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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LFW0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/25/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 05/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/10/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/23/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/22/2013
(L33)

DETERMINATION APPROVAL

CCN# 24-5018

This facility is a Special Focus Facility (SFF).

An abbreviated standard OTC survey was completed on February 15, 2013. The most serious deficiency was cited at a S/S level of D.

On March 8, 2013, a standard OTC survey was completed. The most serious deficiency was cited at a S/S level of E. Since noncompliance continues, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective May 15, 2013

If DOPNA goes into effect, the facility will also be subject to a loss of NATCEP for a two year period beginning May 15, 2013.

A PCR was completed on April 25, 2013, to verify compliance with the abbreviated standard OTC survey that was completed on February 15, 2013 and the standard OTC survey that was completed on March 8, 2013. The facility was found in substantial compliance, effective April 19, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA effective May 15, 2013, be rescinded

The facility would not be subject to the loss of NATCEP if DOPNA is rescinded.

See the attached CMS-2567B forms from these revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5018 May 10, 2013

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

Dear Ms. Aramalay:

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

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

Effective April 19, 2013 the above facility is certified for:

122 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2013

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

RE: Project Number S5018024 and H5018095

Dear Ms. Aramalay:

This facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 22, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 15, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 22, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 15, 2013.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 15, 2013, and the most serious deficiencies at the time of the abbreviated survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) and a standard survey completed on March 8, 2013. The the most serious deficiencies at the time of the standard survey were found to be a pattern deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 25, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey completed on February 15, 2013 and the standard survey completed on March 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 25, 2013, as of April 19, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 22, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 15, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 15, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 15, 2013, is to be rescinded.

In our letter of April 22, 2013, 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 May 15, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 19, 2013, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5018r113.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	4/25/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/19/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/19/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/19/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/19/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/19/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **04/19/2013**
ID Prefix **F0372** Reg. # **483.35(i)(3)** LSC	Correction Completed **04/19/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/19/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	05/10/13	03023	04/25/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/8/2013			

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2013

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

Re: Enclosed Reinspection Results - Project Number S5018024 and H5018095

Dear Ms. Aramalay:

On April 25, 2013 investigators of the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of orders found on the complaint investigation completed on February 15, 2013. Also, on April 25, 2013 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 March 8, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5018r113lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00005	A. Building B. Wing	4/25/2013

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **04/25/2013**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **04/25/2013**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	Correction Completed **04/25/2013**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **04/25/2013**	ID Prefix **21385** Reg. # **MN Rule 4658.0800 Subp. 3** LSC	Correction Completed **04/25/2013**	ID Prefix **21405** Reg. # **MN Rule 4658.0810 Subp. 2** LSC	Correction Completed **04/25/2013**
ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **04/25/2013**	ID Prefix **21735** Reg. # **MN Rule 4658.1420** LSC	Correction Completed **04/25/2013**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **04/25/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/sd	05/10/13	03023	04/25/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/8/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

AH Form Approved

5/10/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00005	A. Building B. Wing	4/25/2013

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20625 Reg. # MN Rule 4658.0450 Subp. 1 A-I LSC	03/27/2013	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	03/27/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GD/sd	05/10/13	05455	04/25/13
Reviewed By CMS RO				

Followup to Survey Completed on: 2/15/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	4/25/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0309 Reg. # 483.25 LSC	03/27/2013	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	03/27/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KL/sd	Date: 05/10/13	Signature of Surveyor: 05455	Date: 04/25/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/15/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LFW0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 04/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/19/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5018

This facility is a Special Focus Facility (SFF).

An abbreviated standard OTC survey was completed on February 15, 2013. The most serious deficiency was cited at a S/S level of D.

On March 8, 2013, a standard OTC survey was completed. The most serious deficiency was cited at a S/S level of E. Since noncompliance continues, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective May 15, 2013

If DOPNA goes into effect, the facility will also be subject to a loss of NATCEP for a two year period beginning May 15, 2013.

See attached CMS-2567 from these visits. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

AMENDED LETTER

April 22, 2013

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

RE: Project Number S5018024 & H5018095

Dear Ms. Aramalay:

PLEASE NOTE: THIS LETTER SERVES TO REPLACE AND CORRECT THE LETTER DATED MARCH 27, 2013 IN ORDER TO REMOVE COMPLAINT H5018092. THERE WAS NO COMPLAINT INVESTIGATION COMPLETED AT THE TIME OF THE MARCH 8, 2013 STANDARD SURVEY. PLEASE ALSO NOTE COMPLAINT H5018095 WAS SUBSTANTIATED AT THE TIME OF THE FEBRUARY 15, 2013 ABBRVIATED STANDARD SURVEY.

This facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on February 15, 2013. 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).

On March 8, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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 May 15, 2013. (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 May 15, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 15, 2013. 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 Program or Competency Evaluation Programs for two years effective May 15, 2013. 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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

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

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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5018s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Revised 2567 to be sent ok per Pam K. At the time of the standard recertification survey a complaint investigation of H5018092 was investigated and was substantiated with deficiencies issued at F241 and F353.	F 000	**F000** It is the policy of Crest View Lutheran Home to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R111) who resisted care was treated respectfully, to ensure 1 of 1 resident (R196) received a timely response to call light use related to dignity with continence, and to ensure residents who ate in the Willow dining room were treated in a dignified manner regarding the use of clothing protectors, having the potential to affect 21 of 22 residents who ate in the dining room.	F 241	**F Tag 241 Dignity** It is the policy of Crest View Lutheran Home to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	All completion dates are 4/19/13

Revised 4-10-13 Lynn Dahlen

per email from Pam K. T.A. Noted 4-10-13 call POC to Lynn 4-19-13 TK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA — TITLE: Administrator — (X6) DATE: 4/8/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 Findings include: R111 was not treated in a dignified manner during meal observations and residents who ate meals in the Willow dining room were not given an opportunity to express preferences in using a clothing protector at the meal. R111 was observed to be pulled by the hand into the dining room and put into a chair without explanation or conversation on 3/4/11, at 4:45 p.m. The nursing assistant (NA)-I exerted down downward pressure on R111's left shoulder and pushed the chair into the back of the resident's legs. A clothing protector was then put on R111 without permission or explanation. R111 mumbled incoherently while sitting in the chair and moved the placemat and silverware around the table. The placemat and silverware were then taken away from him without explanation and were put out of his reach in the middle of the table. Again without explanation, prior to the meal service R111's hands were cleaned with a Sani-Hands pre-moistened wipe. On 3/4/13, at 4:50 p.m. residents from the Willow unit were brought into the dining room for the evening meal. The staff put clothing protectors on 21 out of 22 residents without conversation, or asking the residents' preferences. Because R33 was leaning on the clothing protector, a staff person did ask the resident if she wanted to wear the protector. The resident replied, "No, I rest my arm on it." On 3/8/13, at 10:30 a.m. the Willow residents were brought into the dining room for the brunch	F 241	Resident # 111 was given verbal directions along with physical guidance by hand holding to the dining room after notification on (03/04/13). R #111 was verbally and physically guided to sit in his chair at meal times For R #111 all other residents on the Willow Unit, Clothing protectors and hand washing are verbally offered prior to every meal to each resident, whether they are able to answer or not. No response, as this is a dementia care secure unit, will be considered an affirmation that a clothing protector is accepted by the resident. Education will be to staff members on the policy for Dignity and Respect on April 10, 11 and 12 of 2013. Resident # 111 remains on Willow Unit R #196 was assisted to the bathroom per her request after notification on 3/7/13. Care plan and care sheets were correct at time of incident. Education will be provided to staff members on the policy for Dignity and Respect on April 10, 11 and 12 of 2013.	

