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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TMS6
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 **10/16/2014** (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):
Mandatory DOPNA is rescinded.

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 10/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/27/2014 (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)

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

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/23/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5018

October 27, 2014

Mr. Matt Tobalsky, Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, Minnesota 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 October 21, 2014 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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4875

October 24, 2014

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

RE: Project Number S5018026

Dear Mr. Tobalsky:

On September 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 16, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2014, effective October 21, 2014 and therefore remedies outlined in our letter to you dated September 2, 2014, 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
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

Protecting, Maintaining and Improving the Health of Minnesotans

November 7, 2014

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

RE: Project Number S5018026

Dear Mr. Tobalsky,

Enclosed, please find Post Certification Revisit forms (CMS form 2567B), with revised compliance dates.

Please disregard the CMS 2567B form originally mailed to you on October 24, 2014.

Sincerely,

Anne Kleppe, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing	10/16/2014

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**09/23/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/23/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**09/23/2014**
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	**09/23/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/23/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**09/23/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/23/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/23/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	**09/23/2014**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	**09/23/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**09/17/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	11/07/2014	30951	10/16/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
8/14/2014

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

AH Form Approved
11/7/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00005	A. Building B. Wing	10/16/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20545 Reg. # MN Rule 4658.0400 Subp. LSC	09/23/2014	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	09/23/2014	ID Prefix 20800 Reg. # MN Rule 4658.0510 Subp. LSC	09/23/2014
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	09/23/2014	ID Prefix 20855 Reg. # MN Rule 4658.0520 Subp. LSC	09/23/2014	ID Prefix 21325 Reg. # MN Rule 4658.0725 Subp. LSC	09/23/2014
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Su LSC	09/23/2014	ID Prefix 21540 Reg. # MN Rule 4658.1315 Subp. LSC	09/23/2014	ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. LSC	09/17/2014
ID Prefix 21695 Reg. # MN Rule 4658.1415 Subp. LSC	09/23/2014	ID Prefix 21995 Reg. # MN St. Statute 626.557 Sul LSC	09/23/2014	ID Prefix 22000 Reg. # MN St. Statute 626.557 Su LSC	09/23/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	11/07/2014	30951	10/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/14/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245018	A. Building B. Wing 01 - MAIN BUILDING 01	10/24/2014

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 K0043	09/23/2014	ID Prefix Reg. # NFPA 101 LSC K0103	09/23/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	10/24/2014	28120	10/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/15/2014	

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	10/24/2014

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 K0027	10/13/2014	ID Prefix Reg. # NFPA 101 LSC K0062	10/21/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	10/24/2014	28120	10/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/25/2014				

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4875

October 24, 2014

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

Re: Enclosed Reinspection Results - Project Number S5018026

Dear Mr. Tobalsky:

On October 16, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 14, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TMS6
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 **08/14/2014** (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):

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4677

September 2, 2014

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

RE: Project Number S5018026

Dear Mr. Tobalsky:

On August 14, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. 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;**
>
> **<u>Remedies</u> - 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;**

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

<u>Informal Dispute Resolution</u> - 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, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
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 September 23, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 23, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 November 14, 2014 (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 February 14, 2015 (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.

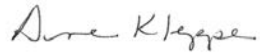
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING ______ B. WING ______	08/14/2014

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	**F 000** It is the policy of Crest View Lutheran Home to follow all federal, state, and local guidelines, laws, regulations, and statues. 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F 225** It is the policy of Crest View Lutheran Home that all alleged violations of mistreatment, neglect or abuse are investigated and reported to the appropriate entities in a timely manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Care Center Administrator — (X6) DATE: 9/12/14

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations involving injuries of unknown source and resident to resident altercations were immediately reported to the State agency (SA) and administrator for 3 of 5 residents (R64, R23, R177). Findings include: R64 was involved in a resident to resident altercation and the incident was not reported to the SA nor was the report thoroughly investigated. Safety measures were not put in place for either resident. R64 reported in an interview on 8/11/14, at 6:30 p.m. another resident had slapped his face because R64 was complaining too much. R64 reported the other resident "never apologized to me, how come, it hurt!" and pointed to his check area and added, "Right there he did that." R64 added it happened in the dining room and staff was aware of the incident. R64's quarterly Minimum Data Set (MDS) dated	F 225	For Residents R64, R23, and R177, , plans of care were reviewed by IDT on 09/15/14 to ensure each resident is free of abusive environments. All staff members were educated on Abuse Prohibition and Reporting policies and procedures on 09/17/14-09/19/14 The policy and procedure related to Abuse Prohibition and Reporting was reviewed by the interdisciplinary team on 09/15/14. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were	

