### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KWZX

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

	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY	AGENCY		Facility	y ID: 00005
MEDICARE/MEDICAID PROVIDER		3. NAME AND AD					4. TYPE O	F ACTION:	7 <sup>(L8)</sup>
NO.(L1) <b>245018</b>		(L3) CREST VIE					1. Initial	2.	Recertification
2. STATE VENDOR OR MEDICAID NO	O.	(L4) 4444 RESER				55421	3. Termin		СНОМ
(L2) <b>935840400</b>		(L5) COLUMBIA					5. Validat 7. On-Site		Complaint Other
5. EFFECTIVE DATE CHANGE OF OW	/NERSHIP	7. PROVIDER/SU			<u>02</u> (L7)		8. Full Su	rvey After Comp	laint
(L9)	104 C (I 24)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP	22 CLIA			
6. DATE OF SURVEY 9/23/2 8. ACCREDITATION STATUS:	2016 (L34) (L10)	03 SNF/NF/Distinct	00 FK1F 07 X-Ray	11 ICF/IID	14 CORF 15 ASC		FISCAL YEA	AR ENDING DA	ATE: (L35)
0 Unaccredited 1 TJC	(E10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09/	/30	
2 AOA 3 Other									
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY		AS:					
From (a):		X A. In Complia			**	ved Waivers Of	٥	•	T
To (b):		Program Re Compliance	equirements e Based On:			nnical Personnel	_	cope of Services	Limit
		_	cceptable POC		3. 24 H	iour RN ay RN (Rural SN		edical Director tient Room Size	
12.Total Facility Beds	<b>122</b> (L18)	1. A	eceptable i oc			Safety Code	<del></del>	eds/Room	
13.Total Certified Beds	<b>122</b> (L17)		npliance with Prog			Safety Code		SUS/KOOIII	
		Requirements	and/or Applied V	Vaivers:	* Code: A		(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY				
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	r 1861 (j) (1):	(L	.15)	
122									
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Γ	Date:
			0.11=1=0.15						
Carrie Euerle, HFE NE II		1	0/17/2016	(L19)	(a <u>mala Fiske-D</u>	owning, Healt	h Program R	<u>epresentativ</u> e	(L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	C OFFICE OF	R SINGLE S	TATE AGE	NCY	
19. DETERMINATION OF ELIGIBILITY	Y	20. COM	IPLIANCE WITH	H CIVIL	21. 1. S	Statement of Finar	ncial Solvency (H	HCFA-2572)	
1. Facility is Eligible to Parti	icinate	RIGH	HTS ACT:			Ownership/Contro Both of the Above		sure Stmt (HCFA	L-1513)
2. Facility is not Eligible	ie ipate				J. 1	Jour of the Above			
	(L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ΓЕ	VOLUNTARY	00		NVOLUNTARY	<u> </u>
01/01/1967					01-Merger, Clos			5-Fail to Meet H	lealth/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	on W/ Reimburse	ement 0	6-Fail to Meet A	greement
25. LTC EXTENSION DATE: 2	27. ALTERNATI	VE SANCTIONS			03-Risk of Involu	untary Terminatio	n <u>c</u>	<u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason	for Withdrawal	0	7-Provider Stati	us Change
(L27)			(L44)				0	00-Active	
(L21)	B. Rescind Su	uspension Date:							
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL		



## 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

**Health Regulation Division** 

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245018

October 17, 2016

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

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

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Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

**Health Regulation Division** 

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



#### 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)

Crest View Lutheran Home October 17, 2016 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REV	VISIT
IDENTIFICATION NUMBER	A. Building			
245018 <sub>Y1</sub>	B. Wing	Y2	9/23/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST VIEW LUTHERAN HO	ME	4444 RESERVOIR BOULEVARD NORTHEAST		
		COLUMBIA HEIGHTS, MN 55421		

ITE Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5
ID Prefix	F0157 483.10(b)(11)	Correction	ID Prefix Reg. #	F0221 483.13	(a)	Correction	ID Prefix Reg. #	F0272 483.20(b)(1)		Correction
Reg. # LSC		08/31/2016	LSC			Completed 08/31/2016	LSC			Completed 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			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE		SIGNATURE C	F SURVEYOR			DATE	
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
<b>FOLLOW</b> 7/14/201		Y COMPLETED ON				ECTED DEFICIEN CIES (CMS-2567)				s 🗆 no

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DA	TE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245018 <sub>Y1</sub>	B. Wing	Y2	9/2	23/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CREST VIEW LUTHERAN HOI	ME	4444 RESERVOIR BOULEVARD NORTHEAST			
		COLUMBIA HEIGHTS, MN 55421			

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5
ID Prefix	F0157 483.10(b)(11)	Correction	ID Prefix F02	221 3.13(a)	Correction	ID Prefix	F0272 483.20(b)(1)		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC		08/31/2016	LSC		08/31/2016	LSC			08/31/2016
ID Prefix	F0276	Correction	ID Prefix F02	282	Correction	ID Prefix	F0309		Correction
Reg. #	483.20(c)	Completed	Reg. # 483	3.20(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 F03	314	Correction	ID Prefix	F0315		Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	3.25(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 F04	425	Correction	ID Prefix	F0441		Correction
Reg. #	483.25(n)	Completed	Reg. #	3.60(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			
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE		OF SURVEYOR			DATE	
		GD/kfd	10/19/2010		3′	1591			/2016
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
<b>FOLLOW</b> 7/14/201		Y COMPLETED ON			RRECTED DEFICIEN NCIES (CMS-2567)			YE	s 🗆 no

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION		DATE OF REV	VISIT
	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 HO	ME	4444 RESERVOIR BOULEVARD NORTHEAST		
		COLUMBIA HEIGHTS, MN 55421		

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	X 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0014	08/12/2016	LSC K001	5	08/12/2016	LSC	K0046	08/12/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	101	Completed	Reg. #		Completed
LSC	K0054	08/12/2016	LSC K005	6	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	<del>.</del>	Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEW STATE A		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 10/17/2016	SIGNATURE OF	SURVEYOR	37009	DAT	RE 8/25/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DAT	ΓE
FOLLOV 7/14/20		Y COMPLETED ON		DR ANY UNCORREC			UE EACH ITVO	YES NO

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVI	ISIT
IDENTIFICATION NUMBER	A. Building 02 - 2007 ADDITION			
245018 <sub>Y1</sub>	B. Wing	Y2	8/25/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST VIEW LUTHERAN HO	ME	4444 RESERVOIR BOULEVARD NORTHEAST		
		COLUMBIA HEIGHTS, MN 55421		

ITE Y4		<b>DATE</b> Y5	ITEM Y4	<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	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		_
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 10/17/2016	SIGNATURE OF SURVEYOR	37009	DATE {	3/25/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOW 7/14/201		Y COMPLETED ON		R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567)		IE EAOU IEVO	ES NO



#### 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:

Crest View Lutheran Home October 19, 2016 Page 2

- 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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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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.

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

Crest View Lutheran Home October 6, 2016 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

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Email: Kamala.Fiske-Downing@state.mn.us



#### 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: 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

			STAT	E FORM: RE	VISIT	REPORT					
_	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building B. Wing	STRUCTIC	DN				Y2	DATE (	OF REVI	SIT Y3
NAME O	F FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE						
CREST	VIEW LUTHERAN HO	ME			4444 RESERVOIR BOULEVARD NORTHEAST						
					COLUN	MBIA HEIGHTS,	, MN 55421				
correctiv	ort is completed by a S re action was accompli ation prefix code previon rm).	ished. Each def	iciency sho	ould be fully iden	tified us	sing either the	regulation	or LSC provision	n numb	er and tl	ne
ITE	М	DATE	ITEM			DATE	ITEM			DATE	
Y4		Y5	Y4			Y5	Y4			Y5	
ID Prefix	20265	Correction	ID Prefix	20505		Correction	ID Prefix	20540		Correc	ction
Reg. #	MN Rule 4658.0085	Completed	Reg. #	MN Rule 4658.03 Subp. 1 A-E	00	Completed	Reg. #	MN Rule 4658.04 Subp. 1 & 2	100	Comp	leted
LSC		08/31/2016	LSC			08/31/2016	LSC			08/31/2	2016
ID Prefix	20550	Correction	ID Prefix	20565		Correction	ID Prefix	20830		Correc	ction
Reg. #	MN Rule 4658.0400 Subp. 4	Completed	Reg. #	MN Rule 4658.04 Subp. 3	05	Completed	Reg.#	MN Rule 4658.05 Subp. 1	520	Comp	leted
LSC	Опор. 4	08/31/2016	LSC	Сибр. о		08/31/2016	LSC	<u> </u>		08/31/2	
ID Prefix	20840	Correction	ID Prefix	20860		Correction	ID Prefix	20905		Correc	ction
Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed	Reg. #	MN Rule 4658.05 Subp. 2 F.	20	Completed	Reg. #	MN Rule 4658.05 Subp. 4	525	Comp	leted
LSC		08/31/2016	LSC			08/31/2016	LSC			08/31/2	2016
ID Prefix	20910	Correction	ID Prefix	21375		Correction	ID Prefix	21426		Correc	ction
Reg. #	MN Rule 4658.0525	Completed	Reg. #	MN Rule 4658.08	00	Completed	Reg. #	MN St. Statute 14	44A.04	Comp	
LSC	Subp. 5 A.B	08/31/2016	LSC	Subp. 1		08/31/2016	LSC	Subd. 3		09/23/2	
										=	
ID Prefix	21555	Correction	ID Prefix			Correction	ID Prefix			Correc	ction
Reg. #	MN Rule 4658.1325 Subp. 2	Completed	Reg. #			Completed	Reg. #			Comp	leted
LSC		08/31/2016	LSC				LSC				

REVIEWED BY		REVIEWED BY	DATE	SIGNATURE OF SURVEYOR	DATE
STATE AGENCY	Ш	(INITIALS) GD/kfd	10/19/2016	31591	9/23/2016
REVIEWED BY CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SI	URVE	Y COMPLETED ON		RANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF TED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	YES NO

Page 1 of 1 EVENT ID: KWZX12

YES NO

7/14/2016

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KWZX

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AG	ENCY		Facilit	y ID: 00005
MEDICARE/MEDICAID PROVI NO.(L1) 245018	DER	3. NAME AND AI (L3) <b>CREST VIE</b>						-	<b>2</b> (L8)
, ,		(L4) 4444 RESEI	RVOIR BOUL	EVARD NO	ORTHEAST		<ol> <li>Initial</li> <li>Termin</li> </ol>		Recertification CHOW
2. STATE VENDOR OR MEDICAL (L2) 935840400	D NO.	(L5) COLUMBIA	A HEIGHTS, N	MN	(L6) <b>55</b>	421	5. Validat 7. On-Site	tion 6.	Complaint Other
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP	22 CLIA		rvey After Comp	
6. DATE OF SURVEY <b>07</b> /8. ACCREDITATION STATUS:	<b>114/2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEA	AR ENDING DA	ATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09	/30	
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		A. In Complia	ance With		And/Or Approved	Waivers Of	The Following I	Requirements:	
To (b):			equirements e Based On:		2. Technic 3. 24 Hou		_	cope of Services edical Director	Limit
12.Total Facility Beds	<b>122</b> (L18)	1. A	cceptable POC		4. 7-Day I	RN (Rural SN	· <del></del>	tient Room Size	
13.Total Certified Beds	122 (L17)	X B. Not in Con	npliance with Pro-	gram	5. Life Sat	fety Code	9. Be	eds/Room	
	, ,		and/or Applied V		* Code: B		(L12)		
14. LTC CERTIFIED BED BREAKD	OWN	•			15. FACILITY ME	ETS			
18 SNF 18/19 SNF 122	19 SNF	ICF	IID		1861 (e) (1) or 18	61 (j) (1):	(L	.15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVE	EY AGENCY	APPROVAL	1	Date:
Carrie Euerle, HFE NE II			08/19/2016	(L19) K	a <u>mala Fiske-Dow</u>	ning, Healt	h Program R	epresentative	08/31/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR S	INGLE S	FATE AGE	NCY	
19. DETERMINATION OF ELIGIBLE 1. Facility is Eligible to	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. Owr			HCFA-2572) sure Stmt (HCFA	A-1513)
2. Facility is not Eligib	le (L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATIO	ON ACTION:		(L30)	
OF PARTICIPATION <b>01/01/1967</b>	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure	_00	_	NVOLUNTARY 05-Fail to Meet H	
(L24)	(L41)		(L25)		02-Dissatisfaction V		ment (	06-Fail to Meet A	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involunta	=	n <u>(</u>	<u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for	Withdrawal	C	7-Provider Stat	us Change
(L27)	B. Rescind Su	spension Date:	(L44)				(	00-Active	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
28. TERMINATION DATE:		. INTERMEDIARY	CARRIER NO.		30. REMARKS				
28. TERMINATION DATE:	(L28)		CARRIER NO.	(L31)	30. REMARKS				

(L33)

DETERMINATION APPROVAL

(L32)



#### 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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

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

PRINTED: 08/19/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 00	00		
F 157 SS=D	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated.  Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  In addition during the complaint investigation of completed. The completed. The completed. The completed and unsubstantiated.  483.10(b)(11) NOT (INJURY/DECLINE)  A facility must immed consult with the resident involving the injury and has the printervention; a signiphysical, mental, or deterioration in heap status in either life to	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with the en electrification survey tion(s) were also completed at dard survey.  complaint H5018107 was inplaint was substantiated at ion of complaint H5018109 I the complaint was	F 1	57		8/31/16
_ABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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 A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/14/2016	
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE  444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 157	significantly (i.e., a existing form of treatment); or a deather esident from the \$483.12(a).  The facility must also and, if known, the ror interested family change in room or specified in \$483.1 resident rights under regulations as specified in section.  The facility must rethe address and philegal representative.  This REQUIREMED by:  Based on interview facility failed to admantibiotic) as ordere physician for the manal resident (R164) res	need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in  so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update one number of the resident's er or interested family member.  NT is not met as evidenced or and document review, the ninister Vancomycin (a ed and failed to notify the issed antibiotic doses for 1 of eviewed for an infection.  Included clostridium difficile Status Post- after procedure]" tained from the After dated 2/12/16.  Targe Orders dated 2/12/16,	F 157	It is the Policy of Crest View Luther. Home to immediately inform a resid physician whenever there is a medic error, or if there are missed doses of prescribed antibiotic for any reason.  Resident R164 was discharged from facility on 2/20/2016, so notification their physician of missed antibiotic of cannot occur.  The Physician Notification Policy an Procedure, along with the Medication Error Policy and Procedure for Crest Lutheran Home was reviewed and updated by an interdisciplinary teams.	ent's cation of a the to doses d n t View	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	ME			TREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	clostridium difficile  During review of th Electronic Medicati (EMAR) was revea been administered indicated on the EM-2/12/16, 8:28 p.m. Hydrochloride (HCI ml by mouth four ti New admit medicat scheduled again at -2/18/16, 8:17 a.m. solution 50 mg/ml g a day for c-diff for 8 (LOA) -2/19/16, 9:45 p.m. solution 50 mg/ml g a day for c-diff for 8 time -2/20/16, 8:40 a.m. solution 50 mg/ml g a day for c-diff for 8 time  On 7/14/16, at 1:49 pharmacist (CP) in including the antibile to deliver on 2/12/1 usually would take arrive at the facility the four o'clock Var doses on 2/18/16, at thought were misse an appointment. Th no documentation in medication doses.	th 4 times daily for 8 days for colitis.  e February 2016, the on Administration Record led the medication had not on the following days as MAR progress notes: indicated Vancomycin L) solution 50 mg/ml give 2.5 mes a day for c-diff for 8 Days. tion not here yet and	F 1	August 10th. The forme instances in which the p resident needs to be not includes, but is not limite errors and missed antibilatter describes the product assessing a resident poerror, who needs to be rerror, and the procedure medication error report.  All nurses will be re-edu policy and procedure by Audits for the proper adantibiotics will be comple four weeks, and then so periodically thereafter by Nursing based on audit Outcomes and results freshold will be brought to the fact quarterly QA meeting food The Director of Nursing responsible for compliants.  Compliance date: 8/31/2	chysician of a tified. This ed to, medication iotic doses. The cedure of st-medication notified of the e for filling out the exacted on this August 25th.  Indicated on this August 25th.  Indicated weekly for cheduled by the Director of results.  In our these audits cility's next or review.  In will be note.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING _		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 157	depending on the do On 7/14/16, at 2:20 would expect the not further stated she wonot aware of what he call the doctor and decision."  On 7/14/16, at 2:06 practitioner stated of facility she never sat documentation indinotified her office of would include faxes NP stated she would informed.  During review of all R164's medical rec 2/12/16 through the documentation was or NP had been up antibiotic doses. Reforms completed by mention of R164's in The facility Administ directed:  "3. Medications must accordance with the required time frame 10. For residents no unavailable to receithe MAR is "flagged stripes, drinking str	about the missed doses lirections of the medication.  I. p.m. the DON stated she urse to pass it on report. DON would not answer, as she was nad occurred. "I preach staff to let the doctor make the p.m. via telephone the nurse during R164's brief stay at the law resident and there was no cating the facility nurses had for the missed doses, which is or phone documentation. The lad have expected to be  the progress notes located in ords from admission on the discharge date on 2/20/16, is lacking to indicate the doctor dated about the missed eview of the medication error of the facility lacked any missed medication doses.  Itering Medications policy st be administered in the orders, including any	F 15			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245018	B. WING _	<del></del>	07/14/2016
	PROVIDER OR SUPPLIER	иЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	Т
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 157	the medication reco the staff were to be In addition the polic staff were suppose been missed.	oolicy did not address since ord was now electronic how alerted of missed medication. y did not address what the d to do when a medication had	F 15		
F 221 SS=D	physical restraints i discipline or conver		F 22		8/31/16
	by: Based on observative review, the facility for rails as a potential of (R25) reviewed for failed to ensure a residents (R53) under the bottom subarrier to getting out. Findings include: R25 was admitted to admission Minimum was completed on a cognitively intact are of one staff person MDS assessment for were not used.  A 2/4/16, side rail as	ion, interview and document ailed to assess the use of side restraint for 1 of 3 residents accidents. In addition, facility esident is not restrained for 2, R62) who had two pillows neets of their beds creating a at of bed.  o the facility on 2/1/15. An a Data Set (MDS) assessment 2/8/16, indicated R25 was add required extensive assistive for bed mobility. The 2/8/16, urther indicated that restraints		It is the Policy of Crest View Luthe Home to ensure residents are free any physical restraints that limit the ability to move, ambulate, or partici ADLs to their maximum capability.  Residents R25, R53, and R62 were re-assessed for their safety risk as for side rail use on August 12th.  For all other residents this deficient practice may have affected, wholeside rail assessments were comple every resident. In addition, a whole environmental services audit of the functionality of side rails was comp Safety Risk assessments, which as the physical devices utilized for the of each resident will be completed quarterly, upon admission, or along any significant change of the MDS.	from ir pate in  well as  house ted for -house leted. ssess safety

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245018	B. WING _		07/-	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
ODECT	//EW/LUTUEDAN LIO			4444 RESERVOIR BOULEVARD NO	ORTHEAST	
CREST	/IEW LUTHERAN HO	WIE		COLUMBIA HEIGHTS, MN 554	21	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 221	of safety devices: 1 bar with side rail cut. A 5/5/16, Safety Ris R25 was independentilized a left and rid device for positionin. On 7/11/16, at 3:38 to have half side rail the bed. The right loose.  On 7/12/16, at 2:23 observed to have his right side rail loose. On 7/12/16, at 2:59 (LPN)-C was asked rail and confirmed to loose. LPN-C state process of a side rail would fill out a main side rail repaired or maintenance check should be tight fittin. A maintenance slip R25's "side rails loor replace" The maint the correction line to that the bed and rail. On 7/13/16, at 12:59 (DR) 7/13/16, at	ted 2/16/16, identified the use /2 side rails and a right grab shions.  Sk Assessment indicated that ent with bed mobility and ght grab bar as a physical ng.  p.m. R25's bed was observed ils on the left and right side of side rail was observed to be  p.m. R25's bed was again alf left and right side rails with ose.  p.m. licensed practical nurse d about R25'S right half side that the half side rail was d that the facility was in all audit. LPN-C stated that she need replaced. LPN-C stated that is the side rails and that they go to the bed.  dated 7/12/16, indicated that ose and need repair or enance slip indicated under hat this was completed and ils were replaced on 7/12/16.	F 23	The Use of Restraints Polic Procedure for Crest View L was reviewed and updated interdisciplinary team on An policy describes the process least restrictive environment residents, which includes the use of restraints. The poutlines the process for recharts periodically by an inteam to ensure restraints a inadvertently in place. The Policy and Procedure of Crutheran Home was also rupdated by an interdisciplir August 10th. This policy deprocess of assessing each the use of side rails in bed, environmental services depresponsibility for ensuring sproper working order.  All staff will be re-educated and procedure by August 2  Room audits for restraints, audits for the appropriatent and their functionality will be weekly for four weeks, and scheduled periodically ther Director of Nursing based of Outcomes and results from will be brought to the facilit quarterly QA meeting for restraints of the process and results from the process of the second control of the facilit quarterly QA meeting for restraints of the process	cy and Lutheran Home I by an Lugust 10th. This lies to create the not for all the prohibition of colicy also viewing resident terdisciplinary Liven't e Side Rail rest View eviewed and hary team on cetails the resident for and the coartment's lies of side rails are in  I on this policy Sth.  along with less of side rails lie completed then lie after by the lies and the lies and the lies and the lies and the lies of side rails lies of side rails lies on audit results. In these audits lies on the lies and the lies on audit results. In these audits lies on the lies and the lies on audit results. In these audits lies on the lies of side rails lies on audit results. In these audits lies on the lies of side rails lies on audit results. In these audits lies on the lies of side rails lies on audit results. In these audits lies of side rails lies on audit results. In these audits lies of side rails lies on audit results. In these audits lies of side rails lies on audit results. In these audits lies of side rails lies on audit results. In these audits lies of side rails lies of side rails lies on audit results. In these audits lies of side rails lies on audit results. In these audits lies of side rails	
		left and right side rails. R25		The Director of Nursing wil		

