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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: R12S

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 **11/19/2013** (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

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

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

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):
Post Certification Revisit (PCR) was completed November 19, 2013 and LSC Revisit was completed on December 19, 2013. Refer to the 2567b.

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 11/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/03/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/20/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245018 January 3, 2014

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

Dear Mr. Tobalsky:

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

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

Effective November 1, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 20, 2013

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

RE: Project Number S5018025

Dear Mr. Tobalsky:

On October 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 26, 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) whereby corrections were required.

On November 19, 2013, the Minnesota Department of Health and the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 26, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 26, 2013, effective November 1, 2013 and therefore remedies outlined in our letter to you dated October 30, 2013, will not be imposed.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	11/18/2013

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **11/01/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **11/01/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/01/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/01/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/01/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/01/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/01/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/01/2013**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BW/AK	12/20/2013	30951	11/18/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/26/2013

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing 01 - MAIN BUILDING 01	12/19/2013

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 Reg. # NFPA 101 LSC K0147	11/01/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 12/20/2013	Signature of Surveyor: 03005	Date: 12/19/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/24/2013		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 A. Building B. Wing	(Y3) Date of Revisit
245018	02 - 2007 ADDITION	12/19/2013

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 Reg. # NFPA 101 LSC K0147	11/01/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 12/20/2013	Signature of Surveyor: 03005	Date: 12/19/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/24/2013		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: R12S

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 **09/26/2013** (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

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):
At the time of the Standard survey, the facility was not in substantial compliance. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Becky Wong, HFE NEII — 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 12/18/2013 (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 12/20/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5865

October 30, 2013

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

RE: Project Number S5018025

Dear Mr. Tobalsky:

Please note that 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 September 26, 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 in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 5, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by December 26, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 26, 2014 (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:

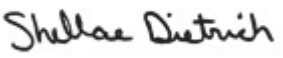
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



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

Enclosure

cc: Licensing and Certification File

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 _____	09/26/2013

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.	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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	Accepted 11-4-13 Jenni Dent **F 156** It is the policy of Crest View Lutheran Home to inform the resident both orally and in writing (in a language that the resident understands) of his/her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Crest View Lutheran Home also provides the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/1/13

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.

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	resident with the notice (if any) of the state developed under §1919(e) (6) of the Act. Such notification is made prior to or upon admission and during the resident's stay. *(Receipt of such information, and any amendments to it, must be acknowledged in writing; the facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i) (A) and (B) of this section.)* *(The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.)*	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate 48 hour notice of denial of skilled nursing coverage for 1 of 4 (R4) residents reviewed for Advanced Beneficiary Notice (ABN)/liability notices. Findings include: R4 was admitted to the facility on 6/3/13, and the last covered Medicare day was 6/7/13. The Denial of Medicare-A Skilled Nursing Facility Coverage was given on 6/7/13, which was the last covered day. Additional information documented "denial letter was given on 6/7/13 because writer was observing and assessing if resident needed to stay covered until the 14th day of stay to be covered under the Medicare 5 day Minimum Data Set [MDS] assessment. Resident no longer qualifying for Medicare part A coverage, thus the denial letter given today on 6/7/13."	F 156	For Resident # 4 she was informed in writing of the benefits outlined in the Medicare program, including but not limited to, covered charges and charges for services that are not covered under Medicare on the day of denial rather than the 48 hour requirement. Resident did not refute the denial, so no changes were made to her financial record. Education was provided for staff members regarding proper denial notice informing process on October 30, 31 and November 1, 2013 Resident # 4 remains in our facility for Long Term Care. For other residents who may be affected by this practice a written description of benefits and charges as outlined above will be provided upon admission and to current residents at their next scheduled care conference. The protocols/practices surrounding Medicare rights and rules, covered and non-covered charges under Medicare and notification, were reviewed and revised by the interdisciplinary team on 10/25/13. A review of the revised	

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F 156	Continued From page 3 On 9/26/13, at 1:00 p.m. the business office staff-A stated she did not give the denial notices, she just received a copy of the notice for her file and the MDS nurse would give the denial notice. On 9/26/13, the MDS coordinator was not on site. On 9/27/13, a voicemail message was left with the administrator to request a return call from the MDS coordinator. On 9/27/13, at 1:49 p.m. the MDS coordinator stated she was aware of the 48 hour required notice and did not give the notice in a timely manner.	F 156	protocols/practices by the Medical Director will be completed to ensure policies meet current standards. Staff members were trained as it relates to their respective roles and responsibilities for the revised policies and procedures on October 30, 31 and November 1, 2013 New admission records will be audited weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The audits will include: all Medicare Residents, date of admission, last covered date and date denial letter was given. 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. The Business Office Manager, Director of Social Services, MDS Coordinator or designee will be responsible for compliance. Date of Correction: 11/01/13.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision and adequate interventions were implemented to minimize the risk for further falls and accidents for 1 of 3 residents (R114) reviewed for falls. Findings include: R114's diagnoses obtained from the Admission Record dated 5/1/10, included dementia, macular degeneration, depression, arthritis, history of epilepsy and history of falls. On 9/26/13, at 3:20 p.m. and R114 was observed ambulating around and between the Evergreen unit with a rolling walker. R114 at the time was observed wearing a pair of loosely fitted shoes without socks in the front lobby with rolling walker. A nurse practitioner (NP) Progress Note dated 7/17/13, indicated R114 had "Dementia and had neg [negative] infections. Continue to fall and to this point without serious injury. She is pleasant and cooperative but can be resistive to cares on occ. [occasion]." Although the NP notes indicated R114 resisted cares due to her dementia, the resistiveness to cares was not on documented R114's plan of care. The care plan dated on 8/5/13, indicated R114 had four falls since 8/5/13 (8/22/13, 9/10/13, 9/13/13, and 9/24/13). The care plan also stated, resident had "potential alteration in safety, falls r/t [related to] balance impairment cognitive depression, neurological disorder and habit of	F 280	**F 280** 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.*	