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F 225	Continued From page 2 7/8/14 identified R64 had a Brief Interview for Mental Status (BIMS - test to determine cognition level) score of fifteen indicating intact cognition. On 8/11/14, at 7:55 p.m. the administrator indicated he was aware of the situation. Review of the Resident Incident Report dated 3/7/14, revealed the incident occurred at 5:00 p.m. in the dining room. The report indicated another resident approached a nurse and reported he had softly slapped R64 on the left jaw. R64 and the alleged perpetrator were interviewed on 3/10/14. The incident report form did not indicate when SA, physician or responsible party had been notified. Progress Note provided by the facility dated 1/10/14, at 11:37 a.m. indicated a verbal altercation between R64 and another resident had occurred in the dining room (DR) at 11:20 a.m. and there was no further documentation provided of a thorough investigation including other residents or staff in the DR that had been interviewed and neither was evidence of follow up for possible injury. In addition there was no further documentation with identified safety measures taken for R64 and the other resident involved in the incident. On 8/14/14, at 2:00 p.m. the administrator reviewed the facility's policy and identified not interpreting the policy correctly and indicated "Because it was first not considered physical abuse or intent to harm the incident was not reported." The administrator verified the incident should have been called into the SA. R23 was involved in verbal abuse and resident to resident altercation and the incident was not reported to the SA immediately nor was it thoroughly investigated.	F 225	trained as it relates to their respective roles and responsibilities regarding the Abuse Prohibition and Reporting policy and procedures on 09/17/14-09/19/14. A Reporting and Investigation audit was created to ensure timeliness of reporting all alleged maltreatment, neglect and abuse. This audit will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. Audits for staff knowledge on identifying and reporting maltreatment, neglect, and abuse will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. The results of these audits 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: 09/23/14	

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F 225	Continued From page 3	F 225		

Crest View Lutheran Home Progress Note dated 6/18/14, at 3:24 p.m. indicated R23 walked back to his room with staff to go to bed. Roommate started yelling and threatening R23 by stating "get the hell out of this room now, if you don't get him out of this room, I'll kill him." After incident the facility put R23 on fifteen minutes checks for his safety.

Crest View Lutheran Home Progress Note dated 7/20/14, at 1:31 p.m. indicated R23's roommate grabbed his arm in the hallway. Staff separated and assisted R23 to the living area immediately. No bruising, no redness noted on arm, nurse practitioner updated.

Crest View Lutheran Home Progress Note dated 8/2/14, at 2:36 p.m. indicated R23's roommate was holding and hitting to R23's thigh in the hallway per staff report. Staff separated and moved R23's roommate to the front desk. No redness, no bruising to hands and thigh noted. R23 stated "I'm fine", supervisor updated and safety checks indicated per policy.

R23 ' s annual MDS dated 3/15/14, indicated R23's BIMS score was three which indicated severe cognition loss. In addition the MDS indicated R23's diagnoses included Alzheimer's, dementia and Parkinson's disease. Furthermore the MDS indicated R23

During interview on 8/14/14, at 11:16 a.m. the administrator confirmed facility policy and resident to resident altercation were reported to him but was not reported to the SA. The Administrator stated "The incidents were not reported to the SA because no harm was caused so we don't report it and also verified when no

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F 225	Continued From page 4 harm was caused the facility did incident reports and followed the facility policy. R177 was found with a large bruise of unknown origin and was not reported immediately to the SA, and the Investigative Report was not submitted timely to the SA. Incident Report dated 7/12/14, for R177 read "Discoloration on left hand with open area on left elbow. At 9:40 a.m. writer assessed resident and found a purple and red and black long discoloration on the front of resident left hand measuring 11 Centimeters [cm] by 5 1/2 cm, another red discoloration on the elbow measuring 3 cm by 1/2 cm with open area in the red discoloration of the elbow measuring 1 cm. Resident can't explain. Has history [Hx] of wandering behavior walking with head facing down when walking and bumping into things. Physician, Responsible party, DON, Supervisor, and Administrator notified on 7/12/14, at 9:40 a.m." Incident Report was submitted two days later to the SA on 7/14/14. The Investigative Report for R177 read "Resident currently resides on the secure memory care unit. Diagnoses include dementia with behavioral disturbances and Alzheimer's. Resident needs and receives assist of 1 with all activities of daily living [ADLs]. Resident is independent with mobility, and is able to ambulate without any assistive devices. Resident has a BIMS cognitive score of 4 of 15, which showed severe cognitive deficits. On the morning of 7/12/14, R177 was observed with a large bruise measuring 11 cm x 5.5 cm on resident's forearm. When asked how it happened, this resident was not able to communicate the source. Family and physician	F 225		

