Findings Include:	K 015	It is the policy of Crest View Lutheran Home to have documented flame spread ratings for all interior finish for rooms and spaces. All interior finish flame spread ratings were obtained from the manufacturers and contractors that Crest View uses. All of these flame spread ratings are now located in the Fire Safety book,	8/12/16

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 _____	**07/14/2016**

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

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K 015	Continued From page 3 On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that there was no documentation of the flame spread ratings for finishes in corridors.. This deficient practice was verified by the Administrator at the time of inspection.	K 015	maintained by the Director of Environmental Services. This was achieved by August 12th 2016. For all additional finishes that are brought into the building in the future, a checklist has been created to ensure these flame spread ratings are captured and documented. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 110 residents. Findings include: On a facility tour between 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that the facility could not documentation for a current smoke detector sensitivity test. This deficient practice was verified by the Administrator at the time of inspection.	K 054	It is the policy of Crest View Lutheran Home to conduct sensitivity testing on all smoke detectors on the fire alarm system. Smoke detector sensitivity testing was completed by Mayer Electric on July 18th, and will be completed annually by their company for Crest View Lutheran Home. These sensitivities are archived in the Fire Safety Book by the Director of Life Enrichment. Audits will be completed yearly to ensure that these sensitivities are being tested and documented. The Director of Environmental Services or hi designee will be responsible for	8/12/16

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 _____	**07/14/2016**

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K 054	Continued From page 4	K 054	compliance. Date of Correction: 8/12/16.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 110 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on July 14, 2016, observation revealed that the current annual automatic sprinkler inspection does not indicate that a five year internal pipe inspection was performed on the system or that the guages were replaced or calibrated.	K 056	It is the policy of Crest View Lutheran Home that the automatic sprinkler system is maintained in accordance with NAPA 13 the Standard for the Sprinkler Systems 1999 edition. Current annual automatic sprinkler system inspections now include a five-year internal pipe inspection. In addition, gauges were replaced. This work was completed by Mayer Electric on 7/26/16. An audit has been created to track the five-year internal sprinkler pipe inspections at Crest View Lutheran Home. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 8/12/16	8/12/16

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K 056	Continued From page 5 This deficient practice was verified by the Administrator at the time of inspection.	K 056		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
August 5, 2016

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

Re: State Nursing Home Licensing Orders - Project Number S5018028, H5018107 and H50181107

Dear Mr. Tobalsky:

The above facility was surveyed on July 11, 2016 through July 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5018107 and H5018109. Complaint number H5018107 was found to be substantiated at 0265 and complaint number H5018109 was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus at (651) 201-3792 or email: gloria.derfus@state.mn.us.

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

Please 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	07/14/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 07/11/2016 - 07/14/2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, at the time of the survey, two complaint investigations were conducted. An investigation of complaint H5018107 which was found to be substantiated at 0265, and investigation of complaint H5018109 which was found to be unsubstantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and	2 000		

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2 000	Continued From page 2 Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for	2 265		8/31/16

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2 265	Continued From page 3 example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to administer Vancomycin (a antibiotic) as ordered and notify the physician for the missed antibiotic doses ordered for 1 of 1 resident (R164) reviewed for discharge. Findings include: R164's diagnoses included clostridium difficile diabetes and "s/p [Status Post- after procedure]" heart transplant obtained from the After Discharge Orders dated 2/12/16. R164's After Discharge Orders dated 2/12/16, revealed the following order: -Vancomycin 50 milligram (mg) per milliliter (ml) take 2.5 ml by mouth 4 times daily for 8 days for clostridium difficile colitis. During review of the February 2016, the Electronic Medication Administration Record (EMAR) was revealed the medication was in the EMAR and had been signed off multiple times by staff as administered however had not been administered on the following days as indicated on the EMAR progress notes: -2/12/16, 8:28 p.m. indicated Vancomycin Hydrochloride (HCL) solution 50 mg/ml give 2.5	2 265	CORRECTED	

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2 265	Continued From page 4 ml by mouth four times a day for c-diff for 8 Days. New admit medication not here yet and scheduled again at 8pm. -2/18/16, 8:17 a.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days out at leave of absence (LOA) -2/19/16, 9:45 p.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days not available at this time -2/20/16, 8:40 a.m. indicated Vancomycin HCl solution 50 mg/ml give 2.5 ml by mouth four times a day for c-diff for 8 Days not available at this time. On 7/14/16, at 1:49 p.m., the consultant pharmacist (CP) indicated R164's medications including the antibiotic had been scanned ready to deliver on 2/12/16, at 8:00 p.m. and thought usually would take approximately an hour to arrive at the facility. CP verified R164 had missed the four o'clock Vancomycin on 2/12/16 and two doses on 2/18/16, at 8:00 a.m. and 12:00 o'clock thought were missed because R164 was out for an appointment. In addition, CP verified on 2/19/16, and 2/20/16, CP the 8:00 p.m. and 8:00 a.m. doses were missed respectively probably because nurses did not know the medication was stored in the refrigerator. CP further stated there was no documentation to explain the missed medication doses. -At 1:52 p.m. the CP stated she would have expected the staff to call the doctor and let them know about the missed doses depending on the directions of the medication. On 7/14/16, at 2:20 p.m. the DON stated she would expect the nurse to pass it on report. DON further stated she would not answer, as she was	2 265		

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2 265	Continued From page 5 not aware of what had occurred. "I preach staff to call the doctor and let the doctor make the decision." On 7/14/16, at 2:06 p.m. via telephone the nurse practitioner stated during R164's brief stay at the facility she never saw resident and there was no documentation indicating the facility nurses had notified her office of the missed doses, which would include faxes or phone documentation. NP stated she would have expected to be informed. During review of all the progress notes located in R164's medical records from admission on 2/12/16 through the discharge date on 2/20/16, documentation was lacking to indicate the doctor or NP had been updated about the missed antibiotic doses. Review of the medication error forms completed by the facility lacked any mention of R164's missed medication doses. The facility Administering Medications policy directed: "3. Medications must be administered in accordance with the orders, including any required time frame. 10. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR is "flagged" with (tags, colored plastic stripes, drinking straws, or paper clips). After completing the medication pass, the nurse returns to the missed resident to administer the medication..." The policy did not address since the medication record was now electronic how the staff were to be alerted of missed medication. In addition the policy did not address what the staff were supposed to do when a medication had been missed. SUGGESTED METHOD OF CORRECTION:	2 265		

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2 265	Continued From page 6 The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 265		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do	2 505		8/31/16

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2 505	Continued From page 7 not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of side rails as a potential restraint for 1 of 3 residents (R25) reviewed for accidents. In addition facility failed to ensure a resident is not restrained for 2 of 4 residents (R53, R62) who had two pillows under the bottom sheets of their beds creating a barrier to getting out of bed. Findings include: R25 was admitted to the facility on 2/1/15. An admission Minimum Data Set (MDS) assessment was completed on 2/8/16, indicated R25 was cognitively intact and required extensive assistive of one staff person for bed mobility. The 2/8/16, MDS assessment further indicated that restraints were not used.	2 505	CORRECTED	

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2 505	Continued From page 8 A 2/4/16, side rail assessment indicated R25 utilized a right grab bar and was able to safely utilize the grab bar. R25's care plan dated 2/16/16, identified the use of safety devices: 1/2 side rails and a right grab bar with side rail cushions. A 5/5/16, Safety Risk Assessment indicated that R25 was independent with bed mobility and utilized a left and right grab bar as a physical device for positioning. On 7/11/16, at 3:38 p.m. R25's bed was observed to have half side rails on the left and right side of the bed. The right side rail was observed to be loose. On 7/12/16, at 2:23 p.m. R25's bed was again observed to have half left and right side rails with the right side rail loose. On 7/12/16, at 2:59 p.m. licensed practical nurse (LPN)-C was asked about R25'S right half side rail and confirmed that the half side rail was loose. LPN-C stated that the facility was in process of a side rail audit. LPN-C stated that she would fill out a maintenance slip to have the loose side rail repaired or replaced. LPN-C stated that maintenance checks the side rails and that they should be tight fitting to the bed. A maintenance slip dated 7/12/16, indicated that R25's "side rails loose and need repair or replace" The maintenance slip indicated under the correction line that this was completed and that the bed and rails were replaced on 7/12/16. On 7/13/16, at 12:53 p.m. R25's bed was	2 505		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 505	Continued From page 9 observed with both left and right side rails. R25 stated that the loose rail was fixed yesterday (7/12/16). LPN-C was interviewed on 7/13/16, at 1:21 p.m. and stated R25's side rail assessment should indicate the use of two half side rails. LPN-C reviewed the 2/4/16, side rail assessment, the 5/5/16, safety risk assessments and R25's care plan with the surveyor and confirmed R25's assessment and care plan do not identify the use of bilateral (left and right) half side rails, however did indicate the use of a grab bar. LPN-C stated that there should be an assessment for two half side rails. LPN-C then added a nursing order to R25's medical record for a side rail assessment to be completed on the evening shift of 7/13/16. The director of nursing (DON) confirmed on 7/13/16, at 2:08 p.m. that assessments and care plans should match what has been assessed and determined appropriate for the resident's use. A side rail assessment was completed on 7/13/16, at 7:13 p.m. that indicated the use of bilateral half side rails for mobility. On 7/14/16, at 9:11 a.m. R25's bed was observed to have a left half side rail and a right grab bar. -At 9:12 a.m. registered nurse (RN)-C confirmed there was a right grab bar and one half side rail on R25's bed. RN-A stated that she did not know where this (grab bar) came from as yesterday R25 had two half side rails on her bed and that her assessment indicated that two half side rails were being used. -At 9:15 a.m. LPN-C confirmed that there was a right grab bar on R25's bed and not two half side rails as the assessment indicated. -At 9:39 a.m. the administrator confirmed that he	2 505		