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F 280	Continued From page 5 bending to p/u [pick up] things, causing falls." The care plan also indicated R114 was to wear gripper socks. Although R114 had a known history of falls, the staff did not identify risk factors such as the observed ill-fitting shoes and lack of gripper socks on both feet. The care plan was revised on 8/5/13, and lacked evidence of any new interventions after each of the falls. On 9/26/13, at 8:05 a.m. both the administrator and director of nursing (DON) stated, they have exhausted the resources for her by consulting with the NP and the psychologist. They have changed the interventions multiple times and they have bought glasses for her which she normally breaks in pieces. The administrator further stated, "Therapy had evaluated her for falls and that she leaned forward picking up things and they don't want to limit her independence with a restraint or tab alarm on her." The policy and procedure revised 6/13, indicated, "All residents who assessed as being at high risk for will be identified and individualized fall precautions will be developed for that resident. Preventative measures shall be taken to decrease the number of falls whenever possible. "2. The form is filled out completely, including immediate follow up measures taken to prevent reoccurrence. 3. The plan of care is updated immediately to reflect this follow measures taken. a, Nursing supervisor assures it is complete. "The policy further noted, "The interdisciplinary team will evaluate the resident's fall in conjunction with the care and often as needed, and develop and revise interventions to reduce further falls."	F 280	For Resident # 114 the care plan was reviewed and revised by the interdisciplinary team on October 24. R 114 is a falls risk and her care plan indicates this. Her team sheets also reflect the interventions in place for this. She was seen by Psychology on 10/07/13 and Nurse Practitioner on 10/11/13. She will be re-seen by the optometrist to re-evaluate her vision. Her care plan and care sheets are reviewed with each incident and updated with new interventions as needed. The interventions that are not working are removed from both the care plan and the team sheets. The NP is aware of every fall. The Residents daughter changes phone numbers frequently and does not update facility with new number. At present, we are unable to reach her to update her or get Waiver signed regarding to falls. Resident is not appropriate for alarms or restraints. Staff education will be completed on this October 30, 31 and November 1, 2013. Resident # 114 remains on Evergreen Unit	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 6 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care as directed for 2 of 3 residents (R93, R65) reviewed for Activities of Daily Living (ADL's) and 1 of 3 residents (R176) reviewed for urinary incontinence. Findings Include: R93 was observed to have several facial hairs the evening of 9/23/13, and during subsequent days of the survey on 9/24/13, 9/25/13 and 9/26/13. R93's quarterly Minimum Data Set (MDS) dated 8/15/13, identified R93 required limited to extensive physical assist of one staff with dressing and personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL) functional /Rehabilitation Potential dated 2/18/13, identified R93 was at risk for self-care decline related to weakness, and frequent falls resulting to humerus fracture. The care plan dated 8/27/13, identified R93 had alteration in self-care, dressing, grooming and bathing related to weakness, impaired balance, impaired cognition and pain due to humerus fracture. Goal "Will accept assist every shift....."Will be clean, well groomed and appropriately dressed daily....."Care plan	F 282	For other residents who may be affected by this practice, an audit on Care Plan changes remains ongoing. All care plans and care sheets are reviewed with each incident and with each MDS. A Falls IDT has been implemented and meets weekly to review all falls and focuses on frequent falls. Upon this review of audits and care plan revisions staff education will be implemented if indicated by October 30, 31 and November 1, 2013 The policy for comprehensive care plans was reviewed by the interdisciplinary team by October 25, 2013. 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 Comprehensive Care Plan policy and procedures October 30, 31 and November 1, 2013 Care plan audits on high risk fall residents 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.	

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F 282	Continued From page 7 indicated R93 required one staff assist with dressing, grooming and bathing. The facility Nursing Assistant (NA) Assignment sheet dated 9/5/13, "Aspen Team 3" directed R93 required assistance of one with ADL's and R93 shower was scheduled for Wednesday morning (AM). On 9/23/13, at 3:42 p.m. during interview R93 was observed to have several white facial hairs to the upper lip and the chin area approximately one half inch long. Resident stated "I hate it. When I was able to remove it I always took care of it. There was a girl that always came by to help but I have not seen her recently. I just can't stand it." On 9/24/13, at 3:40 p.m. observed resident in her room lying in bed covered with a white sheet observed to still have several facial hairs. On 9/25/13, at 10:15 a.m. NA-D was interviewed and stated R93 required extensive assist of one with ADL's and with the shower resident only participated in drying her face off after staff had washed it for her. NA-D further stated R93 would let staff do all the cares including the shower but will never let staff wash her hair and was able to brush her teeth after set-up and staff usually helps to clean the partial. NA-D never mentioned she had assisted R93 with facial hair. On 9/26/13, at 8:43 a.m. both NA-D and licensed practical nurse (LPN)-C verified the resident had several facial hairs and resident has actually stated to staff, "It drives me nuts having this hair and since [proper name of a person] has not been here recently it has gotten long and I just don't like it." LPN-C asked the resident how she removed it and R93 stated "I use the tweezers" pointing to a drawer at the corner of the room.	F 282	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/01/13 **F 282** It is the policy of Crest View Lutheran Home that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. *Included in F282 are the following: ADL assistance including Grooming/Hygiene and Nail Care, Toileting/Turning and Repositioning* For Residents #93, #65 and #176, their care plans were reviewed by IDT on October 24, 2013. Changes were made to ensure Care Plans and Team sheets matched and remain appropriate for all three residents. MDS Nurse will be reviewing and making necessary changes to care plans and team sheets with all MDS assessments. All staff members responsible were educated on ADL's Grooming/Hygiene, Nail Care and Toileting policies and procedures on October 30, 31 and November 1, 2013	