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F 225	Continued From page 5 notified immediately. The bruise was reported due to the facility's policy of reporting an unknown bruise that is larger in size." The Investigative Report was submitted to the SA untimely on 7/28/14, eleven working days after the incident had been discovered. On 8/4/14, at 2:08 p.m. the administrator stated staff are trained to call the administrator immediately after an incident. The administrator stated he decided if the incident is reportable or not, and would go by the regulation. The administrator also stated the team has discussed the abuse policy and stated the policy needed updating. In addition the administrator stated R177's bruise was reportable because of the size of the bruise and also stated he did know investigative reports were to be reported within five working days of incident to the SA. The administrator further stated he did not know why R177's report was submitted late to the SA. The facility's Abuse Investigation Policy dated Rev. 10/12, directed: "1) An incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the Administrator or designee. 2) The administrator or designee will make an initial report of the incident or suspected incident, to the SA immediately in accordance with law. The follow up investigative notes will be submitted to the SA within 5 working days of the initial report."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 6 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy to immediately notify the administrator, the State Agency (SA) and thoroughly investigate potential allegations of resident to resident altercations, injuries of unknown origin and elopement for 3 of 5 residents (R64, R23, R177). Findings include: The facility's Abuse Investigation Policy dated Rev. 10/12, directed: 1) An incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the Administrator or designee. 2) The administrator or designee will make an initial report of the incident or suspected incident, to the SA immediately in accordance with law. The follow up investigative notes will be submitted to the SA within 5 working days of the initial report." In addition, the policy indicated "Suspected or substantiated cases of resident mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property will be thoroughly investigated and documented by the Administrator or designee. Suspected or substantiated cases must also be reported to	F 226	**F 226** It is the policy of Crest View Lutheran Home that all alleged violations of mistreatment, neglect or abuse are investigated and reported to the appropriate entities in a timely manner. For Residents R64, R23, and R177, plans of care were reviewed by IDT on 09/15/14 to ensure each resident is free of abusive environments. All staff members were educated on Abuse Prohibition and Reporting policies and procedures on 09/17/14-09/19/14. The policy and procedure related to Abuse Prohibition and Reporting was reviewed by the interdisciplinary team on 90/15/14. 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 Abuse Prohibition and Reporting policy and procedures on 09/17/14-09/19/14.	

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F 226	Continued From page 7 respective agencies such as state agencies, law enforcement, physician, families, and/or representative. The subject of abuse shall be routinely and openly discussed." R64 was involved in a resident to resident altercation and the incident was not reported to the SA nor was the report thoroughly investigated. Safety measures were not put in place for either resident. Progress Note provided by the facility dated 1/10/14, at 11:37 a.m. indicated a verbal altercation between R64 and another resident had occurred in the dining room (DR) at 11:20 a.m. and there was no further documentation provided of a thorough investigation including other residents or staff in the DR that had been interviewed and neither was evidence of follow up for possible injury. In addition, there was no further documentation with identified safety measures taken for R64 and the other resident involved in the incident. Review of the Resident Incident Report dated 3/7/14, revealed the incident occurred at 5:00 p.m. in the dining room. The report indicated another resident approached a nurse and reported he had softly slapped R64 on the left jaw. R64 and the alleged perpetrator were interviewed on 3/10/14. The incident report form did not indicate when SA, physician or responsible party had been notified. R64 reported in an interview on 8/11/14, at 6:30 p.m. another resident had slapped his face because R64 was complaining too much. R64 reported the other resident "never apologized to me, how come, it hurt!" and pointed to his check area and added, "Right there he did that." R64	F 226	A Reporting and Investigation audit was created to ensure timeliness of reporting all alleged maltreatment, neglect and abuse. This audit will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. Audits for staff knowledge on identifying and reporting maltreatment, neglect, and abuse will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. The results of these audits 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: 09/23/14	

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F 226	Continued From page 8 added it happened in the dining room and staff was aware of the incident. R64's quarterly MDS dated 7/8/14, identified R64 had a BIMS score of fifteen indicating intact cognition. On 8/11/14 at 7:55 p.m. the administrator indicated he was aware of the situation. On 08/14/14, at 2:00 p.m. the administrator reviewed the facility's policy and identified not interpreting the policy correctly and indicated "Because it was first not considered physical abuse or intent to harm the incident was not reported." The administrator verified the incident should have been called into the SA. R23 was involved in verbal abuse and resident to resident altercation and the incident was not reported to the SA immediately nor was it thoroughly investigated. Crest View Lutheran Home Progress Note dated 6/18/14, at 3:24 p.m. indicated R23 walked back to his room with staff to go to bed. Roommate started yelling and threatening R23 by stating "get the hell out of this room now, if you don't get him out of this room, I'll kill him." After incident the facility put R23 on fifteen minutes checks for his safety. Crest View Lutheran Home Progress Note dated 7/20/14, at 1:31 p.m. indicated R23's roommate grabbed his arm in the hallway. Staff separated and assisted R23 to the living area immediately. No bruising, no redness noted on arm, nurse practitioner updated.	F 226		