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2 505	Continued From page 10	2 505		

was aware R25 had a right grab bar and not two half side rails on her bed. The administrator confirmed that two staff were trying to correct what was written on the assessment and care plan. The administrator further stated that maintenance was aware and there would be two side rails put on R25's bed to match what was assessed on 7/13/16. The administrator then confirmed that R25's care plan would also be corrected to reflect what positioning and safety device R25 was utilizing.

A facility policy entitled "Side Bar/Grab Bar Assessment" dated "3/10" indicated that "all residents will be assessed during the admission process and as needed for the use of side rails or grab bars for positioning or increasing self-mobility". The policy further indicated that a nurse would complete the assessment within 7 days of admission and the assessment would be updated annually, with a change in condition or as needed. The policy also indicated the assessment will be reviewed quarterly.

R53's quarterly MDS dated 4/11/16, indicated she was severely cognitively impaired and required assistance for bed mobility, toileting and transfers. The MDS indicated R53 was unsteady but able to stabilize with staff assistance during a surface to surface transfer. A Care Area Assessment (CAA) dated 1/21/16, identified a risk for falls and indicated R53 had difficulty maintaining a standing position and impaired balance during transfers. R53's care plan dated 7/10/16 indicated potential for alteration in safety related cognitive deficits. The care plan directed staff to use a body pillow while in bed.

A review of Crest View Lutheran home Progress

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2 505	Continued From page 11 Notes dated 6/1/16, through 7/12/16, indicated R53 was found on the floor next to her bed on 6/3/16. A progress noted dated 6/6/16, indicated "body pillow has been applied to resident bed." During an observation on 7/12/16, at 2:38 p.m. R53 was lying in bed on her left side. The left side of her bed was placed against a wall and a pillow approximately four feet in length was placed on her right side. The pillow was placed directly on the mattress with the fitted sheet tucked around it. There was a fall mat on the floor and a pressure alarm placed on the bed. During an observation on 7/14/16, at 7:56 a.m. R53's alarm could be heard sounding from the hallway outside her room. Registered nurse (RN)-B responded to the alarm. RN-B stated R53 was sitting up in her bed when she responded to the alarm. She stated R53 was capable of swinging her legs over the side of the bed and will sit on the side of the bed and attempt to stand. RN-B further stated, R53 can be on the floor, "that's why they have a body pillow." During an interview on 7/13/16, at 8:54 a.m. nursing assistant (NA)-I stated R53's care sheet directed her to use a body pillow in bed. She stated the body pillow goes under the fitted sheet if a resident is a fall risk. During an interview on 7/13/16, at 12:51 p.m., NA- E stated the body pillow keeps R53 from falling out of bed. During an interview on 7/14/16, at 8:08 a.m., RN-F stated, a body pillow is not considered a restraint if the resident is able to adjust it. She stated she was aware the facility was using body pillows as interventions for resident's who fall	2 505		

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2 505	Continued From page 12 frequently but was not aware the pillows were being placed under the fitted sheet under the bed. RN-F stated, "If it prevents them from doing something they could do on their own we would call it a restraint." She further stated she was not aware of an assessment specific to restraints. During an interview on 7/14/16, at 9:41 a.m., NA-J stated he always puts the body pillows under the fitted sheet and stated he was unsure if he was trained to do it that way by anyone specific. He stated that's how I have seen it done." During an interview on 7/14/16, at 8:39 a.m., the DON stated the facility uses body pillows to help define the edge of the bed. She stated tucking the body pillows under the fitted sheet is not the correct application. She stated staff need to be educated that it is not OK to do it that way. R62 was lying in bed with the right side of the bed against the wall and two pillows tucked under the bottom sheet on the left side observed on 7/13/16, at 8:03 a.m. LPN-F removed the two pillows from under the sheet. Once LPN-F removed the pillows R62 sat up on the edge of the bed with feet on floor mat. Alarm under R62's pillow did not sound when R62 sat up. R62 took the medications then laid down. R62 then sat back up and said "I need to use the pot." R62 started to stand up when LPN-F asked R62 to sit down and put on the call light for staff to assist R62. LPN-F acknowledged that the two pillows did not belong under R62's bottom sheet. During random observation on 7/14/16, at 6:58 a.m. R62 was lying in bed on left side with lights	2 505		

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2 505	Continued From page 13 off. There were two pillows under the bottom sheet (one of the pillows was part way out from under the sheet). The admission MDS dated 5/2/16, indicated R62 was severely cognitively impaired and required extensive assistive of two staff members for bed mobility. The MDS further indicated restraints were not used. R62's MDS noted R62 diagnoses included generalized weakness, dementia with behaviors, seizure disorder and that R62 was admitted to the facility on 4/25/16. R62's fall CAA dated 5/4/16, indicated R62 was at risk for falls related to a history of falls prior to admission, unsteady balance when moving from seated to standing positions and from bed to wheel chair but did not address the usage of side rails or pillows under the bottom sheet of the bed. R62's fall care plan date 5/16, indicated R62 had fall risk related to weakness, balance impairment, dementia, cardiac disease, and urinary incontinence/urgency. The care plan also indicated R62 crawled out of bed at time, was impulsive and ambulated at time by self. Care plan instructed staff to maintain a clutter free environment, keep call light within reach, 1/2 side rails, sensor alarm in bed and chair. Care plan did not indicate to place pillows under the bottom sheet of the bed on the left side. The Fall Risk Assessment dated 7/12/16, indicated R62 had intermittent confusion, a history of 3 or more falls in the last three months, was chair bound requiring assistance with elimination, had balance problems and decreased muscular coordination. Side Rail Assessment dated 7/13/16, indicated	2 505		

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2 505	Continued From page 14	2 505		

resident did not use grab bars. Restraint assessment was requested but not provided.

The undated Team Sheet indicated R62 was a fall risk, had sensor alarm on bed and wheel chair and required assistance of one staff member for transfers and ambulation.

During interview on 7/13/16, at 10:05 a.m. LPN-F stated, "I am not sure why the pillows are tucked under the bottom sheet, but maybe to prevent [R62] from rolling out." LPN-F also stated R62 was able to stand but should have help. LPN-F verified R62 had fallen since admission. LPN-F verified there were no side rails on R62's bed.

During interview on 7/14/16, at 7:00 a.m. NA-G stated, " [R62] does attempt to get up out of his bed that is why we put the pillows under the sheet." NA-G verified the pillows were under the bottom sheet.

During interview on 7/14/16, at 8:50 a.m. RN-D stated, "I am not sure why the nursing assistants are putting the pillows under the bottom sheet. " RN-D said, " I have seen him get up, That is why he has a sensor alarms so I am not sure why they would put the pillows under the sheets. "

During interview on 7/14/16, at 8:58 a.m. LPN-C stated, the fact staff are putting pillows under the sheets was brought to me by the night nurse downstairs, regarding another resident. LPN-C stated "I did not know about (R62) until I heard you talking to her. Staff are not to put the pillows under the bottom sheet. It would be a restraint if they cannot get over it on their own." When asked if R62 could get over the pillows on own LPN-C stated it depends on the day if R62 could get over it. He has very active days and very sleepy days.