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F 282	Continued From page 8 NA-D stated if she noted facial hair on a resident especially female, she offers to remove it. On 9/26/13, at 8:45 a.m. LPN-C stated her expectation was that residents had to be offered to remove the facial hair with cares and as needed when staff saw it. On 9/26/13, at 2:43 p.m. the director of nursing (DON) stated "staff are supposed to offer to remove the facial hair for all the residents. The DON also stated "I would not even want my own mother to have facial hair." Review of the facility Quality Of Life policy and procedure directed "2. Residents will be groomed as they wish to be groomed. This includes preferences with: a. Hair style, b. Nail care, c. Facial hair....." R65 did not receive nail care as directed by the plan of care. During observations on 9/23/13, at 4:10 p.m. and 9/25/13, at 12:46 p.m. R65's fingernails were noted to be a half inch long. R65's alteration in self-care care plan dated 9/23/13, directed staff assist of two with grooming and nail care provided weekly. Review of the Body Audit/Bath Day form indicated R65 received a bath on 9/2/13, 9/9/13, 9/16/13, and 9/23/13 (Monday evenings). Review of the September 2013, Physician's Orders revealed direction for nurse to trim nails on bath day (Monday PM) related to a diagnosis	F 282	For other residents who may be affected by this practice a comprehensive record review of will be completed by October 29, 2013. After review updates will be made as appropriate for each resident identified. The policy and procedure related to Grooming/Hygiene and Nail Care and Toileting was reviewed by the interdisciplinary team by October 25, 2013. 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 Grooming/Hygiene, Nail Care and Toileting policy and procedures October 30, 21 and November 1, 2013 Grooming/Hygiene, Nail Care and Toileting 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 or designee will be responsible for compliance. Date of Correction: 11/01/13.	

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F 282	Continued From page 9 of diabetes mellitus (DM). When interviewed on 9/25/13, at 1:20 p.m. LPN-A verified R65's nails were long and needed to be trimmed and stated the nurses are responsible to trim R65's nails on bath day or if they are long. Upon interview on 9/26/13, at 11:27 a.m. the DON stated all residents with a diagnosis of DM are to have their nails trimmed by the nurses and verified the directions to trim nails every Monday was included on the treatment record. R176 did not receive assistance with toileting or incontinence care as directed by the care plan. R176's alteration in bowel and bladder function care plan dated 8/22/13, directed toilet every two to three hours to meet resident needs. R176 was continuously observed on 9/25/13, from 7:32 a.m. until 11:05 a.m. (a total of three hours and thirty-three minutes) without being assisted to the toilet or having incontinence care provided. At 11:05 a.m. R176's family member-A and NA-C entered R176's room. R176's shirt, sweat pants and soaker pad were noted to be wet. When interviewed on 9/25/13, at 1:25 p.m. NA-C verified R176 had been incontinent of urine when he was gotten up for brunch (11:24 a.m.) and needed to have his pad and close changed. NA-A stated R176 needed to be toileted when gotten up and every two to three hours and if resistive needed to be re-approached. When interviewed on 9/26/13, at 11:27 a.m. the	F 282		

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 _____	09/26/2013

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F 282	Continued From page 10 DON verified residents need to be assisted with toileting according to their care plan.	F 282	**F 312**	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview the facility failed to provide personal hygiene care for 2 of 3 residents in the sample (R93, and R65) who were dependent upon staff for personal cares. Findings Include: R93 was observed to have several facial hairs the evening of 9/23/13, and during subsequent days of the survey on 9/24/13, 9/25/1,3 and 9/26/13. R93's Admission Record noted R93 was admitted to facility on 2/5/13, and had diagnoses which included cerebral artery occlusion with infarct, difficulty walking, urinary frequency, dementia unspecified without behavior, glaucoma, osteoporosis, hypertension, and degenerative lumbar/lumbosacral intervertebral disc. R93's quarterly Minimum Data Set (MDS) dated 8/15/13, identified R93 required limited to extensive physical assist of one staff with dressing and personal hygiene needs. The Care	F 312	It is the policy of Crest View Lutheran Home, based on the residents comprehensive assessment, to ensure that a resident who enter the facility without an indwelling Catheter is not catheterized unless the residents clinica condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives the appropriate treatment to prevent urinary tract infections and to restore as much normal bladder functio as possible. For Resident # 176 the care plan was reviewed and revised by the interdisciplinary team on October 24. A new 3 day Bowel and Bladder assessment was completed on 10/22/13 Care plan and team sheets are updated and correlate. R 114 is on the secure memory care unit and has had expected decline in all areas of ADL's. His team sheet also reflects the changes in place for this. The NP/MD is aware of decline The Residents wife is very active in his care and care planning. Staff education will be completed on this October 30, 31 and November 1, 2013.	