RECEIVED
APR 09 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 meal, clothing protectors were put on 21 out of 22 residents without conversation, or asking the residents' preferences. R33 was not approached about her clothing protector. R111 was then brought into the dining room and taken to his chair at the table. The resident resisted sitting down at which time a second NA approached and attempted to assist the resident to sit. When R111 continued to resist, he was allowed to leave the dining room and wander. R111 repeatedly entered the dining room, walked the perimeter of the room, and then left the room. After 30 minutes R111 was assisted to his chair by a NA who placed the chair against the back of the resident's knees and asked him to sit down; R111 sat without resistance. R111 was admitted to the facility with diagnoses of Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 1/16/13, indicated R111 was unable to complete an interview for cognitive status or vision screening. R111 had short-term and long-term memory impairment, had severally impaired cognitive skills; experienced continuous inattention, disorganized thinking, altered level of consciousness and psychomotor retardation. R111 had delusions and wandered daily; required supervision to walk in room, walk in corridor, and locomotion on the unit. R111 required extensive assistance of one with eating. R111's care plan dated 1/23/13, identified cognitive impairment, history of wandering, resistive to cares, altered communication related to impaired understanding, and inability to respond to others. Prior to initiating care, the plan directed staff to inform R111 of each task prior to	F 241	Resident # 196 discharged to home on March 30. For other residents who may be affected by this practice an audit regarding dignity with meal times and clothing protectors will continue to be completed to ensure residents are being provided with dignity and respect. For other residents who may be affected by this practice, call light audits continue to be completed on each shift. The policy for Resident Dignity and Respect will be discussed and created by the interdisciplinary team on 04/10/13. All new hires are currently educated on Resident Bill of Rights which includes dignity and respect. This is also completed annually at the yearly in service. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the Resident Dignity and Respect policy and procedures on April 10, 11 and 12 of 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 initiation, explain the cares, use simple phrases and yes/no questions, use redirection and re-orientation, allow resident time to respond, anticipate needs, use task segmentation and a calm approach. On 3/8/12, at 4:05 p.m. a licensed practical nurse (LPN)-I stated she would not expect anyone to force a resident to do anything, and further stated, "We just re-approach." On 3/8/13, at 4:20 p.m. NA-G explained that R111 was supposed to have a chair gently pressed into the back of his knees as a cue for him to sit down while he was being asked to sit. The NA said R111 sometimes resisted and "You just come back and try again later." On 3/8/13, at 4:30 p.m. the administrator and director of nursing (DON) stated all staff had been trained to converse with residents during their cares, and that is what they would have expected. The facility did not have a policy specific to treating residents with dignity, as it was implied in the Resident Bill of Rights. A nursing orientation sheet for Dementia, Alzheimer's Disease, etc. directed the staff to "Always introduce yourself and tell your resident what you are going to do before you do it. There are no rules that say the resident must eat, sleep, bathe, etc. on your time schedule. Be as flexible as necessary to be sure the resident receives the care they need with a minimal amount of stress to their world." Although R196 called out for help repeatedly on 3/7/13, staff did not respond to those calls for	F 241	Dining/mealtime audits will be completed weekly for 4 weeks, monthly for 2 months and then randomly with results reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed corrective action plan. Call light Audits will continue to be completed on every shift weekly The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 1st 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 help to potentially preserve R196's dignity with urinary continence in a timely manner. On 3/7/13, at 5:00 a.m. R196 was observed sitting in a wheelchair in her room holding a dry incontinence product on her lap calling out, "Help! help!" No staff were observed on the unit at the time. NA-C was down one of the hallways assisting another resident. LPN-E was assigned to two units (Linden and Aspen) and was off the unit. At 5:15 a.m. R196 held up the dry incontinence pad on her lap and reported she had been waiting since 3:00 a.m. for help to the bathroom. R196 also reported her roommate ran out of oxygen around 2:00 a.m. and LPN-E was in and out of the room changing the oxygen tank which then interrupted R196's sleep. When R196 turned on the call light to request assistance, she said LPN-E came into the room, turned off the light, and said she would send someone to help. R196 then transferred herself from the bed to the wheelchair and "sat waiting" for someone to assist her into the bathroom. R196 stated she was "very frustrated." When R196 was asked how she knew she had been waiting since 3:00 a.m. the resident pointed to the watch on her left wrist. On 3/7/13, at 5:15 a.m. LPN-E was initially observed by the surveyor and was informed of R196's need for help. The LPN went into a resident's room and informed NA-C R196 needed help to use the bathroom. LPN-E stated R196 had not put on the call light, confirmed she had been in and out of R196's room to assist her roommate and switch oxygen tanks since 2:00 a.m.. At 5:20 a.m. NA-C assisted R196 to the bathroom. Although R196's incontinent product	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5 was observed to be heavily saturated with urine, R196's skin had no signs of skin breakdown or redness. NA-C confirmed the findings and after R196 was toileted, assisted R196 with a dry incontinent product. On 3/7/13, at 5:30 a.m. R196 stated the facility was short on help at night and there was only one nursing assistant to help all of the residents. R196 indicated it did not happen a lot, but when she had to go to the bathroom, she did not like to wait. On 3/7/13, at approximately 7:15 a.m. when asked about staffing, LPN-E stated, "I hope you get the answers to the questions you are asking." Although LPN-E was scheduled to be in charge of the Linden and Aspen units, LPN-E was not able to tell the surveyor how may residents resided on the units. On 3/7/13, at 9:30 a.m. R196 stated she was frustrated that morning waiting for help, but was okay now. R196 stated she did not like to wait for help to go to the bathroom and that she had only wet herself "a couple" of times waiting to get help to go to the bathroom. R196 was admitted to the facility for short stay rehabilitation on 2/15/13, for post fall with fractured ribs. R196's care plan dated 2/15/13, indicated R196 was alert and oriented. The care plan also indicated R196 was incontinent of urine, was to be toileted, and wore large pull-ups. On 3/8/12, at 3:15 p.m. the director of nursing (DON) stated the call lights should be answered and residents assisted within five minutes or less.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 The DON stated two minutes was an acceptable wait time after the resident put on their call light.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan related to bruising risk for 1 of 3 residents (R89) reviewed for non-pressure related skin conditions. Findings include: R89's care plan was not developed for the risk of	F 279	**F Tag 279 Comprehensive Care Plans** It is the policy of Crest View Lutheran Home to utilize the results of the assessment to develop, review and revise the resident's comprehensive plan of care. *The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:* *The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and* *Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 bruising. R89's diagnoses included terminal diagnosis of debilities, prostate cancer, coronary artery disease and back pain. During initial observation and interview with R89 on 3/6/13, at 10:35 a.m. he was noted to have dark purple bruises covering the backs of both hands. When asked about the bruises, R89 stated he "hits them [his hands] on the side rails" when grabbing for them. R89 had half side rails up on both sides of the top half of the bed. During cares on 3/7/13, at 9:48 a.m. R89 was observed using the side rails to turn in bed. R89 was observed to have difficulty finding the rails and to reach out with his hands until he could feel them. Bruising was again observed to the backs of both R89's hands. The Aspen Team 2 nursing assistant assignment sheet dated 3/5/13, indicated R89 had "2 ½ side rails" but did not identify a risk for bruising. The assignment sheet directed, "On bath days & when doing ADL'S [activities of daily living] check for any open areas or pressure sores make sure skin is intact and report any findings to nurse." The assignment sheet lacked direction for reporting bruises. The medication administration record (MAR) for March 2013 revealed R89 received aspirin (a medication known to potentially contribute to bruising) 81 milligrams (mg) daily. The MAR listed Aspirin as an allergy for R89 and also noted a skin check was completed on 3/7/13, on the evening shift.	F 279	For Resident # 89 the care plan was reviewed and revised on 3/8/13 and ongoing. Corresponding updates have been made to care assignment sheets and communicated to the resident and/or designated decision maker. The primary physician was informed of the assessment results and a review of the current physician orders was completed on 3/8/13. Education will be provided for staff members regarding Comprehensive Care Plans on April 10, 11 and 12. Resident # 89 remains on the Aspen Unit For other residents who may be affected by this practice Skin Audits remain ongoing and are completed weekly on resident bath day and daily with cares. Upon this review, care plan revisions will continue to happen as needed. Staff education on this issue will be done April 10, 11 and 12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 A physician's progress note dated 3/5/13, identified R89 had bruising present but did not indicate where the bruising was located and listed aspirin as an allergy for R89. The potential alteration in safety care plan for R89 dated 2/12/13, included, "1/2 side rails x 2," but did not include risk for bruising, such as related to side rail use. The potential alteration in skin integrity care plan dated 2/12/13, did not address R89's risk for bruising and directed staff to "monitor skin with cares." The potential for alteration in sensory perception care plan dated 2/12/13, indicated R89 had cataracts and was blind in the right eye. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated there were no other incident reports for R89 other than the one dated 2/16/13, for a fall. The DON stated she was not aware of the bruises on R89's hands and stated a care plan should have been developed for a resident at risk for bruising.	F 279	The policy for comprehensive care plans will be reviewed and revised by the interdisciplinary team on 4/10/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the comprehensive care plans policy and procedures on April 10, 11 and 12. Care plan audits will be completed weekly for 4 weeks, monthly for 2 months, then randomly to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 1, 2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan to reflect changes in care needs for sleep, activities, mobility, diuretic use and integration of the care plan with Hospice for 1 of 1 resident (R89) reviewed for Hospice. Findings include: The History and Physical indicated R89 returned to the facility from the hospital on 10/18/12, following an admission for urosepsis (a blood infection), hydronephrosis (swelling of the kidneys when urine flow is obstructed in any of part of the urinary tract) and a heart attack. R89 was admitted to Hospice care on 10/18/12, with a diagnosis of terminal debility and with a prognosis of less than six months to live. The Hospice care plan dated 10/19/12, included the following interventions for sleep; assess for possible causes, adapt medication regimen to promote/assist rest, and adapt environment to provide optimal opportunity for rest. Although insomnia was listed on R89's mood care plan	F 280	**F Tag 280 Comprehensive Care Plans (Timeliness)** It is the policy of Crest View Lutheran Home to develop a comprehensive care plan within seven days after the completion of the comprehensive assessment. *The resident has the right to, unless adjudicated incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.* *Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 dated 2/29/12, the care plan was not integrated with the Hospice care plan. The therapeutic recreation care plan dated as reviewed 2/13, indicated R89's goal for activities of interest included sports, spiritual groups, outings, outdoors, television and socials. The care plan included approaches of: orient resident to opportunities for activities around the care center, invite/encourage resident to attend groups of interest, encourage independent exploration of leisure opportunities. A hospice note dated 2/22/13, reported R89 "remains reclusive to his room." Although R89 remained in his room, the care plan was not revised to reflect changes in R89's activity needs at the end of life. The alteration in mobility care plan dated 2/12/12, indicated R89 was independent with wheelchair mobility and needed assist with wheelchair mobility as needed (PRN). The mobility care plan did not include R89 was bed ridden. Further review of the clinical record indicated: - A progress note dated 2/18/13, identified R89 "has been staying in bed since working [with] hospice." - A progress note written by the medical director dated 2/5/13, noted patient was now bedridden. Although R89 was identified as being bed ridden, the care plan was not revised to reflect his changed mobility needs. The mood care plan dated 2/29/13, indicated R89 "remains in bed per his choice, on hospice care," the care plan was not integrated with the Hospice care plan. The alteration in bowel and bladder function care plan dated 2/12/13, included use of a diuretic. Review of the physician's orders dated 3/5/13,	F 280	For Resident # 89 the care plan was reviewed and revised by the interdisciplinary team on 3/8/13. R 89 does have a Foley Catheter D/T Hydronephrosis and BPH with obstruction and Bladder cancer. Discontinuation of the Diuretic did not need to be care planned as the care for his catheter remains unchanged. Mobility ability was changed on his care plan and sleep issues were care planned on 2/12/13. . Corresponding updates have been made to care assignment sheets and communicated to the resident and/or designated decision maker. The primary physician was informed of assessment results and a review of the current physician orders has been completed on 3/8/13. Education has been provided for staff members regarding timeliness of care plan updates and integration with Hospice care plans on April 10, 11 and 12 of 2013. Resident # 89 remains on Aspen Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 revealed the diuretic was discontinued. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated the care plan should have been updated.	F 280	For other residents who may be affected by this practice, an audit has been implemented and is ongoing on Care Plan changes. Staff education will be implemented if indicated by April 10, 11 and 12 of 2013	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide pain management services and failed to identify or implement measures to reduce bruising risk for 1 of 1 resident (R89) reviewed for hospice care. Findings include: On 3/6/13, at 10:27 a.m. R89 stated he experienced pain that was not relieved, although pain medication helped. On 3/7/13, at 7:47 a.m. a nursing assistant (NA) -E was observed to assist R89 to a sitting position in bed. R89 moaned and stated, "The pain is always there." - At 8:32 a.m. R89 was observed to be attempting to hold himself upright using the half side rail on the edge of the bed. The pillows from behind his	F 309	The policy for comprehensive care plans will be reviewed and revised by the interdisciplinary team on 4/10/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the Comprehensive Care Plan policy and procedures on April 10, 11 and 12 of 2013. Care plan audits will be completed weekly for 4 weeks, monthly for 2 months, then randomly to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 back were observed to have fallen away and R89 had no back support. R89 was observed to have facial grimacing and reported back pain. R89 stated he did not get up in a chair for breakfast because, "It is too much work for the staff." - At 9:48 a.m. R89 was observed to continue to experience pain during morning cares. While NA-E assisted R89 to a sitting position, R89 stated, "Oh--Oh" and reported feeling dizzy. R89 winced when he raised his left arm and leaned forward and stated, "Ouch." After being assisted to lie down, R89 pointed at the catheter and stated, "This is the one that hurts." R89 again winced and stated he had to put his legs down. As NA-E provided catheter care, R89 continued wincing. When asked what hurt, R89 pointed to the catheter and stated, "It's the cord that hurts." R89 continued to display facial grimacing after the catheter care was completed. R89 moaned loudly when turned to the right side, had facial grimacing when on his back and when rolled to the left side. R89 continued to have facial grimacing when he was pulled up in bed and when NA-E lifted his legs. A licensed practical nurse (LPN)-G then adjusted R89's catheter. R89's face was red and he had facial wincing while cream was applied to the resident's penis. LPN-G offered R89 pain medication which R89 declined. LPN-G then left R89's room and no other pain interventions were offered. R89 was observed to use pursed lip breathing after LPN-G left the room. - At 2:59 p.m. R89 stated he had a lot of pain in the groin area and was observed to have facial grimacing while he grabbed at his lower abdomen. R89 was asked why he did not take medication for the pain, he stated he did not want to become addicted (to the medication for pain)	F 309	**F Tag 309 Quality of Care** It is the policy of Crest View Lutheran Home to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Care areas included in F309 are end of life, diabetes, renal disease, fractures, congestive heart failure, non-pressure related skin ulcers, pain and fecal impaction. Surveyors will determine whether situation was avoidable or unavoidable. (Was there a complete assessment? Was the care plan consistently implemented? What were the results of the evaluation? Was the plan of care revised with different or new interventions?)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 and thought the pain would go away. - At 8:02 a.m. R89 stated the pain "is always there...It would be nice if it would go away." R89 stated the pulling of the catheter and pain in back and legs was what kept him awake at night and he needed to "move carefully so I don't cause more pain, so I don't wake myself up." The History and Physical indicated R89 returned to the facility from the hospital on 10/18/12, following an admission for urosepsis (a blood infection), hydronephrosis (swelling of the kidneys when urine flow is obstructed in any of part of the urinary tract) and a heart attack. Additional diagnoses included spinal stenosis, back pain, prostate cancer and constipation. The resident was admitted to hospice care on 10/18/12, with a diagnosis of terminal debility. The Hospice care plan dated 10/19/12, directed the following interventions to identify and address R89's pain: assess pain characteristics, assess spiritual/psychosocial contributors to pain; provide opportunities for patient/family to discuss feelings, beliefs, fears regarding pain; explore patient/family expectations, myths regarding pain; education patient/caregivers regarding pain management and resources available. The Hospice care plan directed to administer a medication regimen to relieve distressing pain symptoms and directed non-pharmacological means to provide comfort, such as massage, music, position, heat or cold. The Hospice care plan also included the following interventions to promote sleep such as, assess for possible causes of sleep problems (such as pain), adapt medication regimen to promote/assist rest, and adapt environment to provide optimal opportunity	F 309	For Resident # 89 a new pain assessment was completed on 3/9/13. For Resident# 89 a meeting was held with the MD, NP and hospice team to discuss coordination of care on 3/8/13. Pain medication was increased on 3/8/13. On 3/11/13 Resident requested it be decreased back to the previous dose D/T "feeling too fuzzy in my head". Corresponding updates have been made to care assignment sheets and communicated to the resident and/or designated decision maker. Education will be provided for staff members regarding reporting pain per pain management policy April 10, 11 and 12 of 2013 Resident # 89 remains on Aspen Unit For other residents who may be affected by this practice, an audit regarding Pain management will be started on 4/10/13 and remains ongoing. Upon this review, care plan revisions and/or staff education will be implemented if indicated on April 10, 11 and 12 of 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 for rest. The quarterly Minimum Data Set (MDS) dated 2/9/13, indicated R89 had pain "almost constantly," the pain was rated at 10/10 (on a 0 -10 pain rating scale, zero equaling no pain and 10 the worst imaginable pain) in intensity, the pain made it hard for R89 to sleep at night and limited R89's day-to-day activities. The Care Area Assessment (CAA) dated 11/16/12, indicated R89 had pain and only included a summary of "Resident with chronic joint pain and recent diagnosis of UTI [urinary tract infection]." The CAA did not include information regarding R89's refusal of as needed (PRN) pain medication or not wanting an increase in pain medication. Review of R89's medication pain regimen indicated a physician's order was written on 11/1/12, for clotrimazole 1% cream. The order directed to "apply [clotrimazole cream] to [R89's] scrotum and penis 2x [twice] daily for topical infection and redness." The following day an order was received to give scheduled Methadone 2.5 milligrams (mg) every eight hours. A physician's order dated 11/15/12, directed staff to administer the as needed (PRN) pain medication "liberally" to treat the resident's pain. No other changes were made to the resident's pain regimen until 3/8/13. A progress note dated 1/17/13, indicated R89 was given medication during the Hospice nurse visit for back and penile pain and the facility staff would continue to assess. A Hospice Nursing Visit note of the same date indicated R89 was "grimacing at rest complaining of pain to penis and low back. He winces and jerks with	F 309	The policy for Pain Management will be reviewed by the interdisciplinary team on 4/10/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the Pain Management policy and procedures on April 10, 11 and 12 of 2013 Pain Management audits will be completed weekly for 4 weeks, monthly for 2 months, then randomly to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 1, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 adjustment to catheter. NSS [no signs or symptoms] of external distress. Weight of tubing was pulling at catheter. Encouraged staff to utilize PRN morphne [sic] already ordered for pain." A Pain Management Flow Sheet for Cognitively Intact was completed for R89 on 1/17/13. The flow sheet had two entries which both indicated R89 reported pain at a nine out of ten in his penis and legs. No other entries were included on the flow sheet. A Palliative Care Physical Care Plan (PCPCP) dated 1/23/13, was reviewed and indicated R89 had pain and itching and was complaining of not sleeping well and had a loss of appetite. The goal was for R89 to report less pain, display no grimacing or moaning, maintain body weight and report less itching. The interventions included: assess for pain and provide pain relief measures (non-pharmacological and/or pharmacological), administer medications as ordered/needed. The comment section included "c/o [complained of] pain all over, was unable to rate it, doesn't feel non-pharm [non-pharmacological] methods are effective. Hospice in on 1/11/13 and initiated Sarna lotion for comfort. Discuss sleep aid [with] hospice." The plan noted R89 had the medication Roxanol scheduled and PRN "which he is getting regularly" and Methadone scheduled for pain. The plan directed staff to continue to offer medication PRN and did not provide instruction if R89 declined