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2 505	Continued From page 15 " We started education today on not doing that and will be talking to the night shift. " During interview on 7/14/16, at 10:53 a.m. DON said, "Pillows under the bottom sheet is not our practice. It is a restraint." DON stated it does not give them the ability to be free and do what they want. DON stated, "A pillow in bed might be and intervention for comfort or to define edges of bed but we do not direct staff to put it under a sheet." A facility policy entitled Use of Restraints dated 2016, indicated a restraint is classified as anything that prohibits a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated that the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews, chart audits and room observations. If an advertent restraint is observed it will be removed immediately by a staff member". SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review or revise policies regarding the use of physical restraints. The DON and /or designee could provide education for staff regarding physical restraint use. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 505		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment	2 540		8/31/16

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2 540	Continued From page 16 Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively and accurately assess for potential restraints for 2 of 4 residents (R25, R62) reviewed for restraints. Findings include:	2 540	CORRECTED	

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2 540	Continued From page 17 An admission Minimum Data Set (MDS) assessment was completed on 2/8/16, indicated R25 was cognitively intact and required extensive assistive of one staff person for bed mobility. The 2/8/16, MDS assessment further indicated that restraints were not used and that R25 was admitted to the facility on 2/1/15. A 2/4/16, side rail assessment indicated R25 utilized a right grab bar and was able to safely utilize the grab bar. R25's care plan dated 2/16/16, identified the use of safety devices: 1/2 side rails and a right grab bar with side rail cushions. A 5/5/16, Safety Risk Assessment indicated R25 was independent with bed mobility and utilized a left and right grab bar as a physical device for positioning. On 7/11/16, at 3:38 p.m. R25's bed was observed to have half side rails on the left and right side of the bed. On 7/12/16, at 2:23 p.m. R25's bed was again observed to have half left and right side rails. On 7/13/16, at 12:53 p.m. R25's bed was observed with both left and right side rails. Licensed practical nurse (LPN)-C was interviewed on 7/13/16, at 1:21 p.m. and stated R25's side rail assessment should indicate the use of two half side rails. LPN-C reviewed the 2/4/16, side rail assessment, the 5/5/16, safety risk assessments and R25's care plan with the surveyor and confirmed R25's assessment and care plan did not identify the use of bilateral (left	2 540		

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2 540	Continued From page 18 and right) half side rails, however did indicate the use of a grab bar. LPN-C stated that there should be an assessment for two half side rails. LPN-C then added a nursing order to R25's medical record for a side rail assessment to be completed on the evening shift of 7/13/16. The director of nursing (DON) confirmed on 7/13/16, at 2:08 p.m. that assessments and care plans should match what has been assessed and determined appropriate for the resident's use. A Side Rail assessment was completed on 7/13/16, at 7:13 p.m. and indicated the use of bilateral half side rails for mobility. On 7/14/16, at 9:11 a.m. R25's bed was observed to have a left half side rail and a right grab bar. -At 9:12 a.m. registered nurse (RN)-C confirmed there was a right grab bar and one half side rail on R25's bed. RN-A stated she did not know where that (grab bar) came from, as yesterday R25 had two half side rails on her bed and that her assessment indicated that two half side rails were being used. -At 9:15 a.m. LPN-C confirmed there was a right grab bar on R25's bed and not two half side rails as the assessment indicated. -At 9:39 a.m. the administrator confirmed that he was aware R25 had a right grab bar and not two half side rails on her bed. The administrator confirmed that two staff were trying to correct what was written on the assessment and care plan. The administrator further stated that maintenance was aware and there would be two side rails put on R25's bed to match what was assessed on 7/13/16. The administrator then confirmed R25's care plan would also be corrected to reflect what positioning and safety device R25 was utilizing.	2 540		

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2 540	Continued From page 19 A facility policy entitled Side Bar/Grab Bar Assessment dated 3/10 indicated that "all residents will be assessed during the admission process and as needed for the use of side rails or grab bars for positioning or increasing self-mobility." The policy further indicated that a nurse would complete the assessment within seven days of admission and the assessment would be updated annually, with a change in condition or as needed. The policy also indicated the assessment will be reviewed quarterly. R62 was lying in bed with the right side of the bed against the wall and two pillows tucked under the bottom sheet on the left side as observed on 7/13/16, at 8:03 a.m. LPN-F removed the two pillows from under the sheet. Once LPN-F removed the pillows R62 sat up on the edge of the bed with feet on floor mat. Alarm under R62's pillow did not sound when R62 sat up. R62 took the medications then laid down. R62 then sat back up and said "I need to use the pot." R62 started to stand up when LPN-F asked R62 to sit down and put on the call light for staff to assist R62. LPN-F acknowledged that the two pillows did not belong under R62's bottom sheet. During random observation on 7/14/16, at 6:58 a.m. R62 was lying in bed on left side with lights off. There were two pillows under the bottom sheet (one of the pillows was part way out from under the sheet). R62 was admitted to the facility on 4/25/16. The admission MDS dated 5/2/16, indicated R62 was severely cognitively impaired and required extensive assistive of two staff members for bed mobility. The 5/2/16, MDS further indicated that	2 540		

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2 540	Continued From page 20 restraints were not used. R62's MDS indicated R62 diagnoses included generalized weakness, dementia with behaviors, seizure disorder R62's fall Care Area Assessment dated 5/4/16, indicated R62 was at risk for falls related to a history of falls prior to admission, unsteady balance when moving from seated to standing positions and from bed to wheel chair but did not address the usage of side rails or pillows under the bottom sheet of the bed. R62's fall care plan date 5/16, indicated R62 had fall risk related to weakness, balance impairment, dementia, cardiac disease, and urinary incontinence/urgency. The care plan also indicated Resident crawls out of bed at time, is impulsive and ambulates at time by self. The care plan instructed staff to maintain a clutter free environment, keep call light within reach, 1/2 side rails, sensor alarm in bed and chair. The care plan did not indicate to place pillows under the bottom sheet of the bed on the left side. The Fall Risk Assessment dated 7/12/16, indicated R62 had intermittent confusion, a history of three or more falls in the last three months, was chair bound requiring assistance with elimination, had balance problems and decreased muscular coordination. The Side Rail Assessment dated 7/13/16, indicated resident did not use grab bars. Restraint assessment was requested but not provided. The undated team sheet indicated R62 was a fall risk, had sensor alarm on bed and wheel chair and required assistance of one staff member for transfers and ambulation.	2 540		

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2 540	Continued From page 21 During interview on 7/14/16, at 8:58 a.m. LPN-C said "Staff are not to put the pillows under the bottom sheet. It would be a restraint if they cannot get over it on their own." When asked if R62 could get over the pillows on own LPN-C said It depends on the day if R62 could get over it. He has very active days and very sleepy days. During interview on 7/14/16, at 10:53 a.m. DON said, "Pillows under the bottom sheet is not our practice. It is a restraint." DON said it does not give them the ability to be free and do what they want. DON said, "A pillow in bed might be and intervention for comfort or to define edges of bed but we do not direct staff to put it under a sheet." DON said, "We would not have a restraint assessment because we do not use restraints." The MDS 3.0 manual dated 10/15, defined restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." In addition, the MDS directed the facility to determine if it was a restraint "Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address." A facility policy entitled Use of Restraints dated 2016, indicated a restraint is classified as anything that prohibits a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated that the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews,	2 540		

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2 540	Continued From page 22 chart audits and room observations. If an advertent restraint is observed it will be removed immediately by a staff member." SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could review policy and provide education for staff regarding completion of accurate resident assessments. The Quality Assessment and Assurance committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively re-assess a potential restraint for 1 of 4 residents (R53) reviewed for restraints. Findings include: R53's quarterly MDS dated 4/11/16, indicated she was severely cognitively impaired and required assistance for bed mobility, toileting and transfers.	2 550	CORRECTED	8/31/16

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2 550	Continued From page 23 A Safety Risk Assessment dated 7/7/16, indicated R53 was at risk for falls. The assessment identified the following physical devices: floor mat, perimeter mattress, low bed, bed alarm/sensor, and bed alarm/tabs. The assessment indicated the purpose of the devices was for positioning. The assessment did not identify the use of a body pillow. R53's care plan dated 7/10/16, indicated potential for alteration in safety related cognitive deficits. The care plan directed staff to use a body pillow while in bed. A review of Crest View Lutheran Home Progress Notes dated 6/1/16 through 7/12/16, indicated R53 was found on the floor next to her bed on 6/3/16. A progress note dated 6/6/16, indicated "body pillow has been applied to resident bed." During an observation on 7/12/16, at 2:38 p.m., R53 was lying in bed on her left side. The left side of her bed was placed against a wall and a pillow approximately four feet in length was placed on her right side. The pillow was placed directly on the mattress with the fitted sheet tucked around it. There was a fall mat on the floor and a pressure alarm placed on the bed. During an observation on 7/14/16, at 7:56 a.m., R53's alarm could be heard sounding from the hallway outside her room. Registered nurse (RN)-B responded to the alarm. RN-B stated R53 was sitting up in her bed when she responded to the alarm. She stated R53 was capable of swinging her legs over the side of the bed and will sit on the side of the bed and attempt to stand. RN-B stated, R53 can be on the floor, "that's why they have a body pillow." During an interview on 7/13/16, at 8:54 a.m., nursing assistant (NA)-I stated R53's care sheet	2 550		