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F 226	Continued From page 9	F 226		

Crest View Lutheran Home Progress Note dated 8/2/14, at 2:36 p.m. indicated R23's roommate was holding and hitting to R23's thigh in the hallway per staff report. Staff separated and moved R23's roommate to the front desk. No redness, no bruising to hands and thigh noted. R23 stated "I'm fine", supervisor updated and safety checks indicated per policy.

R23's annual MDS dated 3/15/14, indicated R23's BIMS score was three which indicated severe cognition loss. In addition, the MDS indicated R23's diagnoses included Alzheimer's, dementia and Parkinson's disease.

During interview on 8/14/14, at 11:16 a.m. the administrator confirmed facility policy and resident to resident altercation were reported to him but was not reported to the SA. The administrator stated "The incidents were not reported to the SA because no harm was caused so we do not report it and also verified when no harm was caused the facility did incident reports and followed the facility policy.

R177 was found with a large bruise of unknown origin and was not reported immediately to the SA, and the Investigative Report was not submitted timely to the SA.

Incident Report dated 7/12/14, for R177 read "Discoloration on left hand with open area on left elbow. At 9:40 a.m. writer assessed resident and found a purple and red and black long discoloration on the front of resident left hand measuring 11 centimeters [cm] by 5 1/2 cm, another red discoloration on the elbow measuring 3 cm by 1/2 cm with open area in the red discoloration of the elbow measuring 1 cm.

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F 226	Continued From page 10 Resident can't explain. Has Hx [history] of wandering behavior walking with head facing down when walking and bumping into things. Physician, Responsible party, DON, Supervisor, and Administrator notified on 7/12/14, at 9:40 a.m." Incident Report was submitted two days later to the SA on 7/14/14. The Investigative Report for R177 read "Resident currently resides on the secure memory care unit. Diagnoses include dementia with behavioral disturbances and Alzheimer's. Resident needs and receives assist of 1 with all activities of daily living [ADLs]. Resident is independent with mobility, and is able to ambulate without any assistive devices. Resident has a BIMS cognitive score of 4 of 15, which showed severe cognitive deficits. On the morning of 7/12/14, R177 was observed with a large bruise measuring 11 cm x 5.5 cm on resident's forearm. When asked how it happened, this resident was not able to communicate the source. Family and physician notified immediately. The bruise was reported due to the facility's policy of reporting an unknown bruise that is larger in size." The Investigative Report was submitted to the SA untimely on 7/28/14, eleven working days after the incident had been discovered. On 8/4/14, at 2:08 p.m. the administrator stated staff are trained to call the administrator immediately after an incident. The administrator stated he decided if the incident was reportable or not, and would go by the regulation. The administrator also stated the team has discussed the abuse policy and stated the policy needed updating. In addition the administrator stated R177's bruise was reportable because of the size of the bruise and also stated he did know	F 226		

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F 226	Continued From page 11 investigative reports were to be reported within five working days of incident to the SA. The administrator further stated he did not know why R177's report was submitted late to the SA.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure housekeeping and maintenance services necessary to maintain a sanitary environment were provided for 16 of 114 residents (R172, R49, R5, R3, R188, R187, R78, R81, R124, R64, R62, R14, R7, R2, R64, R23) reviewed for environmental concerns. Findings include: R172, R49, R5, R3 and R188's bathrooms were observed during room observations on 8/11/14, to have a dark brown substance around the base of the toilet and in between the cracks of the tiles on the bathroom floor. R187's bathroom was observed during room observations on 8/11/14, to have rust and dark brown to black debris buildup on the floor behind the bathroom door. R78's bathroom was observed during room observations on 8/11/14, to have to a dark brown substance around the base of the toilet and dark	F 253	**F 253** It is the policy of Crest View Lutheran Home that services provided and maintain a clean and sanitary living situation for all residents residing at Crest View Lutheran Home. For Residents R172, R49, R5, R3, R188, R187, R78, R81, R124, R62, R14, R7, R2, and R23, rooms were cleaned thoroughly by housekeeping staff; this included the removal of old wax build-up in corners of the room and door frames. These rooms were observed by both the Administrator and Director of Environmental Services by 9/23/2014.	