medication or did not want an increase in scheduled medication. A Pain Identification/Review was completed for R89 on 2/6/13, and noted, "Pain relief is adequate [with] current plan." The review did not identify	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16 R89 refused PRN pain medication or would not want an increase in pain medication. R89's care plan dated 2/12/13, indicated R89 had actual pain related to arthritis, spinal stenosis and was evidenced by resident reported or demonstrated discomfort, guarding, facial mask of pain, rubbing area, and grimacing. The goals were for the resident to rate pain at three or fewer on a zero to ten pain scale, participate in activity programs, and to experience three to four hours of uninterrupted sleep. Staff were to administer routine and PRN medication, evaluate effectiveness, observe for side effects, medication before planned activity/exercise, body alignment, update hospice with any changes, teach/coach relaxation techniques, diversion/distraction, reminiscing, activities, music therapy and collaborate with the nurse practitioner/physician (NP/MD) if current pain control measures were ineffective. The care plan also directed staff to "Monitor sleep pattern x 3 nights every month." Sleep tracking documentation for R89 was requested on 3/8/13, at 10:59 a.m., however none was provided. A Hospice Nursing Visit note dated 2/22/13, identified, "Staff reports patient will state he has pain when asked. Pain response observed does not match patient's account. No overt SS [signs and symptoms] of pain during visit other than patient words. Staff believe pain is well controlled at this time." The note also described R89 as cognitively impaired and fatigued. Review of the March 2013 MAR revealed R89 received Tylenol 1000 mg at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., Morphine 5 mg at	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 8:00 p.m. and Methadone 2.5 mg at 12:00 a.m., 8:00 a.m. and 4:00 p.m. The MAR revealed no PRN pain medication was administered during the month of March. The Methadone dose was increased to 5 mg at 8:00 a.m. and 8:00 p.m. on 3/8/13. The clinical record lacked evidence R89's pain was comprehensively assessed, including an assessment of how often and why R89 was refusing PRN pain medications and any other interventions utilized to potentially control R89's pain. A Hospice Nursing Visit note dated 1/23/13, indicated R89, "Comments today with prompting from staff about difficulty sleeping and accepts an offer from writer for medication at bedtime to help him sleep through the night." R89 requested to be reminded the medication was for sleep as, "They give so many different ones and I never know." The note also indicated R89 was spending approximately 18 hours per day sleeping in bed. A physician's order dated 1/23/13, indicated R89's Trazodone (antidepressant commonly used to promote sleep) 50 mg at bedtime was increased to 75 mg on 3/5/13. The physician's progress note dated 3/5/13, noted R89 and increased pain and the cancer could have metastasized into the bones (known to cause back pain). The progress note also indicated R89's back pain was "much improved" since Methadone was added. A progress note written by the Hospice nurse on 3/7/13, noted, "Pt [patient] has chronic pain that he reports as moderate. Writer offered PRN pain med but pt declined stating he doesn't want to get used to more medication. Staff has no new	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 concerns [and] pt is comfortable." The clinical record lacked evidence other alternatives for pain reduction were offered and lacked evidence education was provided to R89 for potential pain control. On 3/8/13, at 9:34 a.m. NA-E stated when she cared for R89 on 3/7/13, he complained of back pain, as well as pain in the groin area with washing and when the catheter tube was moved. NA-E stated she had just begun taking care of R89 again on 3/7/13, after four weeks of a different assignment. Prior to this, NA-E stated R89 did report the catheter caused him pain, but he did not complain of back pain at that time as much as he reported on 3/7/13. NA-E stated she had reported R89's complaints of pain four weeks ago to LPN-G. On 3/8/13, at 9:49 a.m. a trained medication aide (TMA)-A stated R89 requested PRN medication daily, which she then reported to the nurse responsible for administering the PRN pain medications. TMA-A also stated R89 had never refused to take scheduled medications. On 3/8/13, at 10:12 a.m. the Hospice nurse who visited R89 on 3/7/13 stated the facility staff had not reported R89's catheter pain to the agency staff. The Hospice nurse also stated LPN-G told her R89 refused to take PRN medication for pain. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated pain assessments were completed by nurses when a resident was admitted, with MDS assessments, and with any new signs, symptoms, or complaints of pain. The DON stated she would have expected nurses would	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19 relay reports of pain to Hospice staff, and would expect nurses to document and report pain to Hospice. She would expect staff to document if a resident was refusing pain medication and update the physician. In addition, the DON stated she expected staff to educate a resident when concerns regarding potential addiction to pain medication were expressed, and to document the education in the resident's record. At 1:21 p.m. the DON reported a catheter strap had been applied to R89's leg to minimize the risk of pulling and tears by holding the catheter in place and the NP would be increasing R89's pain medication. On 3/8/13, at 1:48 p.m. NA-F stated R89 had pain when the staff tried to change or clean him. NA-F stated R89 also had a hard time rolling over and reported it hurt to do so. NA-F stated R89's pain was experienced in the groin area and it worsened when his legs were moved. NA-F stated R89 yelled out in pain whenever she moved the catheter bag, stated R89 had been experiencing pain for a couple of months and she had reported R89's pain to the nurses. The facility Pain Management Program policy dated 1/13, revealed the following: "POLICY: It is the policy of Crest View Lutheran Home to assure that there is a comprehensive program of pain management for all residents." "PROCEDURES: 1. All residents will be screened for pain on admission and readmission, routinely with MDS assessments, when there is a change in condition or onset of new signs and/or symptoms that may indicate pain. The resident's self-report of pain is	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20 the primary indicator for pain. 2. All staff is trained to recognize signs and/or symptoms of pain or behaviors that may indicate pain. All staff is trained to report that information to the nurse for analysis and action. 3. Residents who show signs and/or symptoms of pain are comprehensively assessed to determine the types and degree of pain, onset, duration, quality, intensity, alleviating, and aggravating factors. 4. Results of this assessment are communicated to the attending physician or NP This communication is documented in the resident record and may be documented on other assessment forms as well. Results are also communicated to members of the resident's interdisciplinary team. 5. In collaboration with the resident and/or family, a goal for pain management is established and a multi-disciplinary plan is written to achieve that goal. Interventions to relieve or reduce pain are both pharmacological and non-pharmacological must follow the pain management protocol." A letter written by the DON dated 3/11/13, indicated R89 "does not like narcotic pain medication, did not want to get addicted to them, and hated the way they make him feel." The letter also indicated R89's "wishes are to not be over medicated." There were no supporting documents provided by the facility to support the above assessment prior to 3/11/13, including education of R89 regarding myths of addiction with severe pain. The information was not included on R89's care plan. A letter written by R89's former physician dated 3/13/13, indicated R89 had continued to battle	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 narcotic related constipation which had been R89's primary concern. The physician stated he did not recall R89 expressing concern about getting addicted to opioids and "We were trying to avoid further constipation which might be expected from higher opioid doses." The letter did not indicate if any non-narcotic medications had been utilized to control R89's pain and only addressed leg and back pain. A Hospice Nursing Visit note dated 3/7/13, indicated R89 had a bowel movement almost daily. A review of the MAR for 3/13, revealed R89 received Miralax daily, Senna laxative three times a day and a suppository daily for his bowels and had not required the use of any PRN medications for his bowels. R89 was observed to have bruises on both hands. R89's diagnoses included a terminal diagnosis of debilities, prostate cancer, coronary artery disease and back pain. During initial observation and interview with R89 on 3/6/13, at 10:35 a.m. he was noted to have large dark bruises covering the backs of both hands. When asked about the bruises, R89 stated he hits them on the side rails when grabbing for them. R89 was noted to have half side rails up on both sides of the top half of the bed. On 3/7/13, during care observations at 9:48 a.m. R89 had difficulty finding the rails and was noted to reach out with his hands until he could find them. Bruising was again noted to the backs of both hands. Incident reports for R89 were requested, however, only a fall report dated 2/16/13, was	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22 provided. The administrator verified there were no other resident incident reports for R89. R89's NA assignment sheet dated 3/5/13, indicated the resident had two half side rails. The assignment sheet directed, "On bath days & when doing ADL'S [activities of daily living] check for any open areas or pressure sores make sure skin is intact and report any findings to nurse." The resident's risk for bruising was not noted, nor did it remind NAs to report bruising. Although aspirin was listed as an allergy for R89, the March 2013 MAR revealed R89 was receiving aspirin 81 milligrams (mg) daily (a medication known to contribute to bruising). The MAR also noted a skin check was completed on the evening shift on 3/7/13. R89's care plan related to safety dated 2/12/13, included, "1/2 side rails x 2." A risk of bruising related to use of aspirin and the side rail use was not identified, nor were there interventions to minimize the bruising risk. The skin integrity plan did not address R89's risk for bruising, but directed staff to "monitor skin with cares." The sensory perception plan revealed R89 had cataracts and was blind in the right eye. The 2/13 Physician's Orders listed aspirin as an allergy for R89. A physician's progress note dated 3/5/13, listed an allergy to aspirin in the note and indicated the presence of bruising, but did not identify potential causes. On 3/8/13, at 9:34 a.m. NA-E stated she had reported the bruises on R89's hands to LPN-G.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 On 3/8/13, at 10:59 a.m. the DON verified there were no other incident reports for R89 and stated she was unaware of the bruises on R89's hands. The DON also stated a care plan should have been developed for the resident's risk for bruising. At 1:21 p.m. the DON stated LPN-G did not remember being told about the bruises on R89's hands and an incident report would be completed. Follow-up correspondence from the DON dated 3/11/13, was reviewed. The letter verified R89 had bruises and R89 "Stated he bumped his hands on the side rail when he reached for them." Although the bruises were noted by the physician on 3/5/13, and observed by the surveyor on 3/6/13, the DON noted "the bruises were new as the night shift had not noted them."	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the Federal Drug Administration (FDA) guidelines for safety and to provide an environment free of accident hazards related to bed rails for 1 of 1 resident (R4) reviewed for accident's related to hazardous	F 323	**F Tag 323 Accidents** It is the policy of Crest View Lutheran Home that each resident receives adequate supervision and assistance to prevent accidents. *Included in F323 are the following: Incidents/Accidents, Incident Reports, Fall Risk, Environmental Safety, Repairs, Preventive Maintenance, DME Equipment, Elopement, Behaviors, Emergency Policies, Resident Rights, Risk/Benefit Analysis, Care Planning, Smoking, Oxygen Use, Temp of Water, Lighting, Noise, Call Systems, Supervision, Bed Rails, Restraints.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 devices. Findings include: R4 had diagnoses to include a history of frequent falls, Alzheimer's disease with cognitive impairments, secondary Parkinson's disease, schizophrenia, and osteoporosis. R4 utilized a bed rail device that was not in compliance with the U.S. Food and Drug Administration (FDA) measurement guidelines, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on 3/10/06, to reduce the risk for entrapment. On 3/4/13, at 5:16 p.m. R4's empty bed was observed with two raised metal brown half bed rails on the upper portion of the bed. The half bed rail away from the wall had a space in zone one, the area inside of the side rail, that did not meet the FDA recommendations. The FDA 2006 recommendation for dimensional limit for zone one indicated the gap should be no greater than 4 and 3/4 inches. At 7:16 p.m. R4 was observed in bed with the both bed rails raised. On 3/6/13, at 4:15 p.m. R4's bed rail was raised and zone one was measured at 5 and 3/4 inches. On 3/7/13, at 5:29 a.m. R4 was observed to be lying in bed with both side rails raised. The dimensions in zone one were measure again at 5 and 3/4 inches. A licensed practical nurse (LPN) -D then reported R4 had "never" been caught between the bed side rail. LPN-D stated since R4's significant change in 1/13, R4 was no longer exhibiting behaviors, agitation or resistance with cares. At 5:45 a.m. a nursing assistant (NA)-D	F 323	For Resident # 4 the assessment for physical devices was reviewed on 3/7/13. Need for 1/2 side rails remains unchanged to enable resident to assist with turning and repositioning. Side rail in question was immediately removed from the resident's bed and a new one was placed on the bed. No new updates have been made to the care plan and care assignment sheet. The primary physician was informed of the assessment results and a review of the current physician orders was completed on 3/7/13. All staff members responsible will be educated on physical device policies and procedures on April 10, 11 and 12 of 2013). Resident # 4 remains on Evergreen Unit. For other residents who may be affected by this practice a care plan audit and physical device audit will be completed by 4/12/13. After review updates will be made as appropriate for each resident identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 verified R4 did not reposition self frequently, was no longer agitated or had anxiety. NA-D stated R4 had "never" been caught in the side rail. R4's current care plan dated 1/21/13, noted a potential for impaired physical mobility. The approaches, included the use of two half side rails. The significant change Minimum Data Set (MDS) dated 1/29/13, identified R4 with severe cognitive loss, a history of falls since admission, and required extensive assistants of two staff for bed mobility. Physician orders dated 1/29/13, were for two half side rails up to assist the resident with bed mobility and transfers. The Care Conference Summary dated 1/29/13, identified the physical devices R4 used were two half side rails. R4's treatment sheet for 3/13, identified there were two half side rails up for assist with bed mobility and transfers. On 3/7/13, at 10:00 a.m. the maintenance director (MD)-A stated when residents were admitted to the facility therapy assessed the need for safety devices which included bed rails. MD-A stated maintenance received the order and put the side rails on the bed. MD-A reported the maintenance department monitored bed rails for dimensional safety every month. MD-A measured R4's bed rail and confirmed zone one measured 5 and 3/4 inches. MD-A stated, "Someone must have bent it." At 11:39 a.m. MD-A stated a bed audit was done on 2/13/13, by maintenance and it indicated R4's side rail was checked and marked as "Ok." MD-A reported	F 323	The policy and procedure physical device will be reviewed by the interdisciplinary team on 4/10/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the Physical Devices policy, Proper bed rail dimensions and bed rail safety. Work order policy re-education began 3/7/13 when the issue was brought to our attention. Further education on this matter will continue on April 10, 11 and 12 of 2013. Physical devices audits will be completed weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The results will be reported to the QA/QI Committee for review and further recommendation. The Director of Nursing, Director of Environmental Services and Quality Control or designee will be responsible for compliance. Date of Correction: May 1, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 between 2/13/13 and the present, someone must have bent the side rail when raising and lowering the bar. MD-A stated staff should have submitted a Work Order Submission because the rail needed replacing. On 3/7/13, at 1:45 p.m. the administrator and director of nursing (DON) confirmed R4's bed rail was not appropriate for dimensional safety related to entrapment. DON verified the facility was aware of the appropriate dimensional safety of side rails related to entrapment risk and staff needed to be retrained on submitting work orders. The facility's Work Order Submission Policy and Procedure revised 11/12, indicated staff should submit a Work order to maintenance when service was needed. The policy directed, "If the Work Order requires adaptive required (i.e. grab bars, side rails, ect. [sic]), the unit nurse or designee completes a maintenance work order form and routes the form to Maintenance to that the proper device/equipment will be implemented/installed."	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident	F 353	**F Tag 353 Nursing Services** It is the policy of Crest View Lutheran Home to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 27 care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staff on the night shift for the subacute/transitional care unit (Aspen and Linden units) to meet the needs of the residents. This had the potential to affect 67 of 67 residents residing on Aspen and Linden units. Findings include: During interviews with residents on 3/4/13, and 3/6/13, the following complaints were made regarding facility staffing: On the Linden Unit: - On 3/4/13, at 4:22 p.m. R105 stated, "Lights [call lights] don't get answered. Sometimes it takes 15 minutes and sometimes it takes an hour [for the call light to be answered]." R105 stated they had to wait a "long time for a pain pill." R105 further stated the night shift "takes a lot longer" to have the call light answered. "I don't think it's good, I think they need more help." - On 3/6/13, at 8:42 a.m. R22 stated it took "too long" for staff to answer the call light. "I think they	F 353	*Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.* The nursing schedule was reviewed. The schedule includes the designation of a "RN Supervisor" on each shift. There is RN coverage in the building 24 hours a day. Our staffing sufficiently meets residents' needs, which is evidenced by our on-going audit tools, that are a part of our CQI program. Per the Nursing Home Compare website, Medicare.gov, Crest View Lutheran Home received four-out-of-five stars for staffing, which is considered "Above Average" (as updated 3/20/2013). The Crest View Staffing Plan was updated to reflect the current staffing pattern which remains appropriate. A Resident Council meeting will be held April 10 at 11:30 AM to explain the staffing model and to allow residents to voice comments related to staffing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 28 need more people." R22 stated facility staff "should answer the call light within 10 minutes." R22 explained she required staff assistance to get to the toilet and remain with her while on the toilet. On the Aspen Unit: - On 3/4/13, at 3:33 p.m. R117 had "waited a long time" to get assistance from staff. R117 stated, "Girls [staff] in the evening complain that they have 30 people to take care of" and stated they did not "get to" R117. - On 3/4/13, at 5:49 p.m. R32 stated the "mornings and evenings," needed more staff. R32 stated they had to wait to get out of bed and get dressed. - On 3/6/13, at 10:28 a.m. R89 stated he has waited "15-30 minutes" for help when he had to go to the bathroom. R89 stated the waiting caused him pain, but but he had not been incontinent due to waiting. On 3/7/13, at 8:30 a.m. the resident council president (R113) was interviewed regarding facility staffing. The R113 identified the residents expressed staffing concerns and stated, "Resident council has brought up call light wait times, had to wait 20 minutes recently with call light on." The R113 president explained she needed to yell out "I'm done! I'm done!" to alert staff. The R113 further stated, "I could hear them talking and joking. At first I thought they didn't like me. The management did respond to the resident council concern and wait times were better for a little while, but then it goes back to the pattern of long wait times." A review of the resident council meeting minutes	F 353	For other residents who may be affected by this practice the daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing levels, and/or to ensure adequate staffing is present. The nursing staffing patterns were reviewed by the interdisciplinary team on 4/8/13. Our Ratio is within State regulation. A review of practices/protocols by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the Staff policy and procedures on April 10, 11 and 12 of 2013. In addition, internal auditing system currently in place was reviewed as it relates to call lights. Call light audits reviewed from 8/7/2012 to 3/7/2013 for night shift call light responses. The average over all call light response time based on the audits during this time frame was 2.7 minutes. Call light audits will continue to ensure timely responses to resident needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 29 and responses from 5/30/12, through 2/22/12, revealed the following: - On 5/30/12, the minutes indicated, "Nursing had concerns about response to call lights and disturbing the resident in the room who had no concerns. This concern was sent to the nursing supervisor. The minutes further indicated, "Another resident wanted 'old' workers who knew his needs better." - A minutes on 6/4/12, indicated survey regulations and plans to address them were reviewed. The minutes indicated the subject of call lights and/or staffing was not discussed. - The response to the 5/31/12, resident council call light concerns dated and signed on 6/14/12, indicated, "Regarding [R113's] concern about the call light response. I have talked with staff to ask when they are responding to call-light and be very courteous and polite as much as possible. Besides, call light audits are going to improve response time. For [R79] we will ensure that regular staff on the floor provide his cares. However this may not always be possible based on staff availability." - The minutes on 6/27/12, indicated, "[R79] shared his concerns about the call light in the evening. This issue was shared last month with no response from nursing." The minutes indicated the staff present "promised to check into this issue promptly." The minutes indicated "no new business" and the meeting was seconded and closed. - Although the subject of call lights were identified as "old business" at the previous resident council meeting, the minutes on 7/25/12, indicated the "old business" discussed did not address the call light concerns identified in the May and June meetings. The response written to the May	F 353	Staffing pattern audits will be completed weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. Call light audits remain ongoing. The results will be reported to the QA/QI Committee for review and further recommendation. The Director of Nursing, Life Enrichment Director and Staffing Coordinator or designee will be responsible for compliance. Date of Correction May 1, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 30 complaint by nursing on 6/14/12, was not mentioned or addressed, such as questioning if the call light response had improved with auditing. The "new business" identified on the minutes regarded an outing. - The minutes on 8/29/12, indicated the facility did not discuss call light response and/or staffing concerns, such as if call light response time had improved since June or since auditing. - The minutes on 9/27/12, indicated, "Call lights