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2 550	Continued From page 24 directed her to use a body pillow in bed. She stated the body pillow goes under the fitted sheet if a resident was a fall risk. During an interview on 7/14/16, at 8:08 a.m., RN-F stated, a body pillow was not considered a restraint if the resident was able to adjust it. She stated she was aware the facility was using body pillows as interventions for resident's who fall frequently but was not aware the pillows were being placed under the fitted sheet under the bed. RN-F stated, "If it prevents them from doing something they could do on their own we would call it a restraint." She further stated she was not aware of an assessment specific to restraints. During an interview on 7/14/16, at 8:39 a.m., the DON stated the facility used body pillows to help define the edge of the bed. She stated tucking the body pillows under the fitted sheet was not the correct application. She stated staff need to be educated that it was not OK to do it that way. She the DON further stated the body pillow was not assessed as a restraint. The MDS 3.0 manual dated 10/15, defined restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." In addition, the MDS directed the facility to determine if it was a restraint "Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address." A facility policy entitled Use of Restraints dated 2016, indicated a restraint is classified as	2 550		

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2 550	Continued From page 25 anything that prohibits a resident from functioning, moving, or performing ADLS's (activities of daily living) freely. The policy further indicated that the "interdisciplinary team will periodically review resident charts to ensure no restraints are present; these reviews will be completed through review of incident reviews, chart audits and room observations. If an advertent restraint is observed it will be removed immediately by a staff member." SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the revision and accuracy of the quarterly assessment process. The DON, or designee(s) could provide an in-service for all appropriate staff on these policies and procedures. The DON, or designee(s) could monitor to assure each resident with a quarterly assessment is accurate and revise. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to follow the plan of care for	2 565	CORRECTED	8/31/16

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2 565	Continued From page 26 1 of 1 residents (R140) reviewed for non-pressure skin conditions observed with bruises of unknown cause. In addition the facility failed to ensure the plan of care was implemented for timely toileting and repositioning for 2 of 2 residents (R45, R122) reviewed for toileting and repositioning and failed to provide to nail care for 1 of 1 resident (R47) reviewed for activities of daily living. Findings include: Non-pressure skin: R140 was observed on 7/11/16, at 4:15 p.m. The resident was observed seated in the day room and was observed with two purple bruises on the left and right hand. On 7/13/16, at 9:26 a.m. R140 observed resident standing outside the activity office in the hallway. R140's bruises visible from standing at the nursing station approximately two feet. The bruise on the left hand appeared dark purple. On 7/14/16, at 7:30 a.m. R140 observed seated at the dining room table eating breakfast. The bruises were visible and several staff observed go by resident none acknowledged the bruises which were visible. On 7/14/16, at 8:40 to 8:49 a.m. nursing assistants (NA)-D and NA-E were observed walk down the hallway with R140 both holding each hand went to room. Both assisted R140 with toileting. During the observation, none of the NA's has acknowledged the visible bruises. At 8:51 a.m., NA-E even brought R140 to the bathroom and assisted resident to wash hands. R140's pressure ulcer Care Area Assessment	2 565		

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2 565	Continued From page 27 (CAA) dated 10/16/15, indicated resident had advanced dementia and needed more assistance. CAA indicated skin would remain intact and directed staff to monitor skin with cares. R140's skin care plan dated 10/15 also, indicated resident had potential for skin alteration related to incontinence and directed staff to monitor skin with cares. R140's quarterly Minimum Dadta Set (MDS) dated 4/5/16, indicated resident had a diagnosis of dementia. In addition, the MDS indicated resident had severely impaired cognition and wandered. R140's Physician's Orders dated 6/27/16, directed staff to complete "Skin Check/Nail Trim on Bath Day every day shift every Wednesday." During review of July 2016, Treatment Administration Record, it was revealed a nurse had signed off the skin check had been completed however during review of the Weekly Body Audit dated 7/6/16, and 7/13/16, no skin concerns were identified in the assessment. On 7/14/16, at 2:01 p.m. registered nurse (RN)-B stated she would have expected staff to report skin changes to the nurse to investigate and staff was to follow the plan of care. On 7/14/16, at 2:03 p.m., NA-E stated she had completed R140's shower on Wednesday 7/13/16, and she had reported to licensed practical nurse (LPN)-E who was orientating in the unit and he had thought the bruise looked old. NA-E stated the bruises on the hands were not new. -At 2:07 p.m. RN-B stated she was shocked the nurse did not document the bruises.	2 565		

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2 565	Continued From page 28 On 2/14/16, at 2:29 p.m. the direct of nursing (DON) she would expect staff to report any skin concerns and to follow the care plan. The facility Care Plan Policy and Procedure revised 9/14, indicated the care plan was to ensure the resident received the appropriate care required to maintain or attain the resident's highest level of practicable function possible. Toileting and Repositioning: R45 was observed on 7/13/16, at 7:09 a.m. for morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45. On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact. During interview on 7/13/16, at 12:14 p.m. R45	2 565		

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2 565	Continued From page 29	2 565		

stated, "I do not use the toilet. I just have my diaper changed. R45 stated I had not been changed since got up and I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being offered to be checked and/or changed for incontinence nor was R45 repositioned.

R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning. R45's urinary incontinence CAA worksheet dated 7/27/15, indicated R45 was always incontinent of urine related to neurogenic bladder (a lack of bladder sensation and control, due to damage to nerves through injury or disease) and multiple sclerosis and needed assistance with all toileting needs.

R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the lower body including legs), and depression.

R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to turn and reposition R45 every two hours and use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan

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2 565	Continued From page 30 indicated R45 was to be repositioned according to tissue tolerance assessment, have a foam cushion in wheelchair, provide peri care after incontinent episodes and apply barrier cream per doctor's order. R45's bowel and bladder care plan dated 7/2016, instructed staff R45 had an alteration in continence related to neurogenic bladder with urinary retention, multiple sclerosis and staff were to toilet R45 every two hours, assist to toilet per resident request, check and change every two hours and as needed. Post void residuals are checked on the first and 15th of each month. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, provide peri care after incontinent episodes and apply barrier cream per doctor's order. Undated Linden Team # team Card indicated R45 was to be checked and changed every two hours and as needed and barrier cream applied to buttocks. It also indicated R45 was to be turned and repositioned every two hours. The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed. During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change and reposition R45 out of the wheel chair during the day shift NA-H responded "two times, that's it."	2 565		

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2 565	Continued From page 31 During interview on 7/13/16, at 1:29 p.m. RN-E said (R45) was to be changed every two hours and as needed. R45 likes to sit up so, when (R45) was changed was when (R45) was repositioned. During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. LPN-C said if changed at 7 a.m., "I would have expected them to do a change (R45) about 9:00 a.m. and 11:00 a.m." During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect residents to be checked and changed according to the care plan and if the residents refuses, the nursing assistants should at least tell the nurse." DON said, "I would expect them to follow the care plan for repositioning." R122 was continuously observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be incontinent of urine. After morning cares were completed R122 was wheeled into the hallway and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel. Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went for three hours and 16 minutes without being offered the use of a bathroom or repostioned according to the care plan. R122's activity of daily living (ADL) CAA worksheet dated 12/1/15, indicated R122	2 565		

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2 565	Continued From page 32 required extensive assistance with toileting and repositioning. R122's care plan, dated December 2015, indicated toileting and repositioning was to be done every two hours. R122's quarterly MDS dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. R122 had severe cognitive impairment. R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive. When interviewed on 7/13/16, at 9:53 a.m. NA-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours. NA-A confirmed R122 had not been repositioned since getting out of bed early in the day. On 7/13/16, at 10:36 a.m. NA-A was asked to take R122 to the bathroom. R122's brief was dry and shook her head "no" when asked if she wanted to use the toilet. R122 stood during this time. When interviewed on 7/13/16, at 1:15 p.m. LPN-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting and repositioning. The LPN-B was interviewed on 7/13/16, at 1:22 p.m. and confirmed R122's care plan indicated "toilet every two hours to meet her needs." LPN-B	2 565		