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F 312	Continued From page 11 Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 2/18/13, identified R93 was at risk for self-care decline related to weakness, and frequent falls resulting to humerus fracture. The care plan dated 8/27/13, identified R93 had alteration in self-care, dressing, grooming and bathing related to weakness, impaired balance, impaired cognition and pain due to humerus fracture. Goal "Will accept assist every shift....."Will be clean, well groomed and appropriately dressed daily....." Care plan indicated R93 required one staff assist with dressing, grooming and bathing. The facility nursing assistant assignment sheet dated 9/5/13, "Aspen Team 3" directed R93 required assistance of one with ADL's and R93 shower was scheduled for Wednesday morning (AM). On 9/23/13, at 3:42 p.m. during interview R93 was observed to have several white facial hairs to the upper lip and the chin area approximately one half inch long. Resident stated "I hate it. When I was able to remove it I always took care of it. There was a girl that always came by to help but I have not seen her recently. I just can't stand it." On 9/24/13, at 3:40 p.m. observed resident in her room lying in bed covered with a white sheet observed to still have several facial hairs. On 9/25/13, during continuous observations: -At 8:10-8:40 a.m. resident in the shower/tub room with NA-D. -At 8:41 a.m. observed NA-D wheeling R93 back to her room from the shower room and assisted her to bed. NA-D left the room and came back to the room with a pink mug of ice water and	F 312	Resident # 176 remains on Willow Unit For other residents who may be affected by this practice, an audit on Care Plan changes and toileting/checking and changing remains ongoing. All care plans and care sheets are reviewed with each MDS. Upon this review, care plan revisions and/or staff education will be implemented by October 30, 31 and November 1, 2013 The policies for comprehensive care plans and Toileting will be reviewed by the interdisciplinary team by October 25, 2013. 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 Comprehensive Care Plan policy and procedures October 30, 31 and November 1, 2013	

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F 312	Continued From page 12 assisted R93 to take a few sips then left the room. -At 8:41 to 9:15 a.m. R93 observed to be lying on her bed with the head of bed elevated and was watching television at that time. R93 stated she did not sleep well last night because of the eye injection discomfort. R93 still observed to have several facial hairs. On 9/25/13, at 10:15 a.m. interviewed NA-D stated R93 required extensive assist of one with ADL's and with the shower resident only participated in drying her face off after staff had washed it for her. NA-D further stated R93 would let staff do all the cares which included the shower but will never let staff wash her hair and was able to brush her teeth after set-up and staff usually helps to clean the partial. NA-D never mentioned she had assisted R93 with facial hair. On 9/25/13, at 1:33 p.m. observed resident in her room asleep on her back observed taking a sip of water still had the facial hair. On 9/26/13, at 8:32 a.m. observed R93 lying on her bed still noted to have several white facial hairs appeared to be dressed up was watching TV at the time. Review of the facility Body Audit dated 9/25/13, was noted as "No issues" and was signed by the licensed practical nurse (LPN)-C and NA-D. On 9/26/13, at 8:43 a.m. both NA-D and LPN-C verified the resident had several facial hairs. The resident stated to staff "It drives me nuts having this hair and since [proper name of a person] has not been here recently it has gotten long and I just don't like it." LPN-C asked the resident how	F 312	Care plan and toileting/checking and changing audits on residents 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: 11/01/13	

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F 312	Continued From page 13 she removed it and R93 stated "I use the tweezers" pointing to a drawer at the corner of the room. NA-D stated if she noted facial hair on a resident especially female, she offers to remove it. On 9/26/13, at 8:45 a.m. LPN-C stated her expectation was that residents had to be offered to remove the facial hair with cares and as needed when staff saw it. On 9/26/13, at 2:43 p.m. the director of nursing (DON) stated "staff are supposed to offer to remove the facial hair for all the residents. DON also stated "I would not even want my own mother to have the facial hair." Review of the facility Quality Of Life policy and procedure directed "2. Residents will be groomed as they wish to be groomed. This includes preferences with: a. Hair style, b. Nail care, c. Facial hair....." R65 was observed to have long fingernails on 9/23/13, and 9/25/13. During observations on 9/23/13, at 4:10 p.m. and 9/25/13, at 12:46 p.m. R65's fingernails were noted to be ½ inch long. R65's left hand had a contracture present with a wash cloth placed in the palm. The quarterly Minimum Data Set (MDS) dated 9/9/13, revealed R65 had a Brief Interview of Mental Status (BIMS) score of three which indicated severe cognitive impairment, required extensive assist of two staff for personal hygiene and total assist of two for bathing.	F 312		

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F 312	Continued From page 14 R65's alteration in self-care care plan dated 9/23/13, directed staff assist of two with grooming and nail care provided weekly. Review of the Body Audit/Bath Day form indicated R65 received a bath on 9/2/13, 9/9/13, 9/16/13 and 9/23/13 (Monday evenings). Review of the September 2013, treatment record revealed a physician's order for nurse to trim nails on bath day (Monday PM) related to a diagnosis of diabetes mellitus (DM). When interviewed on 9/25/13, at 1:20 p.m. LPN-A verified R65's nails were long and needed to be trimmed and stated the nurses are responsible to trim R65's nails on bath day or if they are long. Upon interview 9/26/13, at 11:27 a.m. the DON stated all residents with a diagnosis of DM are to have their nails trimmed by the nurses and verified the directions to trim nails every Monday was included on the treatment record. The facility Quality of Life-Dignity policy and procedures dated 9/13, directed residents will be groomed as they wish to be groomed which included nail care.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	**F 315** For Resident # 176 the care plan was reviewed and revised by the interdisciplinary team on October 24. A new 3 day Bowel and Bladder assessment was completed on 10/22/13. Care Plan and team sheets are updated and correlate. R 114 is on the secure memory care unit and has had expected decline in all areas of ADL's. His team	