not being answered in a timely manner, more workers are needed." The minutes indicated the meeting was continued and closed, the minutes lacked documentation on how the concern would be addressed. - The minutes on 10/31/12, indicated the minutes from the previous meeting were read and approved. The old and new business did not include the September concern of untimely call light responses. The minutes indicated call light concerns from September were not addressed. The Department Review section of the minutes indicated, "Nursing: A resident was concerned about staff speaking in their native tongues. (I can't understand what they are saying!) Also it was mentioned that clearer directions or the passing of information to residents should be made clearer." - The minutes from 11/12 (no actual day documented), indicated the minutes from the previous meeting were reviewed and approved. The minutes indicated a response to the concerns of staff speaking in their native languages and providing clearer directions to the residents. - A Resident Council Action form dated 11/1/12, indicated "3. Call lights not being answered in a timely manner" was communicated to the nursing	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 31 department. The response dated 11/28/12, indicated, "Call lights audited randomly." - The minutes for December, 2012 and January, 2013 did not address call light response or staffing. - The minutes for 2/20/13, indicated, "Nursing: a resident on Linden stated the call lights have not always been answered in a timely manner, a report was given to the director of nursing (DON) on 2/22/13." - The Resident Council Action form dated 2/22/12, identified, "A resident on Linden said call lights were not being answered in a timely manner." The response indicated, "Call light audits will be re-instituted on 2/28/13." Review of the call light audits indicated the forms used to audit were not the same. The audits did not always indicate what unit was being audited, did not indicate the time of day, were not always filled out in a readable manner, and did not contain a key to explain symbols or other non-word notations. A call light audit sheet dated 7/25/12, indicated staff took from six to 37 minutes to answer call lights. A comment entered identified "anywhere from three to six call lights always on." An undated call light audit sheet indicated, "Linden needs auditory alert system too." Review of the facility staffing schedule for 3/4/13 through 3/8/13, indicated between five and 18 schedule changes occurred per day. The January schedule revealed 12 of 31 days the laundry aide was pulled to work as a nursing assistant on a unit, or as the float nursing assistant (NA) position on the night shift. The February schedule revealed eight of 28 days the laundry NA was	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 32 pulled to a unit or the float position on the night shift. The schedule indicated one licensed nurse was scheduled for both the Linden and Aspen units and one NA was scheduled for each of the same units on the night shift (three staff for 67 residents). Review of the medications passed on the night shift (including the potential for as needed medications which could be requested) on 3/6/12, indicated: Aspen Team 1 had ten medications to pass; Aspen Team 2 had 13 medications to pas; Linden Team 1 had 19 medications to pass; Linden Team 2 had 18 medications to pass. This totaled 60 medications for one nurse to pass on the night shift on two units containing 67 residents. Review of facility logs indicated in January 2013 the house supervisor was called to the adjoining facility six times for a total of 106 minutes (1 hour and 46 minutes) of which one hour was on the night shift. In February, 2013 the house supervisor was called to the adjoining facility 11 times for a total of 265 minutes (4 hours and 42 minutes) of which one hour and 25 minutes were on the night shift.	F 353		
	On 3/7/13, at 5:56 a.m. a licensed practical nurse (LPN)-D who confirmed they worked on the Aspen and Linden units during the night shift, stated there was one nurse scheduled for the Linden and Aspen units; one nurse scheduled to cover the Willow and Evergreen units; one house supervisor scheduled to also cover the Royce Place and Boulevard Apartments. LPN-D stated there was one NA scheduled on each unit Aspen,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 33 Linden, Evergreen, and Willow, plus one floating NA and one laundry NA scheduled on the night shift. LPN-D stated the laundry NA could be "pulled if it was really busy." LPN-D stated the staffing was okay for Evergreen and Willow, "because those patients were long-term care [LTC], but depending on what happened on Aspen and Linden it could be extremely busy because those residents were more acute. On Aspen and Linden you had the supervisor to call for help and the laundry NA to pull for help. On Willow and Evergreen, not a lot of people asked for pain medications." LPN-D stated, "If you have an emergency, like someone expired or was having difficulties breathing, then the person asking for pain medications may have to wait until you can get the supervisor to come get the keys and go give them a pain medication." LPN-D further stated, "On Linden and Aspen probably five people want pain medications at the same time, and if someone was having shortness of breath or chest pain, you have to prioritize cares and get the supervisor to help." On On 3/7/13, at 5:58 a.m. nursing assistant (NA) -D stated if the NAs are short, they just find the float, or pull the laundry NA. On 3/8/12, at 8:23 a.m. the DON stated the night shift nurse who covered Aspen and Linden had some "additional duties of Medicare charting," but it was not "every chart every night." The DON further stated the night shift was staffed differently because most people sleep, and the facility was moving away from the check and change every two hours plan, to one where only residents who were assessed to need every two hour checks. The DON stated the sixth NA was to staff for a	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 34 full house and currently there were empty beds. On 3/8/12, at 8:30 a.m. the staffing coordinator (SC) indicated the facility staffing plan had a few "real part time job openings to fill." The facility did not use any outside agencies, but did have an internal nursing pool and nursing assistant pool that were required to pick up four shifts a month. The SC stated the house supervisor was always a registered nurse (RN), or a LPN could replace the house supervisor if there was a RN in the building. The SC stated those hired into the house supervisor position were RN's and the DON was always on call if needed. The SC stated sick calls were replaced as much as possible, but the night shift sick calls always had to be replaced. The SC stated it was her duty to replace shifts openings during the day shift Monday through Friday, but the house supervisor replaced staff who called in sick on the evening shift, night shift and on weekends or when SC was not present in the facility. The SC stated she sometimes got called at home by the house supervisor to come in and help replace sick calls if the house supervisor was too busy, or had an emergency. The SC and RN-A (house supervisor) stated they were unable to hear the call lights from the shared office. Both confirmed the same office was used by the evening and night shift supervisor. On 3/8/13, at approximately 3:10 p.m. the administrator stated "the expectation of call lights being answered should be five or less minutes; two would be optimal, we are people dealing with people and it is our expectation that they are answered." The administrator and DON stated the house supervisor for the night shift assisted	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 35 on Aspen and Linden "if needed;" and stated the amount of time the supervisor was out of the building to respond to Royce Place and Boulevard Apartments was "minimal" and the nursing supervisor always carried a cell phone so he/she could be reached at all times. Both stated the house float NA was available to help all units, but had to be located by calling the different nursing units to find that person. The administrator and DON stated, "When needed, the laundry NA could be pulled to fill in or to help, but again had to be called to be located." The administrator and DON stated the night shift house supervisor should be "out on the units right after getting report from the evening shift supervisor," and was "rarely" in the office. The Crest View Lutheran Home Staffing Plan Policy and Procedures 9/12, indicated "The staffing coordinator on a daily basis complete all staffing for the Nursing Department for twenty-four hours, seven days a week nursing coverage. Staffing is based on and reflects consideration of the needs of resident population along with case mix in determining the composition of the mix levels on a regular basis. The schedule is done ahead to cover two pay periods for all nursing staff. 1. The DON is full time. 2. One full time MDS coordinator is scheduled for 80 hours per pay period Monday-Friday. 3. In the absence of DON the responsibility for continuum and supervision of nursing care is delegated to the RN supervisor. 4. The staffing coordinator is scheduled to work full time, Monday-Friday. 5. At least 1 RN/ADON supervisor and 1 LPN coordinator are scheduled Monday through Friday	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 36 on the 6:30 a.m. to 3:00 p.m. along with 4 other licensed nurses (RN's and /or LPN's). One full time RN supervisor is scheduled from 2:30 p.m. to 11:00 p.m. and 1 RN full time night supervisor is scheduled from 10:30 p.m. to 7:00 a.m. every day. The RN supervisors are responsible for emergency calls to Boulevard, Columbia Village, and Royce Place. 6. Licensed nurses (RN's and LPN's), TMA's and NA's are scheduled for 24 hour coverage, seven days a week by the staffing coordinator, staffing is done on a monthly basis. 7. There is a full time TMA scheduled 7 days a week on the 6:00 a.m. to 2:30 p.m. shift and 2 part time TMA's for heavier med passes from 6 AM-10 AM. There are 3 part time TMA's from 4-8 p.m. 7 days a week. 8. The DON and staffing coordinator work closely together to staff according to census. 9. On Evergreen the ratio is typically 1 NA to 8 residents; on willow 1 to 8 on Aspen 1 to 8, on Linden 1-8 (if Linden is full) (THIS DID NOT SPECIFY SHIFTS). 10. At a minimum 2 RN's or LPN's are scheduled for 10:30 to 7:a.m. 11. At minimum, six NA's are scheduled on the 11:00 p.m. to 7:30 a.m. shift. One NA is scheduled 11:00 to 7:00 a.m. as house float. One NA floats and does personal laundry. 12. In house pool on call staff are scheduled by staffing coordinator to cover during vacations, mental health days, floating holidays, sick leave, leaves of absence (LOA), emergencies and holidays. 13. All nursing staff is required and scheduled to work every other weekend and every other holiday, unless specified otherwise. 14. all master schedule for nursing personnel on	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 37 each shift are posted two weeks prior to the start of the new pay period, on the nursing bulletin board. Each schedule covers one pay period or two weeks. 15. The daily work schedule for each station is completed prior to the next day and posted on the staffing coordinator's office door. 16. Staffing coordinator will adjust productive nursing hours on a daily basis." The facility did not have sufficient staff on the night shift to meet and respond to R196's needs. As a result, staff did not respond to R196's repeated call for help on 3/7/13; resulting in R196 to becoming incontinent of urine. On 3/7/13, at 5:00 a.m. R196 was observed sitting in a wheelchair in her room holding a dry incontinence product on her lap calling out, "Help! help!" No staff were observed on the unit at the time. NA-C was down one of the hallways assisting another resident. LPN-E was assigned to two units (Linden and Aspen) and was off the unit. At 5:15 a.m. R196 held up the dry incontinence pad on her lap and reported she had been waiting since 3:00 a.m. for help to the bathroom. R196 also reported her roommate ran out of oxygen around 2:00 a.m. and LPN-E was in and out of the room changing the oxygen tank which then interrupted R196's sleep. When R196 turned on the call light to request assistance, she said LPN-E came into the room, turned off the light, and said she would send someone to help. R196 then transferred herself from the bed to the wheelchair and "sat waiting" for someone to assist her into the bathroom. R196 stated she was "very frustrated." When R196 was asked how she knew she had been waiting since 3:00	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 38 a.m. the resident pointed to the watch on her left wrist. On 3/7/13, LPN-E was initially observed by the surveyor at 5:15 a.m. and was informed of R196's need for help. LPN-E went into another resident's room and infomed NA-C that R196 needed help to use the bathroom. LPN-E stated R196 had not put on the call light, confirmed she had been in and out of R196's room to assist her roommate and switch oxygen tanks since 2:00 a.m.. LPN-E did not attempt to assist R196 with her needs. At 5:20 a.m. NA-C assisted R196 to the bathroom. Although R196's incontinent product was observed to be heavily saturated with urine, R196's skin had no signs of skin breakdown or redness. NA-C confirmed the findings and after R196 was toileted, assisted R196 with a dry incontinent product. On 3/7/13, at 5:30 a.m. R196 stated the facility was short on help at night and there was only one nursing assistant to help all of the residents. R196 indicated it did not happen a lot, but when she had to go to the bathroom, she did not like to wait. On 3/7/13, at approximately 7:15 a.m. when asked about staffing, LPN-E stated, "I hope you get the answers to the questions you are asking." Although LPN-E was scheduled to be in charge of the Linden and Aspen units, LPN-E was not able to tell the surveyor how may residents resided on the units. On 3/7/13, at 9:30 a.m. R196 stated she was frustrated that morning waiting for help, but was okay now. R196 stated she did not like to wait for	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 39 help to go to the bathroom and that she had only wet herself "a couple" of times waiting to get help to go to the bathroom. R196 was admitted to the facility for short stay rehabilitation on 2/15/13, for post fall with fractured ribs. R196's care plan dated 2/15/13, indicated R196 was alert and oriented. The care plan also indicated R196 was incontinent of urine, was to be toileted, and wore large pull-ups. On 3/8/12, at 3:15 p.m. the director of nursing (DON) stated the call lights should be answered and residents assisted within 5 minutes or less. The DON stated two minutes was an acceptable wait time after the resident put on their call light.	F 353		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly dispose of refuse and address external points of entry to the facility to prevent a potential rodent and pest infestation. This practice had the potential to affect all of the 117 residents residing in the facility. Findings include: On 3/7/13, at 1:10 p.m. during the environmental tour with the environmental director (ED) and the administrator present, two rotted service doors	F 372	**F Tag 372 Sanitary Conditions** It is the policy of Crest View Lutheran Home to dispose of garbage and refuse properly. The area around refuse containers behind the building was cleaned and upon notification on 3/8/13. Garbage continues to be picked up six days per week by the waste removal company contracted by the City.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 40 were observed in a storage room near the outside trash bins. The room was observed to store resident beds, equipment and was located behind the kitchen near the junction of the assisted living complex. The rotted areas on the two doors measured 12 inches by one inch and were located near the bottom aspect of each door. The outside was visible through the rotted areas of both doors. On 3/8/13, at 7:35 a.m. the large blue trash bins outside the facility were observed from the physical therapy room window. The trash bins were observed to have white trash bags overflowing the bin with two trash bags on the ground. A blue colored mattress was observed to be resting up against a green utility box near the bins. The mattress was observed to be covered from top to bottom with snow; the edges of the mattress were visible. On 3/8/13, at 8:50 a.m. the ED stated the garbage was picked up daily, sometimes they came at 6:30 a.m. and that was ideal. The ED further stated sometimes the city, who was contracted to pick up the trash, did not come till later.	F 372	The doors in question had been scheduled to be replaced prior to survey and this remains the plan. The capital budget shown to the surveyor reflects this. They have been ordered and will be replaced this spring per the company replacing them. There have not been signs of issues of rodents in the building. Education will be provided for staff members regarding proper refuse disposal on April 10, 11 and 12 of 2013. For other areas of the building that may affect residents: All external doors have been examined. There are no other problems at this time. The policy and procedure for refuse disposal will be reviewed and revised by the interdisciplinary team on 4/10/13. A review of policies by the Medical Director will be completed to ensure current standards of	
	On 3/8/13, at 11:00 a.m. the pest control specialist (PCS) stated he was aware of the rotted doors and confirmed the holes in the service doors leading to the trash bins were a potential entry area for rodents. The PCS said he had tried to get the facility to replace the two doors for quite a few months. The PCS stated he placed extra bait stations for pest control outside the rotted doors and near the trash bins.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 41 The facility policy and original request for repair of the doors was requested. The facility policy entitled Pest Control dated 11/12, indicated it was the policy of Crest View Lutheran Home to maintain and keep a pest free environment. Reports of any issues must also be reported to the director of environment services and administrator immediately. The Capital Budget Request dated 9/12/12, indicated a request to replace the doors was made for the 2013 fiscal year. The estimated date for replacement of the rusted doors was 4/1/13.	F 372	practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the refuse disposal policy and procedures on April 10, 11and 12 of 2013. Audits regarding refuse disposal and storage will be completed weekly to ensure continued compliance. The results will be reported to the QA/QI Committee for review and further recommendations.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Daily environmental rounds are completed by Maintenance. The Director of Maintenance or designee will be responsible for compliance. Date of Correction: May 1, 2013. **F Tag 441 Infection Control** It is the policy of Crest View Lutheran Home to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 42 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not store a glucometer (equipment used to check blood sugars) for 3 of 9 residents (R7, R57, R140) in a manner which reduced the potential spread of blood borne pathogens. In addition, the facility failed to ensure proper gloving and hand hygiene practices were followed on 2 of 4 units (Aspen, Willow). These practices had the potential to affect 31 of 52 residents. Findings include: The registered nurse (RN)-B was observed to store the soiled glucometer with sterile lancets, clean the glucomter with soiled gloves; obtain blood specimens, administer insulin injections to R7, R57, and R140 without proper glove changes and hand washing. RN-B was observed to clean the glucometer without changing contaminated gloves.	F 441	*The facility must establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Personnel must handle, store, process and transport linens so as to prevent the spread of infection.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 43 During medication pass observation on 3/4/13, at 3:44 p.m. RN-B applied gloves and checked R7's blood sugar. RN-B then put the glucometer on top of the sterile lancets (used to puncture the skin to get a blood sample) in a clear plastic container. RN-B next administered R7's insulin injection. After RN-B administered R7's insulin and without changing the gloves worn while obtaining a blood specimen and administering the insulin, RN-B took the glucometer out of the clear plastic box and wrapped it in a Sani-wipe (a moist towelette used to sanitize equipment). RN-B then removed her gloves and without washing her hands, applied new gloves and prepared insulin for R57. RN-B again wrapped the glucometer with a Sani-wipe and placed it with the sterile lancets in the clear plastic box. RN-B administered R57's insulin and removed her gloves. RN-B returned to the treatment cart without washing her hands, applied new gloves and removed the Sani-wipe from the glucometer and removed her gloves. RN-B applied new gloves, checked R140's blood sugar, removed her gloves, applied new gloves and wrapped the glucometer in a Sani-wipe and then placed it on top of the lancets. RN-B used the same gloves to prepare insulin for R140. RN-B removed her gloves, applied new gloves and administered R140's insulin. After she removed her gloves, RN-B wrapped the glucometer in a Sani-wipe and again placed it on top of the sterile lancets. At 4:06 p.m. RN-B washed her hands. After the observations, RN-B verified she had performed glucometer checks and administered insulin to several residents. RN-B confirmed she had not washed her hands from 3:44 p.m. until 4:06 p.m. RN-B stated she usually used "blue wipes" to clean her hands	F 441	The infection surveillance was reviewed and revised upon notification on 3/8/13 Education on Infection Control, the proper cleaning of Glucometers and proper glove use and hand washing will be provided for staff members on April 10, 11, and 12 of 2013 For other residents who may be affected by this practice a review was completed regarding improper cleaning of Glucometer, Residents with diabetes needing blood glucose monitoring were identified by chart review for monitoring of blood glucose checks. The policy and procedure for Glucometer cleaning, glove use and hand washing will be reviewed and revised by the interdisciplinary team on 04/10/13. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members will be trained as it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44 when she changed gloves, but did not have them. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated hand washing was expected per the policy. An undated form titled HANDWASHING noted, use antimicrobial soap or antimicrobial hand scrub "Immediately after gloves are removed." The facility lacked garbage containers which prevented potential re-contamination of hands after handwashing; a nursing assistant (NA)-H was observed to not follow the accepted standard for handwashing. On 3/4/13, at 5:47 p.m. NA-H was observed to wash her hands in the dining room sink of the Willow unit. NA-H was observed to use one clean hand to open the garbage lid to throw away the paper towels (potentially contaminating her hands). The garbage can was observed to lack a means to lift the lid without contaminating cleaned hands, such as a foot control to lift the lid of the can. NA-H was then observed to walk away from the garbage while wiping her clean hands down the back of her clothing (contaminating her hands), put gloves on and proceeded to clean the hands of the residents with Sani-Hands. The facility Exposure Prevention Procedures for Bloodborne Pathogens policy dated 3/7/13, directed the following for Hand-washing: "Employees shall wash their hands per CDC/MDH [Centers for Disease Control and Minnesota Department of Health] guidelines to include, but not limited to, before and after resident contact, before handling food, when in	F 441	relates to their respective roles and responsibilities regarding the policy and procedures on infection control on April 10, 11, and 12 of 2013 Glucometer cleaning, hand washing and glove use audits will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 1 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 45 contact with any body fluids/secretions/blood and after removing gloves." The facility undated HANDWASHING policy directed handwashing after touching contaminated items and, "Between tasks on the same resident to prevent cross-contamination of different areas of the body (when doing something dirty such as assisting someone off the commode, to doing something clean such as assisting someone to eat)." The facility policy also included the undated World Health Organization (WHO) How to Handwash guide and the undated WHO How to Handrub guide. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated hand washing was expected per the policy.	F 441		