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2 565	Continued From page 33 was unable to locate the last three day data collection tool used to document bowel and bladder habits. LPN-B stated bowel and bladder three day collection tool was done quarterly and with significant changes. On 7/13/16, at 1:59 p.m. the DON was interviewed and stated the care plan was to be followed. Nail Care R47 was observed on 7/12/16, at 8:17 a.m. to have dark debris under eight out of 10 finger nails. On 7/12/16, at 3:19 p.m. and again on 7/13/16, at 1:00 p.m. R47's nails continued to have dark debris under eight of the ten nails. R47's ADL CAA worksheet dated 2/26/16, indicated that R47 had an ADL deficit related to dementia and required extensive assistance with personal hygiene. R47's care plan, dated March 2016, indicated weekly diabetic nail care to be done by nursing. R47's quarterly MDS dated 5/26/16, indicated R47 required extensive assistance with personal hygiene. R47 had moderate cognitive impairment. R47's Admission Record printed 7/14/16, indicated R47's diagnosis included vascular dementia, diabetes mellitus type two and depression. When interviewed on 7/13/16, at 1:09 p.m. LPN-A stated the nurses provide nail care and they are checked on R47's bathed. LPN-A stated that everything with nail care should be done by the nurses. LPN-A confirmed the dark debris under R47's fingernails.	2 565		

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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) COMPLETE DATE
2 565	Continued From page 34 The DON was interviewed on 7/14/16, at 9:19 a.m. The DON stated "the expectation is that nails are to be maintained, clean and short. If their diabetic, the nurse needs to cut but the nursing assistants can clean under the nails." The facility provided an undated policy and procedure titled Grooming and Nail Care. The policy indicated, "Proper grooming and nail care is to be performed in a dignified manner for all residents in need of assistance. Under the procedure section, line five reads "Nurses will be responsible for nail care for all diabetic residents." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff to follow care plans in regards to specific resident cares and services. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		8/31/16

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2 830	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services related to fluid restrictions for 1 of 1 resident (R114) reviewed for dialysis. The facility failed to identify non-pressure related skin conditions for 1 of 1 resident (R140) with observed bruising. Findings include: Dialysis R114's diagnosis include End stage renal disease (ESRD), hypertension, atrial fibrillation, type II diabetes and dementia obtained from the annual Minimum Data Set (MDS) dated 6/10/16. In addition the MDS indicated R114 had moderately impaired cognition. On 7/12/16, at 2:26 p.m. observed resident lying in her bed. When asked how dialysis was going, and the facility coordination with dialysis place, resident stated was going well as she smiled at this surveyor. When asked about her diet and fluid restriction resident stated the facility staff took care of all her food/fluid needs. A pink water pitcher with straw was observed on top of the dresser on the edge to the left and was half way filled. When asked about where the access site was resident point to her right upper shoulder as she left her shirt. When asked who changed the dressing indicated the staff changed it but was not sure which if it was at dialysis or at the facility. Resident indicated she was going to take a nap and would visit with surveyor later.	2 830	CORRECTED	

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2 830	Continued From page 36 On 7/12/16, at 3:27 p.m. the consultant registered dietician (CRD) stated the dietary tech would write the care plan for nutrition and she was in the process of revising her care plan and intakes as resident husband was indicating he had noticed since he was at the facility mostly during meals that resident needed two ounces of milk approximately for cereal and was asking for eight ounces of juice at the two meals, as on non-dialysis days she had continental breakfast and supper and dialysis days brunch and supper. CRD stated resident did not like the Nepro (supplement) and extra fluids between the meals however had 60-90 milliliters (ml) with meds. RD stated resident had been started on a fluid restriction on 7/11/16, and was in the process of revising the fluid intake allotting for the meals. On 7/12/16, at 3:44 p.m. resident was observed up seated on wheelchair at the door to room. The water pitcher was still observed on top of dresser. When asked if she would drink out of the pitcher at times, resident stated, "Yes honey I do when my mouth is dry." When asked if she knew what her fluid restriction was resident stated she did not know as she smiled. On 7/12/16, at 3:56 p.m. licensed practical nurse (LPN)-D stated she thought resident was in a fluid restriction always however, the CRD at the nursing desk corrected LPN-D that resident weights had been stable and was not on a fluid restriction until 7/11/16. LPN-D stated resident intake and output were being monitored and this was at each shift. When asked where the nursing assistants were informed resident fluid restriction she stated would be in the assignment sheet however when she reviewed it, the sheet did not address the fluid restriction. LPN-D also showed surveyor the intake binder which did not mention	2 830		

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2 830	Continued From page 37 the fluid restriction. On 7/12/16, at 4:03 a.m. nursing assistant (NA)-C stated he was not sure what R114's fluid restriction was and directed the surveyor to review the meal ticket for all the dietary and fluid information. When asked if he had been, informed resident was on a fluid restriction as he was assigned to resident NA-C stated he did not know. NA-C stated resident had been given a water pitcher during the shift. On 7/12/16, at 4:06 p.m., CRD and surveyor went to R114's room and from standing at the door; CRD verified R114 had a water pitcher in the room. CRD stated because R114 was on a fluid restriction, she was not supposed to have a water pitcher in the room. When surveyor indicated R114 had reported she took sips out of the pitcher CRD acknowledged the facility did not have an accurate system of monitoring resident fluid intake. On 7/12/16, at 4:07 p.m. trained medication aide (TMA)-B stated he did not know R114 was on a fluid restriction and the only thing he knew was R114 received Nepro supplement which was being recorded in the electronic medication record (EMAR). TMA-B stated he had not been informed R114 was on a fluid restriction now. On 7/12/16, at 4:08 p.m. CRD provided a copy of the updated assignment sheet after concern was brought to facility attention regarding staff not knowing R114 was on a fluid restriction and the water pitcher was removed from the room. On 7/12/16, at 4:11 p.m. LPN-C unit supervisor was approached she acknowledged the nursing assignment sheet had not been updated to reflect	2 830		

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2 830	Continued From page 38 the fluid restriction R114 was on. LPN-C stated she had just done it. On 7/13/16, at 2:37 p.m. via telephone spoke with dialysis registered nurse who indicated, usually with a new order for R114 a nurse from the center would call the facility, would write orders on the facility communication sheet sent each time and the dialysis center staff sent the pre and post run sheet to the facility on dialysis days. When asked about the fluid restriction RN stated R114 had a new order for fluid restriction and had noted during the run for today 7/13/16, she had noticed R114 was "high by 2.8 kilograms from the previous post run weight on Monday 7/11/16." When asked what would attribute to the weight gain RN stated would be mostly not following the fluid restriction and R114 had been put on a fluid restriction because R114's high blood pressures were difficult to manage. On 7/14/16, at 12:18 p.m. LPN-C stated when asked who was responsible for letting the staff know of the fluid restriction there was a break down between. LPN-C stated dietary was notified, and the floor nurse was supposed to let the staff know. LPN-C indicated when she received the order she never went to the room to check to make sure the water pitcher was not in the room. LPN-C stated the supervisor was supposed to update the assignment sheet. On 7/14/16, at 2:14 p.m. the director of nursing (DON) stated she would have expected the staff to know about the fluid restriction if there was no breakdown. Would have expected the water pitcher not to be in the room at the time as resident was on a fluid restriction. In addition stated she would have expected the dialysis care plan to be up to date with all the changes.	2 830		

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2 830	Continued From page 39 The physician's order dated 7/11/16, noted R 114 was on dialysis and was on 1000 milliliter (ml/cc) fluid restrictions. Care plan dated 6/10/16, indicated resident had actual alteration in nutrition related to dementia, type II diabetes and ESRD. Care plan indicated resident had weight fluctuation anticipated related to dialysis/fluid. Care plan directed to monitor the changes in weights, monitor intakes per facility policy, resident was on a renal diet and was on 1000 ml fluid restriction, was to take two ounces (oz) milk and four ounces apple juice (breakfast), four ounces apple juice at lunch and four ounces of apple juice supper. Also indicated resident was receiving Nepro eight oz twice daily. Care plan indicated nursing was to make up 100 cc. Care plan dated 12/15, for dialysis indicated resident had potential for complications with hemodialysis, had ESRD, had renal failure. Care plan approaches- protect shunt from injury, avoid constriction on arm, shut care daily, listen to bruit in the internal fistula, check shunt for infection or leakage , days for dialysis Monday, Wednesday and Friday, emergency protocol. R114's nutrition Care Area Assessment (CAA) dated 6/10/16, indicated R114 had a diagnoses of end stage renal disease and diabetes, received dialysis, had memory problems and had dementia. The facility Dialysis Care policy revised 9/10, indicated it was the policy of Crest View Corporation to maintain communication with and coordinate services with outside dialysis providers for the people the facility serves. The policy directed staff to:	2 830		