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F 315	Continued From page 15 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 3 residents (R176) reviewed for urinary incontinence. Findings include: R176 was continuously observed on 9/25/13, from 7:32 a.m. until 11:05 a.m. (a total of three hours and thirty-three minutes) without being assisted to the toilet or having incontinence care provided. At 11:05 a.m. R176's family member-A and nursing assistant (NA)-C entered R176's room. R176's shirt, sweat pants and soaker pad were noted to be wet. The Admission Record dated 9/26/12, for R176 included diagnoses of Alzheimer's disease, prostate cancer, and enlargement of the prostate. A Plan of Care For Outpatient Rehabilitation dated 6/19/13, indicated for R176 "toileting (he is continent)." The admission Minimum Data Set (MDS) dated 6/25/13, indicated R176 was occasionally incontinent of bladder and was independent with toilet use. The significant change in status (SCSA) MDS dated 8/8/13, revealed R176 had a Brief Interview	F 315	sheet also reflects the changes in place for this. The NP/MD is aware of decline The Residents wife is very active in his care and care planning. Staff education will be completed on this October 30, 3: and November 1, 2013. Resident #176 remains on Willow Unit. For other residents who may be affecte by this practice, an audit on Care Plan changes and toileting/checking and changing remains ongoing. All care plans and care sheets are reviewed with each MDS. Upon this review, care plan revisions and/or staff education will be implemented by October 30, 31 and November 1, 2013. The policies for comprehensive care plans and Toileting will be reviewed by the interdisciplinary team by October 25 2013. 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 Comprehensive Care Plan policy and procedures October 30, 31 and November 1, 2013.	

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F 315	Continued From page 16 of Mental Status (BIMS) score of three (severely impaired cognitive status), required extensive assist of two for toileting and was always incontinent of bladder. The urinary incontinence Care Area Assessment (CAA) dated 8/22/13, indicted R176 had functional incontinence (cannot get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating.) R176's alteration in bowel and bladder function care plan dated 8/22/13, directed toilet every two to three hours to meet resident needs. A Quarterly Bowel and Bladder Assessment (undated) indicated R176's present bladder status frequency was every one to two hours and care planning for every one to two hours. When interviewed on 9/25/13, at 1:25 p.m. NA-C verified R176 had been incontinent of urine when he was gotten up for brunch (11:24 a.m.) and needed to have his pad and close changed. NA-A stated R176 needed to be toileted when gotten up and every two to three hours and if resistive needed to be re-approached. When interviewed on 9/26/13, at 10:45 a.m. licensed practical nurse (LPN)-B verified R176's care plan did not match the most recent bowel and bladder assessment and the care plan needed to be updated. When interviewed on 9/26/13, at 11:27 a.m. the director of nursing verified residents need to be assisted with toileting according to their care plan and all nurses were responsible for updating the care plan.	F 315	Care plan and toileting/checking and changing audits on residents 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: 11/01/13	

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F 315	Continued From page 17 The facility Toileting Residents policy and procedure dated 4/10, directed "Residents are toileted safely on a routine basis in a timely manner and as their individual plan of care indicates."	F 315		
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 ensure supervision and adequate interventions were implemented to minimize the risk for further falls and accidents for 1 of 3 residents (R114) reviewed for falls. Findings include: R114 had falls on 8/22/13, 9/10/13, 9/13/13, and 9/24/13. The current care plan had not been updated with any new interventions to minimize and/or prevent potential injury from further falls. R114's diagnoses obtained from the Admission Record dated 5/1/10, included dementia, macular degeneration, depression, arthritis, history of epilepsy and history of falls.	F 323	**F 323** 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.*	

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F 323	Continued From page 18 On 9/26/13, at 3:20 p.m. and R114 was observed ambulating around and between the Evergreen unit with a rolling walker. R114 at the time was observed wearing a pair of loosely fitted shoes without socks in the front lobby with rolling walker. A nurse practitioner (NP) Progress Note dated 7/17/13, indicated, R114 "Dementia - neg [negative] infections. Continue to fall and to this point without serious injury. She is pleasant and cooperative but can be resistive to cares on occ. [occasion]." Although the NP notes indicated R114 resisted cares due to her dementia. The resistiveness to cares was not on R114's plan of care. The care plan dated on 8/5/13, indicated R114 had four falls since 8/5/13. The care plan goal was "Will have no injury needing more than first aid." In addition, the care plan indicated R114 had interventions to "Ensure resident is wearing proper footwear during transfers/ambulation. If fall occurs, follow facility policy." The care plan also stated, resident had "potential alteration in safety, falls r/t [related to] balance impairment cognitive depression, neurological disorder and habit of bending to p/u [pick up] things, causing falls." The care plan also indicated R114 was to wear gripper socks and also noted R114 was not resistive to cares. Although R114 had a known history of falls, the staff did not identify risk factors such as the observed ill-fitting shoes, lack of gripper on both feet and did not re-evaluate the effectiveness of the current interventions to prevent/minimize R114 from further injury due to the falls. A quarterly Minimum Data Set (MDS) dated 8/8/13, indicated R114 was able to make	F 323	For Resident # 114 a new assessment for Fall Risk and Physical Devices was completed on October 24 2013. She has been and remains a Falls Risk. Care Plan and Team Sheets have reflected this. She was seen by Psychology on 10/07/13. She was seen by the Nurse Practitioner on 10/11/13. She will be re-seen by the Optometrist to re-evaluate her vision. Her care plan and team sheets are updated with changes after every fall. The interventions that are not effective are removed and new interventions are implemented. Nurse Practitioner is aware of every fall and has adjusted medications and has participated in brainstorming new interventions with the Interdisciplinary Team. Resident is not appropriate for alarms or restraints. She has been evaluated by physical therapy. A Falls Interdisciplinary Team has been initiated and meets weekly to discuss frequent falls. The primary physician was informed of the assessment results and a review of the current physician orders was completed on 10/24/13. All staff members will be educated on the Falls	