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F 253	Continued From page 12 brown to black debris buildup behind the bathroom door. R81, R124, R64 and R62's rooms were observed during room observations on 8/11/14, to have soiled dark spot on the floor upon entrance to the room and in the corners of the room. R14, R7, R2, and R9's rooms were observed during room observations on 8/11/14, to have dark brown to black debris buildup on the floors with dark debris in the corners of the rooms. R23's room was observed during room observations on 8/11/14, to have dark brown to black debris buildup in the corners, the floor was very sticky to walk on and the base of the toilet had a dark brown substance around the base of the toilet. A tour of the facility was conducted on 8/14/14, at 10:05 a.m. with the administrator and housekeeping and maintenance supervisor (HMS). The administrator and the HMS verified all the findings listed above. The HMS stated that "the corners are easy to clean with a scraper and we can use a machine to clean behind and around the toilets." The administrator and the HMS both agreed there is room for improvement in cleaning the rooms. On 8/14/14, maintenance policy was requested was indicated there was no policy.	F 253	The policy and procedure related to Resident Room Cleaning was created by the Administrator and Director of Environmental Services and reviewed by the interdisciplinary team by 9/15/2014. Staff members were trained as it relates to their respective roles and responsibilities regarding the Resident Room Cleaning policy and procedure on 9/17/2014 – 9/19/2014. Resident room cleanliness 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 Environmental Services or designee will be responsible for compliance. Date of Correction: 09/23/14	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the	F 274		

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F 274	Continued From page 13 facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive assessment was completed for 1 of 3 residents (R57) reviewed for dental concerns. Findings include: On 8/13/14, at 8:45 a.m. R57 was observed in his room and lying in bed. R57 was non-verbal was not able to respond to any questions. R57 was observed turning his head to the opposite direction started yelling loud then turned his head over to surveyor as he continued to yell and his mouth open. During observation a few of R57's teeth were noted to have a yellow brown discoloration before he closed his mouth again. On 8/12/14, at 9:00 a.m. during interview family member (F)-A stated R57's dentures were not fitting, were on a mechanical soft diet, and were tube fed. When asked if R57 had teeth, gum, mouth sores and denture problems, FA-A stated	F 274	**F 274** It is the policy of Crest View Lutheran Home that a comprehensive assessment of a resident to be completed within 14 days of when the determination has been made that there is a significant change in a resident's physical or mental condition. R 57 has been seen by the dentist on 8/21/2014. For all other residents this may affect, a whole house audit will be completed by the On-Site Services group for dental, podiatry and audiology visit compliance on 9/11/14. An Oral assessment form has been added to our quarterly, annual and significant change MDS assessments as well as the admission assessments. The policy for in house On-Site visits was reviewed by the Inter Disciplinary Team on 9/15/14. A review of new policies by the Medical Director will be completed on 9/16/14. Staff members will be trained on their roles regarding this mater on 9/17-19.	

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F 274	Continued From page 14 "I would like to have him seen by the dentist." F-A indicated dental had not been brought up during the quarterly care conference meetings by the facility and F-A had not thought of asking about dental protocols as she was R57's responsible party. During review of the Apple Tree Dental progress notes the following were revealed: - Dated 10/16/12, indicated R57 had a "firm raised 1 Centimeter (cm) nodule with white hyperkeratotic [a rather common skin condition. It is due to the continual production and accumulation of skin cells on the sin surface] mucosa on his right buccal mucosa near commissure [a joint, seam, suture, or closure; the place where two bodies or parts of a body meet or unite] and heavy plaque was noted throughout." The progress note indicated a limited exam had been completed to evaluate the lesion, R57 was unable to cooperate and the dentist indicated he needed to reschedule R57's initial exam and prophylaxis appointment. - Dated 11/16/12, indicated R57 had been seen and during the visit a raised lesion measuring 6 Millimeters (mm) by 7 mm on R57's "right buccal mucosa near commissure. Lesion has decreased in size from last visit, likely a cheek bite and fibroma..." The progress note also indicated the dentist was safely unable to complete cleaning due to poor cooperation and was unable to do exam due to heavy plaque on teeth. The dentist indicated R57 needed a full-mouth debridement (FMD) before exam which R57 had not cooperated for and dentist had limited exam done to reevaluate the lesion on his right cheek. R57's annual Minimum Data Set (MDS) dated 2/14/14, significant change MDS dated 3/9/14,	F 274	Resident dental, vision and podiatry visits will be audited weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. Results from these audits will be reported to the QA/QI committee for review and further recommendations. Director of Health Information or designee will be responsible for compliance. Date of compliance: 09/23/14	