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2 830	Continued From page 40 "5. Nursing will monitor the referrals to/from the dialysis center to ensure that information regarding the resident's health status are communicated between the facility and the dialysis center. 10. Follow orders from dialysis and doctor as warranted..." Skin condition R140's quarterly MDS dated 4/5/16, indicated resident had a diagnosis of dementia. In addition, the MDS indicated resident had severely impaired cognition and wandered. On 7/11/16, at 4:15 p.m. resident was observed seated in the day room and was observed with two purple bruises on the left and right hand. On 7/13/16, at 9:26 a.m. R140 observed resident standing outside the activity office in the hallway. R140's bruises visible from standing at the nursing station approximately two feet. The bruise on the left hand appeared dark purple. On 7/14/16, at 7:30 a.m. R140 observed seated at the dining room table eating breakfast. The bruises were visible and several staff observed go by resident none acknowledged the bruises which were visible. On 7/14/16, at 8:40 to 8:49 a.m. nursing assistants (NA)-D and NA-E were observed walk down the hallway with R140 both holding each hand went to room. Both assisted R140 with toileting. During the observation, none of the NA's has acknowledged the visible bruises. At 8:51 a.m., NA-E even brought R140 to the bathroom and assisted resident to wash hands.	2 830		

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2 830	Continued From page 41 On 7/14/16, at 2:01 p.m. registered nurse (RN)-B stated she would have expected staff to report skin changes to the nurse to investigate. RN-B reviewed the Weekly Body Audit dated 7/13/16, and the nursing notes indicated she did not see any documentation of the bruises. On 7/14/16, at 2:03 p.m., NA-E stated she had completed R140's shower on Wednesday 7/13/16, and she had reported to LPN-E who was orientating in the unit and he had thought the bruise looked old. NA-E stated the bruises on the hands were not new. -At 2:07 p.m. RN-B stated she was shocked the nurse did not document the bruises. On 2/14/16, at 2:29 p.m. DON stated she would have expected the nurse to document any skin concerns that had been identified and investigate immediately the cause. DON further stated she would expect staff to report any skin concerns and to follow the care plan. R140's pressure ulcer Care Area Assessment (CAA) dated 10/16/15, indicated resident had advanced dementia and needed more assistance. CAA indicated skin would remain intact and directed staff to monitor skin with cares. R140's skin care plan dated 10/15; also, indicated resident had potential for skin alteration related to incontinence and directed staff to monitor skin with cares. R140's physician orders dated 6/27/16, directed staff to complete "Skin Check/Nail Trim on Bath Day every day shift every Wednesday." During review of July 2016, Treatment Administration Record, it was revealed a nurse had signed off the skin check had been	2 830		

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2 830	Continued From page 42 completed however during review of the Weekly Body Audit dated 7/6/16, and 7/13/16, no skin concerns were identified in the assessment. On 7/14/16, at 2:00 p.m. the facility skin policy was requested however, was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring dialysis residents and non-pressure related skin conditions. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents.	2 840		8/31/16

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2 840	Continued From page 43 Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was followed to provide incontinence care for 1 of 1 resident (R45) who was not properly cleansed and who went five hours between check and changes. Findings include: R45 was observed on 7/13/16, at 7:09 a.m. for	2 840	CORRECTED	

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2 840	Continued From page 44	2 840		

morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45.

On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact.

During interview on 7/13/16, at 12:14 p.m. R45 stated, "I do not use the toilet. I just have my diaper changed. R45 stated I had not been changed since got up and I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being offered to be checked and/or changed for incontinence.

R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning. R45's urinary incontinence CAA worksheet dated 7/27/15, indicated R45 was always incontinent of urine related to neurogenic

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2 840	Continued From page 45 bladder (a lack of bladder sensation and control, due to damage to nerves through injury or disease) and multiple sclerosis and needed assistance with all toileting needs. R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the lower body including legs), and depression. R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to turn and reposition R45 every two hours and use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan indicated R45 was to be provided peri care after incontinent episodes and apply barrier cream per doctor's order. R45's bowel and bladder care plan dated 7/2016, instructed staff R45 had an alteration in continence related to neurogenic bladder with urinary retention, multiple sclerosis and staff were to toilet R45 every two hours, assist to toilet per resident request, check and change every two hours and as needed. Post void residuals are checked on the first and 15th of each month. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment,	2 840		

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2 840	Continued From page 46 provide peri care after incontinent episodes and apply barrier cream per doctor's order. Undated Linden Team # team Card indicated R45 was to be checked and changed every two hours and as needed and barrier cream applied to buttocks. The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed. During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change R45 during the day shift, NA-H responded "two times, that's it." During interview on 7/13/16, at 1:29 p.m. RN-E said (R45) was to be changed every two hours and as needed. During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. LPN-C said if changed at 7 a.m., "I would have expected them to do a change (R45) about 9:00 a.m. and 11:00 a.m." During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect residents to be checked and changed according to the care plan and if the residents refuses, the nursing assistants should at least tell the nurse." Toileting policy requested but not provided.	2 840		

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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) COMPLETE DATE
2 840	Continued From page 47 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance with toileting receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 840		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for nail care for 1 of 1 resident (R47) reviewed for activities of daily living. Findings include: R47 was observed on 7/12/16, and 7/13/16. Three observations were made and R47 had dark debris under eight out of ten fingernails. R47's activity of daily living (ADL) Care Area	2 860	CORRECTED	8/31/16

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	00005	A. BUILDING: _____ B. WING _____	07/14/2016

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2 860	Continued From page 48 Assessment (CAA) worksheet dated 2/26/16, indicated that R47 had an ADL deficit related to dementia and required extensive assistance with personal hygiene. R47's care plan, dated March 2016, identified, an "alteration in self care" and an "alteration in health maintenance related to diabetes." R47's care plan revealed "diabetic nail care every week." R47's care plan did not specify what discipline was responsible for the nail care. R47's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 5/26/16, indicated R47 required extensive assistance with personal hygiene. R47's MDS indicated R47 had moderate cognitive impairment. R47's diagnoses included vascular dementia, diabetes mellitus type two and depression. When interviewed on 7/13/16, at 1:09 p.m., licensed practical nurse (LPN)-A stated the nurses provide nail care and the nails are checked on R47's bath day. LPN-A stated everything with nail care should be done by the nurses. LPN-A confirmed the dark debris under R47's fingernails. The director of nursing (DON) was interviewed on 7/14/16, at 9:19 a.m. The DON stated, "The expectation is that nails are to be maintained, clean and short. If they are diabetic, the nurse needs to cut the nails but the nursing assistants can clean under the nails." The facility provided an undated policy and procedure titled Grooming and Nail Care. The policy indicated, "Proper grooming and nail care is to be performed in a dignified manner for all residents in need of assistance." Under the procedure section, line five read "Nurses will be	2 860		

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2 860	Continued From page 49 responsible for nail care for all diabetic residents." SUGGESTED METHOD FOR CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 2 of 2 residents (R45, R122) reviewed for repositioning. Findings include: R45 was observed on 7/13/16, at 7:09 a.m. for morning cares. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of	2 905	CORRECTED	8/31/16

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2 905	Continued From page 50	2 905		

peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to peri rectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45.

On 7/13/16, at 12:46 p.m. NA-H entered R45's room to change R45. R45 was stood up using the EZ Stand and incontinence product was changed and resident lowered back into wheelchair. R45's skin was intact.

During interview on 7/13/16, at 12:14 p.m. R45 stated, "I had not been changed since got up and I have been in my chair since I got up. No one has asked me." R45 went five hours and 35 minutes without being repositioned.

R45's pressure ulcer CAA worksheet dated 7/27/15, indicated R45 was at risk for pressure ulcer development, needed a special mattress and seat cushion, and a regular schedule of turning.

R45's quarterly MDS dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the

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2 905	Continued From page 51	2 905		

covering of the nerves are damaged, interfering with impulse conduction, resulting in physical, mental and sometimes psychiatric problems), paraplegia (paralysis of the lower body including legs), and depression.

R45's mobility care plan dated 7/2016, instructed staff R45 had an alteration in mobility related to Multiple sclerosis and staff were to turn and reposition R45 every two hours and use an EZ Stand (a mechanical lift) for transfers. R45's potential for alteration in skin integrity care plan indicated R45 was to be repositioned according to tissue tolerance assessment, have a foam cushion in wheelchair, provide peri care after incontinent episodes and apply barrier cream per doctor's order.

Undated Linden Team # team Card indicated R45 was to be turned and repositioned every two hours.