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

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245018	B. WING		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTE COLUMBIA HEIGHTS, MN 55421	E	, = 0 . 0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	and stated R25's sindicate the use of reviewed the 2/4/16 5/5/16, safety risk aplan with the surversessment and care of bilateral (left and did indicate the use that there should be side rails. LPN-C the R25's medical record to be completed on The director of nurse 7/13/16, at 2:08 p.r. plans should match determined approperate A side rail assessment and care of the director of nurse 7/13/16, at 2:08 p.r. plans should match determined approperate A side rail assessment and care of the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and care of the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and care of the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 2:08 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment in the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p.r. bilateral half side rail assessment and the director of nurse 7/13/16, at 7:13 p	ewed on 7/13/16, at 1:21 p.m. de rail assessment should two half side rails. LPN-C 6, side rail assessment, the assessments and R25's care yor and confirmed R25's are plan do not identify the use 1 right) half side rails, however of a grab bar. LPN-C stated an assessment for two half are added a nursing order to ard for a side rail assessment and care in what has been assessed and riate for the resident's use.  The was completed on an another that indicated the use of ails for mobility.  The arm R25's bed was observed ide rail and a right grab bar. The red nurse (RN)-C confirmed and bar and one half side rail and a right grab bar. The red nurse (RN)-C confirmed arb bar and one half side rail and a right grab bar. The red nurse (RN)-C confirmed arb bar and one half side rail and a right grab bar. The red nurse (RN)-C confirmed arb bar and one half side rail and a right grab bar. The red nurse (RN)-C confirmed arb bar and one half side rail and a right grab bar. The red nurse from as yesterday are rails on her bed and that dicated that two half side rails are confirmed that there was a 25's bed and not two half side	F 221	Compliance date: 8/31/2016		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING			07/14/2016
	PROVIDER OR SUPPLIER	ме		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	THEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	
F 221	confirmed that two what was written or plan. The administr maintenance was a side rails put on R2 assessed on 7/13/1 confirmed that R25 corrected to reflect device R25 was util A facility policy entit Assessment" dated residents will be as process and as need grab bars for positic self-mobility". The nurse would compled ays of admission a updated annually, was needed. The pol assessment will be R53's quarterly MD was severely cognit assistance for bed transfers. The MDS but able to stabilize surface to surface t	ar bed. The administrator staff were trying to correct in the assessment and care ator further stated that tware and there would be two 5's bed to match what was 6. The administrator then is care plan would also be what positioning and safety izing.  Ided "Side Bar/Grab Bar I "3/10" indicated that "all sessed during the admission edd for the use of side rails or oning or increasing policy further indicated that a set the assessment would be with a change in condition or icy also indicated the reviewed quarterly.  S dated 4/11/16, indicated she tively impaired and required mobility, toileting and indicated R53 was unsteady with staff assistance during a ransfer. A Care Area dated 1/21/16, identified a licated R53 had difficulty ling position and impaired sfers. R53's care plan dated otential for alteration in safety officits. The care plan directed	F 2	21		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245018	B. WING _		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	6/3/16. A progress "body pillow has be During an observat R53 was lying in be of her bed was place approximately four her right side. The the mattress with the trial trees was a fall pressure alarm place. During an observat R53's alarm could be hallway outside her (RN)-B responded was sitting up in heat the alarm. She stat swinging her legs of sit on the side of the RN-B further stated "that's why they have During an interview nursing assistant (Notice the body pillow if a resident is a fall During an interview NA- E stated the body falling out of bed.  During an interview RN-F stated, a body restraint if the resident stated she was away and the stated she was away as a stated the was away as a stated she was a stated she was away as a stated she was a state	the floor next to her bed on noted dated 6/6/16, indicated en applied to resident bed."  ion on 7/12/16, at 2:38 p.m. ed on her left side. The left side ced against a wall and a pillow feet in length was placed on pillow was placed directly on he fitted sheet tucked around mat on the floor and a ced on the bed.  ion on 7/14/16, at 7:56 a.m. be heard sounding from the room. Registered nurse to the alarm. RN-B stated R53 r bed when she responded to ed R53 was capable of over the side of the bed and will be bed and attempt to stand. If, R53 can be on the floor, we a body pillow."  I on 7/13/16, at 8:54 a.m. NA)-I stated R53's care sheet a body pillow in bed. She ow goes under the fitted sheet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING _		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	-	-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	being placed under RN-F stated, "If it p something they could call it a restraint." Saware of an assess During an interview NA-J stated he alway under the fitted she he was trained to do specific. He stated done."  During an interview DON stated the fact define the edge of the body pillows under correct application. educated that it was R62 was lying in be against the wall and bottom sheet on the 7/13/16, at 8:03 a.m. pillows from under the removed the pillows the bed with feet or pillow did not sound the medications the back up and said "I started to stand up down and put on the R62. LPN-F acknowled in the belong under the pillow grand on the puring random obs a.m. R62 was lying off. There were two	ge 9 not aware the pillows were the fitted sheet under the bed. revents them from doing ald do on their own we would he further stated she was not sment specific to restraints.  on 7/14/16, at 9:41 a.m., ays puts the body pillows et and stated he was unsure if o it that way by anyone that's how I have seen it  on 7/14/16, at 8:39 a.m., the illity used body pillows to help he bed. She stated tucking the the fitted sheet was not the She stated staff need to be a not OK to do it that way. It with the right side of the bed of two pillows tucked under the eleft side observed on an LPN-F removed the two the sheet. Once LPN-F as R62 sat up on the edge of a floor mat. Alarm under R62's at when R62 sat up. R62 took an laid down. R62 then sat need to use the pot." R62 when LPN-F asked R62 to sit e call light for staff to assist wledged that the two pillows ar R62's bottom sheet.  ervation on 7/14/16, at 6:58 in bed on left side with lights pillows under the bottom llows was part way out from a llows was part way out from the sheet was part way out from the lower was part way out	F 22	21		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING			07/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	CODE DRTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 221	was severely cogniextensive assistive mobility. The MDS were not used. R62 included generalize behaviors, seizure admitted to the faci R62's fall CAA daterisk for falls related admission, unstead seated to standing wheel chair but did rails or pillows under R62's fall care plan fall risk related to with dementia, cardiace of incontinence/urgen indicated R62 craw impulsive and ambiplan instructed staff environment, keep rails, sensor alarm not indicate to place sheet of the bed on The Fall Risk Asses indicated R62 had in history of 3 or more was chair bound reelimination, had bal muscular coordinaters.	S dated 5/2/16, indicated R62 tively impaired and required of two staff members for bed further indicated restraints and S MDS noted R62 diagnoses diveakness, dementia with disorder and that R62 was lity on 4/25/16.  d 5/4/16, indicated R62 was at to a history of falls prior to by balance when moving from positions and from bed to not address the usage of side at the bottom sheet of the bed. Indicated R62 had eakness, balance impairment, disease, and urinary by the care plan also led out of bed at time, was ulated at time by self. Care if to maintain a clutter free call light within reach, 1/2 side in bed and chair. Care plan dides pillows under the bottom the left side.  Sesment dated 7/12/16, intermittent confusion, a falls in the last three months, quiring assistance with ance problems and decreased		221		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245018	B. WING _		07	/14/2016
-	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	-	, =
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	The undated Team risk, had sensor ala and required assist transfers and ambut During interview on stated, "I am not su under the bottom sl [R62] from rolling o was able to stand be verified R62 had falverified there were During interview on stated, "[R62] does bed that is why we sheet." NA-G verified bottom sheet.  During interview on stated, "I am not su are putting the pillor RN-D said, "I have he has a sensor alawould put the pillow During interview on stated, the fact staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over stated it depends of the staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over stated it depends of the staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over stated it depends of the staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over stated it depends of the staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over stated it depends of the staff sheets was broughdownstairs, regardistated "I did not know you talking to her. Sunder the bottom slithey cannot get over staff sheets was brought staff sheets was brought staff sheets was brought sheets."	quested but not provided.  Sheet indicated R62 was a fallurm on bed and wheel chair ance of one staff member for	F 22	21		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245018	B. WING _		07/	14/2016
NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272 SS=D	and will be talking to During interview on said, "Pillows under practice. It is a restrict give them the ability want. DON stated, intervention for combut we do not direct 2016, indicated a reanything that prohib functioning, moving (activities of daily livindicated the "intercept periodically review restraints are presecompleted through chart audits and rocadvertent restraint immediately by a st 483.20(b)(1) COMFASSESSMENTS  The facility must coa comprehensive, a reproducible assess functional capacity.  A facility must make assessment of a reresident assessment of a reresident assessment by the State. The aleast the following:	ion today on not doing that of the night shift."  7/14/16, at 10:53 a.m. DON of the bottom sheet is not our raint." DON stated it does not of to be free and do what they "A pillow in bed might be and affort or to define edges of bed at staff to put it under a sheet."  Iled Use of Restraints dated estraint was classified as pited a resident from and another to the policy further disciplinary team will resident charts to ensure no one; these reviews will be review of incident reviews, or observations. If an an observed it will be removed aff member."  PREHENSIVE  Induct initially and periodically accurate, standardized sment of each resident's	F 22			8/31/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	COMPLETED	
		245018	B. WING		07/14/2016	
NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLÉTION	
F 272	Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of sthe additional asse areas triggered by Data Set (MDS); an	r patterns; peing; g and structural problems; and health conditions; nal status;  and procedures; l; summary information regarding ssment performed on the care the completion of the Minimum	F 27	2		
	by: Based on observa review, the facility f accurately assess 4 residents (R25, F Findings include: An admission Minir assessment was of R25 was cognitivel	NT is not met as evidenced tion, interview and document failed to comprehensively and for potential restraints for 2 of R62) reviewed for restraints.  The mum Data Set (MDS) completed on 2/8/16, indicated y intact and required extensive aff person for bed mobility. The		It is the Policy of Crest View Lut Home to comprehensively assess resident's functional ability, and that physical capabilities are not due to restraints.  Residents R53 and R62 were re-assessed for their safety risk for side rail use on August 12th.  For all other residents that this d	es each ensure limited as well as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1444 RESERVOIR BOULEVARD NORTHEAS	т	
CREST	IEW LUTHERAN HO	ME		COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 14	F 272			
		sment further indicated that used and that R25 was lity on 2/1/15.		practice may have affected, whole- side rail assessments were comple every resident. In addition, a whole environmental services audit of the	eted for -house	
		ssessment indicated R25 bar and was able to safely		functionality of side rails was comp Safety Risk assessments, which as the physical devices utilized for the of each resident will be completed	ssess	
		ted 2/16/16, identified the use /2 side rails and a right grab ishions.		quarterly, upon admission, or along any significant change of the MDS.		
	was independent w	sk Assessment indicated R25 vith bed mobility and utilized a par as a physical device for		The Use of Restraints Policy and Procedure for Crest View Lutheran was reviewed and updated by an interdisciplinary team on August 10 policy describes the process to cre least restrictive environment for all	th. This	
		p.m. R25's bed was observed ils on the left and right side of		residents, which includes the prohi the use of restraints. The policy als outlines the process for reviewing recharts periodically by an interdiscip	o resident	
		p.m. R25's bed was again alf left and right side rails.		team to ensure restraints aren't inadvertently in place. The Side Ra Policy and Procedure of Crest View	ail	
		3 p.m. R25's bed was left and right side rails.		Lutheran Home was also reviewed updated by an interdisciplinary tear August 10th. This policy details the	n on	
	interviewed on 7/13 R25's side rail asse use of two half side 2/4/16, side rail ass	nurse (LPN)-C was 3/16, at 1:21 p.m. and stated essment should indicate the e rails. LPN-C reviewed the sessment, the 5/5/16, safety		process of assessing each residen the use of side rails in bed, and the environmental services departmen responsibility for ensuring side rails proper working order.	t's	
	surveyor and confine care plan did not id and right) half side	and R25's care plan with the med R25's assessment and entify the use of bilateral (left rails, however did indicate the		All staff will be re-educated on this and procedure by August 25th.		
	be an assessment	_PN-C stated that there should for two half side rails. LPN-C ng order to R25's medical		Room audits for restraints, along wadits for the appropriateness of si and their functionality will be complete.	de rails	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245018	B. WING			07/1	14/2016
	PROVIDER OR SUPPLIER	иЕ		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	record for a side rai on the evening shift  The director of nurs 7/13/16, at 2:08 p.m plans should match determined appropriate A Side Rail assess 7/13/16, at 7:13 p.m bilateral half side rai On 7/14/16, at 9:11 to have a left half si -At 9:12 a.m. regist there was a right gron R25's bed. RN-A where that (grab ba R25 had two half si her assessment ind were being usedAt 9:15 a.m. LPN-0 grab bar on R25's bas the assessment -At 9:39 a.m. the ac was aware R25 had half side rails on he confirmed that two what was written or plan. The administr maintenance was a side rails put on R2 assessed on 7/13/1 confirmed R25's ca corrected to reflect device R25 was util	I assessment to be completed of 7/13/16.  Sing (DON) confirmed on that assessments and care what has been assessed and riate for the resident's use.  Ment was completed on that and indicated the use of and indicated the use of all so the resident's use.  Ment was completed on that are and indicated the use of all so the red and indicated the use of all so the red nurse (RN)-C confirmed ab bar and one half side rail and a right grab bar. Be and that a stated she did not know that are all so the red and that the did and not two half side rails are and not two half side rails indicated. In the administrator confirmed that he did a right grab bar and not two restaff were trying to correct the assessment and care attributed that was and there would be two 5's bed to match what was 6. The administrator then re plan would also be what positioning and safety	F 2	272	weekly for four weeks, and then scheduled periodically thereafter by Director of Nursing based on audit Outcomes and results from these a 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	results.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	/14/2016	
_	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZI 4444 RESERVOIR BOULEVARD I COLUMBIA HEIGHTS, MN 55	P CODE NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 272	process and as ne grab bars for positi self-mobility." The nurse would compleseven days of admitted assessment with the assess	age 16 seessed during the admission eded for the use of side rails or oning or increasing policy further indicated that a ete the assessment within assion and the assessment annually, with a change in eded. The policy also indicated ll be reviewed quarterly.  ed with the right side of the bed d two pillows tucked under the e left side as observed on m. LPN-F removed the two the sheet. Once LPN-F as R62 sat up on the edge of an floor mat. Alarm under R62's d when R62 sat up. R62 took en laid down. R62 then sat I need to use the pot." R62 when LPN-F asked R62 to sit and call light for staff to assist wledged that the two pillows er R62's bottom sheet.  Servation on 7/14/16, at 6:58 In bed on left side with lights or pillows under the bottom willows was part way out from to the facility on 4/25/16. The atted 5/2/16, indicated R62 was by impaired and required of two staff members for bed of MDS further indicated that used. R62's MDS indicated luded generalized weakness, envires seizure disorder	F 2	272			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245018	B. WING		07	/14/2016		
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COE 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	DE .			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 272	indicated R62 was history of falls prior balance when mov positions and from address the usage the bottom sheet on R62's fall care plant fall risk related to with dementia, cardiace incontinence/urgen Resident crawls out and ambulates at the instructed staff to menvironment, keep rails, sensor alarm plant did not indicate bottom sheet of the The Fall Risk Asse indicated R62 had history of three or months, was chair with elimination, had decreased musculated R62 had history of three or months, was chair with elimination, had decreased musculated resident cassessment was resident for a seep sment was resident for a seep sment was resident of a seep sment of a seep	a Assessment dated 5/4/16, at risk for falls related to a to admission, unsteady ing from seated to standing bed to wheel chair but did not of side rails or pillows under f the bed.  I date 5/16, indicated R62 had reakness, balance impairment, disease, and urinary icy. Care plan also indicated it of bed at time, is impulsive ime by self. The care plan maintain a clutter free call light within reach, 1/2 side in bed and chair. The care is to place pillows under the expedit on the left side.  I ssment dated 7/12/16, intermittent confusion, a more falls in the last three bound requiring assistance and balance problems and ar coordination.  I ssment dated 7/13/16, did not use grab bars. Restraint equested but not provided.  I sheet indicated R62 was a fall arm on bed and wheel chair tance of one staff member for	F 272					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING  A. BUILDING		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED			
		245018	B. WING _		07	//14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	ODE PRTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 272	cannot get over it on R62 could get over said It depends on it. He has very active During interview on said, "Pillows under practice. It is a rest give them the ability want. DON said, "A intervention for combut we do not direct DON said, "We wo assessment becauted. The MDS 3.0 manurestraints as "Any mechanical device, attached or adjacenthe individual cannorestricts freedom or to one's body." In a facility to determine using any physical must assess the reresident's needs are the restraint is bein A facility policy entity 2016, indicated a reanything that prohibit functioning, moving (activities of daily linidicated that the "in periodically review restraints are presecompleted through	uld be a restraint if they n their own." When asked if the pillows on own LPN-C the day if R62 could get over we days and very sleepy days.  7/14/16, at 10:53 a.m. DON the bottom sheet is not our raint." DON said it does not y to be free and do what they pillow in bed might be and nfort or to define edges of bed to staff to put it under a sheet." and not have a restraint see we do not use restraints."  Jual dated 10/15, defined manual method or physical or material or equipment and to the resident's body that for remove easily, which if movement or normal access ddition, the MDS directed the fit it was a restraint "Prior to restraint, the nursing home sident to properly identify the and the medical symptom(s) that g employed to address."	F 27			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245018	B. WING		07/14/2016
	PROVIDER OR SUPPLIER	МЕ	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 272 F 276 SS=D	advertent restraint i immediately by a st 483.20(c) QUARTE LEAST EVERY 3 M A facility must asse quarterly review ins and approved by Cl once every 3 month	s observed it will be removed aff member." ERLY ASSESSMENT AT IONTHS  ss a resident using the trument specified by the State MS not less frequently than is.	F 272		8/31/16
	by: Based on observat review, the facility for re-assess a potenti (R53) reviewed for Findings include: R53's quarterly Min 4/11/16, indicated s impaired and requir toileting and transfer A Safety Risk Asser R53 was at risk for identified the follow perimeter mattress, and bed alarm/tabs the purpose of the of The assessment dip pillow. R53's care p potential for alterati deficits. The care p pillow while in bed.	imum Data Set (MDS) dated he was severely cognitively ed assistance for bed mobility,		It is the Policy of Crest View Lutherar Home to comprehensively assess up admission, quarterly, or with a signific MDS change, each resident's function ability, and ensure that physical capabilities are not limited due to restraints.  Resident R53 was re-assessed for th safety risk as well as for side rail use August 12th.  For all other residents that this deficie practice may have affected, Safety Ri assessments, which assess the phys devices utilized for the safety of each resident, will be completed quarterly, admission, or along with any significate change of the MDS.  The Use of Restraints Policy and Procedure for Crest View Lutheran H was reviewed and updated by an interdisciplinary team on August 10th, policy describes the process to create	eir on ent isk ical upon nt ome