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F 274	Continued From page 15 and significant change MDS dated 6/28/14, all three dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. MDS dated 6/28/14, also indicated R57 had both short and long term memory issues. In addition, the dental section Care Area Assessment (CAA) did not trigger for CAA completed on 7/10/14. The care plan dated 7/10/14, identified R57 with alteration in self-care and directed staff to assist with oral care twice daily and as needed. The care plan did not address how often R57 was to be seen by the dentist. R57's diagnoses included multiple myeloma, diabetes mellitus type II, glaucoma, aphasia, malignant neoplasm of prostate, hemiplegia and cerebrovascular disease (CVD) obtained from Admission Record dated 8/14/14. When interviewed on 8/13/14, at 2:22 p.m. registered nurse (RN)-A who was also a MDS coordinator stated the nurses were responsible of doing the dental assessments and she expected the dental assessments to be done at least with each comprehensive MDS if not quarterly. RN-A went through the chart verified the oral assessment was lacking. RN-A further stated after looking at the hydration assessment thought the nurses usually would be looking at the R57's mouth but there was no documentation in the assessment about dental status.	F 274		

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F 274	Continued From page 16 When interviewed on 8/13/14, at 2:31 p.m. licensed practical nurse (LPN)-A stated she felt as though the Oral Inspection Assessment was new to the facility and indicated the form came with new admit information packet and not with the quarterly and annual assessments. LPN verified the Oral Inspection Assessment was lacking in the chart. On 8/14/14, at 4:03 p.m. the director of nursing (DON) stated she expected the MDS nurse to have brought to the facility's attention that R57 had not been seen by the dentist since 11/12/12, and the oral assessment had not been identified and completed in the last three comprehensive assessments when reviewing the MDS.	F 274		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to ensure care plan interventions for fall prevention were followed for 1 of 3 residents (R127) and failed to ensure oral care assistance was provided as directed by the care plan for 1 of 3 residents (R5). Findings include: Falls:	F 282	**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. For Resident's # 127 and # 5, the care plan was reviewed and revised by the interdisciplinary team on 09/15/2014. Corresponding updates have been made to care assignment sheets, care	

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F 282	Continued From page 17 During observation of morning cares on 8/13/14, at 8:47 a.m. nursing assistant (NA)-E and another NA-F are gathering supplies to get R127 cleaned up before breakfast. After gathering the supplies, NA-E began to wash R127 face. -At 8:53 a.m. NA-E raised the bed to a workable height and lowered the head of the bed to a flat position. R127 proceeded to roll to the right side after verbal cueing from NA-E, (no bed alarm sounding) while NA-E placed a white soaker pad underneath R127. NA-E gave R127 verbal cues to roll to the other side (no bed alarm sounding), as the two NA's placed the soaker pad completely under R127. After the soaker pad was in place, the two NA's proceeded to lift the resident up in the bed (no bed alarm sounding). -At 8:57 a.m. NA-E removed R127's brief and performed peri cares, then asked R127 to roll to his left side. NA-E performed the peri cares and removed old brief. NA-E proceeded to apply a new brief and asked R127 to roll side to side so they could apply new brief. After that staff continued clothing R127, lowered the bed, gathered dirty linen and supplies, and got R127 ready for breakfast. During the entire observation no bed alarm was sounding. -At 3:15 p.m. registered nurse (RN)-C went into R127's room to give him a nebulizer (breathing) treatment, after refusal, R127 stated that he was missing his glasses. RN-C proceeded by looking around in R127's. She then went on the left side of his bed and opened up the bottom cabinet of his night stand and the bed alarm started sounding as she opened the night stand. The bed alarm was lying in the bottom of the night stand rolled up. RN-C confirmed that R127 had not had it on all day and went to check R127's care plan. -At 3:32 RN-C and licensed practical nurse (LPN)-H went back to R127's room and placed	F 282	plans and communicated to the resident and/or designated decision maker. The policy for comprehensive care plans was reviewed and revised by the interdisciplinary team on 09/15/14. 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 care plan policy and procedures on 09/17/14-09/19/14. Care plan audits will be completed weekly for 4 weeks, monthly for 2 months, then randomly to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 09/23/14	