The care plan and nursing assistant assignment sheet do not mention R45 having any history of refusing cares. The Physician's Orders dated 7/6/16, instruct staff to document on resident refusals to be changed every shift. Review of R45's progress notes from 7/11 through 7/14/16, do not indicate any refusals to be changed.

During interview on 7/13/16, at 12:37 p.m. NA-H said we change (R45) when we get (R45) up and after brunch. When asked how frequently staff change and reposition R45 out of the wheel chair during the day shift NA-H responded "two times, that's it."

During interview on 7/13/16, at 1:29 p.m. RN-E said, "(R45) likes to sit up so, when (R45) was changed was when (R45) was repositioned."

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2 905	Continued From page 52 During interview on 7/13/16, at 1:31 p.m. LPN-C said (R45) was to turn and reposition every two hours. During interview on 7/13/16, at 1:37 p.m. DON said, "I would expect them to follow the care plan for repositioning." Jaeckels, Michelle R122 was continuously observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be incontinent of urine. After morning cares were completed R122 was wheeled into the hallway and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel. Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went for three hours and 16 minutes without being offered the use of a bathroom or repostioned according to the care plan. R122's activity of daily living (ADL) CAA worksheet dated 12/1/15, indicated R122 required extensive assistance with toileting and repositioning. R122's care plan, dated December 2015, indicated toileting and repositioning was to be done every two hours. R122's quarterly MDS dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. R122 had severe cognitive impairment.	2 905		

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2 905	Continued From page 53 R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive. When interviewed on 7/13/16, at 9:53 a.m. NA-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours. NA-A confirmed R122 had not been repositioned since getting out of bed early in the day. On 7/13/16, at 10:36 a.m. NA-A was asked to take R122 to the bathroom. R122's brief was dry and shook her head "no" when asked if she wanted to use the toilet. R122 stood during this time. When interviewed on 7/13/16, at 1:15 p.m. LPN-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting and repositioning. The LPN-B was interviewed on 7/13/16, at 1:22 p.m. and confirmed R122's care plan indicated "toilet every two hours to meet her needs." LPN-B was unable to locate the last three day data collection tool used to document bowel and bladder habits. LPN-B stated bowel and bladder three day collection tool was done quarterly and with significant changes. On 7/13/16, at 1:59 p.m. the DON was interviewed and stated the care plan was to be followed. SUGGESTED METHOD OF CORRECTION: The	2 905		

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2 905	Continued From page 54 director of nursing or designee could provide education/staff training and complete audits to ensure the position of residents unable to change their own position is changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure services were	2 910	CORRECTED	8/31/16

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2 910	Continued From page 55 implemented for timely toileting for 1 of 2 resident (R122) reviewed for toileting. Findings include: R122 was continuoulys observed on 7/13/16, from 7:14 a.m. through 10:30 a.m. Morning cares were observed when R122 was observed to be incontinent of urine. After morning cares were completed R122 was wheeled into the hallway and placed next to the medication cart in Evergreen Hallway. R122 remained seated in the wheelchair until 10:30 a.m. at which time she was taken to an activity in the chapel. Upon request at 10:30 a.m. R122 was taken back to her room and offered toileting. R122 went three hours and 16 minutes without being offered the use of a bathroom according to the care plan. R122's quarterly Minimum Data Set dated 5/24/16, indicated resident required extensive assistance with actives of daily living. R122's pressure ulcer Care Area Assessment (CAA) dated 12/1/15, indicated frequent incontinence of bowel and bladder related to dementia and limited mobility. R122's CAA indicated R122 required assistance with toileting and staff to provide peri-care as needed. The care plan dated 12/2015 indicated R122 was to be toileted every two hours. When interviewed on 7/13/16, at 1:00 p.m. nursing assistant (NA)-A stated she was aware of the last time R122 was toileted and stated she had not had the time to check on R122. NA-A was aware R122 was to be toileted every two hours.	2 910		

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2 910	Continued From page 56 When interviewed on 7/13/16, at 1:15 p.m. licensed practical nurse (LPN)-A stated R122 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R122 to go three hours and 16 minutes without being offered toileting. LPN-B was interviewed on 7/13/16 at 1:22 p.m. and confirmed R122's toileting plan was "toilet every two hours to meet her needs." LPN-B stated, "I would expect there would attempt to toilet her, bring her into the bathroom, depending on her willingness, see if she will void." On July 13, 2016, at 1:59 p.m., the director of nursing was interviewed and stated the care plan was to be followed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would provide staff education/training and complete audits to ensure based on the comprehensive resident assessment, a nursing home must ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		8/31/16

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21375	Continued From page 57 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop the infection control program to include surveillance for infection, ongoing tracking and analysis, and tracking of antibiotic resistance to prevent the spread of infection. This deficient practice had the potential to affect all 112 residents who resided in the facility. In addition the facility failed to ensure hand hygiene was completed in 1 of 4 dining rooms. This had the potential to affect 8 residents who received room trays. Furthermore facility failed to ensure appropriate hand hygiene and glove usage for 1 of 1 resident (R45) observed for urinary incontinence, The facility failed to have a system to track, trend and analyze illness to determine if the cases had developed within the facility, or from an exposure of a resident admitted with an infection. It was unclear from facility documentation the number and types of infections, if they were developed in the facility, and for example if the 2, wounds on a unit were on one or two residents. Findings include: The facility's infection control logs from 1/16 to 6/16, were reviewed. The log included total numbers of residents with various infection diseases, such as urinary tract infection, pneumonia, cellulitis (skin infection), wounds. Total number of residents per unit each month were recorded. The log, however, lacked enough information to determine an analysis. The logs lacked resident name and room number, date of onset of infection, symptoms, reoccurance, and resolution dates, as well as other pertinent information. One resident on Linden was	21375	CORRECTED	

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identified as having a wound/incision that read, "1 on-going w/ [with] no stop date." On Evergreen one resident had "elevated temp" with no additional information, and another resident "groin" with no additional information. Information regarding residents with pneumonia did not reflect the type of pneumonia such as aspiration, bacterial, viral, etc.
During an interview on 7/14/16, at 9:20 a.m. a registered nurse (RN)-A the July 2016 infection control logs were reviewed. The logs indicated the facility four cases of pneumonia on one unit. One resident was admitted with pneumonia and the rest were acquired in-house. RN-A could not say if the one resident came in with it and the the other resident acquired from that one resident. The logs lacked evidence of dates or any other information to determine the cause of the three in-house acquired pneumonia. RN-A stated she could not state that from looking at her surveillance system if they had an in-house spread of the pnemonia.

During an interview on 7/14/16, at 9:20 a.m. a registered nurse (RN)-A explained the facility's general infection control program. RN-A stated she was primarily responsible for the overall program, with assistance from a licensed practical nurse (LPN)-B and the director of nursing (DON). RN-A explained she received the data from the supervisors, recorded it on her own form, and then transferred the monthly data to the Infection Control Log. She looked for new infections and for trends. If trends were noted, she informed the DON and gave her the log information. The DON then took the information to the quality committee for review. If further action was needed, the medical director was informed. RN-A stated, "I kind of keep track and if I notice an increase in amount of urinary tract

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21375	Continued From page 59 infections, I educate staff and ask the charge nurse to educate any female residents about pericare." She also looked at nursing reports to determine if symptoms were resolving. "I do not track at all for anyone not on an antibiotic--I just look at trends." RN-A verified the logs did not specify resident names and pertinent information such as the actual organism/illness, whether it was aquired at the facility, when symptoms started or resolved, whether antibiotics were effective or were changed, etc. The DON explained in an interivew on 7/14/16, at 12:32 p.m. that after she received the data from the infection control nurse she took the information to quality improvement (QI) committee for review. The QI committee reviewed the information and looked for patterns and then gave it to the medical director for review. The facility's 7/11/16, Infection Prevention Guidelines indicated the purpose was "To provide cares and an environment which prevents infections in our residents...Surveillance of resident infections including review of antibiotics, documentation of infections and analysis of data and Surveillance of the environment...preventative and control measures shall be as recommended per the Center for Disease Control (CDC), the MN Department of Health (MDH) evidence based nursing practice. " Linden Unit: On 7/11/16, at 4:52 p.m. the dietary supervisor looked on the floor and noted a puddle of water after a resident had wheeled off the area and asked nursing assistant (NA)-F to get a towel. NA-F was observed go into the linen closet by the dinning area and came out with two wash towels	21375		

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and laid both on the puddle. Then NA-A was asked by R78 to pick a napkin she had dropped right next to the wheelchair for her. NA-F was observed bend over and with bare hands picked the napkin which was soiled with brown sputum off the floor took it to the garbage can by the window. NA-F used both hands to push the lip inward tossed the napkin then and returned to the food rack and observed proceed to get food from the steam table and set the room trays without washing his hands. As NA-F set the trays was observed touch the drinking glass covers stacked on the cart by the nursing desk; touched the rims of the four ounce drinking glasses went over to the juice machine and obtained juice still holding the rims of the glasses with the soiled hands.
-At 4:56 p.m. when NA-F was picking one of the trays off the rack to bring to the room, surveyor intervened. NA-F acknowledged he had not washed his hands after picking the soiled napkin off the floor.
-At 5:00 p.m. after washing his hands NA-F came back to the trays he had set up with the soiled hands and attempted to bring the trays to the room at this time surveyors intervened again. NA-F stated he had only touched the covers and had gotten different covers and was just going to use the same tray of food set up. At this point the dietary supervisor was observed set different trays and asked NA-F to leaved the contaminated trays alone.