S5018024
CREST VIEW LUTHERAN HOME

ASE-Q SURVEY – Supervisor Checklist

1. **Review package in ACO and close**

2. **Exit survey in Paradise**

3. **Email MN Enforcement of survey completion**

4. **When the POC comes back from the facility:**
   - Ensure POC is date stamped when received
   - Verify provider signed and dated first page
   - If licensing orders were issued ensure the facility returned a signed copy of the orders by the time of the PCR
   - Verify each deficiency has a correction date
   - Verify completion date is same as date certain (as in the cover letter) or earlier
   - Date and initial the first page of the 2567 once approved
   - Complete a plan of correction letter (POCA) and send to the facility
   - Enter the date the package has been scanned in the Project Tracking screen under Sent to L&C in Paradise

5. **If onsite PCR, ensure PCR package has a copy of the 2567 with the POC (including licensing orders, if applicable)**

6. **Administrative support staff will scan the following forms into the Admin folder into the QIS pool.**
   - Items 1, 2 and 3 on the team coordinator checklist
   - Approved POC
   - First page of signed licensing orders

7. **For IJ or SQC, email to MN Enforcement once an acceptable POC is received. Program Assurance will send out the appropriate notices.**
   - Send letter to the Board of Nursing Home Administrator
   - Send letter to the Board of Nursing, if directed by the APM
   - Include list of names/addresses of the physicians for any residents involved in the SQC

Please scan into pool
TOPA 4/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crest View Lutheran Homewas found 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. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction typed is II (111) The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of117 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**03/06/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crest View Lutheran Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. Bldg # 2 was constructed in 2007. It is a one story building with full basement. The construction type is determined to be type II(111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility is licensed for 122 beds and 117 were occupied at the time of inspection.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED LETTER

April 22, 2013

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

RE: Project Number S5018024

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5018024

Dear Ms. Aramalay:

PLEASE NOTE: THIS LETTER SERVES TO REPLACE AND CORRECT THE LETTER DATED MARCH 27, 2013 IN ORDER TO REMOVE COMPLAINT H5018092. THERE WAS NO COMPLAINT INVESTIGATION COMPLETED AT THE TIME OF THE MARCH 8, 2013 STANDARD SURVEY.

The above facility was surveyed on March 4, 2013 through March 8, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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 me.

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.

Please feel free to call me with any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Crest View
SENIOR COMMUNITIES

4444 Reservoir Blvd NE
Columbia Heights, MN 55421
Phone: 763-782-1611
Fax: 763-782-0857
www.crestviewcares.org

FAX TRANSMISSION

DATE: 4/10/13 TIME: 1:10 pm

TO: Gloria Derfus
Unit Supervisor

FROM: Talia Aramalay,
Administrator

FAX NUMBER: 651-201-3790

COMMENTS: State Licensing Correction Order

TRANSMITTAL CONTAINS 3 PAGES (including cover sheet)
If you have any problems with this transmittal, please call 763-782-1611

CONFIDENTIALITY NOTICE: The information contained in this e-mail or fax communication and any attached documentation may be privileged, confidential or otherwise protected from disclosure and is intended only for the use of the designated recipient (s). Any unauthorized person does not intend it for transmission to, or receipt. The use, distribution, transmittal or re-transmittal by an unintended recipient of this communication is strictly prohibited without our express approval in writing or by e-mail or fax. If you are not the intended recipient of this e-mail or fax, please delete it from your system without copying it and notify the above sender so that our e-mail address may be corrected

Crest View
SENIOR COMMUNITIES

4444 Reservoir Blvd. NE
Columbia Heights, MN 55421
763-782-1611 FAX 763-782-0857
www.crestviewcares.org

April 10, 2013

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Division of Compliance Monitoring
Licensing and Certification
85th East 7th Place
Suite 220
St. Paul, MN 55164-0882

Dear Ms. Derfus,

Enclosed is the State Licensing Correction Order form, signed.

If you have any further questions, please do not hesitate to contact me at 763-782-1620 or via email at taramalay@crestviewcares.org.

Respectfully Submitted,

Talia Aramalay, LNHA

Talia Aramalay, LNHA
Administrator
Crest View Lutheran Home

BECOME PART OF A CARING COMMUNITY WITH TRADITIONAL VALUES AND AN ADVANCED PHILOSOPHY ON SERVING PEOPLE

CREST VIEW SENIOR COMMUNITIES IS AN EQUAL OPPORTUNITY EMPLOYER

EQUAL HOUSING OPPORTUNITY

PRINTED: 03/27/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/4/13, through 3/8/13, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