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F 323	Continued From page 19 self-understood and ability to understand others. The MDS did not indicate R114 had behaviors of resistiveness. R114's Brief Interview for Mental Status (BIMS- a tool used to determine cognitive status) was rated at a 9 out of a possible 15 score (8 to 12 denotes moderate impairment). In addition, the MDS indicated R114 required one person limited assist for walking in room supervision with transfers and locomotion. The resident Incident Report notes and interdisciplinary team (IDT) discussion notes and intervention review revealed the following: On 8/22/13, at 7:20 p.m. the resident Incident Report notes indicated "per visitor at Aviary. res. [resident] lost balance and they caught her, helped her sit on the floor. Re [sic] [R114] did not hit her head." The Incident Report lacked evidence of any new interventions being put into place to minimize potential injury from falls. On 9/10/13, at 9:20 a.m. "OT [occupation therapist] was walking through main dining room and heard a Thud. She looked over and saw res. On the floor by the table. Res stated 'I was picking up something off the floor and slid out of my chair.'" On 9/11/13, with no time indicated, "Res. has behavior care planned. All interventions remain appropriate. Res I [independent] with ambulation with walker. Was wearing approp [appropriate] foot wear, glasses and had walker with her. D/T [due to] memory - we are unable to change res behavior with habits." On 9/13/13, at 4:15 p.m. "Resident was found sitting on the floor according to supervisor. Unable to respond." On 9/16/13, with no time indicated, "Res is conti [continue]... found picking imaginary/items of the floor. She was a house	F 323	policies and procedures on October 30, 31 and November 1, 2013 Resident #114 remains on Evergreen Unit. For other residents who may be affected by this practice, a comprehensive record review of will be completed by October 29, 2013. After review updates will be made as appropriate for each resident identified. The policy and procedure related to Falls was reviewed by the interdisciplinary team on October 25, 2013. 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 accidents and hazards policy and procedures. Falls 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 or designee will be responsible for compliance. Date of Correction: 11/01/13	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 cleaner in profession. Multiple interventions have been attempted but d/t memory issues, she cannot stay focused. Alarms are not approp as she is independent with ambulation. She was assesses by PT [physical therapy] but is no approp D/T high physical functioning level. No new interventions at this time." On 9/24/13, at unknown time per resident incident report, "Noted approx. [approximate] 2 cm [centimeters] abrasion superficial on forehead. Res. stated, I fell after brunch today while walking in hallway." "Res has hx [history] of self reported falls. Fall was not witnessed. She does have scratch on her forehead. There is no bruising around abrasion or swelling in area. She does have longer fingernails and abrasion does appear to be a scratch. Fingernails were trimmed." On another note at 12:01 p.m. on the Progress Notes indicated "res. up and about per usual without any complaints and cheerful. Noted approx. 2 cm length superficial pink abrasion on forehead. Background: Res. has history of multiple falls and falls often. Res. has senile dementia with delusional features. Assessment: Res. has sharp fingernails on it. hand. VS [vital signs] =97, 20, sitting bp [blood pressure] =110/60, standing-108/60, sats [oxygen saturation level] = 99 r/a [room air]. Denies pain/discomfort." The 9/24/13, incident report lacked evidence of any new interventions that were put into place to minimize the potential of injury from further falls. The incident report noted to continue the same care plan interventions. The undated Nursing Assistant Assignment Sheet (NA) "Evergreen Team 3" directed R114 required assistance of one with activities of daily living's (ADL's) and which included transfers. In addition,	F 323		

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 _____	09/26/2013

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

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F 323	Continued From page 21 the NA assignment revealed, "Encourage wearing gripper sock, and attending activities. Remind to use walker. Watch for her bending/stooping to pick items off the floor-redirect her." Although R114 had a known history of falls, R114's plan of care was not revised to include new interventions after the falls. R114 was not observed to have gripper socks on her feet on 9/26/13, at 3:20 p.m. and R114 was wearing ill-fitting shoes. On 9/26/13, at 8:05 a.m. both the administrator and director of nursing (DON) stated, they have exhausted the resources for her by consulting with the NP and the psychologist. They have changed the interventions multiple times and they have bought glasses for her which she normally breaks in pieces. The administrator further stated, "Therapy had evaluated her for falls and that she leaned forward picking up things and they don't want to limit her independence with a restraint or tab alarm on her." On 9/26/13, at 8:10 a.m. the licensed practical nurse (LPN)-F stated, "resident likes to picking up things from the floor even after she has been redirected and will still continue with the same behavior." LPN-F further stated, the resident "liked to walk fast with her walker. We cannot restrain her or put tabs alarm on her because we want to keep her as independent as possible." On 9/26/13, at 8:15 a.m. the OT stated, "Last time we work with resident was in June 2012." OT record review revealed R114 last work with OT was in June 2012 and no current referrals were offered to OT for R114. On 9/26/13, at 8:55 a.m. the physical therapy director (PTD) stated "I don't recall anything and I	F 323		

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	245018	A. BUILDING _____ B. WING _____	09/26/2013