On 7/11/16, at 5:10 p.m. the director of nursing (DON) stated she appreciated the surveyors intervening. When asked what her expectation was DON stated she would expect staff to have washed hands.

R45:

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	00005	A. BUILDING: _____ B. WING _____	07/14/2016

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21375	Continued From page 61 On 7/13/16 at 7:09 a.m. morning cares were observed for R45. -Nursing assistant (NA)-H washed hands put on gloves and removed R45's gown and washed upper body. NA-H removed gloves put on new gloves without washing or sanitizing hands. NA-H dressed R45's upper body. NA-H removed R45's incontinence brief, which was wet and had smear of soft brown stool on it. NA-H washed front of peri area then changed gloves without washing or sanitizing hands. NA-H dried R45's peri area and changed gloves without washing or sanitizing hands. NA-H assisted R45 to roll to left side. NA-H wiped R45's bottom and then applied barrier cream. NA-H started to apply a clean incontinence brief. Surveyor ask NA-H if she was done washing R45's bottom. NA-H said, "Yes." Surveyor ask NA-H to check between R45's buttocks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then using same gloves applied barrier cream to perirectal area then to front of perineum. NA-H then removed gloves, and put new gloves on and applied a new incontinence brief on R45. NA-H put ted hose, pants and shoes on R45. R45's Quarterly Minimum Data Set dated 4/9/16, indicated R45 was cognitively intact, required extensive assistance of one staff member for activities of daily living including transfers, bed mobility and toileting. MDS indicated R45 was frequently incontinent of bowel and bladder and at risk for pressure ulcer development. MDS indicated R45's diagnoses included multiple sclerosis (a disease in which the covering of the nerves are damaged, interfering with impulse conduction resulting in physical, mental and sometimes psychiatric problems) , paraplegia (paralysis of the lower body including legs), and depression.	21375		

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21375	Continued From page 62 During interview on 7/13/16, at 12:37 p.m. NA-H said, "I normally wash my hands when I remove my gloves." NA-H acknowledged only washed hands when startted and was done. NA-H denied using sanitizer. NA-H acknowledged used the same glove to apply barrier cream to R45's bottom and then to R45's front, including peri area. During interview on 7/14/16, at 9:47 a.m. registered nurse (RN)-A stated expected staff to wash hands; before contact with a resident, after contact, when removing gloves, if handling trash, if staff has been to the bathroom. When asked are staff to change gloves and wash or sanitize their hands after cleaning up stool? RN-A responded, Staff are allowed to put incontinence product on then change gloves and wash or sanitize hands before touching anything else. RN-A said the staff cannot apply barrier cream with a glove hand to the rectal area and then use the same gloved hand to apply barrier cream to the perineal area. RN-A said staff "have to go front to back always, do not go to the rear until they are done with the front." During interview on 7/14/16, at10:56 a.m. director of nursing (DON) said staff are to wash or sanitize hands before and after cares and any time staff change gloves, or any time they touch someting dirty. DON said she expects staff when applying barrier cream to go from clean to dirty; from the peri area to the rectal area. Undated Incontinent Care Policy instructs staff to explain to resident what they are going to do and provide privacy for resident. It further instructs them: "6. Wash hands and apply gloves.	21375		

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21375	Continued From page 63 7. Remove soiled diaper and place in diaper pail , at bed side. 8. Wet disposable washcloth with warm water. Apply soap or use peri-wash spray 9. Wash genital area, washing from urethral meatus back toward anal area. Separate labia with fingers to cleanse area well. 10. Wash entire buttock area and any additional body part that is soiled. 11. Using same disposable wshcloth, rinse residents's skin thoroughly. 12. Dry the skin well with the second clean disposable washcloth. 13. Apply clean diaper and other linen as needed. 14. Assist in redressing resident in clean clothing, as necessary. 15. Change necessary bed linen and place soiled linen in hamper. 16. Prompt and thorough cleansing of any floors, chairs, mattress, etc., which might have been soiled. 17. Remove supplies and leave unit in order. 18. Document provision of care on the form in the NA/R book." Policy lacked direction for staff on when to change gloves or perform hand washing or sanitizing when providing incontinence cares. Hand Washing Policy and Proceedures dated 2/08, instructed staff, "Hand washing/ Hand Sanitizing must be done: a. Before performing invasive procedures. b. Before contact with particularly susceptible residents c. Before touching food or medications to be given to residents. d. Before and after touching wounds of any kind. e. Before and after providing personal cares for a resident. f. After removing gloves	21375		

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21375	Continued From page 64 g. After touching anything that may have been contaminated with blood or bodily fluids. h. After caring for a resident with an active infection. i. After going to the bathroom, nose blowing, covering a sneeze and coughing. j. Before eating and before going home at the end of the shift." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the facility's infection control practices and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		8/31/16

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21426	Continued From page 65 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete accurate baseline tuberculosis (TB) screenings for 1 of 5 residents (R25) reviewed for TB. Findings include: R25 was admitted to the facility on 2/1/15 with diagnoses that included pneumonia, acute respiratory failure and chronic kidney disease. Review of R25's medical record identified R25 received a mantoux (TB test) on 2/1/16 that was read by facility staff on 2/3/16 to be negative. R25 also recieved a second step mantoux on 2/11/16 that was read on 2/13/16 that was also negative. R25's medical record did not include a TB screening assessment prior to the intial mantoux administered on 2/1/16. On 7/14/16 at 1:30 p.m. LPN-C confirmed R25's medical record did not include an inital TB screening asessment. A facility policy entitled "Tuberculosis Testing" dated 9/14 identified "all residents must be screened upon admission with a 2 step PPD test or have proof of testing that shows free from active pulmonary TB disease or written documentation of a negative two-step Mantoux PPD within 90 days prior to admission".	21426	CORRECTED	

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21426	Continued From page 66 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure tuberculosis screening is completed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21555	MN Rule 4658.1325 Subp. 2 Administrationof Medications Staff designated Subp. 2. Staff designated to administer medications. A nurse or unlicensed nursing personnel, as described in part 4658.1360, must be designated as responsible for the administration of medications during each work period. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe and accurate administration of a prescribed medication for 1 of 2 residents (R122) observed during observation of morning cares.. Findings include: R122's Admission Record printed 7/14/16, indicated R122's diagnoses included dementia and adult failure to thrive. R122's quarterly Minimum Data Set (MDS) (a standardized,	21555	CORRECTED	8/31/16

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21555	Continued From page 67	21555		

primary screening and assessment tool) dated 5/24/16, indicated that R122 required extensive assistance with toileting and repositioning. A Brief Interview of Mental Status (BIMS) was done on 6/2/16. R122 scored five out of 15 that indicated severe cognitive impairment.

During observation on 7/13/16, at 7:14 a.m., nursing assistant (NA)-A was observed to have a paper medication cup with white cream in it. NA-A stated that it was medication to apply to the red bumps on R122's face. NA-A stated that the nurse gives the cream to the nursing assistants to apply. NA-A was observed to apply the white cream to R122's to red bumps on her face.

R122's Physician Orders dated 4/26/16, read: hydrocortisone 1% (percent) apply lightly to reddened areas on face one time daily until resolved

When interviewed on 7/13/16, at 1:59 p.m. the director of nursing (DON) stated that she expects a nurse to apply the hydrocortisone cream to R122's face. The DON also stated it was unacceptable for it to be applied by NA.

When interviewed on 7/14/16, at 12:27 p.m., the consulting pharmacist (Rph) stated that the hydrocortisone should be applied by an nurse. The Rph had written a recommendation to the primary physician regarding the long-term use of the hydrocortisone cream

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure, other than residents self administration as appropriate, only qualified staff is administering medications. The DON or designee could educate all appropriate staff on

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21555	Continued From page 68 these systems. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21555		