STATEMENT OF DEFICIE AND PLAN OF CORRECT					SURVEY PLETED		
		245018	B. WING			07/1	4/2016
NAME OF PROVIDER C	R SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	017	
				44	444 RESERVOIR BOULEVARD NORTHEAS	Т	
CREST VIEW LUTI	HERAN HO	ME		С	OLUMBIA HEIGHTS, MN 55421		
PREFIX (EAC	H DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 276 Continue	ed From pa	age 20	' F 2	76			
Notes da R53 was 6/3/16. A "body pil During a R53 was of her be approxin her right the matt it. There pressure During a R53's all hallway (RN)-B r was sitting the alarm swinging sit on the RN-B stated the stated the farestraint stated sl pillows a frequent	ated 6/1/16 found on a progress low has be nobservate lying in be ed was place at lying in be ed was a fall e alarm place and could lead to the responded and up in heart lead of the ated, R53 ce a body per ninterview assistant (Ner to use to be body pille ent was a minterview ated, a bodiff the residence was awas intervently but was	through 7/12/16, indicated the floor next to her bed on note dated 6/6/16, indicated ten applied to resident bed."  ion on 7/12/16, at 2:38 p.m., ed on her left side. The left side ced against a wall and a pillow feet in length was placed on pillow was placed directly on he fitted sheet tucked around mat on the floor and a ced on the bed.  ion on 7/14/16, at 7:56 a.m., be heard sounding from the room. Registered nurse to the alarm. RN-B stated R53 ar bed when she responded to ed R53 was capable of over the side of the bed and will be bed and attempt to stand. Can be on the floor, "that's why illow."  on 7/13/16, at 8:54 a.m., NA)-I stated R53's care sheet a body pillow in bed. She ow goes under the fitted sheet	F 2	276	least restrictive environment for all residents, which includes the prohit the use of restraints. The policy als outlines the process for reviewing restraints periodically by an interdiscip team to ensure restraints aren't inadvertently in place.  All staff will be re-educated on this and procedure by August 25th.  Room audits for restraints, along we audits for the appropriateness of si and their functionality will be compleweekly for four weeks, and then scheduled periodically thereafter by Director of Nursing based on audit.  Outcomes and results from these awill 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	o esident linary policy ith de rails eted y the results.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245018	B. WING _	·····	07/	/14/2016
	PROVIDER OR SUPPLIER	МЕ		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	DDE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 276	something they coucall it a restraint." Saware of an assess  During an interview director of nursing (body pillows to help She stated tucking fitted sheet was not stated staff need to OK to do it that way the body pillow was  The MDS 3.0 manurestraints as "Any mechanical device, attached or adjacer the individual cannor restricts freedom of to one's body." In a facility to determine using any physical must assess the resresident's needs and the restraint is being A facility policy entit 2016, indicated a reanything that prohib functioning, moving (activities of daily livindicated that the "in periodically review restraints are presecompleted through chart audits and roc	and do on their own we would the further stated she was not ment specific to restraints.  on 7/14/16, at 8:39 a.m., the DON) stated the facility used define the edge of the bed. The body pillows under the the correct application. She be educated that it was not a She the DON further stated not assessed as a restraint.  It all dated 10/15, defined manual method or physical or material or equipment at to the resident's body that a tremove easily, which movement or normal access addition, the MDS directed the first was a restraint "Prior to restraint, the nursing home sident to properly identify the different to properly identify the different to address."  Iled Use of Restraints dated estraint is classified as sits a resident from an or performing ADLS's ring) freely. The policy further interdisciplinary team will resident charts to ensure no ant; these reviews will be review of incident reviews, on observations. If an sobserved it will be removed	F 2'	76		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/14/2016	6
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	TION
F 282 F 282 SS=E	483.20(k)(3)(ii) SER PERSONS/PER CA The services provided by	RVICES BY QUALIFIED	F 28		8/31/10	6
	by: Based on observar review, facility failed 1 of 1 residents (Ranon-pressure skin obruises of unknowr failed to ensure the implemented for tinfor 2 of 2 residents toileting and reposinail care for 1 of 1 activities of daily live.  Non-pressure skin: R140 was observed resident was observed left and right hand.  On 7/13/16, at 9:26 standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the left hand appont to the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the R140's bruises visil nursing station appont the standing outside the standing outside the R140's bruises visil nursing station appont the standing outside the	conditions observed with a cause. In addition the facility plan of care was nely toileting and repositioning (R45, R122) reviewed for tioning and failed to provide to resident (R47) reviewed for ing.  If on 7/11/16, at 4:15 p.m. The ved seated in the day room with two purple bruises on the a.m. R140 observed resident e activity office in the hallway. Ole from standing at the roximately two feet. The bruise beared dark purple.		It is the Policy of Crest View Luther Home to provide services by qualific staff in accordance with each reside written plan of care.  For Resident R140, a risk manager incident report was completed on Ju 14th for bruises observed during the annual survey. Her written plan of c was updated by qualified staff at that to note her potential risk for bruising well as interventions to prevent futu bruises. This incident was reviewed interdisciplinary team on July 15th.  For residents R45 and R122, toileting turning and repositioning assessment were initiated by August 12th.  Resident R47's nails were checked August 11th, in addition to her sched bath day to ensure her nails were claimed clean, per her plan of care. Her care will be assessed weekly in addition to her scheduled bath day.  The Resident Incident and Skin Chair in the scheduled bath and Skin C	ed ent's  ment uly e are at time g, as re l by an  ang and ents  on duled lipped r nail lition to	
	standing outside th R140's bruises visil nursing station app on the left hand app On 7/14/16, at 7:30	e activity office in the hallway. ole from standing at the roximately two feet. The bruise		bath day to ensure her nails were cl and clean, per her plan of care. Her care will be assessed weekly in add	lipped nail lition to anges	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/	14/2016	
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	bruises were visible go by resident none which were visible.  On 7/14/16, at 8:40 assistants (NA)-D a down the hallway whand went to room toileting. During the has acknowledged a.m., NA-E even brand assisted resided R140's pressure ule (CAA) dated 10/16/advanced dementia assistance. CAA inintact and directed cares. R140's skin indicated resident hrelated to incontine monitor skin with care R140's quarterly M dated 4/5/16, indica of dementia. In addresident had severe wandered.  R140's Physician's directed staff to coron Bath Day every	e and several staff observed acknowledged the bruises  to 8:49 a.m. nursing and NA-E were observed walk with R140 both holding each Both assisted R140 with observation, none of the NA's the visible bruises. At 8:51 rought R140 to the bathroom and to wash hands.  The Care Area Assessment (15, indicated resident had a and needed more dicated skin would remain staff to monitor skin with care plan dated 10/15 also, and potential for skin alteration ince and directed staff to ares.  This indicated resident had a diagnosis lition, the MDS indicated ely impaired cognition and  Orders dated 6/27/16, implete "Skin Check/Nail Trim day shift every Wednesday."	F 282	,	Nail Care View Ind eam on les the ruises, as so for pectively. e deficient li be ind liddition, roper use P AND to best cion such lown, etc. by August cositioning, led weekly led rector of see audits ext		
	Administration Rec had signed off the s completed howeve Body Audit dated 7	ord, it was revealed a nurse skin check had been r during review of the Weekly 6/16, and 7/13/16, no skin otified in the assessment.		The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245018	B. WING			07/	14/2016
	PROVIDER OR SUPPLIER	ME		4444 RE	ADDRESS, CITY, STATE, ZIP CODE SERVOIR BOULEVARD NORTHEAS MBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	stated she would haskin changes to the was to follow the pl On 7/14/16, at 2:03 completed R140's s 7/13/16, and she has practical nurse (LP) the unit and he had NA-E stated the brunewAt 2:07 p.m. RN-B nurse did not docur On 2/14/16, at 2:29 (DON) she would e concerns and to fol The facility Care Plarevised 9/14, indicate ensure the resident required to maintain highest level of practical to maintain hi	p.m. registered nurse (RN)-B ave expected staff to report enurse to investigate and staff an of care.  In p.m., NA-E stated she had shower on Wednesday and reported to licensed N)-E who was orientating in a thought the bruise looked old. Lises on the hands were not stated she was shocked the ment the bruises.  In p.m. the direct of nursing expect staff to report any skin low the care plan.  In Policy and Procedure and the care plan was to be received the appropriate care in or attain the resident's exticable function possible.	F 2	82			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	//14/2016	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COE 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	DE	,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE	
F 282	Surveyor ask NA-H buttocks. There was tool. NA-H cleaner using same gloves rectal area then to removed gloves, ar applied a new incommoder of the removed gloves, are applied a new incommoder of the removed glov	I to check between R45's is a large amount of soft brown of the remaining stool, then applied barrier cream to perifront of perineum. NA-H then and put new gloves on and intinence brief on R45.  If p.m. NA-H entered R45's is is R45 was stood up using the intinence product was changed and back into wheelchair. R45's in 7/13/16, at 12:14 p.m. R45 is the toilet. I just have my is stated I had not been up and I have been in my chair one has asked me." R45 went initiates without being offered for changed for incontinence itioned.  The CAA worksheet dated incontinence itioned.  The CAA worksheet dated incontinence changed a special mattress and a regular schedule of any incontinence CAA incontinence	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	/14/2016
	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	toileting. MDS indicincontinent of bower pressure ulcer dever R45's diagnoses in disease in which the damaged, interferir resulting in physical psychiatric problem lower body includin R45's mobility care staff R45 had an al Multiple sclerosis a reposition R45 ever Stand (a mechanical potential for alteration in wheelch incontinent episode doctor's order.  R45's bowel and bluinstructed staff R45 continence related urinary retention, more toilet R45 every tresident request, chours and as needed checked on the firs R45's potential for a plan indicated R45 according to tissue provide peri care aff apply barrier cream.  Undated Linden Tewas to be checked.	ated R45 was frequently and bladder and at risk for elopment. MDS indicated cluded multiple sclerosis (a e covering of the nerves are gwith impulse conduction, I, mental and sometimes is), paraplegia (paralysis of the glegs), and depression.  plan dated 7/2016, instructed teration in mobility related to a staff were to turn and ty two hours and use an EZ al lift) for transfers. R45's on in skin integrity care plan to be repositioned according assessment, have a foam air, provide peri care after and apply barrier cream per adder care plan dated 7/2016, is had an alteration in to neurogenic bladder with altiple sclerosis and staff were two hours, assist to toilet per neck and change every two ed. Post void residuals are than 15th of each month. Calteration in skin integrity care was to be repositioned tolerance assessment, fer incontinent episodes and a per doctor's order.  am # team Card indicated R45 and changed every two hours barrier cream applied to	F 2	282		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245018	B. WING		<del></del>	07/	14/2016
	PROVIDER OR SUPPLIER	ИE		44	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	buttocks. It also ind and repositioned ever The care plan and is sheet do not mention refusing cares. The 7/6/16, instruct staff refusals to be chanked to not indicate any During interview on said we change (Rafter brunch. When change and repositioned during the day shift that's it."  During interview on said (R45) was to be and as needed. R4 (R45) was changed repositioned.  During interview on said (R45) was to thours. LPN-C said have expected ther 9:00 a.m. and 11:00 During interview on said, "I would expect changed according residents refuses, that least tell the nurse them to follow the control of the control	icated R45 was to be turned very two hours.  nursing assistant assignment on R45 having any history of Physician's Orders dated for to document on resident ged every shift. Review of es from 7/11 through 7/14/16, refusals to be changed.  7/13/16, at 12:37 p.m. NA-H H5) when we get (R45) up and asked how frequently staff ion R45 out of the wheel chair NA-H responded "two times,  7/13/16, at 1:29 p.m. RN-E e changed every two hours be likes to sit up so, when I was when (R45) was  7/13/16, at 1:31 p.m. LPN-C curn and reposition every two from the changed at 7 a.m., "I would not do a change (R45) about	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	completed R122 wa and placed next to Evergreen Hallway, wheelchair until 10: taken to an activity  Upon request at 10 to her room and off three hours and 16 the use of a bathroot to the care plan.  R122's activity of doworksheet dated 12 required extensive repositioning.  R122's care plan, dindicated toileting a done every two hours and repositioning a	After morning cares were as wheeled into the hallway the medication cart in R122 remained seated in the 30 a.m. at which time she was in the chapel.  30 a.m. R122 was taken back ered toileting. R122 went for minutes without being offered om or repostioned according ally living (ADL) CAA 2/1/15, indicated R122 assistance with toileting and lated December 2015, and repositioning was to be urs.  DS dated 5/24/16, indicated extensive assistance with tioning. R122 had severe at.  Record printed 7/14/16, agnoses included dementia thrive.  Do 7/13/16, at 9:53 a.m. NA-A are of the last time R122 was she had not had the time to a was aware R122 was to be ours. NA-A confirmed R122 witioned since getting out of	F 282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING _		07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	On 7/13/16, at 10:3 take R122 to the ba and shook her hea wanted to use the time.  When interviewed stated R122 was to hours and as need would not be acceptours and 16 minutoileting and reposition. The LPN-B was intp.m. and confirmed "toilet every two howas unable to local collection tool used bladder habits. LPN three day collection with significant challowed.	athroom. R122's brief was dry d "no" when asked if she toilet. R122 stood during this on 7/13/16, at 1:15 p.m. LPN-A be be offered toileting every two ed per the care plan, and it otable for R122 to go three tes without being offered ditioning.  The erviewed on 7/13/16, at 1:22 d R122's care plan indicated ours to meet her needs." LPN-B te the last three day data d to document bowel and N-B stated bowel and bladder in tool was done quarterly and	F 28	2		
	have dark debris un nails. On 7/12/16, a 7/13/16, at 1:00 p.r	on 7/12/16, at 8:17 a.m. to nder eight out of 10 finger at 3:19 p.m. and again on m. R47's nails continued to nder eight of the ten nails.				
	indicated that R47 dementia and requ personal hygiene. I	orksheet dated 2/26/16, had an ADL deficit related to ired extensive assistance with R47's care plan, dated March ekly diabetic nail care to be				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/	/14/2016	
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	4444 RESERVOIR BOULEVARD NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 282	R47 required exten hygiene. R47 had not required exten hygiene. R47 had not repolicy indicated R47's diagram and responding to the respond	ge 30  S dated 5/26/16, indicated sive assistance with personal noderate cognitive impairment.  ecord printed 7/14/16, gnosis included vascular mellitus type two and  on 7/13/16, at 1:09 p.m. LPN-A rovide nail care and they are bathed. LPN-A stated that care should be done by the firmed the dark debris under viewed on 7/14/16, at 9:19 and "the expectation is that stained, clean and short. If the pan clean under the nails."  It an undated policy and proper grooming and nail care in a dignified manner for all	F 2	282			
F 309 SS=D	procedure section, responsible for nail 483.25 PROVIDE O HIGHEST WELL B		F3	309		8/31/16	
	provide the necessary or maintain the high	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		E SURVEY PLETED
		245018	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	CODE DRTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	and plan of care.	age 31 e comprehensive assessment  NT is not met as evidenced	F 3	009		
	review, the facility f services related to resident (R114) rev the facility failed to	tion, interview and document ailed to provide care and fluid restrictions for 1 of 1 riewed for dialysis. In addition, identify non-pressure related 1 of 1 resident (R140) with		It is the Policy of Crest Vie Home to provide services to maintain the highest practic physical or psychosocial was residents, in accordance was plan of care.	to attain or cable mental, ell-being for all rith their written	
	(ESRD), hypertens diabetes and deme Minimum Data Set	nclude end stage renal disease ion, atrial fibrillation, type II entia obtained from the annual (MDS) dated 6/10/16. In ndicated R114 had moderately		For Resident R114, her ord restriction was communicathat work on her nursing upon consultation with her regist an education was given an each staff member on her which described her fluid reto monitor her intake, and residents with an order for restrictions will be identified care sheets.	ted to all staff nit. In ered dietician, d signed by nursing unit, estriction, how how future fluid	
	in her bed. When a and the facility coor resident stated was this surveyor. Whe fluid restriction resi took care of all her pitcher with straw v dresser on the edg filled. When asked was resident point she left her shirt. W dressing indicated	s p.m. observed resident lying isked how dialysis was going, rdination with dialysis place, is going well as she smiled at in asked about her diet and dent stated the facility staff food/fluid needs. A pink water was observed on top of the e to the left and was half way about where the access site to her right upper shoulder as then asked who changed the the staff changed it but was was at dialysis or at the facility.		For all other residents that practice may have affected with orders for fluid restrict identified on the team care front line staff, and fluid do will be set up in their electr record.  For Resident R140, a risk incident report was comple 14th for bruises observed annual survey. Her written was updated by qualified s to note her potential risk fo	d, all residents ions will be sheet by the cumentation onic health management sted on July during the plan of care taff at that time	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245018	B. WING			<b>07</b> /1	14/2016
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	ME			44 RESERVOIR BOULEVARD NORTHEAS	Γ	
				CO	DLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 32 she was going to take a nap	F3		well as interventions to prevent futu	ıre	
	and would visit with	surveyor later.			bruises. This incident was reviewed interdisciplinary team on July 15th.		
	dietician (CRD) sta write the care plan process of revising resident husband we since he was at the that resident needed approximately for counces of juice at to non-dialysis days so and supper and dia CRD stated resider (supplement) and endial to however had 60-90 stated resident had restriction on 7/11/17 revising the fluid into	p.m. the consultant registered ted the dietary tech would for nutrition and she was in the her care plan and intakes as as indicating he had noticed facility mostly during meals of two ounces of milk ereal and was asking for eight he two meals, as on he had continental breakfast alysis days brunch and supper. In the did not like the Nepro extra fluids between the meals of milliliters (ml) with meds. RD been started on a fluid 16, and was in the process of take allotting for the meals.			For all other residents that these depractices may affect, all staff will be re-educated on these policies and procedures by August 25th. In additional staff were re-educated on the proper of the INTERACT tool, the STOP A WATCH form. This tool is used to be communicate changes in condition as bruise, redness, skin breakdowr This education was completed by A 25th.  The Fluid Restriction Policy and Procedure and Resident Incident at Changes Investigation Policy and Procedure for Crest View Lutheran were reviewed and updated by an interdisciplinary team on August 10 These policies describe the process.	tion, er use ND pest such n, etc. august  Home th.	
	When asked if she at times, resident s my mouth is dry." Wher fluid restriction not know as she sn On 7/12/16, at 3:56 (LPN)-D stated she restriction always h nursing desk correction until 7/11 intake and output was at each shift.	would drink out of the pitcher tated, "Yes honey I do when When asked if she knew what was resident stated she did niled.  I p.m. licensed practical nurse thought resident was in a fluid owever, the CRD at the cted LPN-D that resident stable and was not on a fluid /16. LPN-D stated resident were being monitored and this When asked where the nursing premed resident fluid restriction.			managing and documenting fluid restrictions for residents, as well as steps to take in order to report and document incidents, such as bruise Audits for fluid restriction protocols completed weekly for four weeks, a then scheduled periodically thereafthe Director of Nursing based on auresults.  Outcomes and results from these a will be brought to the facility's next quarterly QA meeting for review.  The Director of Nursing will be responsible for compliance	will be and ter by udit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245018	B. WING			07/ <sup>-</sup>	14/2016
	PROVIDER OR SUPPLIER			<b>4</b> 4	TREET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	however when she address the fluid resurveyor the intake the fluid restriction.  On 7/12/16, at 4:03 stated he was not restriction was and review the meal tidinformation. When informed resident was assigned to reknow. NA-C stated water pitcher durin  On 7/12/16, at 4:03 to R114's room and CRD verified R114 room. CRD stated restriction, she was pitcher in the room R114 had reported pitcher CRD acknown an accurate of fluid intake.  On 7/12/16, at 4:03 (TMA)-B stated he fluid restriction and R114 received Nepbeing recorded in trecord (EMAR). The	be in the assignment sheet reviewed it, the sheet did not estriction. LPN-D also showed be binder which did not mention as a.m. nursing assistant (NA)-C sure what R114's fluid a directed the surveyor to ket for all the dietary and fluid asked if he had been, was on a fluid restriction as he esident NA-C stated he did not a resident had been given a	F3	09	Compliance date: 8/31/2016		
	the updated assign brought to facility a	3 p.m. CRD provided a copy of ment sheet after concern was attention regarding staff not on a fluid restriction and the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING			E SURVEY PLETED
		245018	B. WING			07/	14/2016
	PROVIDER OR SUPPLIER	иЕ		STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 309	On 7/12/16, at 4:11 was approached shasignment sheet in the fluid restriction is she had just done in On 7/13/16, at 2:37 dialysis registered in with a new order for would call the facility about the fluid restriction the dialysis center is sheet to the facility about the fluid restriction government of the fluid restriction because were difficult to main on 7/14/16, at 12:1 asked who was resknow of the fluid restriction between. LPN and the floor nurseknow. LPN-C indicatorder she never we make sure the water LPN-C stated the supdate the assignment.	p.m. LPN-C unit supervisor le acknowledged the nursing lad not been updated to reflect R114 was on. LPN-C stated it.  p.m. via telephone spoke with nurse who indicated, usually r R114 a nurse from the center y, would write orders on the ion sheet sent each time and staff sent the pre and post run on dialysis days. When asked iction RN stated R114 had a restriction and had noted oday 7/13/16, she had noticed 2.8 kilograms from the reight on Monday 7/11/16." would attribute to the weight lid be mostly not following the R114 had been put on a fluid R114's high blood pressures hage.  8 p.m. LPN-C stated when ponsible for letting the staff striction there was a break N-C stated dietary was notified, was supposed to let the staff atted when she received the not to the room to check to be pitcher was not in the room. Supervisor was supposed to	F3	309			

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		245018	B. WING		0	7/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	to know about the f breakdown. Would pitcher not to be in resident was on a f stated she would haplan to be up to dat. The physician's ord was on dialysis and fluid restrictions.  Care plan dated 6/actual alteration in type II diabetes and resident had weight to dialysis/fluid. Care changes in weights policy, resident was 1000 ml fluid restrictions in type II diabetes and resident had weight to dialysis/fluid. Care changes in weights policy, resident was 1000 ml fluid restriction; on milk and four of four ounces apple j of apple juice support of	luid restriction if there was no have expected the water the room at the time as luid restriction. In addition ave expected the dialysis care to with all the changes.  Iter dated 7/11/16, noted R 114 It was on 1000 milliliter (ml/cc)  10/16, indicated resident had nutrition related to dementia, if ESRD. Care plan indicated to fluctuation anticipated related to plan directed to monitor the monitor intakes per facility is on a renal diet and was on ction, was to take two ounces to the action, was to take two ounces ounces apple juice (breakfast), uice at lunch and four ounces in the action of the complications with eact to make up 100 cc.  15, for dialysis indicated the complications with eact the complications with eact the complications with eact the complication of the complication or dialysis Monday, Wednesday	F 3	09		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		COMPLETED		
		245018	B. WING		07	7/14/2016
	PROVIDER OR SUPPLIER	МЕ		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	DE THEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	indicated it was the Corporation to mair coordinate services for the people the fadirected staff to: "5. Nursing will mor dialysis center to er regarding the reside communicated betw dialysis center.	Gare policy revised 9/10, policy of Crest View stain communication with and with outside dialysis providers acility serves. The policy surfer that information ent's health status are ween the facility and the som dialysis and doctor as	F3	09		
	R140's quarterly MI resident had a diag the MDS indicated cognition and wand On 7/11/16, at 4:15 seated in the day ro two purple bruises on 7/13/16, at 9:26 standing outside the R140's bruises visit nursing station apponthe left hand apponthe left hand appont the dining room to bruises were visible go by resident none which were visible.	p.m. resident was observed oom and was observed with on the left and right hand.  a.m. R140 observed resident e activity office in the hallway. Die from standing at the roximately two feet. The bruise				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING _	· · · · · · · · · · · · · · · · · · ·	07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	down the hallway whand went to room toileting. During the has acknowledged a.m., NA-E even be and assisted reside.  On 7/14/16, at 2:01 stated she would have stated she would have and the nursing not any documentation.  On 7/14/16, at 2:03 completed R140's 7/13/16, and she horientating in the ubruise looked old. I hands were not neter a concerns that had immediately the concerns that had immediately the cate would expect staff and to follow the cate of the concerns that had immediately the cate of the concerns that had imm	and NA-E were observed walk with R140 both holding each. Both assisted R140 with e observation, none of the NA's the visible bruises. At 8:51 rought R140 to the bathrooment to wash hands.  I. p.m. registered nurse (RN)-B ave expected staff to report e nurse to investigate. RN-B kly Body Audit dated 7/13/16, tes indicated she did not see of the bruises.  B. p.m., NA-E stated she had shower on Wednesday ad reported to LPN-E who was nit and he had thought the NA-E stated the bruises on the w.  B. stated she was shocked the ment the bruises.  D. p.m. DON stated she would nurse to document any skin been identified and investigate use. DON further stated she to report any skin concerns	F 30	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245018	B. WING		07/14/2016
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	Т
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 312 SS=D	staff to complete "S Day every day shift During review of Ju Administration Rechad signed off the scompleted however Body Audit dated 7/concerns were ider On 7/14/16, at 2:00 was requested how 483.25(a)(3) ADL ODEPENDENT RES A resident who is undaily living receives	ders dated 6/27/16, directed kin Check/Nail Trim on Bath every Wednesday."  ly 2016, Treatment ord, it was revealed a nurse kin check had been during review of the Weekly 6/16, and 7/13/16, no skin tified in the assessment.  p.m. the facility skin policy ever, was not provided.  EARE PROVIDED FOR	F 309		8/31/16
	by: Based on observation review, the facility for care was implement resident (R47) revieiliving. In addition faplan was followed to	ion, interview, and document ailed to ensure the plan of ted for nail care for 1 of 1 ewed for activities of daily cility failed to ensure the care o provide incontinence care R45) who went five hours changes.		It is the Policy of Crest View Luthe Home assess and provide necessa assistance with activities of daily liv maintain good nutrition, grooming, personal and oral hygiene.  Resident R47's nails were checked August 11th, in addition to her sche bath day to ensure her nails were cand clean, per her plan of care. He care will be assessed weekly along	ing to and I on eduled lipped r nail