Received 4-10-13

Minnesota Department of Health

Julie McCoy, LNHA

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

TITLE: Administrator

(X6) DATE: 4/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/4/13, through 3/8/13, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; P.O. Box 64900, St Paul, Minnesota 55164-0900.	2 000	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 which 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.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557,	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 2 subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan related to bruising risk for 1 of 3 residents (R89) reviewed for non-pressure related skin conditions. Findings include: R89's care plan was not developed for the risk of bruising. R89's diagnoses included terminal diagnosis of debilities, prostate cancer, coronary artery disease and back pain. During initial observation and interview with R89 on 3/6/13, at 10:35 a.m. he was noted to have dark purple bruises covering the backs of both hands. When asked about the bruises, R89 stated he "hits them [his hands] on the side rails" when grabbing for them. R89 had half side rails up on both sides of the top half of the bed. During cares on 3/7/13, at 9:48 a.m. R89 was observed using the side rails to turn in bed. R89 was observed to have difficulty finding the rails and to reach out with his hands until he could feel them. Bruising was again observed to the backs of both R89's hands. The Aspen Team 2 nursing assistant assignment sheet dated 3/5/13, indicated R89 had "2 ½ side rails" but did not identify a risk for bruising. The assignment sheet directed, "On bath days & when doing ADL'S [activities of daily living] check for any open areas or pressure sores make sure	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 skin is intact and report any findings to nurse." The assignment sheet lacked direction for reporting bruises. The medication administration record (MAR) for March 2013 revealed R89 received aspirin (a medication known to potentially contribute to bruising) 81 milligrams (mg) daily. The MAR listed Aspirin as an allergy for R89 and also noted a skin check was completed on 3/7/13, on the evening shift. A physician's progress note dated 3/5/13, identified R89 had bruising present but did not indicate where the bruising was located and listed aspirin as an allergy for R89. The potential alteration in safety care plan for R89 dated 2/12/13, included, "1/2 side rails x 2," but did not include risk for bruising, such as related to side rail use. The potential alteration in skin integrity care plan dated 2/12/13, did not address R89's risk for bruising and directed staff to "monitor skin with cares." The potential for alteration in sensory perception care plan dated 2/12/13, indicated R89 had cataracts and was blind in the right eye. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated there were no other incident reports for R89 other than the one dated 2/16/13, for a fall. The DON stated she was not aware of the bruises on R89's hands and stated a care plan should have been developed for a resident at risk for bruising. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan to reflect changes in care needs for sleep, activities, mobility, diuretic use and integration of the care plan with Hospice for 1 of 1 resident (R89) reviewed for Hospice. Findings include: The History and Physical indicated R89 returned to the facility from the hospital on 10/18/12, following an admission for urosepsis (a blood infection), hydronephrosis (swelling of the kidneys when urine flow is obstructed in any of part of the	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 urinary tract) and a heart attack. R89 was admitted to Hospice care on 10/18/12, with a diagnosis of terminal debility and with a prognosis of less than six months to live. The Hospice care plan dated 10/19/12, included the following interventions for sleep; assess for possible causes, adapt medication regimen to promote/assist rest, and adapt environment to provide optimal opportunity for rest. Although insomnia was listed on R89's mood care plan dated 2/29/12, the care plan was not integrated with the Hospice care plan. The therapeutic recreation care plan dated as reviewed 2/13, indicated R89's goal for activities of interest included sports, spiritual groups, outings, outdoors, television and socials. The care plan included approaches of: orient resident to opportunities for activities around the care center, invite/encourage resident to attend groups of interest, encourage independent exploration of leisure opportunities. A hospice note dated 2/22/13, reported R89 "remains reclusive to his room." Although R89 remained in his room, the care plan was not revised to reflect changes in R89's activity needs at the end of life. The alteration in mobility care plan dated 2/12/12, indicated R89 was independent with wheelchair mobility and needed assist with wheelchair mobility as needed (PRN). The mobility care plan did not include R89 was bed ridden. Further review of the clinical record indicated: - A progress note dated 2/18/13, identified R89 "has been staying in bed since working [with] hospice." - A progress note written by the medical director dated 2/5/13, noted patient was now bedridden. Although R89 was identified as being bed ridden,	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 the care plan was not revised to reflect his changed mobility needs. The mood care plan dated 2/29/13, indicated R89 "remains in bed per his choice, on hospice care," the care plan was not integrated with the Hospice care plan. The alteration in bowel and bladder function care plan dated 2/12/13, included use of a diuretic. Review of the physician's orders dated 3/5/13, revealed the diuretic was discontinued. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated the care plan should have been updated. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure hospice care plans are devloped. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staff on the night shift for the subacute/transitional care unit (Aspen and Linden units) to meet the needs of the residents. This had the potential to affect 67 of 67 residents residing on Aspen and Linden units. Findings include: During interviews with residents on 3/4/13, and 3/6/13, the following complaints were made regarding facility staffing: On the Linden Unit: - On 3/4/13, at 4:22 p.m. R105 stated, "Lights [call lights] don't get answered. Sometimes it takes 15 minutes and sometimes it takes an hour [for the call light to be answered]." R105 stated they had to wait a "long time for a pain pill." R105 further stated the night shift "takes a lot longer" to have the call light answered. "I don't think it's good, I think they need more help." - On 3/6/13, at 8:42 a.m. R22 stated it took "too long" for staff to answer the call light. "I think they need more people." R22 stated facility staff "should answer the call light within 10 minutes." R22 explained she required staff assistance to get to the toilet and remain with her while on the toilet. On the Aspen Unit: - On 3/4/13, at 3:33 p.m. R117 had "waited a long time" to get assistance from staff. R117 stated, "Girls [staff] in the evening complain that they have 30 people to take care of" and stated they did not "get to" R117. - On 3/4/13, at 5:49 p.m. R32 stated the	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 8 "mornings and evenings," needed more staff. R32 stated they had to wait to get out of bed and get dressed. - On 3/6/13, at 10:28 a.m. R89 stated he has waited "15-30 minutes" for help when he had to go to the bathroom. R89 stated the waiting caused him pain, but but he had not been incontinent due to waiting. On 3/7/13, at 8:30 a.m. the resident council president (R113) was interviewed regarding facility staffing. The R113 identified the residents expressed staffing concerns and stated, "Resident council has brought up call light wait times, had to wait 20 minutes recently with call light on." The R113 president explained she needed to yell out "I'm done! I'm done!" to alert staff. The R113 further stated, "I could hear them talking and joking. At first I thought they didn't like me. The management did respond to the resident council concern and wait times were better for a little while, but then it goes back to the pattern of long wait times." A review of the resident council meeting minutes and responses from 5/30/12, through 2/22/12, revealed the following: - On 5/30/12, the minutes indicated, "Nursing had concerns about response to call lights and disturbing the resident in the room who had no concerns. This concern was sent to the nursing supervisor. The minutes further indicated, "Another resident wanted 'old' workers who knew his needs better." - A minutes on 6/4/12, indicated survey regulations and plans to address them were reviewed. The minutes indicated the subject of call lights and/or staffing was not discussed. - The response to the 5/31/12, resident council call light concerns dated and signed on 6/14/12,	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 9 indicated, "Regarding [R113's] concern about the call light response. I have talked with staff to ask when they are responding to call-light and be very courteous and polite as much as possible. Besides, call light audits are going to improve response time. For [R79] we will ensure that regular staff on the floor provide his cares. However this may not always be possible based on staff availability." - The minutes on 6/27/12, indicated, "[R79] shared his concerns about the call light in the evening. This issue was shared last month with no response from nursing." The minutes indicated the staff present "promised to check into this issue promptly." The minutes indicated "no new business" and the meeting was seconded and closed. - Although the subject of call lights were identified as "old business" at the previous resident council meeting, the minutes on 7/25/12, indicated the "old business" discussed did not address the call light concerns identified in the May and June meetings. The response written to the May complaint by nursing on 6/14/12, was not mentioned or addressed, such as questioning if the call light response had improved with auditing. The "new business" identified on the minutes regarded an outing. - The minutes on 8/29/12, indicated the facility did not discuss call light response and/or staffing concerns, such as if call light response time had improved since June or since auditing. - The minutes on 9/27/12, indicated, "Call lights not being answered in a timely manner, more workers are needed." The minutes indicated the meeting was continued and closed, the minutes lacked documentation on how the concern would be addressed. - The minutes on 10/31/12, indicated the minutes from the previous meeting were read and	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 10 approved. The old and new business did not include the September concern of untimely call light responses. The minutes indicated call light concerns from September were not addressed. The Department Review section of the minutes indicated, "Nursing: A resident was concerned about staff speaking in their native tongues. (I can't understand what they are saying!) Also it was mentioned that clearer directions or the passing of information to residents should be made clearer." - The minutes from 11/12 (no actual day documented), indicated the minutes from the previous meeting were reviewed and approved. The minutes indicated a response to the concerns of staff speaking in their native languages and providing clearer directions to the residents. - A Resident Council Action form dated 11/1/12, indicated "3. Call lights not being answered in a timely manner" was communicated to the nursing department. The response dated 11/28/12, indicated, "Call lights audited randomly." - The minutes for December, 2012 and January, 2013 did not address call light response or staffing. - The minutes for 2/20/13, indicated, "Nursing: a resident on Linden stated the call lights have not always been answered in a timely manner, a report was given to the director of nursing (DON) on 2/22/13." - The Resident Council Action form dated 2/22/12, identified, "A resident on Linden said call lights were not being answered in a timely manner." The response indicated, "Call light audits will be re-instituted on 2/28/13." Review of the call light audits indicated the forms used to audit were not the same. The audits did not always indicate what unit was being audited,	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 11 did not indicate the time of day, were not always filled out in a readable manner, and did not contain a key to explain symbols or other non-word notations. A call light audit sheet dated 7/25/12, indicated staff took from six to 37 minutes to answer call lights. A comment entered identified "anywhere from three to six call lights always on." An undated call light audit sheet indicated, "Linden needs auditory alert system too." Review of the facility staffing schedule for 3/4/13 through 3/8/13, indicated between five and 18 schedule changes occurred per day. The January schedule revealed 12 of 31 days the laundry aide was pulled to work as a nursing assistant on a unit, or as the float nursing assistant (NA) position on the night shift. The February schedule revealed eight of 28 days the laundry NA was pulled to a unit or the float position on the night shift. The schedule indicated one licensed nurse was scheduled for both the Linden and Aspen units and one NA was scheduled for each of the same units on the night shift (three staff for 67 residents). Review of the medications passed on the night shift (including the potential for as needed medications which could be requested) on 3/6/12, indicated: Aspen Team 1 had ten medications to pass; Aspen Team 2 had 13 medications to pas; Linden Team 1 had 19 medications to pass; Linden Team 2 had 18 medications to pass. This totaled 60 medications for one nurse to pass on the night shift on two units containing 67 residents. Review of facility logs indicated in January 2013 the house supervisor was called to the adjoining	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 12 facility six times for a total of 106 minutes (1 hour and 46 minutes) of which one hour was on the night shift. In February, 2013 the house supervisor was called to the adjoining facility 11 times for a total of 265 minutes (4 hours and 42 minutes) of which one hour and 25 minutes were on the night shift. On 3/7/13, at 5:56 a.m. a licensed practical nurse (LPN)-D who confirmed they worked on the Aspen and Linden units during the night shift, stated there was one nurse scheduled for the Linden and Aspen units; one nurse scheduled to cover the Willow and Evergreen units; one house supervisor scheduled to also cover the Royce Place and Boulevard Apartments. LPN-D stated there was one NA scheduled on each unit Aspen, Linden, Evergreen, and Willow, plus one floating NA and one laundry NA scheduled on the night shift. LPN-D stated the laundry NA could be "pulled if it was really busy." LPN-D stated the staffing was okay for Evergreen and Willow, "because those patients were long-term care [LTC], but depending on what happened on Aspen and Linden it could be extremely busy because those residents were more acute. On Aspen and Linden you had the supervisor to call for help and the laundry NA to pull for help. On Willow and Evergreen, not a lot of people asked for pain medications." LPN-D stated, "If you have an emergency, like someone expired or was having difficulties breathing, then the person asking for pain medications may have to wait until you can get the supervisor to come get the keys and go give them a pain medication." LPN-D further stated, "On Linden and Aspen probably five people want pain medications at the same time, and if someone was having shortness of breath or chest pain, you have to prioritize cares and get the supervisor to help."	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 13 On On 3/7/13, at 5:58 a.m. nursing assistant (NA) -D stated if the NAs are short, they just find the float, or pull the laundry NA. On 3/8/12, at 8:23 a.m. the DON stated the night shift nurse who covered Aspen and Linden had some "additional duties of Medicare charting," but it was not "every chart every night." The DON further stated the night shift was staffed differently because most people sleep, and the facility was moving away from the check and change every two hours plan, to one where only residents who were assessed to need every two hour checks. The DON stated the sixth NA was to staff for a full house and currently there were empty beds. On 3/8/12, at 8:30 a.m. the staffing coordinator (SC) indicated the facility staffing plan had a few "real part time job openings to fill." The facility did not use any outside agencies, but did have an internal nursing pool and nursing assistant pool that were required to pick up four shifts a month. The SC stated the house supervisor was always a registered nurse (RN), or a LPN could replace the house supervisor if there was a RN in the building. The SC stated those hired into the house supervisor position were RN's and the DON was always on call if needed. The SC stated sick calls were replaced as much as possible, but the night shift sick calls always had to be replaced. The SC stated it was her duty to replace shifts openings during the day shift Monday through Friday, but the house supervisor replaced staff who called in sick on the evening shift, night shift and on weekends or when SC was not present in the facility. The SC stated she sometimes got called at home by the house supervisor to come in and help replace sick calls if the house supervisor was too busy, or had an	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 14 emergency. The SC and RN-A (house supervisor) stated they were unable to hear the call lights from the shared office. Both confirmed the same office was used by the evening and night shift supervisor. On 3/8/13, at approximately 3:10 p.m. the administrator stated "the expectation of call lights being answered should be five or less minutes; two would be optimal, we are people dealing with people and it is our expectation that they are answered." The administrator and DON stated the house supervisor for the night shift assisted on Aspen and Linden "if needed;" and stated the amount of time the supervisor was out of the building to respond to Royce Place and Boulevard Apartments was "minimal" and the nursing supervisor always carried a cell phone so he/she could be reached at all times. Both stated the house float NA was available to help all units, but had to be located by calling the different nursing units to find that person. The administrator and DON stated, "When needed, the laundry NA could be pulled to fill in or to help, but again had to be called to be located." The administrator and DON stated the night shift house supervisor should be "out on the units right after getting report from the evening shift supervisor," and was "rarely" in the office. The Crest View Lutheran Home Staffing Plan Policy and Procedures 9/12, indicated "The staffing coordinator on a daily basis complete all staffing for the Nursing Department for twenty-four hours, seven days a week nursing coverage. Staffing is based on and reflects consideration of the needs of resident population along with case mix in determining the composition of the mix levels on a regular basis. The schedule is done ahead to cover two pay	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 15 periods for all nursing staff. 1. The DON is full time. 2. One full time MDS coordinator is scheduled for 80 hours per pay period Monday-Friday. 3. In the absence of DON the responsibility for continuum and supervision of nursing care is delegated to the RN supervisor. 4. The staffing coordinator is scheduled to work full time, Monday-Friday. 5. At least 1 RN/ADON supervisor and 1 LPN coordinator are scheduled Monday through Friday on the 6:30 a.m. to 3:00 p.m. along with 4 other licensed nurses (RN's and /or LPN's). One full time RN supervisor is scheduled from 2:30 p.m. to 11:00 p.m. and 1 RN full time night supervisor is scheduled from 10:30 p.m. to 7:00 a.m. every day. The RN supervisors are responsible for emergency calls to Boulevard, Columbia Village, and Royce Place. 6. Licensed nurses (RN's and LPN's), TMA's and NA's are scheduled for 24 hour coverage, seven days a week by the staffing coordinator, staffing is done on a monthly basis. 7. There is a full time TMA scheduled 7 days a week on the 6:00 a.m. to 2:30 p.m. shift and 2 part time TMA's for heavier med passes from 6 AM-10 AM. There are 3 part time TMA's from 4-8 p.m. 7 days a week. 8. The DON and staffing coordinator work closely together to staff according to census. 9. On Evergreen the ratio is typically 1 NA to 8 residents; on willow 1 to 8 on Aspen 1 to 8, on Linden 1-8 (if Linden is full) (THIS DID NOT SPECIFY SHIFTS). 10. At a minimum 2 RN's or LPN's are scheduled for 10:30 to 7:a.m. 11. At minimum, six NA's are scheduled on the 11:00 p.m. to 7:30 a.m. shift. One NA is scheduled 11:00 to 7:00 a.m. as house float. One NA floats and does personal laundry.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 16 12. In house pool on call staff are scheduled by staffing coordinator to cover during vacations, mental health days, floating holidays, sick leave, leaves of absence (LOA), emergencies and holidays. 13. All nursing staff is required and scheduled to work every other weekend and every other holiday, unless specified otherwise. 14. all master schedule for nursing personnel on each shift are posted two weeks prior to the start of the new pay period, on the nursing bulletin board. Each schedule covers one pay period or two weeks. 15. The daily work schedule for each station is completed prior to the next day and posted on the staffing coordinator's office door. 16. Staffing coordinator will adjust productive nursing hours on a daily basis." The facility did not have sufficient staff on the night shift to meet and respond to R196's needs. As a result, staff did not respond to R196's repeated call for help on 3/7/13; resulting in R196 to becoming incontinent of urine. On 3/7/13, at 5:00 a.m. R196 was observed sitting in a wheelchair in her room holding a dry incontinence product on her lap calling out, "Help! help!" No staff were observed on the unit at the time. NA-C was down one of the hallways assisting another resident. LPN-E was assigned to two units (Linden and Aspen) and was off the unit. At 5:15 a.m. R196 held up the dry incontinence pad on her lap and reported she had been waiting since 3:00 a.m. for help to the bathroom. R196 also reported her roommate ran out of oxygen around 2:00 a.m. and LPN-E was in and out of the room changing the oxygen tank which then interrupted R196's sleep. When R196 turned on the call light to request assistance, she	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 17 said LPN-E came into the room, turned off the light, and said she would send someone to help. R196 then transferred herself from the bed to the wheelchair and "sat waiting" for someone to assist her into the bathroom. R196 stated she was "very frustrated." When R196 was asked how she knew she had been waiting since 3:00 a.m. the resident pointed to the watch on her left wrist. On 3/7/13, LPN-E was initially observed by the surveyor at 5:15 a.m. and was informed of R196's need for help. LPN-E went into another resident's room and infomed NA-C that R196 needed help to use the bathroom. LPN-E stated R196 had not put on the call light, confirmed she had been in and out of R196's room to assist her roommate and switch oxygen tanks since 2:00 a.m.. LPN-E did not attempt to assist R196 with her needs. At 5:20 a.m. NA-C assisted R196 to the bathroom. Although R196's incontinent product was observed to be heavily saturated with urine, R196's skin had no signs of skin breakdown or redness. NA-C confirmed the findings and after R196 was toileted, assisted R196 with a dry incontinent product. On 3/7/13, at 5:30 a.m. R196 stated the facility was short on help at night and there was only one nursing assistant to help all of the residents. R196 indicated it did not happen a lot, but when she had to go to the bathroom, she did not like to wait. On 3/7/13, at approximately 7:15 a.m. when asked about staffing, LPN-E stated, "I hope you get the answers to the questions you are asking." Although LPN-E was scheduled to be in charge of the Linden and Aspen units, LPN-E was not able to tell the surveyor how may residents resided on	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 18 the units. On 3/7/13, at 9:30 a.m. R196 stated she was frustrated that morning waiting for help, but was okay now. R196 stated she did not like to wait for help to go to the bathroom and that she had only wet herself "a couple" of times waiting to get help to go to the bathroom. R196 was admitted to the facility for short stay rehabilitation on 2/15/13, for post fall with fractured ribs. R196's care plan dated 2/15/13, indicated R196 was alert and oriented. The care plan also indicated R196 was incontinent of urine, was to be toileted, and wore large pull-ups. On 3/8/12, at 3:15 p.m. the director of nursing (DON) stated the call lights should be answered and residents assisted within 5 minutes or less. The DON stated two minutes was an acceptable wait time after the resident put on their call light. Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure staff work load was appropriate across all the units. Devise one call light audit form and ensure auditing staff were trained on it's use to provide the most reliable data. Revise the system as needed and educate staff on the system in place. Monitor and review complaints of call lights responses to the resident council, ombusdmen and state agency. Time Period for Correction: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide pain management services and failed to identify or implement measures to reduce bruising risk for 1 of 1 resident (R89) reviewed for hospice care. Findings include: On 3/6/13, at 10:27 a.m. R89 stated he experienced pain that was not relieved, although pain medication helped. On 3/7/13, at 7:47 a.m. a nursing assistant (NA) -E was observed to assist R89 to a sitting position in bed. R89 moaned and stated, "The pain is always there." - At 8:32 a.m. R89 was observed to be attempting to hold himself upright using the half side rail on the edge of the bed. The pillows from behind his back were observed to have fallen away and R89 had no back support. R89 was observed to have facial grimacing and reported back pain. R89 stated he did not get up in a chair for breakfast because, "It is too much work for the staff."	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20 - At 9:48 a.m. R89 was observed to continue to experience pain during morning cares. While NA-E assisted R89 to a sitting position, R89 stated, "Oh--Oh" and reported feeling dizzy. R89 winced when he raised his left arm and leaned forward and stated, "Ouch." After being assisted to lie down, R89 pointed at the catheter and stated, "This is the one that hurts." R89 again winced and stated he had to put his legs down. As NA-E provided catheter care, R89 continued wincing. When asked what hurt, R89 pointed to the catheter and stated, "It's the cord that hurts." R89 continued to display facial grimacing after the catheter care was completed. R89 moaned loudly when turned to the right side, had facial grimacing when on his back and when rolled to the left side. R89 continued to have facial grimacing when he was pulled up in bed and when NA-E lifted his legs. A licensed practical nurse (LPN)-G then adjusted R89's catheter. R89's face was red and he had facial wincing while cream was applied to the resident's penis. LPN-G offered R89 pain medication which R89 declined. LPN-G then left R89's room and no other pain interventions were offered. R89 was observed to use pursed lip breathing after LPN-G left the room. - At 2:59 p.m. R89 stated he had a lot of pain in the groin area and was observed to have facial grimacing while he grabbed at his lower abdomen. R89 was asked why he did not take medication for the pain, he stated he did not want to become addicted (to the medication for pain) and thought the pain would go away. - At 8:02 a.m. R89 stated the pain "is always there...It would be nice if it would go away." R89 stated the pulling of the catheter and pain in back and legs was what kept him awake at night and he needed to "move carefully so I don't cause more pain, so I don't wake myself up."	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 21 The History and Physical indicated R89 returned to the facility from the hospital on 10/18/12, following an admission for urosepsis (a blood infection), hydronephrosis (swelling of the kidneys when urine flow is obstructed in any of part of the urinary tract) and a heart attack. Additional diagnoses included spinal stenosis, back pain, prostate cancer and constipation. The resident was admitted to hospice care on 10/18/12, with a diagnosis of terminal debility. The Hospice care plan dated 10/19/12, directed the following interventions to identify and address R89's pain: assess pain characteristics, assess spiritual/psychosocial contributors to pain; provide opportunities for patient/family to discuss feelings, beliefs, fears regarding pain; explore patient/family expectations, myths regarding pain; education patient/caregivers regarding pain management and resources available. The Hospice care plan directed to administer a medication regimen to relieve distressing pain symptoms and directed non-pharmacological means to provide comfort, such as massage, music, position, heat or cold. The Hospice care plan also included the following interventions to promote sleep such as, assess for possible causes of sleep problems (such as pain), adapt medication regimen to promote/assist rest, and adapt environment to provide optimal opportunity for rest. The quarterly Minimum Data Set (MDS) dated 2/9/13, indicated R89 had pain "almost constantly," the pain was rated at 10/10 (on a 0 -10 pain rating scale, zero equaling no pain and 10 the worst imaginable pain) in intensity, the pain made it hard for R89 to sleep at night and limited R89's day-to-day activities. The Care Area	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 22 Assessment (CAA) dated 11/16/12, indicated R89 had pain and only included a summary of "Resident with chronic joint pain and recent diagnosis of UTI [urinary tract infection]." The CAA did not include information regarding R89's refusal of as needed (PRN) pain medication or not wanting an increase in pain medication. Review of R89's medication pain regimen indicated a physician's order was written on 11/1/12, for clotrimazole 1% cream. The order directed to "apply [clotrimazole cream] to [R89's] scrotum and penis 2x [twice] daily for topical infection and redness." The following day an order was received to give scheduled Methadone 2.5 milligrams (mg) every eight hours. A physician's order dated 11/15/12, directed staff to administer the as needed (PRN) pain medication "liberally" to treat the resident's pain. No other changes were made to the resident's pain regimen until 3/8/13. A progress note dated 1/17/13, indicated R89 was given medication during the Hospice nurse visit for back and penile pain and the facility staff would continue to assess. A Hospice Nursing Visit note of the same date indicated R89 was "grimacing at rest complaining of pain to penis and low back. He winces and jerks with adjustment to catheter. NSS [no signs or symptoms] of external distress. Weight of tubing was pulling at catheter. Encouraged staff to utilize PRN morphne [sic] already ordered for pain." A Pain Management Flow Sheet for Cognitively Intact was completed for R89 on 1/17/13. The flow sheet had two entries which both indicated R89 reported pain at a nine out of ten in his penis and legs. No other entries were included on the flow sheet.