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F 323	Continued From page 22 have no documentation regarding her being on Physical therapy for falls." PTD further stated, he normally saw the resident going around and picking up things from the floor and also R114 had poor eye sight. PTD further stated "I have seen her several times not using her walker properly." PTD stated, "resident should have been screened and evaluated." On 9/26/13, at 2:00 p.m. the NA-F stated, "Resident does require physical help in bathing, limited assist with personal hygiene, requires assistance sometimes with toileting but she is independent with bed mobility, transfers, walking and locomotion on and off unit." On 9/26/13, at 2:05 p.m. the registered nurse (RN)-D stated, "The issue with multiple falls for resident was not brought to my attention and they do not bring falls to my attention if staff was not involve." The policy and procedure revised 6/13, indicated, "All residents who assessed as being at high risk for will be identified and individualized fall precautions will be developed for that resident. Preventative measures shall be taken to decrease the number of falls whenever possible. "2. The form is filled out completely, including immediate follow up measures taken to prevent reoccurrence. 3. The plan of care is updated immediately to reflect this follow measures taken. a, Nursing supervisor assures it is complete. 4. Similarly, nursing assistant assignment sheet are updated immediately to reflect follow up measures taken, as appropriate." The policy further noted, "The interdisciplinary team will evaluate the resident's fall in conjunction with the care and often as needed, and develop and	F 323		

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F 323	Continued From page 23 revise interventions to reduce further falls." R114's incidents reports were void of any follow up measures taken after each fall immediately.	F 323	**F 431**	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	*It is the policy of Crest View Lutheran Home to properly store and label all drugs and biological, including but not limited to oral medications, inhalers and eye drops.* For resident #98 the non-labeled Advair Diskus was discarded and replaced with a new STAT order re-fill of the medication. Resident # 98 has been discharged back to home from the Linden unit. For other residents who may be affected by this practice, audits on the medication carts remain on-going. Staff education will be implemented by October 30, 31 and November 1, 2013.	

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F 431	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that medications were stored and labeled properly for 2 of 2 residents (R98, R174) reviewed for medication storage. Findings include: On 9/23/13, at 11:46 a.m. during medication storage tour with licensed practical nurse (LPN)-E on the Linden unit, the following was observed, an Advair Diskus (inhaler for the treatment of asthma) stored in the medication cart was undated for R98. The medication had been dispensed by the pharmacy on 7/23/13. The facility had used the newest medication first and when that medication was done then they reverted back to the oldest medication which was dispensed on 7/23/13. R98's diagnoses included chronic pulmonary heart disease, obstructive sleep apnea, obstructive chronic bronchitis with acute bronchitis and unspecified heart failure obtained from the Admission Report dated 9/30/12. The admission Minimum Data Set (MDS) dated 7/30/13, indicated R98 had diagnoses of chronic obstructive pulmonary disease. R98's Physician Orders signed 7/23/13, indicated resident received Advair Diskus aerosol powder breath (used to treat asthma) activated 250-50 mcg (micrograms) per dose 1 puff inhale orally every 12 hours.	F 431	The policy for Medication Storage and Labeling was reviewed by the interdisciplinary team on October 24, 2013. 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 Medication Storage and Labeling policy and procedure on October 30, 31 and November 1, 2013. Medication Cart storage and labeling 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 11/01/13	

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F 431	Continued From page 25 Review of the July through September 2013 Medication Administration Record (MAR) indicated R98 received 1 puff of Advair Diskus twice daily from when she was admitted to the facility on 7/23/13, to 9/23/13. On 9/23/13, at 11:48 a.m. LPN-E stated that she was orientating with another nurse but thought all medications which included inhalers and eye drops had to be dated when opened per facility policy. On 9/26/13, at 11:22 a.m. LPN-D stated her expectation was to have all multiple dose bottles to be dated and additionally all inhalers, insulin and eye drops had to be dated when opened. LPN-D further stated when medications are sent to the facility there is always sticker which the staff can use to date the medication when it was opened and if no sticker the facility has made some for staff to use to date medications. On 9/26/13, at 2:32 p.m. the director of nursing (DON) stated all medications have to be dated when opened and this was something that she had been working very much with the staff to make sure it was done correctly. On 9/26/13, at 2:46 p.m. the consultant pharmacist (CP) stated her expectation was all medications need to be labeled accordingly when medication was opened, she added the Advair Diskus was good for one month since the time it was opened. On 10/1/13, at 9:20 a.m. phone interview with Omnicare Pharmacy customer service staff stated "Resident had 2 Advair Diskus despensed according to the records on 7/23/13, and on	F 431		

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F 431	Continued From page 26 8/27/13." R174's medication was not stored properly. An unlocked treatment cart was sitting in the Linden hallway, outside of room L29 on 9/26/13, at 2:30 p.m. A Nystatin powder (antibiotic powder for yeast infection of the skin) bottle for R174 was stored in an Aspart insulin bag for R174. The assistant director of nursing (ADON) came past and was shown the unlocked treatment cart. The ADON stated she would not expect to find prescribed medications unsecured, and would not expect to see nystatin powder stored in an insulin bag. The CP was called on 9/26/13, at 2:45 p.m. and verified she would not expect to find prescribed medications in an unsecured cart in the hallway, and stated she would not expect to find a medication stored incorrectly in a bag labeled with another medication. The facility Receiving Medications policy and procedure revised 5/13, directed "5. All other medications will be put in the appropriate place in the medication cart...." The policy lacked directions on storage of external and internal medications separately and labeling of medications after being opened.	F 431		
F 441 SS=D	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	F 441	**F 441** It is the policy of Crest View Lutheran Home to establish and maintain an Infection Control Program designed to	