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245018	B. WING			<b>07</b> /1	4/2016
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421	г	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Three observations debris under eight of R47's activity of dai Assessment (CAA) indicated that R47 I dementia and requipersonal hygiene. F 2016, identified, an "alteration in health diabetes." R47's cacare every week." F what discipline was R47's quarterly Minstandardized, primatool) dated 5/26/16, extensive assistant R47's MDS indicate impairment. R47's dementia, diabetes depression.  When interviewed of licensed practical in nurses provide nail checked on R47's everything with nail nurses. LPN-A cont R47's fingernails.  The director of nurse 7/14/16, at 9:19 a.n expectation is that it clean and short. If the context of the con	on 7/12/16, and 7/13/16. It were made and R47 had dark out of ten fingernails.  Ity living (ADL) Care Area worksheet dated 2/26/16, had an ADL deficit related to ired extensive assistance with R47's care plan, dated March "alteration in self care" and an maintenance related to ire plan revealed "diabetic nail R47's care plan did not specify responsible for the nail care.  Immum Data Set (MDS) (a lary screening and assessment indicated R47 required lary screening and assessment indicated R47 had moderate cognitive diagnoses included vascular mellitus type two and  In 7/13/16, at 1:09 p.m., urse (LPN)-A stated the care and the nails are loath day. LPN-A stated care should be done by the firmed the dark debris under sing (DON) was interviewed on in. The DON stated, "The nails are to be maintained, they are diabetic, the nurse ils but the nursing assistants	F 3	312	her scheduled bath day on a schedulasis. For resident R45, a new toileting assessment was initiated by August 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 the Incontinence Policy and Proced Crest View Lutheran Home was revand updated by an interdisciplinary on August 10th. These policies described the process of how to provide good and grooming care for all residents, how to best provide incontinence cabased on the Incontinence Assessmall staff will be re-educated on this pand 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 Director of Nursing based on audit to Outcomes and results from these awill 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	t 12th. cient on e, and lure for viewed team cribe nail , and are ment. policies	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		INSTRUCTION		E SURVEY IPLETED
		245018	B. WING			07/	14/2016
	PROVIDER OR SUPPLIER	ME		4444	ET ADDRESS, CITY, STATE, ZIP CODE RESERVOIR BOULEVARD NORTHEAS JMBIA HEIGHTS, MN 55421	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	The facility provide procedure titled Gr policy indicated, "P is to be performed residents in need of procedure section, responsible for nair R45 was observed morning cares. NA incontinence brief, of soft brown stool peri area then chars sanitizing hands. Notanged gloves with hands. NA-H assis NA-H wiped R45's barrier cream. NA-incontinence brief. done washing R45 Surveyor ask NA-H buttocks. There was stool. NA-H cleane using same gloves rectal area then to removed gloves, a applied a new incomorphism of the composition	d an undated policy and ooming and Nail Care. The roper grooming and nail care in a dignified manner for all of assistance." Under the line five read "Nurses will be care for all diabetic residents." on 7/13/16, at 7:09 a.m. for	F3	812			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	` '	E SURVEY PLETED
		245018	B. WING			07/	14/2016
	PROVIDER OR SUPPLIER	ЛЕ		4444	ET ADDRESS, CITY, STATE, ZIP CODE RESERVOIR BOULEVARD NORTHEAS UMBIA HEIGHTS, MN 55421	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	to be checked and/ R45's pressure ulce 7/27/15, indicated Fulcer development, and seat cushion, a turning. R45's urina worksheet dated 7/ always incontinent o bladder (a lack of b due to damage to n disease) and multip assistance with all t  R45's quarterly MD was cognitively inta assistance of one s daily living including toileting. MDS indic incontinent of bowe pressure ulcer deve R45's diagnoses in disease in which the damaged, interferin resulting in physica psychiatric problem lower body including R45's mobility care staff R45 had an ali Multiple sclerosis a reposition R45 ever Stand (a mechanica potential for alterati indicated R45 was incontinent episode doctor's order.	or changed for incontinence.  er CAA worksheet dated R45 was at risk for pressure needed a special mattress and a regular schedule of ry incontinence CAA 27/15, indicated R45 was of urine related to neurogenic ladder sensation and control, erves through injury or alle sclerosis and needed	F3	12			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY MPLETED
		245018	B. WING		07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	instructed staff R45 continence related urinary retention, in to toilet R45 every resident request, chours and as need checked on the firs R45's potential for plan indicated R45 according to tissue provide peri care a apply barrier cream.  Undated Linden Te was to be checked and as needed and buttocks.  The care plan and sheet do not mentirefusing cares. The 7/6/16, instruct staff refusals to be char R45's progress not do not indicate any.  During interview or said we change (R after brunch. Wher change R45 during responded "two tim.  During interview or said (R45) was to be and as needed.  During interview or said (R45) was to be and as needed.	5 had an alteration in to neurogenic bladder with nultiple sclerosis and staff were two hours, assist to toilet per heck and change every two ed. Post void residuals are and 15th of each month. alteration in skin integrity care was to be repositioned tolerance assessment, fter incontinent episodes and a per doctor's order.  The am # team Card indicated R45 and changed every two hours disparrier cream applied to nursing assistant assignment on R45 having any history of e Physician's Orders dated ff to document on resident aged every shift. Review of the from 7/11 through 7/14/16, or refusals to be changed.  1. 7/13/16, at 12:37 p.m. NA-H 45) when we get (R45) up and a asked how frequently staff the day shift, NA-H	F 312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION  G		E SURVEY PLETED
		245018	B. WING _		07/	14/2016
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	9:00 a.m. and 11:00  During interview on said, "I would expect changed according residents refuses, that least tell the nurse."	n to do a change (R45) about 0 a.m."  7/13/16, at 1:37 p.m. DON of residents to be checked and to the care plan and if the he nursing assistants should e."	F 31			8/31/16
SS=D	PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and	F 31	4		6/31/16
	by: Based on observat review, the facility for repositioning for 2 of were reviewed for p Findings include: R122 was continuo from 7:14 a.m. thro were observed whe incontinent of urine	ion, interview, and document ailed to provide timely of 2 residents (R122, R45) who ressure ulcers.  usly observed on 7/13/16, ugh 10:30 a.m. Morning cares n R122 was observed to be After morning cares were as wheeled into the hallway		It is the Policy of Crest View Luther Home to assess and ensure that a resident who enters the facility with pressure sores does not develop the unless their clinical condition demonstrates that they are unavoing For residents R122 and R45, new and repositioning assessments, as incontinence assessments were in by August 12th.	nout hem dable. turning well as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		245018	B. WING		07/1	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED T	JLD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 44	F 314			
	and placed next to Evergreen Hallway wheelchair until 10: taken to an activity  Upon request at 10 to her room and off three hours and 16 the use of a bathroto the care plan.  R122's activity of dworksheet dated 12 required extensive repositioning.  R122's care plan, cindicated toileting adone every two hours and 16 the use of a bathroto the care plan.  R122's activity of dworksheet dated 12 required extensive repositioning.  R122's care plan, cindicated toileting and repositioning and adult failure to when interviewed of stated she was awatoileted and stated check on R122. Natoileted every two hours are repositioned interviewed of stated she was awatoileted and stated check on R122. Natoileted every two hours are repositioned in the reposition of the reposi	the medication cart in . R122 remained seated in the 30 a.m. at which time she was in the chapel.  :30 a.m. R122 was taken back ered toileting. R122 went for minutes without being offered om or repostioned according  aily living (ADL) CAA 2/1/15, indicated R122 assistance with toileting and lated December 2015, and repositioning was to be ars.  DS dated 5/24/16, indicated extensive assistance with tioning. R122 had severe int.  Record printed 7/14/16, agnoses included dementia thrive.  on 7/13/16, at 9:53 a.m. NA-A are of the last time R122 was she had not had the time to a-A was aware R122 was to be iours. NA-A confirmed R122 sitioned since getting out of		For all other residents that this depractice may have affected, turn repositioning assessments, and incontinent assessments will be completed upon admission, qual with any significant change to the The Turning and Repositioning Forcedure, as well as the Incontext Policy and Procedure for Crest Nutheran Home were reviewed a updated by an interdisciplinary to August 10th. These policies desprocess of assessing each residindividual risk of skin breakdown incontinence needs. They also of the procedure of assisting with repositioning and peri-care.  All staff will be re-educated on the policies and procedures by August Audits for proper turning and repositioning, incontinence care peri-care will be completed week weeks, and then scheduled perithereafter by the Director of Nursbased on audit results.  Outcomes and results from these will be brought to the facility's neguraterly QA meeting for review.  The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	rterly, and e MDS. Policy and inence /iew and eam on cribe the ent's and lescribe  nese ust 25th.  and kly for four odically sing e audits ext	
		6 a.m. NA-A was asked to athroom. R122's brief was dry				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY MPLETED
	245018	B. WING		· · · · · · · · · · · · · · · · · · ·	07	/14/2016
	МЕ		4444 RESER	VOIR BOULEVARD NORTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	(EAC	CH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
and shook her head wanted to use the time.  When interviewed of stated R122 was to hours and as needed would not be accept hours and 16 minut toileting and reposit.  The LPN-B was integrated intoileting and confirmed intoiletion tool used bladder habits. LPN three day collection with significant chains and the significant chains are sent and the significant chains and the significant chains are sent	d "no" when asked if she oilet. R122 stood during this on 7/13/16, at 1:15 p.m. LPN-A be offered toileting every two ed per the care plan, and it table for R122 to go three es without being offered tioning.  Perviewed on 7/13/16, at 1:22 R122's care plan indicated urs to meet her needs." LPN-B e the last three day data to document bowel and I-B stated bowel and bladder tool was done quarterly and nges.  p.m. the DON was ted R122 should have offered nours.  on 7/13/16, at 7:09 a.m. for I-H removed R45's which was wet and had smear on it. NA-H washed front of 19ed gloves without washing or A-H dried R45's peri area and hout washing or sanitizing ed R45 to roll to left side. Soottom and then applied H started to apply a clean Surveyor ask NA-H if she was so bottom. NA-H said, "Yes." to check between R45's sa large amount of soft brown		14			
	PROVIDER OR SUPPLIER  //EW LUTHERAN HOI  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa and shook her head wanted to use the titime.  When interviewed of stated R122 was to hours and as needed would not be accept hours and 16 minut toileting and reposit  The LPN-B was integrated "toilet every two how was unable to locat collection tool used bladder habits. LPN three day collection with significant chair  On 7/13/16, at 1:59 interviewed and sta toileting every two how R45 was observed morning cares. NA- incontinence brief, of soft brown stool peri area then chan sanitizing hands. Na changed gloves wit hands. NA-H assist NA-H wiped R45's la barrier cream. NA- incontinence brief. Si done washing R45's Surveyor ask NA-H buttocks. There wa stool. NA-H cleaned	PROVIDER OR SUPPLIER  // IEW LUTHERAN HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 45 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 assisted R45 to roll to left side. NA-H wiped 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	PROVIDER OR SUPPLIER    245018   B. WING	PROVIDER OR SUPPLIER    245018   B. WING	PROVIDER OR SUPPLIER  ### Z45018  ### Z450	PROVIDER OR SUPPLIER  245018  245018  B. WING  TREW LUTHERAN HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 45  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 buttooks. There was a large amount of soft brown stool. NA-H cleaned the remaining stool, then

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURV COMPLETE	
		245018	B. WING _		07/14/20	16
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	DE THEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 314	removed gloves, ar applied a new income applied a new income of the property o	front of perineum. NA-H then and put new gloves on and antinence brief on R45.  66 p.m. NA-H entered R45's perine product was changed and back into wheelchair. R45's perine related back into wheelchair. R45 was at risk for pressure perine related back into matteress and a regular schedule of any incontinence CAA (27/15, indicated R45 was of urine related to neurogenic bladder sensation and control, herves through injury or ble sclerosis and needed	F 31	4		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		245018	B. WING		07	/14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	R45's mobility care staff R45 had an almost Multiple sclerosis a Stand (a mechanica potential for alteration indicated R45 was to tissue tolerance cushion in wheelch incontinent episode doctor's order.  R45's potential for a plan dated 7/2016, repositioned accordassessment, provide episodes and apply order.  Undated Linden Tewas to be turned an hours.  The care plan and sheet do not mention refusing cares. The 7/6/16, instruct staffer sals to be chan R45's progress not do not indicate any During interview on said we change (R4 after brunch. When change and reposition indicate and reposition with the staffer said we change (R4 after brunch. When change and reposition indicate and reposition with the staffer said we change and reposition and staffer said we change and reposition with the staffer said we change and reposition and said we change and reposition with the staffer said we change and reposition and said we change and reposition with the staffer said and said we change and reposition and said we change a	glegs), and depression.  plan dated 7/2016, instructed teration in mobility related to nd staff were to use an EZ all lift) for transfers. R45's on in skin integrity care plan to be repositioned according assessment, have a foam air, provide peri care after and apply barrier cream per alteration in skin integrity care indicated R45 was to be ding to tissue tolerance le peri care after incontinent abarrier cream per doctor's  am # team Card indicated R45 and repositioned every two  nursing assistant assignment on R45 having any history of Physician's Orders dated for to document on resident ged every shift. Review of the strong from 7/11 through 7/14/16, refusals to be changed.  7/13/16, at 12:37 p.m. NA-H as) when we get (R45) up and asked how frequently staff ion R45 out of the wheel chair NA-H responded "two times,	F 314			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245018	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEA COLUMBIA HEIGHTS, MN 55421	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	During interview on said (R45) was to be and as needed. R4 (R45) was changed repositioned.  During interview on said (R45) was to the hours. LPN-C said have expected ther 9:00 a.m. and 11:00.  During interview on said, "I would expediaccording to the carefuses, the nursing the nurse."  Turning and Repos Procedures revised "Tuning [sic] and Reis to be completed and with significant."	7/13/16, at 1:29 p.m. RN-E to changed every two hours is likes to sit up so, when I was when (R45) was  7/13/16, at 1:31 p.m. LPN-C turn and reposition every two if changed at 7 a.m., "I would in to do a change (R45) about	F3	14		
F 315 SS=D	observation of sacrother pressure points same position. To be down positions. If reinterval the resident repositioned every present a 2 hours than drepositioned every 483.25(d) NO CATHRESTORE BLADD.  Based on the resident assessment, the factors and repositioned every 483.25(d) NO CATHRESTORE BLADD.	um, coccyx,buttock and any its at 1-hour after being in the se done in the sitting and lying edness occurs at the 1-hour to needs to be turned and one hour. If no redness is nen resident must be turned very 2 hrs [hours]."  HETER, PREVENT UTI,	F 3	15		8/31/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING	·····	07/-	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	CODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 315	resident's clinical c catheterization was who is incontinent of treatment and servinfections and to refunction as possible.  This REQUIREMED by: Based on observareview, the facility fimplemented for time (R122) reviewed for Findings include:  R122 was continued from 7:14 a.m. throwere observed whe incontinent of urine completed R122 wand placed next to Evergreen Hallway wheelchair until 10 taken to an activity  Upon request at 10 to her room and off hours and 16 minutil	is not catheterized unless the ondition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder e.  NT is not met as evidenced tion, interview, and document failed to ensure services were nely toileting for 1 of 1 resident or toileting.  Soulys observed on 7/13/16, bugh 10:30 a.m. Morning cares en R122 was observed to be a After morning cares were as wheeled into the hallway the medication cart in . R122 remained seated in the :30 a.m. at which time she was	F3	,	e that each receives are in s. continence y August 12th. This deficient incontinent eted upon ith any DS.  d Procedure me was a gust 10th. This is of assessing e needs, and re in	
	5/24/16, indicated assistance with act			All staff will be re-educated policies and procedures by	August 25th.	
		cer Care Area Assessment 5, indicated frequent		Audits for incontinence care completed weekly for four v		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245018	B. WING _	<del></del>	07/1	14/2016
	ROVIDER OR SUPPLIER	иЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	dementia and limite indicated R122 requand staff to provide  The care plan dated to be toileted every  When interviewed on ursing assistant (Nother last time R122 with ad not had the time was aware R122 withours.  When interviewed of licensed practical net to be offered toileting needed per the care acceptable for R122 minutes without being LPN-B was interviewed confirmed R122 every two hours to extend the confirmed R122 every two hours to extend the confirmed R123 every two hours to extend the confirmed R124 every two hours to extend the confirmed R125 e	wel and bladder related to ad mobility. R122's CAA uired assistance with toileting peri-care as needed.  d 12/2015 indicated R122 was two hours.  on 7/13/16, at 1:00 p.m.  NA)-A stated she was aware of was toileted and stated she e to check on R122. NA-A as to be toileted every two  on 7/13/16, at 1:15 p.m.  urse (LPN)-A stated R122 was ag every two hours and as e plan, and it would not be 2 to go three hours and 16 ng offered toileting.  wed on 7/13/16 at 1:22 p.m. 2's toileting plan was "toilet meet her needs." LPN-B beet there would attempt to into the bathroom, depending	F 31	then scheduled periodically thereaf the Director of Nursing based on auresults.  Outcomes and results from these awill 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	udit	
F 334 SS=E	483.25(n) INFLUEN IMMUNIZATIONS	NZA AND PNEUMOCOCCAL	F 33	44		8/31/16
	ino idomi, madi do	Table benefits and procedured				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	07/14/2016	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 554	CODE ORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 334	each resident, or the representative receivements and potentimmunization; (ii) Each resident is immunization Octo annually, unless the contraindicated or immunized during (iii) The resident or representative has immunization; and (iv) The resident's documentation that following:  (A) That the resident or representative was the benefits and point immunization; and (B) That the resident influenza immunization on the facility must detait ensure that (i) Before offering to immunization, each legal representative the benefits and point immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contraint already been immunization already been immunization.	the influenza immunization, he resident's legal sives education regarding the tial side effects of the soffered an influenza ber 1 through March 31 the immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse medical record includes the indicates, at a minimum, the ent or resident's legal provided education regarding offential side effects of influenza the entitle received the ation or did not receive the ation due to medical refusal.  Evelop policies and procedures the pneumococcal of resident, or the resident's the receives education regarding offential side effects of the soffered a pneumococcal side the immunization is dicated or the resident has	F 3:	34			

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		07/14/2016		
	NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1444 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 334	immunization; and (iv) The resident's in documentation that following:  (A) That the resident representative was the benefits and population of the pneumococcal immunities that the pneumococcal immunication or (v) As an alternative and practitioner recogneumococcal immunication, unle	the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F 334				
	by: Based on interview facility failed to ens were offered to 2 o whose immunization addition, the facility for Pneumococcal Conjugate Vaccine Centers for Disease Finding include:	NT is not met as evidenced and document review, the ure pneumococcal vaccines f 5 residents (R56, R173) on records were reviewed. In failed to develop guidelines PCV (Pneumococcal )-13 as recommended by the e Control (CDC).		It is the Policy of Crest View Luthera Home to offer, gain consent, and administer the appropriate pneumocimmunizations, per current CDC guidelines, for the residents we serv For residents R56 and R173, conservation and administer the pneumococcal vaccing was obtained and administration was scheduled by August 12th.  For all other residents that this defice	re.  nt to nes s		
		Immunization records revealed		practice may have affected, a	ICIIL		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/-	14/2016	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421	DE THEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 334	Continued From pa	ige 53 ceived pneumococcal	F 334	whole-house audit was cond	icted to		
	polysaccharide vac	cination (PPV-23) on 11/13/98. ation the PCV-13 had been		determine which residents had not received the vaccination (who hadn't, consent forms wheir responsible parties. In a	ad and had s). For those ere given to ddition, the		
received a PPV-23 on 5/10/06 repeated again on 5/19/15, ho record lacked evidence the re offered the PCV-13 vaccination by the CDC.		Immunization records revealed on 5/10/06, which was 5/19/15, however, the medical ence the resident was also a vaccination as recommended		standing house orders for pn vaccinations were ordered in up-to-date with current CDC Letters were then sent to all rephysicians detailing the upda house orders, and to request immunization records for the residing in our facility.	order to be guidelines. residents' ted standing previous		
	(RN)-A who was re infection control pro facility had not impl	5 a.m. a registered nurse sponsible for the facility's ogram acknowledged the emented the use of PCV-13, in their pneumococcal policy.		The Pneumococcal Vaccination and Procedure for Crest View Home was reviewed and upon interdisciplinary team on Aug policy includes the current CI	v Lutheran lated by an ust 10th. This		
	11:54 a.m. "I really the pneumovax gui me."	sing stated on 7/14/16, at do not know anything about deline changes. It is new to		and administration recomme All staff responsible for pneur administration, consent, or tra- be re-educated on these poli- procedures by August 25th.	ndations. mococcal acking, will		
	interview with RN-A received PPV-23 va 5/19/15, but there valso received the P verified R56 had pr when hospitalized p	7 p.m. during a follow up A, she confirmed R173 had accinations on 5/10/06 and was no record the resident had CV-13 vaccination. RN-A eviously declined PPV-23 prior to admission, but there resident was offered		Audits for pneumococcal vac administration will be comple for four weeks, and then sche periodically thereafter by the Nursing based on audit resul Outcomes and results from the	ted weekly eduled Director of ts.		
	The facility's 8/13, I policy directed staff be offered a pneum	Pneumococcal Vaccination as follows: "Each resident will nococcal immunization, unless medically contraindicated or		will be brought to the facility's quarterly QA meeting for revi  The Director of Nursing will b responsible for compliance.  Compliance date: 8/31/2016	ew.		
		ready been immunized." The		3011plia1100 date. 0/01/2010			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07/14/2016	
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 334		ge 54 I not incorporate the new CDC e residents were offered timely	F 334	ı		
F 425 SS=D		RMACEUTICAL SVC - EDURES, RPH	F 425	5	8/31/16	
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn law permits, but onl supervision of a lice.  A facility must provide (including procedura acquiring, receiving administering of all the needs of each realicensed pharmace).	art. The facility may permit el to administer drugs if State y under the general ensed nurse.  de pharmaceutical services es that assure the accurate , dispensing, and drugs and biologicals) to meet esident.  apploy or obtain the services of eist who provides consultation er provision of pharmacy				
	by: Based on observat review the facility fa accurate administra	NT is not met as evidenced ion, interview and document iled to ensure safe and ation of a prescribed 2 residents (R122) observed of morning cares		It is the Policy of Crest View Luther Home to administer necessary medications and treatments, by a linurse, to all residents.  For resident R122, all medications treatments will be administered by licensed nurse. This includes her	censed	