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F 282	Continued From page 18 the bed alarm on his bed properly and confirmed R127 was to have a bed alarm on his bed per care plan. R127's care plan dated 7/9/14, identified him as a high risk for falls, related to weakness, balance impairment, impaired cognition, poor judgment, antipsychotic and antidepressant use, incontinence and depression. The care plan interventions included safety devices such as 1/2 side rails x2, sensor alarm on bed, secured unit, ensure brakes locked on bed and wheelchair during transfer, and reorient resident as needed. During interview on 8/13/14, at 3:22 p.m. RN-C confirmed that bed alarm was to be on R127's and stated "he is a high risk for falls." RN-C verified bed alarm was to be in bed per care plan. During interview on 8/13/14, at 3:22 p.m. LPN-H confirmed care plan and R127 was to have bed alarm on his bed due to being high risk for falls. During interview on 8/14/14, at 8:54 a.m. NA-F confirmed that R127 was to have a bed alarm on his bed and verified that R127 did not have one on his bed the previous day. During interview on 8/14/14, at 8:54 a.m. NA-E confirmed that R127 was to have a bed alarm on his bed and verified that R127 did not have one on his bed the previous day. Oral care: R5 was not provided assistance with oral cares. During observation on 8/13/14, at 8:08 a.m. NA-D began routine morning cares and R5 is refusing	F 282		

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F 282	Continued From page 19 to let her wash her up. NA-D granted R5 her wishes of refusal and begins to dress R5's upper body with assistance from NA-E. -At 8:12 a.m. NA-D and NA-E removes R5's brief and began to wash R5's peri area in the front and then her buttocks area. -At 8:13 a.m. NA-D and NA-E proceed to apply a clean brief on R5 and then assist her with putting on her pants. R5 is not providing any assistance with getting dressed or personal hygiene. -At 8:16 a.m. R5 stated "get me up" NA-D and NA-E proceeded to get Hoyer lift (mechanical transfer lift) and transferred R5 to her wheelchair. -At 8:22 a.m. NA-D shaved R5's facial hair, while NA-E was combing her hair, R5 was made comfortable in her wheelchair and was taken down to breakfast at 8:25 a.m. and oral cares was not offered or provided to R5 during this time. R5's care plan, dated 7/14/14, indicated staff to assist with oral cares twice a day and as needed. During interview on 8/13/14, at 2:25 p.m. NA-F verified oral cares was not done and had not been offered to R5. During interview on 8/13/14, at 2:25 p.m. NA-E verified oral cares was not done and was not offered to R5 and stated "when we get her up, we normally ask her." During interview on 8/13/14, at 2:30 p.m. NA-D verified oral cares was not done and was not offered to R5 and stated "we usually do it when we get her up." During interview on 8/14/14, at 4:21 p.m. director of nursing (DON) indicated she expected staff to	F 282		

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F 282	Continued From page 20 offer oral cares everyday if the resident is unable to do it themselves and stated "not doing it is wrong." Review of facility policy titled Care Plan Policy And Procedure, revised on 10/12, indicated staff will ensure the resident is receiving the appropriate care required to maintain or attain the residents highest level of practicable function possible.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with oral care for 1 of 1 resident (R5) who required assistance with dental hygiene. Findings include: During observation on 8/13/14, at 8:08 a.m. nursing assistant (NA)-D began routine morning cares and R5 is refusing to let her wash her up. NA-D granted R5 her wishes of refusal and begins to dress R5's upper body with assistance from NA-E. -At 8:12 a.m. NA-D and NA-E removes R5's brief and began to wash R5's peri area in the front and then her buttocks area.	F 312	**F 312** It is the policy of Crest View Lutheran Home to ensure that 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. For Resident # 127 a new Safety Risk Assessment was completed on 09/10/2014. For resident # 5 a new Oral Assessment was completed on 9/11/2014 .Corresponding updates have been made to care assignment sheets, care plans and communicated	

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F 312	Continued From page 21 -At 8:13 a.m. NA-D and NA-E proceed to apply a clean brief on R5 and then assist her with putting on her pants. R5 is not providing any assistance with getting dressed or personal hygiene. -At 8:16 a.m. R5 stated "get me up" NA-D and NA-E proceeded to get Hoyer lift (mechanical transfer lift) and transferred R5 to her wheelchair. -At 8:22 a.m. NA-D shaved R5's facial hair, while NA-E was combing her hair, R5 was made comfortable in her wheelchair and was taken down to breakfast at 8:25 a.m. and oral cares was not offered or provided to R5 during this time. R5's quarterly Minimum Data Set (MDS) dated 7/14/14, indicated severe cognitive impairment, and R5 required total dependence with activities of daily living such as; bed mobility, transferring, locomotion, toileting, and personal oral hygiene. R5's care plan, dated 7/14/14, indicated staff was to assist with oral cares twice a day and as needed. During interview on 8/13/14, at 2:25 p.m. NA-F verified oral cares was not done and had not been offered to R5. During interview on 8/13/14, at 2:25 p.m. NA-E verified oral cares was not done and was not offered to R5 and stated "when we get her up, we normally ask her." During interview on 8/13/14, at 2:30 p.m. NA-D verified oral cares was not done and was not offered to R5 and stated "we usually do it when we get her up." During interview on 8/14/14, at 4:21 p.m. director	F 312	to the resident and/or designated decision maker. staff education will be completed on 09/17/14-09/19/14. For other residents who may be affected by this practice, audits on Team sheet/devices and oral care will be completed weekly on an on-going basis. Results will be 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: 09/23/14	