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 A Palliative Care Physical Care Plan (PCPCP) dated 1/23/13, was reviewed and indicated R89 had pain and itching and was complaining of not sleeping well and had a loss of appetite. The goal was for R89 to report less pain, display no grimacing or moaning, maintain body weight and report less itching. The interventions included: assess for pain and provide pain relief measures (non-pharmacological and/or pharmacological), administer medications as ordered/needed. The comment section included "c/o [complained of] pain all over, was unable to rate it, doesn't feel non-pharm [non-pharmacological] methods are effective. Hospice in on 1/11/13 and initiated Sarna lotion for comfort. Discuss sleep aid [with] hospice." The plan noted R89 had the medication Roxanol scheduled and PRN "which he is getting regularly" and Methadone scheduled for pain. The plan directed staff to continue to offer medication PRN and did not provide instruction if R89 declined medication or did not want an increase in scheduled medication. A Pain Identification/Review was completed for R89 on 2/6/13, and noted, "Pain relief is adequate [with] current plan." The review did not identify R89 refused PRN pain medication or would not want an increase in pain medication. R89's care plan dated 2/12/13, indicated R89 had actual pain related to arthritis, spinal stenosis and was evidenced by resident reported or demonstrated discomfort, guarding, facial mask of pain, rubbing area, and grimacing. The goals were for the resident to rate pain at three or fewer on a zero to ten pain scale, participate in activity programs, and to experience three to four hours of uninterrupted sleep. Staff were to administer routine and PRN medication, evaluate	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 24 effectiveness, observe for side effects, medication before planned activity/exercise, body alignment, update hospice with any changes, teach/coach relaxation techniques, diversion/distraction, reminiscing, activities, music therapy and collaborate with the nurse practitioner/physician (NP/MD) if current pain control measures were ineffective. The care plan also directed staff to "Monitor sleep pattern x 3 nights every month." Sleep tracking documentation for R89 was requested on 3/8/13, at 10:59 a.m., however none was provided. A Hospice Nursing Visit note dated 2/22/13, identified, "Staff reports patient will state he has pain when asked. Pain response observed does not match patient's account. No overt SS [signs and symptoms] of pain during visit other than patient words. Staff believe pain is well controlled at this time." The note also described R89 as cognitively impaired and fatigued. Review of the March 2013 MAR revealed R89 received Tylenol 1000 mg at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., Morphine 5 mg at 8:00 p.m. and Methadone 2.5 mg at 12:00 a.m., 8:00 a.m. and 4:00 p.m. The MAR revealed no PRN pain medication was administered during the month of March. The Methadone dose was increased to 5 mg at 8:00 a.m. and 8:00 p.m. on 3/8/13. The clinical record lacked evidence R89's pain was comprehensively assessed, including an assessment of how often and why R89 was refusing PRN pain medications and any other interventions utilized to potentially control R89's pain. A Hospice Nursing Visit note dated 1/23/13, indicated R89, "Comments today with prompting from staff about difficulty sleeping and accepts an	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 25 offer from writer for medication at bedtime to help him sleep through the night." R89 requested to be reminded the medication was for sleep as, "They give so many different ones and I never know." The note also indicated R89 was spending approximately 18 hours per day sleeping in bed. A physician's order dated 1/23/13, indicated R89's Trazodone (antidepressant commonly used to promote sleep) 50 mg at bedtime was increased to 75 mg on 3/5/13. The physician's progress note dated 3/5/13, noted R89 and increased pain and the cancer could have metastasized into the bones (known to cause back pain). The progress note also indicated R89's back pain was "much improved" since Methadone was added. A progress note written by the Hospice nurse on 3/7/13, noted, "Pt [patient] has chronic pain that he reports as moderate. Writer offered PRN pain med but pt declined stating he doesn't want to get used to more medication. Staff has no new concerns [and] pt is comfortable." The clinical record lacked evidence other alternatives for pain reduction were offered and lacked evidence education was provided to R89 for potential pain control. On 3/8/13, at 9:34 a.m. NA-E stated when she cared for R89 on 3/7/13, he complained of back pain, as well as pain in the groin area with washing and when the catheter tube was moved. NA-E stated she had just begun taking care of R89 again on 3/7/13, after four weeks of a different assignment. Prior to this, NA-E stated R89 did report the catheter caused him pain, but he did not complain of back pain at that time as much as he reported on 3/7/13. NA-E stated she had reported R89's complaints of pain four weeks	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26 ago to LPN-G. On 3/8/13, at 9:49 a.m. a trained medication aide (TMA)-A stated R89 requested PRN medication daily, which she then reported to the nurse responsible for administering the PRN pain medications. TMA-A also stated R89 had never refused to take scheduled medications. On 3/8/13, at 10:12 a.m. the Hospice nurse who visited R89 on 3/7/13 stated the facility staff had not reported R89's catheter pain to the agency staff. The Hospice nurse also stated LPN-G told her R89 refused to take PRN medication for pain. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated pain assessments were completed by nurses when a resident was admitted, with MDS assessments, and with any new signs, symptoms, or complaints of pain. The DON stated she would have expected nurses would relay reports of pain to Hospice staff, and would expect nurses to document and report pain to Hospice. She would expect staff to document if a resident was refusing pain medication and update the physician. In addition, the DON stated she expected staff to educate a resident when concerns regarding potential addiction to pain medication were expressed, and to document the education in the resident's record. At 1:21 p.m. the DON reported a catheter strap had been applied to R89's leg to minimize the risk of pulling and tears by holding the catheter in place and the NP would be increasing R89's pain medication. On 3/8/13, at 1:48 p.m. NA-F stated R89 had pain when the staff tried to change or clean him. NA-F stated R89 also had a hard time rolling over and reported it hurt to do so. NA-F stated R89's pain was experienced in the groin area and it	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 27 worsened when his legs were moved. NA-F stated R89 yelled out in pain whenever she moved the catheter bag, stated R89 had been experiencing pain for a couple of months and she had reported R89's pain to the nurses. The facility Pain Management Program policy dated 1/13, revealed the following: "POLICY: It is the policy of Crest View Lutheran Home to assure that there is a comprehensive program of pain management for all residents." "PROCEDURES: 1. All residents will be screened for pain on admission and readmission, routinely with MDS assessments, when there is a change in condition or onset of new signs and/or symptoms that may indicate pain. The resident's self-report of pain is the primary indicator for pain. 2. All staff is trained to recognize signs and/or symptoms of pain or behaviors that may indicate pain. All staff is trained to report that information to the nurse for analysis and action. 3. Residents who show signs and/or symptoms of pain are comprehensively assessed to determine the types and degree of pain, onset, duration, quality, intensity, alleviating, and aggravating factors. 4. Results of this assessment are communicated to the attending physician or NP This communication is documented in the resident record and may be documented on other assessment forms as well. Results are also communicated to members of the resident's interdisciplinary team. 5. In collaboration with the resident and/or family, a goal for pain management is established and a multi-disciplinary plan is written to achieve that goal. Interventions to relieve or reduce pain are	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28 both pharmacological and non-pharmacological must follow the pain management protocol." A letter written by the DON dated 3/11/13, indicated R89 "does not like narcotic pain medication, did not want to get addicted to them, and hated the way they make him feel." The letter also indicated R89's "wishes are to not be over medicated." There were no supporting documents provided by the facility to support the above assessment prior to 3/11/13, including education of R89 regarding myths of addiction with severe pain. The information was not included on R89's care plan. A letter written by R89's former physician dated 3/13/13, indicated R89 had continued to battle narcotic related constipation which had been R89's primary concern. The physician stated he did not recall R89 expressing concern about getting addicted to opioids and "We were trying to avoid further constipation which might be expected from higher opioid doses." The letter did not indicate if any non-narcotic medications had been utilized to control R89's pain and only addressed leg and back pain. A Hospice Nursing Visit note dated 3/7/13, indicated R89 had a bowel movement almost daily. A review of the MAR for 3/13, revealed R89 received Miralax daily, Senna laxative three times a day and a suppository daily for his bowels and had not required the use of any PRN medications for his bowels. R89 was observed to have bruises on both hands. R89's diagnoses included a terminal diagnosis of debilities, prostate cancer, coronary artery disease and back pain.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29 During initial observation and interview with R89 on 3/6/13, at 10:35 a.m. he was noted to have large dark bruises covering the backs of both hands. When asked about the bruises, R89 stated he hits them on the side rails when grabbing for them. R89 was noted to have half side rails up on both sides of the top half of the bed. On 3/7/13, during care observations at 9:48 a.m. R89 had difficulty finding the rails and was noted to reach out with his hands until he could find them. Bruising was again noted to the backs of both hands. Incident reports for R89 were requested, however, only a fall report dated 2/16/13, was provided. The administrator verified there were no other resident incident reports for R89. R89's NA assignment sheet dated 3/5/13, indicated the resident had two half side rails. The assignment sheet directed, "On bath days & when doing ADL'S [activities of daily living] check for any open areas or pressure sores make sure skin is intact and report any findings to nurse." The resident's risk for bruising was not noted, nor did it remind NAs to report bruising. Although aspirin was listed as an allergy for R89, the March 2013 MAR revealed R89 was receiving aspirin 81 milligrams (mg) daily (a medication known to contribute to bruising). The MAR also noted a skin check was completed on the evening shift on 3/7/13. R89's care plan related to safety dated 2/12/13, included, "1/2 side rails x 2." A risk of bruising related to use of aspirin and the side rail use was not identified, nor were there interventions to minimize the bruising risk. The skin integrity plan did not address R89's risk for bruising, but	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 30 directed staff to "monitor skin with cares." The sensory perception plan revealed R89 had cataracts and was blind in the right eye. The 2/13 Physician's Orders listed aspirin as an allergy for R89. A physician's progress note dated 3/5/13, listed an allergy to aspirin in the note and indicated the presence of bruising, but did not identify potential causes. On 3/8/13, at 9:34 a.m. NA-E stated she had reported the bruises on R89's hands to LPN-G. On 3/8/13, at 10:59 a.m. the DON verified there were no other incident reports for R89 and stated she was unaware of the bruises on R89's hands. The DON also stated a care plan should have been developed for the resident's risk for bruising. At 1:21 p.m. the DON stated LPN-G did not remember being told about the bruises on R89's hands and an incident report would be completed. Follow-up correspondence from the DON dated 3/11/13, was reviewed. The letter verified R89 had bruises and R89 "Stated he bumped his hands on the side rail when he reached for them." Although the bruises were noted by the physician on 3/5/13, and observed by the surveyor on 3/6/13, the DON noted "the bruises were new as the night shift had not noted them." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate staff on policies to ensure that all residents are assessed and provided necessary care and services to ensure non-pressure related skin conditions are monitored and treated accordingly. The director of nursing or her designee could develop monitoring systems to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 31 ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not store a glucometer (equipment used to check blood sugars) for 3 of 9 residents (R7, R57, R140) in a manner which reduced the potential spread of blood borne pathogens. In addition, the facility failed to ensure proper gloving and hand hygiene practices were followed on 2 of 4 units (Aspen, Willow). These practices had the potential to affect 31 of 52 residents. Findings include: The registered nurse (RN)-B was observed to store the soiled glucometer with sterile lancets, clean the glucomter with soiled gloves; obtain blood specimens, administer insulin injections to R7, R57, and R140 without proper glove changes and hand washing. RN-B was observed to clean the glucometer without changing contaminated gloves.	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 32 During medication pass observation on 3/4/13, at 3:44 p.m. RN-B applied gloves and checked R7's blood sugar. RN-B then put the glucometer on top of the sterile lancets (used to puncture the skin to get a blood sample) in a clear plastic container. RN-B next administered R7's insulin injection. After RN-B administered R7's insulin and without changing the gloves worn while obtaining a blood specimen and administering the insulin, RN-B took the glucometer out of the clear plastic box and wrapped it in a Sani-wipe (a moist towelette used to sanitize equipment). RN-B then removed her gloves and without washing her hands, applied new gloves and prepared insulin for R57. RN-B again wrapped the glucometer with a Sani-wipe and placed it with the sterile lancets in the clear plastic box. RN-B administered R57's insulin and removed her gloves. RN-B returned to the treatment cart without washing her hands, applied new gloves and removed the Sani-wipe from the glucometer and removed her gloves. RN-B applied new gloves, checked R140's blood sugar, removed her gloves, applied new gloves and wrapped the glucometer in a Sani-wipe and then placed it on top of the lancets. RN-B used the same gloves to prepare insulin for R140. RN-B removed her gloves, applied new gloves and administered R140's insulin. After she removed her gloves, RN-B wrapped the glucometer in a Sani-wipe and again placed it on top of the sterile lancets. At 4:06 p.m. RN-B washed her hands. After the observations, RN-B verified she had performed glucometer checks and administered insulin to several residents. RN-B confirmed she had not washed her hands from 3:44 p.m. until 4:06 p.m. RN-B stated she usually used "blue wipes" to clean her hands when she changed gloves, but did not have them. On 3/8/13, at 10:59 a.m. the director of nursing	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 33 (DON) stated hand washing was expected per the policy. An undated form titled HANDWASHING noted, use antimicrobial soap or antimicrobial hand scrub "Immediately after gloves are removed." The facility lacked garbage containers which prevented potential re-contamination of hands after handwashing; a nursing assistant (NA)-H was observed to not follow the accepted standard for handwashing. On 3/4/13, at 5:47 p.m. NA-H was observed to wash her hands in the dining room sink of the Willow unit. NA-H was observed to use one clean hand to open the garbage lid to throw away the paper towels (potentially contaminating her hands). The garbage can was observed to lack a means to lift the lid without contaminating cleaned hands, such as a foot control to lift the lid of the can. NA-H was then observed to walk away from the garbage while wiping her clean hands down the back of her clothing (contaminating her hands), put gloves on and proceeded to clean the hands of the residents with Sani-Hands. The facility Exposure Prevention Procedures for Bloodborne Pathogens policy dated 3/7/13, directed the following for Hand-washing: "Employees shall wash their hands per CDC/MDH [Centers for Disease Control and Minnesota Department of Health] guidelines to include, but not limited to, before and after resident contact, before handling food, when in contact with any body fluids/secretions/blood and after removing gloves." The facility undated HANDWASHING policy directed handwashing after touching contaminated items and, "Between tasks on the same resident to prevent	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 34 cross-contamination of different areas of the body (when doing something dirty such as assisting someone off the commode, to doing something clean such as assisting someone to eat)." The facility policy also included the undated World Health Organization (WHO) How to Handwash guide and the undated WHO How to Handrub guide. On 3/8/13, at 10:59 a.m. the director of nursing (DON) stated hand washing was expected per the policy. Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure staff was not re-contaminating hands to dispose of hand towels. Revise the system as needed and educate staff on the system in place. Monitor and review hand washing and adjust the system as needed. Time Period for Correction: Twenty-one (21) days.	21385		
21405	MN Rule 4658.0810 Subp. 2 Resident Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subp 2 Resident Tuberculosis Program is waved. Condition of Waiver: - Follow the U.S. Centers for Disease Control and Prevention's "(Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," (MMWR) 2005; 54	21405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21405	Continued From page 35 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to the "CDC Guidelines" for complete definitions of terms. - Assign administrative responsibility for the tuberculosis (TB) infection control & prevention program to appropriate personnel. Administrative responsibilities include establishment of an infection control team (one or more individuals), completion (and periodic review) of a written TB risk assessment, and development (and periodic review) of a written TB infection control plan. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to complete the Tuberculosis (TB) annual facility risk assessment worksheet for health care settings. This had the potential to affect all of the residents and staff at the facility. Findings include: When interviewed on 3/8/13 at 1:30 p.m., the infection control nurse (ICN) was asked to provide a copy of the facilities TB risk assessment. The ICN could not provide this and asked instruction on how to complete one. The ICN was directed to the Minnesota Department of Health website.	21405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21405	Continued From page 36 On 3/8/13 at 3:00 p.m., the ICN provided the survey team with a TB facility risk assessment that was dated 3/8/13. The ICN confirmed that it was completed after it was requested by the survey team. The assessment listed the facility as a low risk facility. The ICN was reminded that the facility needs to have a current written TB risk assessment that is reviewed and updated periodically.	21405		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the Federal Drug Administration (FDA) guidelines for safety and to provide an environment free of accident hazards related to bed rails for 1 of 1 resident (R4) reviewed for accident's related to hazardous devices. Findings include: R4 had diagnoses to include a history of frequent falls, Alzheimer's disease with cognitive impairments, secondary Parkinson's Disease, Schizophrenia, and osteoporosis. R4 utilized a bed rail device that was not in compliance with	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 37 the U.S. Food and Drug Administration (FDA) measurement guidelines, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on 3/10/06, to reduce the risk for entrapment. On 3/4/13, at 5:16 p.m. R4's empty bed was observed with two raised metal brown half bed rails on the upper portion of the bed. The half bed rail away from the wall had a space in zone one, the area inside of the side rail, that did not meet the FDA recommendations. The FDA 2006 recommendation for dimensional limit for zone one indicated the gap should be no greater than 4 and 3/4 inches. At 7:16 p.m. R4 was observed in bed with the both bed rails raised. On 3/6/13, at 4:15 p.m. R4's bed rail was raised and zone one was measured at 5 and 3/4 inches. On 3/7/13, at 5:29 a.m. R4 was observed to be lying in bed with both side rails raised. The dimensions in zone one were measure again at 5 and 3/4 inches. On 3/7/12, at 5:30 a.m. a licensed practical nurse (LPN)-D reported R4 had "Never" been caught between the bed side rail. LPN-D stated since R4's significant change in 1/13, R4 was no longer exhibiting behaviors, agitation or resistance with cares. On 3/7/12, at 5:45 a.m. a nursing assistant (NA) -D verified R4 did not reposition self frequently, was no longer agitated or had anxiety. NA-D stated R4 had "Never" been caught in the side rail. R4's current care plan dated 1/21/13, noted a potential for impaired physical mobility. The	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 38 approaches, included the use of two half side rails. The significant change Minimum Data Set (MDS) dated 1/29/13, identified R4 with severe cognitive loss, a history of falls since admission, and required extensive assistants of two staff for bed mobility. Physician orders dated 1/29/13, indicated R4 should have two half side rails up for assistance with bed mobility and transfers. The Care Conference Summary dated 1/29/13, identified the physical devices R4 used were two half side rails. R4's treatment sheet for 3/13, identified there were two half side rails up for assist with bed mobility and transfers. On 3/7/13, at 10:00 a.m. the maintenance director (MD)-A stated when residents were admitted to the facility therapy assessed the need for safety devices which included bed rails. MD-A stated maintenance received the order and put the side rails on the bed. MD-A reported the maintenance department monitored bed rails for dimensional safety every month. MD-A measured R4's bed rail and confirmed zone one measured 5 and 3/4 inches. MD-A stated, "Someone must have bent it." At 11:39 a.m. MD-A stated a bed audit was done on 2/13/13, by maintenance and it indicated R4's side rail was checked and marked as "Ok." MD-A reported between 2/13/13, and now someone must have bent the side rail when raising and lowering the bar. MD-A stated staff should have submitted a "Work Order Submission" because the rail needed replacing.	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 39 On 3/7/13, at 1:45 p.m. the administrator and director of nursing (DON) confirmed R4's bed rail was not appropriate for dimensional safety related to entrapment. DON verified the facility was aware of the appropriate dimensional safety of side rails related to entrapment risk and staff needed to be retrained on submitting work orders. The facility's Work Order Submission Policy and Procedure revised 11/12, indicated staff should submit a Work order to maintenance when service was needed. The policy directed, "If the Work Order requires adaptive required (i.e. grab bars, side rails, ect. [sic]), the unit nurse or designee completes a maintenance work order form and routes the form to Maintenance to that the proper device/equipment will be implemented/installed." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure side rails and resident equipment are kept in good repair. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21685		
21735	MN Rule 4658.1420 Solid Waste Disposal Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a	21735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21735	Continued From page 40 breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly dispose of refuse and address external points of entry to the facility to prevent a potential rodent and pest infestation. This practice had the potential to affect all of the 117 residents residing in the facility. Findings include: On 3/7/13, at 1:10 p.m. during the environmental tour with the environmental director (ED) and the administrator present, two rotted service doors were observed in a storage room near the outside trash bins. The room was observed to store resident beds, equipment and was located behind the kitchen near the junction of the assisted living complex. The rotted areas on the two doors measured 12 inches by one inch and were located near the bottom aspect of each door. The outside was visible through the rotted areas of both doors. On 3/8/13, at 7:35 a.m. the large blue trash bins outside the facility were observed from the physical therapy room window. The trash bins were observed to have white trash bags overflowing the bin with two trash bags on the ground. A blue colored mattress was observed to be resting up against a green utility box near the bins. The mattress was observed to be covered from top to bottom with snow; the edges of the mattress were visible.	21735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21735	Continued From page 41 On 3/8/13, at 8:50 a.m. the ED stated the garbage was picked up daily, sometimes they came at 6:30 a.m. and that was ideal. The ED further stated sometimes the city, who was contracted to pick up the trash, did not come till later. On 3/8/13, at 11:00 a.m. the pest control specialist (PCS) stated he was aware of the rotted doors and confirmed the holes in the service doors leading to the trash bins were a potential entry area for rodents. The PCS said he had tried to get the facility to replace the two doors for quite a few months. The PCS stated he placed extra bait stations for pest control outside the rotted doors and near the trash bins. The facility policy and original request for repair of the doors was requested. The facility policy entitled Pest Control dated 11/12, indicated it was the policy of Crest View Lutheran Home to maintain and keep a pest free environment. Reports of any issues must also be reported to the director of environment services and administrator immediately. The Capital Budget Request dated 9/12/12, indicated a request to replace the doors was made for the 2013 fiscal year. The estimated date for replacement of the rusted doors was 4/1/13. Suggested Method for Correction: The administrator or designee could review and/or revise the facility's system, policy and procedure(s) for disposal of waste and prevention of pests. The administrator or designee could educate facility staff on these areas and develop a system of monitoring to ensure compliance. Time Period for Correction: Twenty-one (21) days.	21735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R111) who resisted care was treated respectfully, to ensure 1 of 1 resident (R196) received a timely response to call light use related to dignity with continence, and to ensure residents who ate in the Willow dining room were treated in a dignified manner regarding the use of clothing protectors, having the potential to affect 21 of 22 residents who ate in the dining room. Findings include: R111 was not treated in a dignified manner during meal observations and residents who ate meals in the Willow dining room were not given an opportunity to express preferences in using a clothing protector at the meal. R111 was observed to be pulled by the hand into the dining room and put into a chair without explanation or conversation on 3/4/11, at 4:45 p.m. The nursing assistant (NA)-I exerted down downward pressure on R111's left shoulder and pushed the chair into the back of the resident's legs. A clothing protector was then put on R111 without permission or explanation. R111 mumbled incoherently while sitting in the chair and moved the placemat and silverware around	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 43	21805		