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 tolleting 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 role dedened 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 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-e-ducated 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			DATE SURVEY COMPLETED	
CREST VIEW LUTHERAN HOME  CAUMMARY STATEMENT OF DEFICIENCIES (ACHO DEFICIENCY MUST BE PRECEDED BY PILL PREFIX TAG)  FACE  FACE  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 tolieting 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 in 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 a nurse.			245018	B. WING		07/1	4/2016
FREETX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 it was medication to apply to the red bumps on R122's force 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 1:2-27 p.m., the consulting pharmacist (Rph) stated that the hydrocortisone should be applied by an nurse.			ME	4	1444 RESERVOIR BOULEVARD NORTHEAS		
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The Rph had written a recommendation to the primary physician regarding the long-term use of the hydrocortisone cream  F 441 483.65 INFECTION CONTROL, PREVENT F 441 8/31/16		R122's Admission I indicated R122's di and adult failure to Minimum Data Set primary screening a 5/24/16, indicated t assistance with toil Interview of Mental 6/2/16. R122 score severe cognitive im During observation nursing assistant (N paper medication of stated that it was moumps on R122's finurse gives the creapply. NA-A was observed to R122's Physician C hydrocortisone 1% reddened areas on resolved  When interviewed director of nursing a nurse to apply the R122's face. The Dunacceptable for it  When interviewed of consulting pharmachydrocortisone shood The Rph had writte primary physician rethe hydrocortisone	Record printed 7/14/16, agnoses included dementia thrive. R122's quarterly (MDS) (a standardized, and assessment tool) dated hat R122 required extensive eting and repositioning. A Brief Status (BIMS) was done on d five out of 15 that indicated pairment.  on 7/13/16, at 7:14 a.m., NA)-A was observed to have a up with white cream in it. NA-A nedication to apply to the red ace. NA-A stated that the am to the nursing assistants to be served to apply the white red bumps on her face.  Orders dated 4/26/16, read: (percent) apply lightly to face one time daily until  on 7/13/16, at 1:59 p.m. the (DON) stated that she expects hydrocortisone cream to DON also stated it was to be applied by NA.  on 7/14/16, at 12:27 p.m., the cist (Rph) stated that the uld be applied by an nurse. In a recommendation to the egarding the long-term use of cream		The Application of Prescription Top Ointments Policy and Procedure for View Lutheran Home was reviewed updated by an interdisciplinary teat August 10th. This policy states that 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 proby August 25th.  Audits for staff knowledge on medicand treatment administration will be completed weekly for four weeks, then scheduled periodically thereat the Director of Nursing based on a results.  Outcomes and results from these 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	cedure ication e and fter by audits	8/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING		07	07/14/2016	
	NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP COI 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 441 SS=F	Infection Control Pr safe, sanitary and of to help prevent the of disease and infer (a) Infection Control The facility must est Program under whi (1) Investigates, con in the facility; (2) Decides what pushould be applied to (3) Maintains a reconstruction related to in (b) Preventing Spres (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable disest from direct contact direct contact will tr (3) The facility must hands after each dith and washing is incorprofessional practical (c) Linens Personnel must has	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.  I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections.  The add of Infection in Control Program esident needs isolation to of infection, the facility must interest prohibit employees with a rease or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 4	141			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
		245018	B. WING		07/:	07/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	240010		STREET ADDRESS, CITY, STATE, ZIP C		14/2016	
	/IEW LUTHERAN HO	ME		4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 441	by:	age 57  NT is not met as evidenced v and document review, the	f 44	It is the Policy of Crest View	w Lutheran		
	facility failed to dev program to include ongoing tracking an antibiotic resistance infection. This defice to affect all 112 res facility. In addition thand hygiene was rooms. This had the who received room failed to ensure app	elop the infection control surveillance for infection, and analysis, and tracking of the to prevent the spread of sient practice had the potential idents who resided in the the facility failed to ensure completed in 1 of 4 dining the potential to affect 8 residents trays. Furthermore facility propriate hand hygiene and of 1 resident (R45) observed		Home to establish and mair Infection Control Program to provide a safe, sanitary, a comfortable environment and transmediseases and infections by and employees.  It is also the Policy and Procest View Lutheran Home appropriate hand washing a changing, per current CDC  For all residents that the de	ntain an hat is designed and nd to prevent mission of both residents  cedure of to practice and glove guidelines.		
	and analyze illness developed within the of a resident admitt unclear from facility and types of infection the facility, and for unit were on one or Findings include:			control program may have a tracking log for all resident a infections was created and This log will be used to mor analyze infections and their trends throughout the facilit from the infection control procommunicated during all fut QA committee meetings.	affected, a new and employee implemented. nitor and potential y. Outcomes rogram will be ture quarterly		
	The facility's infecti 6/16, were reviewe numbers of resider diseases, such as pneumonia, celluliti Total number of reswere recorded. The information to dete lacked resident naronset of infection, s	on control logs from 1/16 to d. The log included total hts with various infection urinary tract infection, is (skin infection), wounds. sidents per unit each monthe log, however, lacked enough rmine an analysis. The logs me and room number, date of symptoms, reoccurance, and is well as other pertinent		For resident R45, proper had and glove use will be used I members that perform her of the form all other residents that the handwashing and glove charmay have affected, Handwashing and Procedure, along with the Policy and Procedure for Colutheran Home were review updated by an interdisciplin	by all staff care.  the deficient anging practice ashing Policy the Glove Use rest View wed and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	information. One ridentified as having on-going w/ [with] rone resident had "eadditional informati" "groin" with no add regarding residents reflect the type of pacterial, viral, etc. During an interview registered nurse (Fcontrol logs were rothe facility four cas One resident was at the rest were acquisay if the one resident acquisate in-house acquired could not state that surveillance systems pread of the pnen During an interview RN-A explained the control program. Responsible for the assistance from a lack the information to determine the control Log. She logor trends. If trends DON and gave her then took the information to determine the control Log. She logor trends. If trends DON and gave her then took the information to determine the control Log. She logor trends. If trends DON and gave her then took the information to determine the control Log. She logor trends. If trends DON and gave her then took the information to determine the control Log. She logor trends. If trends DON and gave her then took the information to determine the control Log. She logor trends are the control to the control Log. She logor trends are the control to the c	esident on Linden was a a wound/incision that read, "1 no stop date." On Evergreen elevated temp" with no ion, and another resident itional information. Information with pneumonia did not oneumonia such as aspiration, on 7/14/16, at 9:20 a.m. a RN)-A the July 2016 infection eviewed. The logs indicated es of pneumonia on one unit. admitted with pneumonia and ired in-house. RN-A could not lent came in with it and the the uired from that one resident. idence of dates or any other rmine the cause of the three pneumonia. RN-A stated she a from looking at her if they had an in-house	F 441	August 10th. These policies descorrect procedures for washing changing gloves by all staff mental All staff will be re-educated on the policies and procedures by August Audits for handwashing, glove uperi-care will be completed wee weeks, and then scheduled perithereafter by the Director of Nurbased on audit results.  Outcomes and results from these will be brought to the facility's nequarterly QA meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 8/31/2016	hands and nbers. nese ust 25th. use, and kly for four odically sing		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING _		07	/14/2016	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	,	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	amount of urinary tand ask the charge residents about per nursing reports to or resolving. "I do not an antibioticI just the logs did not spepertinent informatio organism/illness, wfacility, when symp whether antibiotics changed, etc.  The DON explained 12:32 p.m. that after the infection control information to qualicommittee for reviet the information and gave it to the medicares and an environment infections in our resident infections documentation of in and Surveillance of environmentpreviet shall be as recomn Disease Control [Control of the nursing practice." Linden Unit On 7/11/16, at 4:52 looked on the floor after a resident had	and if I notice an increase in ract infections, I educate staff a nurse to educate any female ricare." She also looked at determine if symptoms were track at all for anyone not on look at trends." RN-A verified ecify resident names and on such as the actual rhether it was aquired at the toms started or resolved, were effective or were  d in an interivew on 7/14/16, at er she received the data from all nurse she took the ity improvement (QI) ew. The QI committee reviewed d looked for patterns and then call director for review.  6, Infection Prevention and the purpose was "To provide comment which prevents sidentsSurveillance of including review of antibiotics, infections and analysis of data	F 44				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING			07/ <sup>-</sup>	14/2016
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAS 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	dinning area and ca and laid both on the asked by R78 to pic right next to the who observed bend ove the napkin which wo off the floor took it to window. NA-F used inward tossed the refood rack and obset the steam table and washing his hands, observed touch the on the cart by the nofe the four ounce do the juice machine at the rims of the glastander of the floor. At 4:56 p.m. when trays off the rack to intervened. NA-F and washed his hands and off the floor. At 5:00 p.m. after we hands and attempte room at this time standard gotten different use the same tray of dietary supervisor we trays and asked NA trays alone.	ge 60 d go into the linen closet by the ame out with two wash towels a puddle. Then NA-A was a ck a napkin she had dropped eelchair for her. NA-F was a rand with bare hands picked as soiled with brown sputum of the garbage can by the both hands to push the liphapkin then and returned to the rived proceed to get food from diset the room trays without As NA-F set the trays was drinking glass covers stacked ursing desk; touched the rims rinking glasses went over to and obtained juice still holding ses with the soiled hands.  NA-F was picking one of the bring to the room, surveyor cknowledged he had not after picking the soiled napkin washing his hands NA-F came a had set up with the soiled ed to bring the trays to the covers and was just going to of food set up. At this point the was observed set different and the covers and was just going to of food set up. At this point the was observed set different and the covers intervening. When the proceed the contaminated are the point was DON stated she was been as DON stated she to have washed hands.	F	141			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	observed for R45. I gloves and remove upper body. NA-H r gloves without wash dressed R45's upper incontinence brief, of soft brown stool peri area then chansanitizing hands. Nachanged gloves with hands. NA-H assist NA-H wiped R45's barrier cream. NA-H incontinence brief. I done washing R45' Surveyor ask NA-H buttocks. There wastool. NA-H cleaned using same gloves perirectal area then then removed glove applied a new incoput ted hose, pants  R45's Quarterly Mir 4/9/16, indicated R45 was and bladder and at development. MDS included multiple so the covering of the interfering with impophysical, mental and	a.m. morning cares were NA-H washed hands put on d R45's gown and washed removed gloves put on new hing or sanitizing hands. NA-H er body. NA-H removed R45's which was wet and had smear on it. NA-H washed front of ged gloves without washing or A-H dried R45's peri area and hout washing or sanitizing red R45 to roll to left side. bottom and then applied H started to apply a clean Surveyor ask NA-H if she was so bottom. NA-H said, "Yes." to check between R45's a large amount of soft brown defined barrier cream to a to front of perineum. NA-H es, and put new gloves on and ntinence brief on R45. NA-H and shoes on R45.  Inimum Data Set (MDS) dated the sassistance of one staff read and to illeting. MDS frequently incontinent of bowel risk for pressure ulcer indicated R45's diagnoses belerosis (a disease in which nerves are damaged, ulse conduction resulting in d sometimes psychiatric regia (paralysis of the lower	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		245018	B. WING		07	/14/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542		CODE ORTHEAST	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	said, "I normally we my gloves." NA-H hands when startte using sanitizer. NA same glove to app bottom and then to area.  During interview or stated expected st contact with a resire removing gloves, if been to the bathrous change gloves and after cleaning up sare allowed to put change gloves and touching anything apply barrier creamental area and the apply barrier creamental area.  The undated Incomstaff to explain to metal area.	n 7/13/16, at 12:37 p.m. NA-H ash my hands when I remove acknowledged only washed ed and was done. NA-H denied A-H acknowledged used the lay barrier cream to R45's at R45's front, including perion 7/14/16, at 9:47 a.m. RN-A aff to wash hands; before dent, after contact, when f handling trash, if staff has om. When asked are staff to d wash or sanitize their hands tool? RN-A responded, Staff incontinence product on then d wash or sanitize hands before else. RN-A said the staff cannot m with a glove hand to the en use the same gloved hand to n to the perineal area. RN-A go front to back always, do not they are done with the front."  n 7/14/16, at10:56 a.m. DON ash or sanitize hands before d any time staff change gloves, uch someting dirty. DON said when applying barrier cream to inty; from the peri area to the other can be according to the control of the control of the perineal area. It further	F 44				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	` '	TE SURVEY MPLETED
		245018	B. WING	· · · · · · · · · · · · · · · · · · ·	07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	ODE ORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	at bed side.  8. Wet disposable Apply soap or use 9. Wash genital ard meatus back towal with fingers to clead 10. Wash entire but body part that is so 11. Using same dis residents's skin that 12. Dry the skin wed disposable washold 13. Apply clean dia 14. Assist in redrest as necessary. 15. Change necest linen in hamper. 16. Prompt and that chairs, mattress, esoiled. 17. Remove supplial 18. Document prov NA/R book." Policy lacked direct change gloves or partizing when prov Hand Washing Pol 2/08, instructed state Sanitizing must be a. Before contact we residents c. Before touching given to residents. d. Before and after	diaper and place in diaper pail, washcloth with warm water. peri-wash spray ea, washing from urethral rd anal area. Separate labia nse area well. attock area and any additional biled. Sposable wshcloth, rinse broughly. Ell with the second clean oth. aper and other linen as needed. Sposable with rinen as needed. Sposable with the second clean oth. Apper and other linen as needed. Sposable with rinen as needed. Sposable with the second clean other. Sposable with the second clean other linen as needed. Sposable with the second clean clothing, was a sposable with the second clean of the sposable wit	F 44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245018	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	МЕ		STREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	)E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 441	contaminated with I h. After caring for a infection. i. After going to the covering a sneeze a	loves bything that may have been blood or bodily fluids. resident with an active bathroom, nose blowing,	F4	41		

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245018 B. WING 07/14/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4444 RESERVOIR BOULEVARD NORTHEAST **CREST VIEW LUTHERAN HOME COLUMBIA HEIGHTS, MN 55421** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**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.

Facility ID: 00005

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING <b>01 - MAIN BUILDING 01</b>		re survey MPLETED
		245018	B. WING		_ 07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 4444 RESERVOIR BOULEV COLUMBIA HEIGHTS, M	ARD NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INF  1. A description of to correct the defice  2. The actual, or push and responsible for comprehent a reoccurrent and responsible for comprehent a reoccurrent with a partial base constructed in 1960 Construction types of Type II (111) and basement. The bull protected. The fact system with smok spaces open to the	DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	KO	00		
K 014 SS=C	has a licensed cap census of 110 at to The requirement a NOT MET as evid NFPA 101 LIFE So Interior finish for mexposed interior s fixed or movable to ceilings has a flan Class B. Interior fit December 17, 20 wall and ceilings to 1/28 inch shall be	pacity of 122 beds and had a he time of the survey.  at 42 CFR Subpart 483.70(a) is	K	014		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245018	B. WING_		07/	14/2016
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	CODE ORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 014	This STANDARD in Documentation reverseled that facility documentation of finishes in egress with 101 (LSC) 19.3.3.1 practice could effect Findings Include:  On a facility tour be and 01:00 PM on Jurevealed that there flame spread rating passageways.	B.3.2, NFPA TIA 00-2 s not met as evidenced by: view and staff interview y did not maintain lame spread ratings for interior vays in accordance with NFPA , 19.3.3.2 This deficient	K 0*	It is the policy of Crest Vie Home to have documented ratings for all interior finish egress, including exposed surfaces of buildings such movable walls, partitions, of ceilings at a rating of Class.  All interior finish, for mean flame spread ratings were the manufacturers and con Crest View uses. All of the spread ratings are now lock Safety book, maintained be Environmental Services. The achieved by August 12th 22 For all additional finishes the into the building in the future has been created to ensure spread ratings are captured documented.	d flame spread for means of interior as fixed columns, and s A or Class B. s of egress, obtained from ntractors that ese flame cated in the Fire by the Director of his was 2016. that are brought are, a checklist re these flame	
K 015 SS=C	Interior finish for ro corridors or exitway surfaces of building walls, partitions, co- flame spread rating fully-sprinklered bu Class C may be co-	AFETY CODE STANDARD  coms and spaces not used for ys, including exposed interior gs such as fixed or movable plumns, and ceilings has a g of Class A or Class B. (In illdings, flame spread rating of continued in use within rooms dance with 19.3.6 from the exit	ΚO	The Director of Environment his designee will be responsible to compliance. Date of Correction: 8/12/1	nsible for	8/12/16

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATI	E SURVEY PLETED
1445 OF 5	DOLUBER OF CURRULES	245018	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	14/2016
IAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				4444 RESERVOIR BOULEVARD NORTHEA COLUMBIA HEIGHTS, MN 55421	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 015	Documentation revealed that facilit documentation of f finishes in areas no accordance with NI 19.3.3.2. This deficit 110 residents.  Findings Include:  On a facility tour be and 01:00 PM on J revealed that there flame spread rating.	19.3.3.1, 19.3.3.2 s not met as evidenced by: view and staff interview	K 01	It is the policy of Crest View Luth Home to have documented flame ratings for all interior finish for rospaces.  All interior finish flame spread ratwere obtained from the manufact and contractors that Crest View of these flame spread ratings are 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 into the building in the future, a chas been created to ensure these spread ratings are captured and documented.  The Director of Environmental Schi designee will be responsible frompliance. Date of Correction: 8/12/16.	e spread oms and ings turers uses. All e now s e brought hecklist e flame	
K 046	Emergency lighting	FETY CODE STANDARD  of at least 1 1/2 hour duration tically in accordance with 7.9.	K 04			8/12/16
	18.2.9.1, 19.2.9.1. This STANDARD Based on docume the facility failed to lighting in accordar	is not met as evidenced by: nt review and staff interview, provide adequate emergency nce with LSC (00) 19.2.8. This an effect all 110 residents.		It is the policy of Crest View Lutl Home to provide effective and sa lighting.	afe,	
	Findings include: On a facility tour be	etween 09:00 AM and 01:00		The battery operated emergency was removed and capped off. Al are backed up by a generator, as battery operated emergency ligh	l lights nd the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245018	B. WING		07/	14/2016
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP C 1444 RESERVOIR BOULEVARD NOI COLUMBIA HEIGHTS, MN 5542	RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	there was no document annual test for batter egress lighting.  This deficient pract Administrator at the NFPA 101 LIFE SA All required smoke activating door hole maintained, inspect with the manufacture This STANDARD Based on document facility has not testing of the smokesystem in accordant 7-3.2.1. This deficitive residents.  Findings include:  On a facility tour be PM on July 14, 20 the facility could not smoke detector see This deficient prace	6, observation revealed that mentation of a 90 minute ery operated emergency  cice was verified by the etime of inspection.  JEETY CODE STANDARD  detectors, including those depopen devices, are approved, ted and tested in accordance erer's specifications. 9.6.1.3 is not met as evidenced by: int review and staff interview, been conducting sensitivity the detectors on the fire alarm ance with NFPA 72 (99), Sec. ent practice could affect all 110 etween 09:00 AM and 01:00 left, observation revealed that of documentation for a current	K 046	not necessary. Therefore, n light testing will need to occur This was achieved by August The Director of Environmen hi designee will be responsi compliance.  Date of Correction: 8/12/16	v Lutheran testing on all alarm system. testing was c on July 18th, ally by their theran Home. ived in the Fire of Life arly to ensure being tested atal Services or ible for	
K 056 SS=F	Where required by	AFETY CODE STANDARD  section 19.1.6, Health care rotected throughout by an	K 05			8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED	
		245018	B. WING,		07/	14/2016	
	NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP ( 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	RTHEAST	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
K 056	in accordance with systems are equipy switches which are the building fire ala construction, altern shall be permitted in protection in specific regulations prohibit NPFA 13  This STANDARD Based on observal automatic sprinkler maintained in accostandard for the In 1999 edition. The system in compliar allow system being decrease in the fire the event of an em 110 residents.  Findings include:  On a facility tour be and 01:00 PM on Journal of the complete in the complete in the system or that calibrated.  This deficient practice.	sed automatic sprinkler system section 9.7. Required sprinkler sed with water flow and tamper electrically interconnected to	KO	It is the policy of Crest Vie Home that the automatic s is maintained in accordance the Standard for the Sprink 1999 edition.  Current annual automatic s inspections now include a internal pipe inspection. In gauges were replaced. This completed by Mayer Electronal An audit has been created five-year internal sprinkler inspections at Crest View In The Director of Environme his designee will be response compliance.  Date of Correction: 8/12/16	prinkler system e with NAPA 13 der Systems sprinkler system five-year addition, s work was ic on 7/26/16. to track the pipe utheran Home. ntal Services or sible for		

F5018029

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG <b>02 - 2007 ADDITION</b>		E SURVEY MPLETED	
		245018	B. WING_		07/	07/14/2016	
	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	ALLEGATION OF DEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CM VERIFICATION OF UPON RECEIPT OF ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HAD ACCORDANCE WAS A Life Safety Code Minnesota Department of this survey Building 1 was four compliance with the in Medicare/Medica 483.70(a), Life Safedition of National (NFPA) Standard 1 Chapter 18 New HAD PLEASE RETURN CORRECTION FOR DEFICIENCIES TO Healthcare Fire Instate Fire Marshal 445 Minnesota St., St. Paul, MN 5510	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.  OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.  Survey was conducted by the ment of Public Safety, State on on July 14, 2016. At the Crest View Lutheran Home, and not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), ealth Care.  THE PLAN OF OR THE FIRE SAFETY D: spections Division Suite 145	K 00		C		
	By email to: Marian.Whitney@s Angela.Kappenma					(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Facility ID: 00005

(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 A, BUILDING 02 - 2007 ADDITION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING	<u> </u>	07	/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	ΚŒ	000		
		PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or p	roposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.				
	with a partial base constructed in 196 Construction typed of Type II (111) and basement. The buprotected. The fac system with smoke spaces open to the automatic fire departs a licensed cap	an Home is a 2-story building ment. The building was 4 with an addition in 1968. It is II (111). The 2007 edition is d is a 1-story building with a ilding is fully fire sprinkler ility has a complete fire alarm a detection in the corridors and a corridor, that is monitored for artment notification. The facility bacity of 122 beds and had a ne time of the survey.				
	NOT MET as evide	t 42 CFR Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K	014		8/12/16
SS=C	exposed interior some fixed or movable with ceilings has a flame Class B. Lower has exceeding 4ft in he flame spread ration NFPA TIA 00-2	neans of egress, including surfaces of buildings such as valls, partitions, columns, and the spread rating of Class A or lif of corridor walls, not eight, may have a Class C g. 10.2, 18.3.3.1, 18.3.3.2; is not met as evidenced by:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION IG <b>02 - 2007 ADDITION</b>		(X3) DATE SURVEY COMPLETED 07/14/2016	
		245018	B, WING		07 <i>l</i>		
	NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  4444 RESERVOIR BOULEVARD NORTHEAST  COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
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.						
	and 01:00 PM on J revealed that there	etween the hours of 09:00 AM luly 14, 2016, observation was no documentation of the gs for finishes in egress					
K 015 SS=C	Administrator at the NFPA 101 LIFE SA Interior finish for recorridors or exitwa	tice was verified by the etime of inspection.  AFETY CODE STANDARD for yes, including exposed interior gs such as fixed or movable	K 0 <sup>2</sup>	15		8/12/16	
	flame spread rating (Rooms not over 4 persons in capacitating of Class A, Class A, Class A, Class Class A, Class C	olumns, and ceilings has a g of Class A or Class B.  city may have a flame spread Class B, or Class C). 18.3.3.1,  is not met as evidenced by: view and staff interview by did not maintain clame spread ratings for interior of used as exit passageways in FPA 101 (LSC) 18.3.3.1,		It is the policy of Crest View Home to have documented for ratings for all interior finish for spaces.	lame spread		
		cient practice could effect all		All interior finish flame spread were obtained from the manuand contractors that Crest Vi of these flame spread ratings located in the Fire Safety body	ufacturers lew uses. All s are now		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( ·-/ ····	TIPLE CONSTRUCTION NG <b>02 - 2007 ADDITION</b>		SURVEY PLETED
		245018	B. WING		07/-	14/2016
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, 4444 RESERVOIR BOU COLUMBIA HEIGHTS	STATE, ZIP CODE LEVARD NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 015	and 01:00 PM on a revealed that there flame spread rating.  This deficient prac	age 3 etween the hours of 09:00 AM July 14, 2016, observation e was no documentation of the gs for finishes in corridors  tice was verified by the e time of inspection.	K	maintained by the Environmental Stachieved by Augustin For all additional into the building it has been created spread ratings and documented.  The Director of E	ervices. This was ust 12th 2016.  finishes that are brought in the future, a checklist d to ensure these flame re captured and  Environmental Services or be responsible for	
K 054 SS=F	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.		K	It is the policy of Home to conduct smoke detectors.  Smoke detector completed by Matand will be company for Creater These sensitivities Safety Book by the Enrichment.	f Crest View Lutheran It sensitivity testing on all Is on the fire alarm system. Is sensitivity testing was ayer Electric on July 18th, Deted annually by their Test View Lutheran Home. Test Siew Lutheran Home. The Director of Life Impleted yearly to ensure Sivities are being tested Siew Lutheran Home.	
		tice was verified by the etime of inspection.			Environmental Services or be responsible for	

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 02 - 2007 ADDITION COMPLETE			
		245018	B. WING			7/14/2016
	PROVIDER OR SUPPLIER	ME		44	REET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHEAST OLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
K 054	Continued From pa	age 4		054	compliance. Date of Correction: 8/12/16.	8/12/16
SS=F	in accordance with Installation of Sprin components, devic complete coverage Systems are equip switches, which are system. In Type I a protection measure substituted for sprin areas where State sprinklers. 18.3.5, This STANDARD is Based on observa automatic sprinkler maintained in acco Standard for the Insulation of	atic sprinkler system installed NFPA13, Standard for the akler Systems, with approved e and equipment, to provide of all portions of the facility. Ped with waterflow and tamper e connected to the fire alarm and II construction, alternative as shall be permitted to be akler protection in specific or local regulations prohibit 18.3.5.1. Is not met as evidenced by: tions and staff interview, the existence with NAPA 13 the stallation of Sprinkler Systems failure to maintain the sprinkler are with NAPA 13 (99) could applace out of service causing a protection system capability in ergency that could affect all etween the hours of 09:00 AM and 14, 2016, observation continuation does not indicate that a five aspection was performed on the guages were replaced or			It is the policy of Crest View Lutheran Home that the automatic sprinkler syste is maintained in accordance with NAPA 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 Hor The Director of Environmental Services hi designee will be responsible for compliance.  Date of Correction: 8/12/16	13 em

Event ID: KWZX21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 02 - 2007 ADDITION	COMPLETED
		245018	B. WING		07/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
K 056		page 5 etice was verified by the ne time of inspection.	K 056		



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Crest View Lutheran Home August 4, 2016 Page 2

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, Program Specialist

Licensing and Certification Program Health Regulation Division

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 09/07/2016 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST VIEW LIITHERAN HOME			ERVOIR BO A HEIGHTS	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	nether a violation has been compliance with all rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <a href="http://www.health.">http://www.health.</a>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 08/12/16

STATE FORM 6899 KWZX11 If continuation sheet 1 of 69

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016
CREST VIEW LUTHERAN HOME 4444 RE			, ,	STATE, ZIP CODE ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Department of Heal you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceed completion date, the corrected prior to el Minnesota Department's staff, the following correct Please indicate in y correction that you and identify the date. In addition, at the tircomplaint investigation of comfound to be substar investigation of comfound to be unsubstinguing the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag must be stated to minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag must be stated to the statement of the State Licensing federal software. The assigned tag must be stated to the statement of the State Licensing federal software. The assigned tag must be stated to the statement of the statement, evidence by." Follow the statement of the statem	oth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the ent of Health.  1/14/2016 surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, ewhen they will be completed.  The of the survey, two tions were conducted. An aplaint H5018107 which was utiated at 0265, and aplaint H5018109 which was	2 000			

Minnesota Department of Health

STATE FORM 6899 KWZX11 If continuation sheet 2 of 69

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST VIEW LITTHERAN HOME			ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	Time period for Cor	rection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Rule 4658.0089 Resident Health Sta	5 Notification of Chg in atus	2 265			8/31/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	C. a need to al	ter treatment significantly, for				

Minnesota Department of Health

STATE FORM 6899 KWZX11 If continuation sheet 3 of 69

_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00005	B. WING		07/1	4/2016
	CREST VIEW LUTHERAN HOME 4444 RES			STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 265	example, a need to of treatment due to begin a new form of the properties of the manner of the manner of the missed antibiotic of the missed antib	discontinue an existing form adverse consequences, or to f treatment; to transfer or discharge the tursing home; or ad unexpected resident deaths.  The tild unexpected resident deaths and document review, the principle of the physician for its doses ordered for 1 of 1 priewed for discharge.  The tild tild tild tild tild tild tild tild	2 265	CORRECTED		
	-2/12/16, 8:28 p.m.					