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F 441	Continued From page 27 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing staff provided wound care to minimize the risk of infection of a pressure ulcer for 1 of 1 resident	F 441	provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. *Included in F 441: The Infection Control Program must Investigate, control and prevent infections in the facility, decide what procedures, such as isolation, should be applied to an individual resident and maintain a record of incident s and corrective action related to infections. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice* For Resident # 65 the nurse has been re-educated on the proper use of gloves and hand washing after removal of gloves. R 65 is on the secure memory care unit and has had expected decline in all areas of ADL's. She receives wound care per MD order and is followed by the wound MD/nurse weekly. Staff education will be completed on this October 30, 31 and November 1, 2013. Resident # 65 remains on Willow Unit	

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F 441	Continued From page 28 (R65) reviewed for pressure ulcers. Findings include: R65's Admission Record dated 9/30/11, included diagnoses of dementia, pressure ulcer to buttocks, hypertension and diabetes. The quarterly Minimum Data Set (MDS) dated 9/9/13, revealed R65 had a Stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) On 9/26/13, at 8:35 a.m. licensed practical nurse (LPN)-A was observed to provide wound care to R65's pressure ulcer on the coccyx. During the observation, R65 was noted to have a liquid consistency bowel movement (BM). LPN-A used a wipe to clean the BM, removed her gloves, applied new gloves without washing her hands and removed the packing material from R65's pressure ulcer. R65 again had a liquid consistency BM which LPN-A cleaned up with a wipe. After cleaning up the BM, LPN-A removed her gloves, applied new gloves without washing her hands and placed gauze packing into the pressure ulcer and covered the wound with an Allevyn wound cover dressing. When interviewed on 9/26/13, at 9:14 a.m. LPN-A verified she had not washed her hands after cleaning BM and removing her gloves during the pressure ulcer care for R65. When interviewed on 9/26/13, at 10:45 a.m. the wound nurse LPN-B verified LPN-A did not wash her hands when changing gloves.	F 441	For other residents who may be affected by this practice, an audit on gloves and hand washing remains ongoing. All staff have been and will continue to be educated on this upon hire and annually. All staff re-education will be done October 30, 31 and November 1, 2013 The policy for comprehensive hand washing and glove use was reviewed by the interdisciplinary team on October 25, 2013. It remains appropriate. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were re- trained as it relates to their respective roles and	

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F 441	Continued From page 29 Upon interview 9/26/13, at 11:10 a.m. the infection control registered nurse (RN)-A stated hands needed to be washed every time gloves are removed and staff had been trained on hand washing and glove use. The facility Hand Washing policy dated 2/08, directed staff hand washing/ hand sanitizing must be done after removing gloves to prevent cross contamination and infection. The facility Glove Technique policy dated 2/08, indicated "It is always possible that gloves have minute leaks."	F 441	responsibilities regarding the hand washing and glove use procedures October 30, 31 and November 1, 2013 Infection Control audits on hand washing and glove use 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: 11/01/13	

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	245018	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**09/24/2013**

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

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K 000	INITIAL COMMENTS 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 119 were occupied at the time of inspection.	K 000	**K 000** It is the policy of Crest View Lutheran Home to follow all regulations and statutes as they relate to the Life Safety Code. 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.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, multi-plug power strips were found to be in use. This deficient practice could affect all occupants.	K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/1/13

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.

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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**09/24/2013**

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K 147	Continued From page 1 Findings include: During the facility tour on 9-24-12 at 9:45 AM, it was observed that four (4) multi-plug power strips were plugged into one another (daisy chained) at the main phone panel located in the lower level. This arrangement of electrical wiring is not allowed per NFPA 70. This deficient practice was confirmed by the Maintenance Supervisor (DK) and the Administrator (MT) at the time of exit.	K 147	**K 147** It is the policy of Crest View Lutheran Home to have all electrical wiring and equipment in accordance with NFPA 70, National Electric Code. 9.1.2 The multi-plug power strips that were in use and plugged in to one another were un-plugged and re-directed in a way that they did not connect off of one another. To ensure that this deficient practice is corrected, environmental audits of electrical wiring and equipment are completed weekly for 4 weeks, monthly for 2 months, and then randomly thereafter. The Director of Environmental Services or hi designee will be responsible for compliance. Date of Correction: 11/01/13.	

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 _____	**09/24/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 of 119 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, multi-plug power strips were found to be in use. This deficient practice could affect all occupants.	K 147		

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 **01 - MAIN BUILDING 01** B. WING _____	**09/24/2013**

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K 147	Continued From page 1 Findings include: During the facility tour on 9-24-12 at 9:45 AM, it was observed that four (4) multi-plug power strips were plugged into one another (daisy chained) at the main phone panel located in the lower level. This arrangement of electrical wiring is not allowed per NFPA 70. This deficient practice was confirmed by the Maintenance Supervisor (DK) and the Administrator (MT) at the time of exit.	K 147		

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 _____	**09/24/2013**

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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 119 were occupied at the time of inspection.	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, multi-plug power strips were found to be in use. This deficient practice could affect all occupants.	K 147		

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 _____	**09/24/2013**

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K 147	Continued From page 1 Findings include: During the facility tour on 9-24-12 at 9:45 AM, it was observed that four (4) multi-plug power strips were plugged into one another (daisy chained) at the main phone panel located in the lower level. This arrangement of electrical wiring is not allowed per NFPA 70. This deficient practice was confirmed by the Maintenance Supervisor (DK) and the Administrator (MT) at the time of exit.	K 147		