the table. The placemat and silverware were then taken away from him without explanation and were put out of his reach in the middle of the table. Again without explanation, prior to the meal service R111's hands were cleaned with a Sani-Hands pre-moistened wipe.

On 3/4/13, at 4:50 p.m. residents from the Willow unit were brought into the dining room for the evening meal. The staff put clothing protectors on 21 out of 22 residents without conversation, or asking the residents' preferences. Because R33 was leaning on the clothing protector, a staff person did ask the resident if she wanted to wear the protector. The resident replied, "No, I rest my arm on it."

On 3/8/13, at 10:30 a.m. the Willow residents were brought into the dining room for the brunch meal, clothing protectors were put on 21 out of 22 residents without conversation, or asking the residents' preferences. R33 was not approached about her clothing protector.

R111 was then brought into the dining room and taken to his chair at the table. The resident resisted sitting down at which time a second NA approached and attempted to assist the resident to sit. When R111 continued to resist, he was allowed to leave the dining room and wander. R111 repeatedly entered the dining room, walked the perimeter of the room, and then left the room. After 30 minutes R111 was assisted to his chair by a NA who placed the chair against the back of the resident's knees and asked him to sit down; R111 sat without resistance.

R111 was admitted to the facility with diagnoses of Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 1/16/13, indicated R111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 44 was unable to complete an interview for cognitive status or vision screening. R111 had short-term and long-term memory impairment, had severally impaired cognitive skills; experienced continuous inattention, disorganized thinking, altered level of consciousness and psychomotor retardation. R111 had delusions and wandered daily; required supervision to walk in room, walk in corridor, and locomotion on the unit. R111 required extensive assistance of one with eating. R111's care plan dated 1/23/13, identified cognitive impairment, history of wandering, resistive to cares, altered communication related to impaired understanding, and inability to respond to others. Prior to initiating care, the plan directed staff to inform R111 of each task prior to initiation, explain the cares, use simple phrases and yes/no questions, use redirection and re-orientation, allow resident time to respond, anticipate needs, use task segmentation and a calm approach. On 3/8/12, at 4:05 p.m. a licensed practical nurse (LPN)-I stated she would not expect anyone to force a resident to do anything, and further stated, "We just re-approach." On 3/8/13, at 4:20 p.m. NA-G explained that R111 was supposed to have a chair gently pressed into the back of his knees as a cue for him to sit down while he was being asked to sit. The NA said R111 sometimes resisted and "You just come back and try again later." On 3/8/13, at 4:30 p.m. the administrator and director of nursing (DON) stated all staff had been trained to converse with residents during their cares, and that is what they would have expected. The facility did not have a policy	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 45 specific to treating residents with dignity, as it was implied in the Resident Bill of Rights. A nursing orientation sheet for Dementia, Alzheimer's Disease, etc. directed the staff to "Always introduce yourself and tell your resident what you are going to do before you do it. There are no rules that say the resident must eat, sleep, bathe, etc. on your time schedule. Be as flexible as necessary to be sure the resident receives the care they need with a minimal amount of stress to their world." Although R196 called out for help repeatedly on 3/7/13, staff did not respond to those calls for help to potentially preserve R196's dignity with urinary continence in a timely manner. On 3/7/13, at 5:00 a.m. R196 was observed sitting in a wheelchair in her room holding a dry incontinence product on her lap calling out, "Help! help!" No staff were observed on the unit at the time. NA-C was down one of the hallways assisting another resident. LPN-E was assigned to two units (Linden and Aspen) and was off the unit. At 5:15 a.m. R196 held up the dry incontinence pad on her lap and reported she had been waiting since 3:00 a.m. for help to the bathroom. R196 also reported her roommate ran out of oxygen around 2:00 a.m. and LPN-E was in and out of the room changing the oxygen tank which then interrupted R196's sleep. When R196 turned on the call light to request assistance, she said LPN-E came into the room, turned off the light, and said she would send someone to help. R196 then transferred herself from the bed to the wheelchair and "sat waiting" for someone to assist her into the bathroom. R196 stated she was "very frustrated." When R196 was asked	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 46 how she knew she had been waiting since 3:00 a.m. the resident pointed to the watch on her left wrist. On 3/7/13, at 5:15 a.m. LPN-E was initially observed by the surveyor and was informed of R196's need for help. The LPN went into a resident's room and informed NA-C R196 needed help to use the bathroom. LPN-E stated R196 had not put on the call light, confirmed she had been in and out of R196's room to assist her roommate and switch oxygen tanks since 2:00 a.m.. At 5:20 a.m. NA-C assisted R196 to the bathroom. Although R196's incontinent product was observed to be heavily saturated with urine, R196's skin had no signs of skin breakdown or redness. NA-C confirmed the findings and after R196 was toileted, assisted R196 with a dry incontinent product. On 3/7/13, at 5:30 a.m. R196 stated the facility was short on help at night and there was only one nursing assistant to help all of the residents. R196 indicated it did not happen a lot, but when she had to go to the bathroom, she did not like to wait. On 3/7/13, at approximately 7:15 a.m. when asked about staffing, LPN-E stated, "I hope you get the answers to the questions you are asking." Although LPN-E was scheduled to be in charge of the Linden and Aspen units, LPN-E was not able to tell the surveyor how may residents resided on the units. On 3/7/13, at 9:30 a.m. R196 stated she was frustrated that morning waiting for help, but was okay now. R196 stated she did not like to wait for help to go to the bathroom and that she had only wet herself "a couple" of times waiting to get help	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	03/08/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 47 to go to the bathroom. R196 was admitted to the facility for short stay rehabilitation on 2/15/13, for post fall with fractured ribs. R196's care plan dated 2/15/13, indicated R196 was alert and oriented. The care plan also indicated R196 was incontinent of urine, was to be toileted, and wore large pull-ups. On 3/8/12, at 3:15 p.m. the director of nursing (DON) stated the call lights should be answered and residents assisted within five minutes or less. The DON stated two minutes was an acceptable wait time after the resident put on their call light. Suggested Method for Correction: The administrator or designee could review the facility system in place to educate staff and supervisors to ensure staff are interacting with residents appropriately. Revise the system as needed and educate staff on the system in place. Monitor and review staff interactions with cognitively impaired residents and ensure the system was adjusted as needed. Time Period for Correction: Fourteen (14) days.	21805		