Minnesota Department of Health

STATE FORM 6899 KWZX11 If continuation sheet 4 of 69

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CREST VIEW LITTHERAN HOME			ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	ml by mouth four tir New admit medicat scheduled again at -2/18/16, 8:17 a.m. solution 50 mg/ml ga day for c-diff for 8 (LOA) -2/19/16, 9:45 p.m. solution 50 mg/ml ga day for c-diff for 8 time -2/20/16, 8:40 a.m. solution 50 mg/ml ga day for c-diff for 8 time.  On 7/14/16, at 1:49 pharmacist (CP) incincluding the antibiot to deliver on 2/12/1 usually would take arrive at the facility. the four o'clock Var doses on 2/18/16, at thought were missed an appointment. In 2/19/16, and 2/20/1 a.m. doses were m because nurses did stored in the refrige was no documental medication dosesAt 1:52 p.m. the C expected the staff the known about the mist directions of the medications	mes a day for c-diff for 8 Days. ion not here yet and 8pm. indicated Vancomycin HCl give 2.5 ml by mouth four times a Days out at leave of absence indicated Vancomycin HCl give 2.5 ml by mouth four times a Days not available at this indicated Vancomycin HCl give 2.5 ml by mouth four times a Days not available at this indicated Vancomycin HCl give 2.5 ml by mouth four times a Days not available at this indicated R164's medications of the had been scanned ready 6, at 8:00 p.m. and thought approximately an hour to CP verified R164 had missed acomycin on 2/12/16 and two at 8:00 a.m. and 12:00 o'clock and because R164 was out for addition, CP verified on 6, CP the 8:00 p.m. and 8:00 issed respectively probably I not know the medication was erator. CP further stated there the tion to explain the missed ocall the doctor and let them seed doses depending on the edication.  p.m. the DON stated she	2 265			
		urse to pass it on report. DON vould not answer, as she was				

Minnesota Department of Health

STATE FORM 6899 KWZX11 If continuation sheet 5 of 69

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00005	B. WING		07/1	14/2016
	PROVIDER OR SUPPLIER VIEW LUTHERAN HOI	4444 RES		STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	not aware of what he to call the doctor and decision."  On 7/14/16, at 2:06 practitioner stated of facility she never sa documentation indinotified her office of would include faxes stated she would had During review of all R164's medical rec 2/12/16 through the documentation was or NP had been upon antibiotic doses. Reforms completed by mention of R164's in The facility Administ directed:  "3. Medications munaccordance with the required time frame 10. For residents not unavailable to receit the MAR is "flagged stripes, drinking stracompleting the medication" The put the medication receit the staff were to be In addition the policities of the staff were supposed been missed.	p.m. via telephone the nurse during R164's brief stay at the aw resident and there was no cating the facility nurses had f the missed doses, which or phone documentation. NP ave expected to be informed.  the progress notes located in ords from admission on edischarge date on 2/20/16, a lacking to indicate the doctor dated about the missed eview of the medication error or the facility lacked any missed medications policy st be administered in eorders, including any	2 265			

Minnesota Department of Health

STATE FORM 6899 KWZX11 If continuation sheet 6 of 69

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	MIE	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
	develop policies an resident's represen changes in condition treatments. The DC all appropriate staff and monitor to ensure TIME PERIOD FOR	sing (DON) or designee could d procedures to ensure each tative is promptly notified of all n and/or changes in DN or designee could educate on the policies/procedures, ure ongoing compliance.  R CORRECTION: Twenty One				
	(21) Days.					
2 505	MN Rule 4658.0300 Restraints	) Subp. 1 A-E Use of	2 505			8/31/16
		ons. For purposes of this part, have the meanings given.				
	method or physical material, or equipm the resident's body remove easily whice movement or norm Physical restraints also included finition of a restration of a resident in wall that the wall prising. Bed rails are restrict freedom of used solely to assist help the resident go is not used as a reson clothing that trig	straints" means any manual or mechanical device, ent attached or adjacent to that the individual cannot in restricts freedom of al access to one's body. Include, but are not limited to, restraints, hand mitts, soft ties inchair safety bars. Physical de practices which meet the aint, such as tucking in a sheet dent confined to bed cannot airs that prevent rising; or in a wheelchair so close to a events the resident from the considered a restraint if they movement. If the bed rail is the resident in turning or to be to ut of bed, then the bed rail straint. Wrist bands or devices ger electronic alarms to warn is leaving a room or area do				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00005	B. WING	<del></del>	07/	14/2016
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 505	not, in and of thems movement and sho restraints.  B. "Chemical repsychopharmacolog discipline or convertreat medical symptor." "Discipline" nursing home for the penalizing a resider D. "Convenient solely to control restresident with a less in the resident's bear in the remarked procession of the penalizing a resider to control restresident with a less in the resident's bear in the resident's bear in the resident's penalizing a resident with a less in the resident with a less in the resident's penalizing a remarked procession of the resident's penalizing a remarked procession of the resident with a less in the resident's penalizing a remarked procession of the resident with a less in the resident action of the remarked procession of the rem	selves, restrict freedom of uld not be considered estraints" means any gic drug that is used for nience and is not required to toms.  means any action taken by the purpose of punishing or nt.  ce" means any action taken ident behavior or maintain a er amount of effort that is not interest.  measures" means the necessary to alleviate an in or sudden occurrence of a	2 505			
	by: Based on observati review, the facility for rails as a potential reviewed for failed to ensure a resoft 4 residents (R53 under the bottom slabarrier to getting out Findings include:  R25 was admitted to admission Minimum was completed on a cognitively intact and of one staff person	on, interview and document ailed to assess the use of side restraint for 1 of 3 residents accidents. In addition facility esident is not restrained for 2, R62) who had two pillows neets of their beds creating a at of bed.  To the facility on 2/1/15. An an Data Set (MDS) assessment 2/8/16, indicated R25 was ad required extensive assistive for bed mobility. The 2/8/16, urther indicated that restraints		CORRECTED		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 505	A 2/4/16, side rail as utilized a right grab utilize the grab bar.  R25's care plan dat of safety devices: 1, bar with side rail cur.  A 5/5/16, Safety Ris R25 was independe utilized a left and rig device for positionir  On 7/11/16, at 3:38 to have half side rail the bed. The right sloose.  On 7/12/16, at 2:23 observed to have hat right side rail loose.  On 7/12/16, at 2:59 (LPN)-C was asked rail and confirmed to loose. LPN-C stated process of a side rail would fill out a main side rail repaired or maintenance check should be tight fittin  A maintenance slip R25's "side rails looreplace" The maintenance.	ed 2/16/16, identified the use /2 side rails and a right grab shions.  Sk Assessment indicated that ent with bed mobility and ght grab bar as a physical ng.  p.m. R25's bed was observed ils on the left and right side of side rail was observed to be  p.m. R25's bed was again alf left and right side rails with ose.  p.m. licensed practical nurse about R25'S right half side hat the half side rail was d that the facility was in all audit. LPN-C stated that she of the nance slip to have the loose replaced. LPN-C stated that she is the side rails and that they	2 505	DEFICIENCY)		
		ls were replaced on 7/12/16.  3 p.m. R25's bed was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0171	4/2010
CREST	VIEW LUTHERAN HO	МЕ	ERVOIR BO	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 505	observed with both stated that the loos (7/12/16).  LPN-C was intervie and stated R25's sindicate the use of reviewed the 2/4/16 5/5/16, safety risk a plan with the surve assessment and ca of bilateral (left and did indicate the use that there should be side rails. LPN-C the R25's medical record to be completed on The director of nurry 7/13/16, at 2:08 p.r. plans should match determined approper A side rail assessment and findicate the use that there should be completed on The director of nurry 7/13/16, at 7:13 p.r. plans should match determined approper A side rail assessment in the	left and right side rails. R25 se rail was fixed yesterday  ewed on 7/13/16, at 1:21 p.m. ide rail assessment should two half side rails. LPN-C 6, side rail assessment, the assessments and R25's care yor and confirmed R25's are plan do not identify the use diright) half side rails, however ever of a grab bar. LPN-C stated the an assessment for two half then added a nursing order to ord for a side rail assessment in the evening shift of 7/13/16.  Issing (DON) confirmed on the evening shift of 7/13/16.  Is ing (DON) confirmed on the evening shift of maximum and care in what has been assessed and oriate for the resident's use.  In that indicated the use of ails for mobility.  In a.m. R25's bed was observed aide rail and a right grab bar. It is the did not know are and one half side rail. A stated that she did not know are came from as yesterday ide rails on her bed and that dicated that two half side rails.  C confirmed that there was a 25's bed and not two half side.	2 505			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	ΛF	SERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
2 505	was aware R25 had half side rails on he confirmed that two what was written or plan. The administr maintenance was a side rails put on R2 assessed on 7/13/1 confirmed that R25 corrected to reflect device R25 was util A facility policy entit Assessment" dated residents will be as process and as nee grab bars for positic self-mobility". The nurse would comple days of admission a updated annually, was needed. The pol assessment will be R53's quarterly MD was severely cognit assistance for bed transfers. The MDS but able to stabilize surface to surface the Assessment (CAA) risk for falls and indicated purelated cognitive destaff to use a body in the confirmation of the complete of	d a right grab bar and not two r bed. The administrator staff were trying to correct the assessment and care ator further stated that ware and there would be two 5's bed to match what was 6. The administrator then so care plan would also be what positioning and safety izing.  Iled "Side Bar/Grab Bar "3/10" indicated that "all sessed during the admission add for the use of side rails or oning or increasing policy further indicated that a lete the assessment within 7 and the assessment would be with a change in condition or icy also indicated the reviewed quarterly.  S dated 4/11/16, indicated she tively impaired and required mobility, toileting and indicated R53 was unsteady with staff assistance during a ransfer. A Care Area dated 1/21/16, identified a licated R53's care plan dated otential for alteration in safety ficits. The care plan directed	2 505			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CREST VIEW LIITHERAN HOME			ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST , MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 505	Continued From pa	ge 11	2 505				
	R53 was found on the 6/3/16. A progress of "body pillow has be"  During an observation R53 was lying in be of her bed was placed approximately four her right side. The put the mattress with the it. There was a fall of pressure alarm placed buring an observation of the first pressure alarm placed buring alarm placed buring an observation of the first pressure alarm placed buring an observation of the first placed buring an observation of the first	ion on 7/14/16, at 7:56 a.m.					
	hallway outside her (RN)-B responded to was sitting up in he the alarm. She state swinging her legs of sit on the side of the	be heard sounding from the room. Registered nurse to the alarm. RN-B stated R53 or bed when she responded to ed R53 was capable of ver the side of the bed and will be bed and attempt to stand.  R53 can be on the floor, we a body pillow."					
	nursing assistant (Ndirected her to use	on 7/13/16, at 8:54 a.m. IA)-I stated R53's care sheet a body pillow in bed. She by goes under the fitted sheet risk.					
		on 7/13/16, at 12:51 p.m., ody pillow keeps R53 from					
	RN-F stated, a body restraint if the resid stated she was awa	on 7/14/16, at 8:08 a.m., y pillow is not considered a ent is able to adjust it. She are the facility was using body ons for resident's who fall					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HO	ME	ERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 505	frequently but was being placed under RN-F stated, "If it p something they coucall it a restraint." Saware of an assess During an interview NA-J stated he alw under the fitted she he was trained to d specific. He stated done."  During an interview DON stated the fact define the edge of the body pillows under correct application. educated that it is resulted. R62 was lying in be against the wall and bottom sheet on the 7/13/16, at 8:03 a.n pillows from under removed the pillows the bed with feet or pillow did not sound the medications the back up and said "I started to stand up down and put on the R62. LPN-F acknowledge.	not aware the pillows were the fitted sheet under the bed. In a trevents them from doing all do on their own we would the further stated she was not sment specific to restraints.  If on 7/14/16, at 9:41 a.m., ays puts the body pillows set and stated he was unsure if that is how I have seen it and stated he was unsure if that is how I have seen it and stated tucking the the fitted sheet is not the sheet sheet is not the She stated staff need to be not OK to do it that way.  The dility uses body pillows to help the bed. She stated tucking the the fitted sheet is not the she stated staff need to be not OK to do it that way.  The dility uses body pillows to help the bed of the fitted sheet is not the she stated staff need to be not OK to do it that way.  The dility uses bedy pillows to help the bed of the b	2 505			
		servation on 7/14/16, at 6:58 in bed on left side with lights				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	CREST VIEW LUTHERAN HOME 4444 RE			STATE, ZIP CODE ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 505	off. There were two sheet (one of the pi under the sheet).  The admission MDs was severely cogniextensive assistive mobility. The MDS were not used. R62 included generalize behaviors, seizure admitted to the faci R62's fall CAA daterisk for falls related admission, unstead seated to standing wheel chair but did rails or pillows under line or pillows	pillows under the bottom llows was part way out from S dated 5/2/16, indicated R62 tively impaired and required of two staff members for bed further indicated restraints S MDS noted R62 diagnoses d weakness, dementia with disorder and that R62 was lity on 4/25/16.  d 5/4/16, indicated R62 was at to a history of falls prior to by balance when moving from positions and from bed to not address the usage of side for the bottom sheet of the bed.  date 5/16, indicated R62 had reakness, balance impairment, disease, and urinary cy. The care plan also led out of bed at time, was callated at time by self. Care for maintain a clutter free call light within reach, 1/2 side in bed and chair. Care plan did be pillows under the bottom the left side.  Sesment dated 7/12/16, intermittent confusion, a falls in the last three months, quiring assistance with ance problems and decreased				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00005	B. WING		07/	14/2016	
NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOM	4444 RES	, ,	TATE, ZIP CODE JLEVARD NORTHEAST MN 55421			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
The undated Team Srisk, had sensor alar and required assistat transfers and ambulation of stated, "I am not surunder the bottom shall registed there were in the property of t	grab bars. Restraint quested but not provided.  Sheet indicated R62 was a fall rm on bed and wheel chair ince of one staff member for ation.  7/13/16, at 10:05 a.m. LPN-Fire why the pillows are tucked eet, but maybe to prevent at." LPN-Fire also stated R62 at should have help. LPN-Fire en since admission. LPN-Fire since admission. LPN-Fire side rails on R62's bed.  7/14/16, at 7:00 a.m. NA-Gistatempt to get up out of his but the pillows under the different the different the different side at the pillows were under the different side at the pillows at the pillows are tucked at	2 505				

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	NT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 505	and will be talking to During interview on said, "Pillows under practice. It is a restingive them the ability want. DON stated, intervention for combut we do not direct A facility policy entit 2016, indicated a reanything that prohib functioning, moving (activities of daily livindicated that the "inperiodically review in restraints are prese completed through chart audits and rocadvertent restraint in immediately by a st SUGGESTED MET The director of nurse could review or revior physical restraint us and Assurance (QA random audits to en	tion today on not doing that of the night shift. "  7/14/16, at 10:53 a.m. DON of the bottom sheet is not our raint." DON stated it does not by to be free and do what they "A pillow in bed might be and affort or to define edges of bed at staff to put it under a sheet."  Iled Use of Restraints dated estraint is classified as oits a resident from and, or performing ADLS's ving) freely. The policy further interdisciplinary team will resident charts to ensure no ont; these reviews will be review of incident reviews, om observations. If an is observed it will be removed aff member".  THOD FOR CORRECTION: Sing (DON) and/or designee is policies regarding the use is. The DON and for designee ation for staff regarding se. The Quality Assessment and or committee could do	2 505				
2 540	MN Rule 4658.0400 Resident Assessme	O Subp. 1 & 2 Comprehensive ent	2 540			8/31/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
		00005	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	MF 4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 540	Subpart 1. Assessiconduct a compreh resident's needs, we capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive resused to develop, recomprehensive plate 4658.0405.  Subp. 2. Informat comprehensive resinclude at least the A. medically demedical history;  B. medical state C. physical and D. sensory and E. nutritional state G. mental and H. discharge political conditions. J. activities pot K. rehabilitation L. cognitive state M. drug therapy N. resident president	ment. A nursing home must ensive assessment of each hich describes the resident's n daily life functions and ents in functional capacity. A st conducted according to section 148.171, subdivision apart of the comprehensive nt. The results of the ident assessment must be view, and revise the resident's n of care as defined in part ation gathered. The ident assessment must following information: If mental functional status; I physical impairments; ments or procedures; psychosocial status; otential; ion; ential; n potential; itus; or; and	2 540	CORRECTED		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING	····	07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	ME	ERVOIR BO	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 17	2 540			
	assessment was co R25 was cognitively assistive of one sta 2/8/16, MDS asses	num Data Set (MDS) ompleted on 2/8/16, indicated y intact and required extensive ff person for bed mobility. The sment further indicated that used and that R25 was lity on 2/1/15.				
		ssessment indicated R25 bar and was able to safely				
	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.					
		p.m. R25's bed was observed ils on the left and right side of				
		p.m. R25's bed was again alf left and right side rails.				
		3 p.m. R25's bed was left and right side rails.				
	R25's side rail asse use of two half side 2/4/16, side rail ass risk assessments a surveyor and confir	nurse (LPN)-C was 3/16, at 1:21 p.m. and stated essment should indicate the rails. LPN-C reviewed the essment, the 5/5/16, safety and R25's care plan with the med R25's assessment and entify the use of bilateral (left				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	MIE		ULEVARD NORTHEAST		
COLUMB			A HEIGHTS,	MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 18	2 540			
	use of a grab bar. L be an assessment then added a nursin record for a side ra on the evening shift					
	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 barAt 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.					
	grab bar on R25's k as the assessment -At 9:39 a.m. the ac was aware R25 had half side rails on he confirmed that two what was written or plan. The administr	C confirmed there was a right bed and not two half side rails indicated.  Idministrator confirmed that he d a right grab bar and not two bed. The administrator staff were trying to correct in the assessment and care ator further stated that the two ware and there would be two				
	side rails put on R2 assessed on 7/13/1 confirmed R25's ca	5's bed to match what was 6. The administrator then re plan would also be what positioning and safety				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	ME	IA HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 19	2 540			
	Assessment dated residents will be as process and as need grab bars for position self-mobility." The process would complese to a days of admixed a condition or as need residents.	tled Side Bar/Grab Bar 3/10 indicated that "all sessed during the admission eded for the use of side rails or oning or increasing policy further indicated that a ete the assessment within ission and the assessment annually, with a change in ded. The policy also indicated I be reviewed quarterly.				
	against the wall and bottom sheet on the 7/13/16, at 8:03 a.n pillows from under removed the pillows the bed with feet or pillow did not sound the medications the back up and said "I started to stand up down and put on the R62. LPN-F acknowledges."	ed with the right side of the bed of two pillows tucked under the eleft side as observed on in. LPN-F removed the two the sheet. Once LPN-F is R62 sat up on the edge of in floor mat. Alarm under R62's diwhen R62 sat up. R62 took en laid down. R62 then sat need to use the pot." R62 when LPN-F asked R62 to sit in e call light for staff to assist wledged that the two pillows er R62's bottom sheet.				
	a.m. R62 was lying off. There were two	ervation on 7/14/16, at 6:58 in bed on left side with lights pillows under the bottom illows was part way out from				
	admission MDS da severely cognitively extensive assistive	to the facility on 4/25/16. The ted 5/2/16, indicated R62 was impaired and required of two staff members for bed 6, MDS further indicated that				

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE (X3) DATE S					
		00005	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 540	restraints were not R62 diagnoses includementia with behat R62's fall Care Area indicated R62 was history of falls prior balance when moving positions and from address the usage the bottom sheet of R62's fall care plan fall risk related to with dementia, cardiace of incontinence/urgent indicated Resident impulsive and ambiguate plan instructed environment, keep rails, sensor alarm plan did not indicate bottom sheet of the The Fall Risk Assess indicated R62 had in history of three or months, was chair like with elimination, had decreased musculated The Side Rail Assessindicated resident of assessment was retained.	used. R62's MDS indicated uded generalized weakness, viors, seizure disorder  a Assessment dated 5/4/16, at risk for falls related to a to admission, unsteady ng from seated to standing bed to wheel chair but did not of side rails or pillows under the bed.  date 5/16, indicated R62 had eakness, balance impairment, disease, and urinary by the care plan also crawls out of bed at time, is ulates at time by self. The at staff to maintain a clutter free call light within reach, 1/2 side in bed and chair. The care be to place pillows under the bed on the left side.  Sement dated 7/12/16, netermittent confusion, a nore falls in the last three bound requiring assistance displaced balance problems and ar coordination.  Sesment dated 7/13/16, lid not use grab bars. Restraint quested but not provided.	2 540			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00005	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	During interview on said "Staff are not to bottom sheet. It wo cannot get over it on R62 could get over said It depends on it. He has very active. During interview on said, "Pillows under practice. It is a rest give them the ability want. DON said, "A intervention for combut we do not direct DON said, "We won assessment because. The MDS 3.0 manurestraints as "Any mechanical device, attached or adjacenthe individual cannot restricts freedom of to one's body." In a facility to determine using any physical must assess the reresident's needs and the restraint is being A facility policy entite 2016, indicated a reanything that prohibit functioning, moving (activities of daily livindicated that the "iperiodically review restraints are presentative."	7/14/16, at 8:58 a.m. LPN-C or put the pillows under the full be a restraint if they in their own." When asked if the pillows on own LPN-C the day if R62 could get over the day and very sleepy days.  7/14/16, at 10:53 a.m. DON the bottom sheet is not our raint." DON said it does not to be free and do what they pillow in bed might be and affort or to define edges of bed at staff to put it under a sheet." The se we do not use restraints are we do not use restraints."  It all dated 10/15, defined the nanual method or physical or material or equipment to the resident's body that to the resident's body that the tremove easily, which is movement or normal access addition, the MDS directed the fif it was a restraint "Prior to restraint, the nursing home sident to properly identify the add the medical symptom(s) that the gemployed to address."	2 540			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE  ULEVARD NORTHEAST		
CREST \	/IEW LUTHERAN HO	ME	A HEIGHTS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 540	chart audits and rocadvertent restraint immediately by a st SUGGESTED MET The DON and/or de and provide educat completion of accurate Quality Assess committee could de compliance.	om observations. If an s observed it will be removed	2 540			
2 550	Resident Assessment Subp. 4. Review of home must examin quarterly and must comprehensive assecontinued accurace.  This MN Requirement by: Based on observation review, the facility for re-assess a potention (R53) reviewed for Findings include:  R53's quarterly MD was severely cogni	f assessments. A nursing e each resident at least revise the resident's sessment to ensure the y of the assessment.  ent is not met as evidenced on, interview and document ailed to comprehensively al restraint for 1 of 4 residents	2 550	CORRECTED		8/31/16

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	ETED
00005 B. WING 07/14/2	/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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 on her might side. The pillow was placed on her might side. The pillow as placed incetty 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	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
CREST	/IEW LUTHERAN HOI	MIE	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 24	2 550			
		a body pillow in bed. She bw goes under the fitted sheet fall risk.				
	RN-F stated, a bod restraint if the resid stated she was awa pillows as intervent frequently but was being placed under RN-F stated, "If it p something they coucall it a restraint." S	on 7/14/16, at 8:08 a.m., y pillow was not considered a ent was able to adjust it. She are the facility was using body ions for resident's who fall not aware the pillows were the fitted sheet under the bed. revents them from doing ald do on their own we would the further stated she was not sment specific to restraints.				
	DON stated the factorine the edge of the body pillows under correct application. educated that it was	on 7/14/16, at 8:39 a.m., the ility used body pillows to help he bed. She stated tucking the the fitted sheet was not the She stated staff need to be s not OK to do it that way. She ated the body pillow was not raint.				
	restraints as "Any n mechanical device, attached or adjacer the individual cannot restricts freedom of to one's body." In a facility to determine using any physical must assess the re resident's needs an the restraint is bein	ual dated 10/15, defined nanual method or physical or material or equipment at to the resident's body that of remove easily, which is movement or normal access addition, the MDS directed the easily if it was a restraint "Prior to restraint, the nursing home sident to properly identify the add the medical symptom(s) that g employed to address."				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 501251110.			
		00005	B. WING		07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CREST V	IEW LUTHERAN HO	MI-	A HEIGHTS	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550	(activities of daily livindicated that the "i periodically review restraints are prese completed through chart audits and roadvertent restraint immediately by a st SUGGESTED MET DON or designee(s necessary the policithe revision and ac assessment process could provide an in staff on these policior designee(s) coul resident with a qua and revise.	bits a resident from g, or performing ADLS's ving) freely. The policy further nterdisciplinary team will resident charts to ensure no ent; these reviews will be review of incident reviews, om observations. If an is observed it will be removed	2 550			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the t.	2 565			8/31/16
	by: Based on observat	ent is not met as evidenced ion, interview and document d to follow the plan of care for		CORRECTED		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			E SURVEY PLETED		
	00005	B. WING		07/	14/2016
NAME OF PROVIDER OR SUPPORT OF SUPPORT OF PROVIDER OF SUPPORT OF S	N HOME	T ADDRESS, CITY, S RESERVOIR BO MBIA HEIGHTS	ULEVARD NORTHEAST		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
non-pressure bruises of unk failed to ensur implemented of for 2 of 2 residential to a care for 1 activities of data findings included the control of the co	ts (R140) reviewed for skin conditions observed with known cause. In addition the facilize the plan of care was for timely toileting and repositionidents (R45, R122) reviewed for epositioning and failed to provide of 1 resident (R47) reviewed for aily living.  de:  skin: served on 7/11/16, at 4:15 p.m. Tobserved seated in the day room erved with two purple bruises on the nand.  t 9:26 a.m. R140 observed reside the activity office in the hallwas visible from standing at the napproximately two feet. The brund appeared dark purple.  t 7:30 a.m. R140 observed seate oom table eating breakfast. The visible and several staff observed tonne acknowledged the bruises	ng to  ne ne ne nt y. nise d			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	MIE	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 27	2 565			
	advanced dementia assistance. CAA indintact and directed cares. R140's skin indicated resident had related to incontine monitor skin with care	dicated skin would remain staff to monitor skin with care plan dated 10/15 also, had potential for skin alteration nation ares.  nimum Dadta Set (MDS)				
	of dementia. In add	ated resident had a diagnosis lition, the MDS indicated ely impaired cognition and				
	directed staff to cor	Orders dated 6/27/16, mplete "Skin Check/Nail Trim day shift every Wednesday."				
	Administration Rec had signed off the s completed however Body Audit dated 7/	ly 2016, Treatment ord, it was revealed a nurse skin check had been during review of the Weekly 6/16, and 7/13/16, no skin tiffied in the assessment.				
	stated she would ha	p.m. registered nurse (RN)-B ave expected staff to report a nurse to investigate and staff an of care.				
	completed R140's s 7/13/16, and she had practical nurse (LP) the unit and he had NA-E stated the brunew.	p.m., NA-E stated she had shower on Wednesday ad reported to licensed N)-E who was orientating in thought the bruise looked old. uises on the hands were not stated she was shocked the ment the bruises.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
CREST \	/IEW LUTHERAN HO	MI I	ERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 28	2 565			
	(DON) she would e concerns and to fol The facility Care PI revised 9/14, indica ensure the resident required to maintain	p.m. the direct of nursing expect staff to report any skin low the care plan.  an Policy and Procedure sted the care plan was to the received the appropriate care nor attain the resident's cticable function possible.				
	morning cares. NA incontinence brief, of soft brown stool peri area then char sanitizing hands. N changed gloves with hands. NA-H assist NA-H wiped R45's barrier cream. NA-Incontinence brief. done washing R45's Surveyor ask NA-H buttocks. There wastool. NA-H cleane using same gloves rectal area then to removed gloves, an applied a new incontinence of 7/13/16, at 12:4 room to change R4 EZ Stand and incontinence and resident lowers skin was intact.	on 7/13/16, at 7:09 a.m. for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE SURVEY  COMPLETED			
	00005	B. WING		07/	14/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CREST VIEW LUTHERAN HOM	MIE	ERVOIR BOU A HEIGHTS,	JLEVARD NORTHEAST MN 55421		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
diaper changed. R4 changed since got usince I got up. No of ive hours and 35 m to be checked and/onor was R45 reposition R45's pressure ulcer 7/27/15, indicated Fulcer development, and seat cushion, a turning. R45's urina worksheet dated 7/2 always incontinent of bladder (a lack of bladder (a lack of bladder (a lack of bladder (a lack of bladder) and multiplassistance with all to the sease) and multiplassistance of one seasify living including toileting. MDS indicating incontinent of bowe pressure ulcer deversaries along in which the damaged, interfering resulting in physical psychiatric problem lower body including R45's mobility care staff R45 had an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever Stand (a mechanical staff R45 and an alta Multiple sclerosis and reposition R45 ever S45 and R45	e the toilet. I just have my 15 stated I had not been up and I have been in my chair ne has asked me." R45 went ninutes without being offered or changed for incontinence itioned.  er CAA worksheet dated R45 was at risk for pressure needed a special mattress and a regular schedule of ary incontinence CAA 27/15, indicated R45 was of urine related to neurogenic ladder sensation and control, ierves through injury or ole sclerosis and needed	2 565			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
CREST \	IEW LUTHERAN HO	ME	A HEIGHTS	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 30	2 565			
	to tissue tolerance a cushion in wheelcha incontinent episode doctor's order. R45's bowel and bla instructed staff R45 continence related a urinary retention, m	to be repositioned according assessment, have a foam air, provide peri care after s and apply barrier cream per adder care plan dated 7/2016, had an alteration in to neurogenic bladder with ultiple sclerosis and staff were				
	resident request, ch hours and as neede checked on the first R45's potential for a plan indicated R45 according to tissue	wo hours, assist to toilet per neck and change every two ed. Post void residuals are t and 15th of each month. alteration in skin integrity care was to be repositioned tolerance assessment, ter incontinent episodes and per doctor's order.				
	was to be checked and as needed and	am # team Card indicated R45 and changed every two hours barrier cream applied to icated R45 was to be turned very two hours.				
	sheet do not mentic refusing cares. The 7/6/16, instruct staff refusals to be chan R45's progress note	nursing assistant assignment on R45 having any history of Physician's Orders dated f to document on resident ged every shift. Review of es from 7/11 through 7/14/16, refusals to be changed.				
	said we change (R4 after brunch. When change and reposit	7/13/16, at 12:37 p.m. NA-H 45) when we get (R45) up and asked how frequently staff ion R45 out of the wheel chair NA-H responded "two times,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00005	B. WING	<del></del>	07/	14/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	MIE	SERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 31	2 565			
	said (R45) was to b and as needed. R4	7/13/16, at 1:29 p.m. RN-E e changed every two hours 5 likes to sit up so, when I was when (R45) was				
	said (R45) was to to hours. LPN-C said	7/13/16, at 1:31 p.m. LPN-C urn and reposition every two if changed at 7 a.m., "I would n to do a change (R45) about a.m."				
	said, "I would expect changed according residents refuses, that least tell the nurse."	7/13/16, at 1:37 p.m. DON ct residents to be checked and to the care plan and if the he nursing assistants should se." DON said, "I would expect care plan for repositioning."				
	from 7:14 a.m. thro were observed whe incontinent of urine completed R122 wa and placed next to Evergreen Hallway.	usly observed on 7/13/16, ugh 10:30 a.m. Morning cares in R122 was observed to be. After morning cares were as wheeled into the hallway the medication cart in R122 remained seated in the 30 a.m. at which time she was in the chapel.				
	to her room and off three hours and 16	:30 a.m. R122 was taken back ered toileting. R122 went for minutes without being offered om or repostioned according				
		aily living (ADL) CAA 2/1/15, indicated R122				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CREST \	IEW LUTHERAN HO	ME	ERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 32	2 565				
	required extensive repositioning.	assistance with toileting and					
	R122's care plan, dated December 2015, indicated toileting and repositioning was to be done every two hours.						
	that R122 required	DS dated 5/24/16, indicated extensive assistance with tioning. R122 had severe nt.					
		Record printed 7/14/16, agnoses included dementia thrive.					
	stated she was awa toileted and stated check on R122. NA toileted every two h	on 7/13/16, at 9:53 a.m. NA-A are of the last time R122 was she had not had the time to A-A was aware R122 was to be ours. NA-A confirmed R122 sitioned since getting out of A.					
	take R122 to the ba	6 a.m. NA-A was asked to athroom. R122's brief was dry d "no" when asked if she oilet. R122 stood during this					
	stated R122 was to hours and as need would not be accep	on 7/13/16, at 1:15 p.m. LPN-A be offered toileting every two ed per the care plan, and it stable for R122 to go three tes without being offered tioning.					
	p.m. and confirmed	erviewed on 7/13/16, at 1:22 I R122's care plan indicated urs to meet her needs." LPN-B					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CREST \	/IEW LUTHERAN HO	ME	ERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST , MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 565	collection tool used bladder habits. LPN three day collection with significant cha On 7/13/16, at 1:59 interviewed and sta followed.  Nail Care R47 was observed have dark debris un nails. On 7/12/16, at 7/13/16, at 1:00 p.n have dark debris un R47's ADL CAA wo indicated that R47 dementia and requipersonal hygiene. F 2016, indicated we done by nursing.  R47's quarterly MD R47 required exten hygiene. R47 had not R47's Admission Rindicated R47's dia dementia, diabetes depression.  When interviewed of stated the nurses prochecked on R47's keverything with nail	te the last three day data to document bowel and N-B stated bowel and bladder tool was done quarterly and					

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY	
		00005	B. WING		07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST V	IEW LUTHERAN HOI	VI II	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST . MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 34	2 565			
	a.m. The DON state nails are to be main their diabetic, the nain nursing assistants of the facility provided procedure titled Gropolicy indicated, "Prist to be performed in residents in need of procedure section, responsible for nail SUGGESTED MET The director of nurst follow care plans in cares and services. compliance.	viewed on 7/14/16, at 9:19 ed "the expectation is that stained, clean and short. If urse needs to cut but the can clean under the nails." d an undated policy and coming and Nail Care. The roper grooming and nail care in a dignified manner for all f assistance. Under the line five reads "Nurses will be care for all diabetic residents." THOD OF CORRECTION: sing could in-service all staff to regards to specific resident Also to monitor for				
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and e; General	2 830			8/31/16
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (COMF		SURVEY LETED			
		00005	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	4444 RES		STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830		ge 35 ent is not met as evidenced	2 830			
	Based on observati review, the facility face services related to resident (R114) rev failed to identify nor	on, interview and document ailed to provide care and fluid restrictions for 1 of 1 iewed for dialysis. The facility n-pressure related skin resident (R140) with		CORRECTED		
	Findings include:					
	(ESRD), hypertensi diabetes and deme Minimum Data Set	clude End stage renal disease on, atrial fibrillation, type II ntia obtained from the annual (MDS) dated 6/10/16. In idicated R114 had moderately				
	in her bed. When a and the facility coor resident stated was this surveyor. Wher fluid restriction resident cook care of all her pitcher with straw widresser on the edge filled. When asked was resident point to she left her shirt. Widressing indicated to not sure which if it was resident point to sure which if it was resident points.	p.m. observed resident lying sked how dialysis was going, dination with dialysis place, going well as she smiled at a asked about her diet and dent stated the facility staff food/fluid needs. A pink water was observed on top of the et to the left and was half way about where the access site to her right upper shoulder as then asked who changed the the staff changed it but was was at dialysis or at the facility. She was going to take a nap surveyor later.				

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NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME  A444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421  [KAILD] FREED (EACH OF PROVIDER OF SEPTICEACIES) FREED (EACH OF PROVIDER OF AUXILIARY OF SEPTICEACIES) FREED (EACH OF PROVIDER OF AUXILIARY OF SEPTICEACIES) FREED (EACH OF PROVIDER OF AUXILIARY OF SEPTICEACIES) FREED (EACH OF SEPTICEACIES) FREED	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
CREST VIEW LUTHERAN HOME			00005	B. WING		07/1	4/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL) TAG (EACH DEFICIENCY MUST BE PRECEDED BY PILL) REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 36  On 7/12/16, at 3:27 p.m. the consultant registered dieticain (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 knew what her fluid restriction was 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	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 36  On 7/12/16, at 3:27 p.m. the consultant registered dietical (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 imilk 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 meals. 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 beingent monitored and this	CREST \	CREST VIEW LITTHERAN HOME					
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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	On 7/12/16, at 3:27 dietician (CRD) state write the care plant process of revising resident husband with since he was at the that resident neede approximately for counces of juice at the non-dialysis days stand supper and dia CRD stated resident (supplement) and ehowever had 60-90 stated resident had restriction on 7/11/1 revising the fluid into On 7/12/16, at 3:44 up seated on wheel water pitcher was so When asked if she at times, resident simy mouth is dry." Wher fluid restriction on the fluid restriction always hoursing desk correct weights had been so restriction until 7/11 intake and output wowas at each shift. Wassistants were inforts she stated would be however when she address the fluid restriction residents.	p.m. the consultant registered ted the dietary tech would for nutrition and she was in the her care plan and intakes as as indicating he had noticed facility mostly during meals d two ounces of milk ereal and was asking for eight ne two meals, as on he had continental breakfast lysis days brunch and supper. It did not like the Nepro extra fluids between the meals milliliters (ml) with meds. RD been started on a fluid 6, and was in the process of ake allotting for the meals.  p.m. resident was observed chair at the door to room. The till observed on top of dresser. would drink out of the pitcher tated, "Yes honey I do when When asked if she knew what was resident stated she did niled.  p.m. licensed practical nurse thought resident was in a fluid owever, the CRD at the cited LPN-D that resident table and was not on a fluid of 16. LPN-D stated resident rere being monitored and this when asked where the nursing ormed resident fluid restriction in the assignment sheet reviewed it, the sheet did not striction. LPN-D also showed	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	4444 RES	, ,	STATE, ZIP CODE ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	the fluid restriction.  On 7/12/16, at 4:03 stated he was not s restriction was and review the meal tick information. When informed resident w was assigned to resknow. NA-C stated water pitcher during.  On 7/12/16, at 4:06 to R114's room and CRD verified R114 room. CRD stated by restriction, she was pitcher in the room. R114 had reported pitcher CRD acknown have an accurate signification and R114 received Nep being recorded in the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:08 the updated assign brought to facility at knowing R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR). The informed R114 was water pitcher was roon 7/12/16, at 4:11 was approached she can be shown as a course of the record (EMAR).	a.m. nursing assistant (NA)-C cure what R114's fluid directed the surveyor to ket for all the dietary and fluid asked if he had been, was on a fluid restriction as he sident NA-C stated he did not resident had been given a	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HON	/I <del>-</del>		ULEVARD NORTHEAST		
		COLUMBI	IA HEIGHTS,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 38	2 830			
	the fluid restriction I she had just done it	R114 was on. LPN-C stated				
	dialysis registered r with a new order for would call the facility facility communication the dialysis center is sheet to the facility about the fluid restration new order for fluid restration during the run for to R114 was "high by a previous post run we When asked what we gain RN stated would fluid restriction and	p.m. via telephone spoke with nurse who indicated, usually R114 a nurse from the center y, would write orders on the ion sheet sent each time and staff sent the pre and post run on dialysis days. When asked iction RN stated R114 had a estriction and had noted aday 7/13/16, she had noticed 2.8 kilograms from the eight on Monday 7/11/16." would attribute to the weight ald be mostly not following the R114 had been put on a fluid R114's high blood pressures nage.				
	asked who was resknow of the fluid resdown between. LPN and the floor nurseknow. LPN-C indicaorder she never wemake sure the wate LPN-C stated the supdate the assignment on 7/14/16, at 2:14 (DON) stated she was to know about the floreakdown. Would pitcher not to be in resident was on a floated she would have	8 p.m. LPN-C stated when ponsible for letting the staff striction there was a break N-C stated dietary was notified, was supposed to let the staff sted when she received the nt to the room to check to er pitcher was not in the room. Supervisor was supposed to sent sheet.  p.m. the director of nursing yould have expected the staff suid restriction if there was no have expected the water the room at the time as suid restriction. In addition are expected the dialysis care e with all the changes.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00005	B. WING	····	07/	14/2016
-	PROVIDER OR SUPPLIER	MF 4444 RES	, ,	STATE, ZIP CODE  ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	The physician's ord was on dialysis and fluid restrictions.  Care plan dated 6/1 actual alteration in type II diabetes and resident had weight to dialysis/fluid. Car changes in weights policy, resident was 1000 ml fluid restric (oz) milk and four of four ounces apple j of apple juice supporteceiving Nepro eigindicated nursing where constriction on arm in the internal fistulal leakage, days for cand Friday, emerge R114's nutrition Candated 6/10/16, indicend stage renal distillations, had memodementia.  The facility Dialysis indicated it was the Corporation to mair coordinate services	der dated 7/11/16, noted R 114 I was on 1000 milliliter (ml/cc)  10/16, indicated resident had nutrition related to dementia, if ESRD. Care plan indicated to fluctuation anticipated related re plan directed to monitor the monitor intakes per facility on a renal diet and was on etion, was to take two ounces nunces apple juice (breakfast), uice at lunch and four ounces et. Also indicated resident was alst oz twice daily. Care plan as to make up 100 cc.  15, for dialysis indicated ial for complications with ESRD, had renal failure. Care rotect shunt from injury, avoid, shut care daily, listen to bruit a, check shunt for infection or dialysis Monday, Wednesday	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00005		B. WING		07/1	4/2016
NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME	4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST , MN 55421		
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830 Continued From page 40  "5. Nursing will monitor the refe dialysis center to ensure that in regarding the resident's health communicated between the fact dialysis center.  10. Follow orders from dialysis warranted"  Skin condition R140's quarterly MDS dated 4/5 resident had a diagnosis of den the MDS indicated resident had cognition and wandered.  On 7/11/16, at 4:15 p.m. reside seated in the day room and was two purple bruises on the left and standing outside the activity offi R140's bruises visible from starnursing station approximately to on the left hand appeared dark  On 7/14/16, at 7:30 a.m. R140 at the dining room table eating bruises were visible and severa go by resident none acknowled which were visible.  On 7/14/16, at 8:40 to 8:49 a.m. assistants (NA)-D and NA-E we down the hallway with R140 both hand went to room. Both assist toileting. During the observation has acknowledged the visible ba.m., NA-E even brought R140	formation status are sility and the and doctor as 5/16, indicated nentia. In addition, I severely impaired at was observed with and right hand.  observed resident ice in the hallway. Inding at the wo feet. The bruise purple.  observed seated breakfast. The all staff observed ged the bruises  I nursing ere observed walk the holding each ed R140 with an none of the NA's ruises. At 8:51	2 830	DEFICIENCY		

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TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 830 Continued From page 41  Con 7/14/16, at 2:01 p.m. registered nurse (FN)-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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER  CREST VIEW LUTHERAN HOME  X444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421    X3   ID PRIEFIX   SUMMARY STATEMENT OF DEFICIENCIES   X44   ID PRIEFIX   (EACH DEFICIENCY MUST BE PRECEDED BY ILLI, TAG   YA2   ID PRIEFIX   (EACH DEFICIENCY MUST BE PRECEDED BY ILLI, TAG   YA3   ID PRIEFIX   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETE DEFICIENCY MUST BE PRECEDED BY ILLI, TAG   YA3   ID PRIEFIX   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETE DEFICIENCY MUST BE PRECEDED BY ILLI, TAG   YA3   YA4   YA5   YA5			00005	B. WING	·····	07/1	4/2016
PRÉÉIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 10/15/15, 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	_		4444 RES	ERVOIR BO	ULEVARD NORTHEAST	·	
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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	2 830	On 7/14/16, at 2:01 stated she would haskin changes to the reviewed the Week and the nursing not any documentation  On 7/14/16, at 2:03 completed R140's s 7/13/16, and she has orientating in the urbruise looked old. Nands were not new-At 2:07 p.m. RN-B nurse did not docur  On 2/14/16, at 2:29 have expected the concerns that had be immediately the case would expect staff than to follow the case as R140's pressure uld (CAA) dated 10/16/advanced demential assistance. CAA indicated resident has related to incontine monitor skin with case R140's physician or staff to complete "S Day every day shift."  During review of Juring review	p.m. registered nurse (RN)-B ave expected staff to report nurse to investigate. RN-B by Body Audit dated 7/13/16, es indicated she did not see of the bruises.  p.m., NA-E stated she had shower on Wednesday ad reported to LPN-E who was nit and he had thought the JA-E stated the bruises on the v. stated she was shocked the ment the bruises.  p.m. DON stated she would nurse to document any skin been identified and investigate use. DON further stated she or report any skin concerns re plan.  Deer Care Area Assessment 15, indicated resident had and needed more dicated skin would remain staff to monitor skin with care plan dated 10/15; also, and potential for skin alteration noce and directed staff to ares.  Teders dated 6/27/16, directed skin Check/Nail Trim on Bath every Wednesday."	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00005	B. WING		07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST V	IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 42	2 830			
	Body Audit dated 7, concerns were ider On 7/14/16, at 2:00	r during review of the Weekly /6/16, and 7/13/16, no skin htified in the assessment.				
	was requested how SUGGESTED MET Director of Nursing polices and proced monitoring dialysis related skin condition or her designee con policies and proced or her designee con system to ensure re appropriate care.	rever, was not provided.  THOD OF CORRECTION: The or her designee could develop ures regarding assessing and residents and non-pressure ons. The Director of Nursing uld educate staff on the dures. The Director of Nursing uld develop a monitoring esidents receive the				
2 840	(21) Days	0 Subp. 2 B Adequate and	2 840			8/31/16
		or determining adequate and criteria for determining er care include:				
	odors. A bathing plane of condition requires to must be given a coother day and more incontinent resident every two hours, ar following each epis	and freedom from offensive lan must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least and must receive perineal care ode of incontinence.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CREST \	VIEW LUTHERAN HO	ME	ERVOIR BO IA HEIGHTS	ULEVARD NORTHEAST , MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 840	Notwithstanding Min 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this into documented in the Clean linens or clot promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritat types of protectors completely covered contact with the resident areas to protection. This MN Requirements of the contact with the resident areas to protections.	nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan. ]  hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be l, and not come in direct sident. Soiled linen and moved immediately from revent odors.	2 840				
	Based on observati review, the facility fa was followed to pro 1 resident (R45) wh and who went five h changes.	on, interview, and document ailed to ensure the care plan vide incontinence care for 1 of no was not properly cleansed nours between check and		CORRECTED			
	Findings include:						
	R45 was observed	on 7/13/16, at 7:09 a.m. for					

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	00005		B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	4444 RES	ERVOIR BO	STATE, ZIP CODE ULEVARD NORTHEAST		
		COLUMB	IA HEIGHTS,	MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 840	morning cares. NA- incontinence brief, of soft brown stool of peri area then chan sanitizing hands. Nachanged gloves with hands. NA-H assist NA-H wiped R45's I barrier cream. NA-I incontinence brief, done washing R45's Surveyor ask NA-H buttocks. There wastool. NA-H cleaned using same gloves rectal area then to fremoved gloves, ar applied a new incoron on 7/13/16, at 12:4 room to change R4 EZ Stand and incoron and resident loweres skin was intact.  During interview on stated, "I do not used diaper changed. R4 changed since got is since I got up. No of five hours and 35 m to be checked and/ R45's pressure ulce 7/27/15, indicated Fulcer development, and seat cushion, a turning. R45's urina worksheet dated 7/2					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
	CREST VIEW LUTHERAN HOME 4444 RES			STATE, ZIP CODE  ULEVARD NORTHEAST  MN 55421		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 840	bladder (a lack of bdue to damage to ndisease) and multipassistance with all the R45's quarterly MD was cognitively inta assistance of one sdaily living including toileting. MDS indictincontinent of bower pressure ulcer dever R45's diagnoses in disease in which the damaged, interfering resulting in physical psychiatric problems lower body including R45's mobility carestaff R45 had an all Multiple sclerosis a reposition R45 ever Stand (a mechanica potential for alteration indicated R45 was incontinent episoded doctor's order.  R45's bowel and blainstructed staff R45 continence related urinary retention, more toilet R45 every tresident request, chours and as needed.	ladder sensation and control, erves through injury or ble sclerosis and needed	2 840	DEFICIENCY		
	plan indicated R45	alteration in skin integrity care was to be repositioned tolerance assessment,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HO	MIE	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 46	2 840			
	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."					
		7/13/16, at 1:29 p.m. RN-E e changed every two hours				
	said (R45) was to to hours. LPN-C said	7/13/16, at 1:31 p.m. LPN-C urn and reposition every two if changed at 7 a.m., "I would n to do a change (R45) about a.m."				
	said, "I would expeding changed according	7/13/16, at 1:37 p.m. DON of residents to be checked and to the care plan and if the he nursing assistants should be."				
	Toileting policy requ	ested but not provided.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
			<del></del>				
		00005	B. WING		07/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CREST VIEW LIITHERAN HOME			A HEIGHTS	ULEVARD NORTHEAST , MN 55421			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 840	The director of nursidevelop and impler to ensure that reside with toileting receives taff as appropriate systems or audit to Report the findings Committee.  TIME PERIOD FOR (21) days.	ETHOD FOR CORRECTION: sing (DON) or designee could ment policies and procedures lents who require assistance we timely services; educate et; then develop monitoring ensure ongoing compliance. to the Quality Assurance	2 840			9/21/16	
2 860	Proper Nursing Cal Subp. 2. Criteria for proper care. The cadequate and prop E. per care and att Fingernails and toe trimmed.	or determining adequate and riteria for determining er care include: rention to hands and feet. nails must be kept clean and	2 860			8/31/16	
	by: Based on observat review, the facility f care was implement resident (R47) revieuslying.	ent is not met as evidenced ion, interview, and document ailed to ensure the plan of steed for nail care for 1 of 1 ewed for activities of daily		CORRECTED			
	Findings include:						
	Three observations	on 7/12/16, and 7/13/16. were made and R47 had dark out of ten fingernails.					
	R47's activity of da	ily living (ADL) Care Area					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00005	B. WING		07/	14/2016	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CREST VIEW LUTHERAN HOME		ERVOIR BOI IA HEIGHTS,	ULEVARD NORTHEAST MN 55421			
PREFIX (EACH DEFICIENCY MUS	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
personal hygiene. R47's 2016, identified, an "alte "alteration in health main diabetes." R47's care placare every week." R47's what discipline was responded by the second of the second	ksheet dated 2/26/16, an ADL deficit related to extensive assistance with care plan, dated March eration in self care" and an intenance related to an revealed "diabetic nail care plan did not specify consible for the nail care.  In Data Set (MDS) (a creening and assessment cated R47 required th personal hygiene.  If had moderate cognitive noses included vascular litus type two and  If 3/16, at 1:09 p.m.,  (LPN)-A stated the eand the nails are day. LPN-A stated eshould be done by the earth of the dark debris under  (DON) was interviewed on the DON stated, "The are to be maintained, are diabetic, the nurse at the nursing assistants is."  undated policy and ng and Nail Care. The regrooming and nail care dignified manner for all sistance." Under the	2 860				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING	·····	07/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE  ULEVARD NORTHEAST		
CREST V	IEW LUTHERAN HOI	ME	A HEIGHTS			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 49	2 860			
	responsible for nail	care for all diabetic residents."				
	The DON could ins as to their responsi residents with assis to facility policy. The	THOD FOR CORRECTION: ure that staff are re-inserviced bility to provide dependent stance with nail care according e DON could conduct audits to being provided as indicated needed.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			8/31/16
	positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	g. Residents must be body alignment. The position to change their own position t least every two hours, it time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.				
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview and document ailed to follow the plan of care (R45, R122) reviewed for		CORRECTED		
	Findings include:					
	morning cares. NA- incontinence brief,	on 7/13/16, at 7:09 a.m. for H removed R45's which was wet and had smear on it. NA-H washed front of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	14/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO!	MIE	ERVOIR BO IA HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 905	peri area then chan sanitizing hands. Nachanged gloves with hands. NA-H assist NA-H wiped R45's Ibarrier cream. NA-hincontinence brief. Surveyor ask NA-H buttocks. There was stool. NA-H cleaned using same gloves rectal area then to fremoved gloves, an applied a new incordon 7/13/16, at 12:4 room to change R4 EZ Stand and incordand resident lowereskin was intact.  During interview on stated, "I had not be I have been in my chas asked me." R4 minutes without bei R45's pressure ulce 7/27/15, indicated Fulcer development, and seat cushion, a turning.  R45's quarterly MD was cognitively inta assistance of one sidaily living including toileting. MDS indictions in the sanitation of the sidal plant in the sanitation of the sidal plant in the sanitation of the sanita	ged gloves without washing or A-H dried R45's peri area and hout washing or sanitizing ed R45 to roll to left side. Bottom and then applied H started to apply a clean Surveyor ask NA-H if she was so bottom. NA-H said, "Yes." to check between R45's a large amount of soft brown the remaining stool, then applied barrier cream to peri ront of perineum. NA-H then ad put new gloves on and antinence brief on R45.  6 p.m. NA-H entered R45's 5. R45 was stood up using the attinence product was changed and back into wheelchair. R45's peen changed since got up and thair since I got up. No one 5 went five hours and 35	2 905			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
	CREST VIEW LUTHERAN HOME 4444 RES			STATE, ZIP CODE ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 905	covering of the nerwith impulse condumental and sometin paraplegia (paralys legs), and depressi R45's mobility care staff R45 had an al Multiple sclerosis a reposition R45 ever Stand (a mechanica potential for alterational indicated R45 was to tissue tolerance cushion in wheelch incontinent episode doctor's order.  Undated Linden Tewas to be turned an hours.  The care plan and sheet do not mention refusing cares. The 7/6/16, instruct staff refusals to be chan R45's progress not do not indicate any During interview on said we change (R4 after brunch. When change and reposit during the day shift that's it."	ves are damaged, interfering ction, resulting in physical, mes psychiatric problems), is of the lower body including on.  plan dated 7/2016, instructed teration in mobility related to nd staff were to turn and ry two hours and use an EZ all lift) for transfers. R45's on in skin integrity care plan to be repositioned according assessment, have a foam air, provide peri care after and apply barrier cream per am # team Card indicated R45 and repositioned every two  nursing assistant assignment on R45 having any history of Physician's Orders dated to document on resident ged every shift. Review of es from 7/11 through 7/14/16, refusals to be changed.  17/13/16, at 12:37 p.m. NA-H 45) when we get (R45) up and asked how frequently staff ion R45 out of the wheel chair NA-H responded "two times,	2 905			
	said, "(R45) likes to	o sit up so, when (R45) was (R45) was repositioned."				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CREST \	/IEW LUTHERAN HOI	ME	ERVOIR BO A HEIGHTS.	ULEVARD NORTHEAST			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 905	Continued From pa	ge 52	2 905				
	said (R45) was to to hours.  During interview on	7/13/16, at 1:31 p.m. LPN-C urn and reposition every two 7/13/16, at 1:37 p.m. DON of them to follow the care plan					
	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.						
	that R122 required	DS dated 5/24/16, indicated extensive assistance with tioning. R122 had severe nt.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	CREST VIEW LUTHERAN HOME 4444 RES			STATE, ZIP CODE  ULEVARD NORTHEAST  MN 55421		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 53	2 905			
	indicated R122's diand adult failure to  When interviewed of stated she was awatoileted and stated check on R122. NA toileted every two had not been reposibed early in the day  On 7/13/16, at 10:3 take R122 to the batand shook her head	on 7/13/16, at 9:53 a.m. NA-A are of the last time R122 was she had not had the time to A-A was aware R122 was to be ours. NA-A confirmed R122 sitioned since getting out of				
	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.					
	p.m. and confirmed "toilet every two how was unable to locat collection tool used bladder habits. LPN	erviewed on 7/13/16, at 1:22 I R122's care plan indicated urs to meet her needs." LPN-B ee the last three day data to document bowel and I-B stated bowel and bladder tool was done quarterly and nges.				
	On 7/13/16, at 1:59 interviewed and sta followed.	p.m. the DON was ted the care plan was to be				
	SUGGESTED MET	HOD OF CORRECTION: The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		` /	ATE SURVEY DMPLETED	
			7. BOILDING.			
	00005 B. WING		07/1	4/2016		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST V	IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	education/staff trair ensure the position their own position is hours, including pe has been put to be physician has docu every two hours du unnecessary or the different interval. TIME PERIOD FOR (21) days.	ge 54 or designee could provide hing and complete audits to of residents unable to change is changed at least every two riods of time after the resident do for the night, unless the mented that repositioning ring this time period is physician has ordered a	2 905			
2 910	Incontinence  Subp. 5. Incontine have a continuous management to recunnecessary use o comprehensive reshome must ensure  A. a resident without an indwellinunless the resident that catheterization  B. a resident wireceives appropriat prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ig catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to infections and to restore as er function as possible.	2 910			8/31/16
	by: Based on observat	ent is not met as evidenced on, interview, and document ailed to ensure services were		CORRECTED		

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
CREST \	/IEW LUTHERAN HOI	ME	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 910	Continued From page 55		2 910			
	implemented for timely toileting for 1 of 2 resident (R122) reviewed for toileting.					
	Findings include:					
	from 7:14 a.m. thro were observed whe incontinent of urine completed R122 wa and placed next to Evergreen Hallway.	ulys observed on 7/13/16, ugh 10:30 a.m. Morning cares on R122 was observed to be . After morning cares were as wheeled into the hallway the medication cart in R122 remained seated in the 30 a.m. at which time she was in the chapel.				
	to her room and off hours and 16 minut	:30 a.m. R122 was taken back ered toileting. R122 went three es without being offered the according to the care plan.				
		nimum Data Set dated esident required extensive ves of daily living.				
	(CAA) dated 12/1/1 incontinence of bow dementia and limite indicated R122 requ	cer Care Area Assessment 5, indicated frequent wel and bladder related to ed mobility. R122's CAA uired assistance with toileting peri-care as needed.				
	The care plan dated to be toileted every	d 12/2015 indicated R122 was two hours.				
	nursing assistant (Natherlast time R122 Natherlast time R122 Natherland the time	on 7/13/16, at 1:00 p.m. NA)-A stated she was aware of was toileted and stated she e to check on R122. NA-A as to be toileted every two				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETE	
2 910	2 910 Continued From page 56		2 910			
	licensed practical n to be offered toiletin needed per the care acceptable for R122 minutes without bein LPN-B was interviewand confirmed R122 every two hours to stated, "I would exptoilet her, bring her on her willingness, so On July 13, 2016, a nursing was interviewas to be followed. SUGGESTED MET director of nursing of staff education/train ensure based on the assessment, a nursing resident who is incompropriate treatment."	wed on 7/13/16 at 1:22 p.m. 2's toileting plan was "toilet meet her needs." LPN-B eect there would attempt to into the bathroom, depending see if she will void."  It 1:59 p.m., the director of ewed and stated the care plan  THOD OF CORRECTION: The predesignee would provide a ning and complete audits to be comprehensive resident sing home must ensure that a continent of bladder receives ent and services to restore as				
		er function as possible.  R CORRECTION: Twenty One				
21375	. , ,	Subp. 1 Infection Control;	21375			8/31/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	5 Continued From page 57		21375			
	by: Based on interview facility failed to deverge program to include ongoing tracking ar antibiotic resistance infection. This defict to affect all 112 resifacility. In addition thand hygiene was crooms. This had the who received room failed to ensure apprent of the same of the sam	and document review, the elop the infection control surveillance for infection, and analysis, and tracking of e to prevent the spread of cient practice had the potential idents who resided in the he facility failed to ensure completed in 1 of 4 dining e potential to affect 8 residents trays. Furthermore facility propriate hand hygiene and f 1 resident (R45) observed ence,		CORRECTED		
	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.					
	6/16, were reviewed numbers of resident diseases, such as a pneumonia, cellulitity Total number of resident number of resident number of the information to determine the conset of infection, so resolution dates, as	on control logs from 1/16 to d. The log included total its with various infection urinary tract infection, s (skin infection), wounds. Sidents per unit each month its log, however, lacked enough rmine an analysis. The logs in eand room number, date of symptoms, reoccurance, and its well as other pertinent esident on Linden was				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. Boilbing.				
		00005	B. WING		07/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
CREST \	/IEW LUTHERAN HOI	ΛF -		ULEVARD NORTHEAST			
011201	TEW EOTHERANTION	COLUMBI	A HEIGHTS,	MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
21375	75 Continued From page 58		21375				
	on-going w/ [with] none resident had "eadditional information "groin" with no addivegarding residents reflect the type of pacterial, viral, etc. During an interview registered nurse (Roontrol logs were rethe facility four case One resident was athe rest were acquisay if the one resident acquitally the logs lacked evinformation to deterin-house acquired products and the could not state that	if they had an in-house					
	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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	infections, I educate nurse to educate at pericare." She also determine if symptot track at all for anyolook at trends." RN specify resident nat such as the actual was aquired at the started or resolved effective or were characteristic the infection controling information to qualic committee for reviet the information and gave it to the medic The facility's 7/11/1 Guidelines indicate cares and an envirolinfections in our resident infections documentation of in and Surveillance of environmentprevishall be as recomm Disease Control (Chealth (MDH) evided Linden Unit: On 7/11/16, at 4:52 looked on the floor	e staff and ask the charge by female residents about to looked at nursing reports to oms were resolving. "I do not one not on an antibioticI just I-A verified the logs did not omes and pertinent information organism/illness, whether it facility, when symptoms whether antibiotics were nanged, etc.  I in an interivew on 7/14/16, at or she received the data from I nurse she took the ty improvement (QI) ow. The QI committee reviewed I looked for patterns and then cal director for review.  Infection Prevention of the purpose was "To provide onment which prevents sidentsSurveillance of including review of antibiotics, offections and analysis of data	21375			
	NA-F was observed	stant (NA)-F to get a towel.  If go into the linen closet by the lame out with two wash towels				

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		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST	/IEW LUTHERAN HO	ME	ERVOIR BO A HEIGHTS	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	and laid both on the asked by R78 to pic right next to the wh observed bend ove the napkin which w off the floor took it twindow. NA-F used inward tossed the r food rack and obsethe steam table and washing his hands. observed touch the on the cart by the nof the four ounce dithe juice machine at the rims of the glas -At 4:56 p.m. when trays off the rack to intervened. NA-F awashed his hands a off the floorAt 5:00 p.m. after what is and attempter oom at this time sunday and attempter oom at the same tray of dietary supervisor was and asked NA trays alone.  On 7/11/16, at 5:10 (DON) stated she as intervening. When a server was a serv	e puddle. Then NA-A was ck a napkin she had dropped eelchair for her. NA-F was r and with bare hands picked as soiled with brown sputum to the garbage can by the d both hands to push the lip napkin then and returned to the rived proceed to get food from d set the room trays without As NA-F set the trays was drinking glass covers stacked ursing desk; touched the rims rinking glasses went over to and obtained juice still holding ses with the soiled hands.  NA-F was picking one of the bring to the room, surveyor cknowledged he had not after picking the soiled napkin washing his hands NA-F came e had set up with the soiled ed to bring the trays to the urveyors intervened again. If only touched the covers and to covers and was just going to be food set up. At this point the was observed set different the tolerand the contaminated of p.m. the director of nursing appreciated the surveyors asked what her expectation he would expect staff to have	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
	PROVIDER OR SUPPLIER	MF 4444 RES		STATE, ZIP CODE  ULEVARD NORTHEAST  MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	On 7/13/16 at 7:09 observed for R45Nursing assistant (gloves and remove upper body. NA-H r gloves without wash dressed R45's upper incontinence brief, of soft brown stool operi area then chan sanitizing hands. Nachanged gloves with hands. NA-H assist NA-H wiped R45's barrier cream. NA-H incontinence brief. Surveyor ask NA-H buttocks. There was stool. NA-H cleaned using same gloves perirectal area then then removed glove applied a new incoput ted hose, pants  R45's Quarterly Mir indicated R45 was extensive assistance activities of daily living mobility and toileting frequently incontiner risk for pressure ulcondicated R45's diagraphicated R45's diagr	ge 61 a.m. morning cares were (NA)-H washed hands put on d R45's gown and washed emoved gloves put on new ning or sanitizing hands. NA-H er body. NA-H removed R45's which was wet and had smear on it. NA-H washed front of ged gloves without washing or A-H dried R45's peri area and hout washing or sanitizing ed R45 to roll to left side. bottom and then applied H started to apply a clean Surveyor ask NA-H if she was s bottom. NA-H said, "Yes." to check between R45's s a large amount of soft brown d the remaining stool, then applied barrier cream to to front of perineum. NA-H es, and put new gloves on and ntinence brief on R45. NA-H and shoes on R45.  nimum Data Set dated 4/9/16, cognitively intact, required te of one staff member for ing including transfers, bed g. MDS indicated R45 was ent of bowel and bladder and at the development. MDS gnoses included multiple se in which the covering of the ed, interfering with impulse g in physical, mental and tric problems), paraplegia wer body including legs), and	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER	ME 4444 RES		STATE, ZIP CODE ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	During interview on said, "I normally wa my gloves." NA-H a hands when startte using sanitizer. NA-same glove to apply bottom and then to area.  During interview on registered nurse (R wash hands; before contact, when remoif staff has been to are staff to change their hands after cle responded, Staff ar product on then chasanitize hands before RN-A said the staff with a glove hand to the same gloved had the perineal area. Front to back always they are done with the same gloved had they are done with sanitize hands before the perineal area. Front to back always they are done with they are done with sanitize hands before the staff change grown to grow they are done with sanitize hands before the staff change grown they are at Undated Incontiner explain to resident.	7/13/16, at 12:37 p.m. NA-H ash my hands when I remove acknowledged only washed d and was done. NA-H denied H acknowledged used the y barrier cream to R45's R45's front, including peri  7/14/16, at 9:47 a.m. N)-A stated expected staff to econtact with a resident, after owing gloves, if handling trash, the bathroom. When asked gloves and wash or sanitize eaning up stool? RN-A e allowed to put incontinence ange gloves and wash or or touching anything else. cannot apply barrier cream to the rectal area and then use and to apply barrier cream to RN-A said staff "have to go s, do not go to the rear until the front."  7/14/16, at10:56 a.m. director aid staff are to wash or ore and after cares and any loves, or any time they touch N said she expects staff when am to go from clean to dirty; o the rectal area.  It Care Policy instructs staff to what they are going to do and resident. It further instructs	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00005	B. WING		07/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREST	VIEW LUTHERAN HO	MIE	ERVOIR BO A HEIGHTS	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	7. Remove soiled of at bed side. 8. Wet disposable was poly soap or use part of the soar with fingers to clear to wash entire but body part that is so to soa the soa to soa to so to soa to so to soa to so to soa to so to s	iaper and place in diaper pail, washcloth with warm water. peri-wash spray a, washing from urethral d anal area. Separate labia nse area well. ttock area and any additional iled. posable wshcloth, rinse roughly. Il with the second clean oth. per and other linen as needed. sing resident in clean clothing, cary bed linen and place soiled rough cleansing of any floors, c., which might have been es and leave unit in order. ision of care on the form in the ion for staff on when to erform hand washing or viding incontinence cares.  cy and Proceedures dated ff, "Hand washing/ Hand done: g invasive procedures. iith particularly susceptible food or medications to be touching wounds of any kind. providing personal cares for a	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CREST V	IEW LUTHERAN HO	ME	A HEIGHTS,	ULEVARD NORTHEAST MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21375	Continued From page 64		21375				
	contaminated with h. After caring for a infection. i. After going to the covering a sneeze j. Before eating and of the shift."  SUGGESTED MET	d before going home at the end HOD 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.						
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			8/31/16	
	<ul> <li>(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.</li> <li>(b) Written compliance with this subdivision must be maintained by the nursing home.</li> </ul>						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00005	B. WING		07/1	4/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CREST V	IEW LUTHERAN HOI	ME	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE	
21426	Continued From page 65		21426				
21420	This MN Requirements: Based on interview facility failed to compute tuberculosis (TB) so (R25) reviewed for Findings include: R25 was admitted the diagnoses that inclures piratory failure and the received a mantoux read by facility staff also recieved a sectivate was read on 2/10 Con 7/14/16 at 1:30 medical record did screening assessments.  A facility policy entity dated 9/14 identifies screened upon admore have proof of test active pulmonary Testing assessments.	and document review the aplete accurate baseline creenings for 1 of 5 residents TB.  o the facility on 2/1/15 with uded pneumonia, acute and chronic kidney disease.  edical record identified R25 (TB test) on 2/1/16 that was on 2/3/16 to be negative. R25 and step mantoux on 2/11/16 that was also negative.  In did not include a TB ent prior to the intial mantoux include an inital TB.	21420	CORRECTED			

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
			A. BUILDING.			
		00005	B. WING	·····	07/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	MIE	ERVOIR BO A HEIGHTS:	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Director of Nursing review, and/or revise ensure tuberculosis residents. The Direcould educate all apand procedures. The designee could devensure ongoing continue PERIOD FOR (21) days.	THOD OF CORRECTION: The or designee could develop, see policies and procedures to a screening is completed for all ctor of Nursing or designee oppropriate staff on the policies see Director of Nursing or relop monitoring systems to impliance.  R CORRECTION: Twenty-one	21426			0/01/10
21555	Medications Staff des Subp. 2. Staff des medications. A nur personnel, as desci be designated as re	ignated to administer se or unlicensed nursing ribed in part 4658.1360, must	21555			8/31/16
	by: Based on observati review the facility fa accurate administra	ent is not met as evidenced on, interview and document illed to ensure safe and ation of a prescribed 2 residents (R122) observed of morning cares		CORRECTED		
	Findings include:					
	indicated R122's dia and adult failure to	Record printed 7/14/16, agnoses included dementia thrive. R122's quarterly (MDS) (a standardized,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00005	B. WING		07/	14/2016
	PROVIDER OR SUPPLIER VIEW LUTHERAN HOI	ME 4444 RES		TATE, ZIP CODE JLEVARD NORTHEAST 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE	
21555	primary screening a 5/24/16, indicated that assistance with toile Interview of Mental 6/2/16. R122 scores severe cognitive im  During observation nursing assistant (Nursing assistant (Nursing assistant) paper medication of stated that it was murse gives the creapply. NA-A was observed to R122's formation of the R122's Physician Control of the R122's face. The Europe description of the R122's face. The Europe	and assessment tool) dated hat R122 required extensive eting and repositioning. A Brief Status (BIMS) was done on dive out of 15 that indicated pairment.  on 7/13/16, at 7:14 a.m., IAA)-A was observed to have a up with white cream in it. NA-A edication to apply to the reduce. NA-A stated that the am to the nursing assistants to eserved to apply the white red bumps on her face.  orders dated 4/26/16, read: (percent) apply lightly to face one time daily until and 7/13/16, at 1:59 p.m. the DON) stated that she expects hydrocortisone cream to DON also stated it was to be applied by NA.  on 7/14/16, at 12:27 p.m., the cist (Rph) stated that the uld be applied by an nurse. In a recommendation to the egarding the long-term use of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		00005	B. WING		07/1	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE						
21555	Continued From page 68		21555									
	these systems. The DON or designee could develop monitoring systems to ensure ongoing compliance.											
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.											