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F 312	Continued From page 22 of nursing (DON) indicated she expected staff to offer oral cares everyday if the resident was unable to do it themselves and stated "not doing it is wrong." Review of facility policy titled Care Plan Policy And Procedure, revised on 10/12, indicated staff will ensure the resident is receiving the appropriate care required to maintain or attain the residents highest level of practicable function possible.	F 312		
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 interview, the facility failed to ensure consistent fall safety measures were in place to minimize the risk of falls for 1 of 3 residents (R127). Findings include: During observation of morning cares on 8/13/14, the following was observed: - At 8:47 a.m. nursing assistant (NA)-E and another NA-F gathered supplies to get R127 cleaned up before breakfast. After gathering the supplies NA-E began to wash R127's face.	F 323	**F 323** It is the policy of Crest View Lutheran Home that each resident receives adequate supervision and assistance to prevent accidents. For Resident # 127 a new assessment for Fall Risk and Physical Devices was completed on 9/10/2014. Corresponding updates have been made to care assignment sheets, care plans and communicated to the resident and/or designated decision maker. 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.	

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F 323	Continued From page 23 - At 8:53 a.m. NA-E raised the bed to a workable height and lowered the head of the bed to a flat position. R127 proceeded to roll to the right side after verbal cueing from NA-E, (no bed alarm sounding) while NA-E placed a white soaker pad underneath R127, then NA-E gave R127 verbal cues to roll to the other side (no bed alarm sounding) as the two NA's placed the soaker pad completely under R127. After the soaker pad was in place, the two NA's proceeded to lift the resident up in the bed (no bed alarm sounding). - At 8:57 a.m. NA-E performed peri care and then asked R127 to roll to the left side as NA-E continued to do peri cares on his back side. NA-E proceeded to ask R127 to roll side to side so they could apply new brief. After that, staff continued by putting a new gown on R127, lowered the bed, gathered dirty linen and supplies and got R127 ready for breakfast. During the entire observation no bed alarm was sounding. - At 3:15 p.m. registered nurse (RN)-C went into R127's room to give him a nebulizer treatment (breathing treatment), after refusal, R127 stated that he was missing his glasses. RN-C proceeded by looking around in R127's. She then went on the left side of his bed and opened up the bottom cabinet of his night stand and the bed alarm started sounding as she opened the night stand. The bed alarm was lying in the bottom of the night stand rolled up. RN-C confirmed R127 had not had it on all day and went to check R127's care plan. - At 3:32 RN-C and licensed practical nurse (LPN)-H went back to R127's room and placed the bed alarm on his bed properly and confirmed R127 was to have a bed alarm on his bed per care plan. R127's care plan dated 7/9/14, identified him as a	F 323	The policy and procedure related to Falls was reviewed by the interdisciplinary team on 9/15/2014. 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 09/17/14-09/19/14. 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: 09/23/14	

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F 323	Continued From page 24 high risk for falls, related to weakness, balance impairment, impaired cognition, poor judgment, antipsychotic and antidepressant use, incontinence and depression. The care plan interventions included safety devices whoch were 1/2 side rails x2, sensor alarm on bed, secured unit, ensure brakes were locked on bed and wheelchair during transfer, and reorient resident as needed. R127's re-admission Minimum Data Set (MDS) dated 7/22/14, indicated R127 had fallen since admission one time and had no injury. During interview on 8/13/14, at 3:22 p.m. RN-C confirmed that bed alarm was to be on R127's and stated "he is a high risk for falls." RN-C verified bed alarm was to be in bed per care plan. During interview on 8/13/14, at 3:22 p.m. LPN-H confirmed care plan and R127 was to have bed alarm on his bed due to being high risk for falls. During interview on 8/14/14, at 8:54 a.m. NA-F confirmed that R127 was to have a bed alarm on his bed and verified that R127 did not have one on his bed the previous day. During interview on 8/14/14, at 8:54 a.m. NA-E confirmed that R127 was to have a bed alarm on his bed and verified that R127 did not have one on his bed the previous day. R127 did not receive the needed assistive device to minimize potential injury from falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	Continued From page 25 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for adverse side effects for 1 of 5 residents (R45) who received antipsychotic medications. Findings include: The Crest View Admission Record dated 8/1/12, indicated R45's diagnoses included vascular dementia with delusions with onset date 1/6/13. The Care Area Assessment (CAA) date 8/11/13,	F 329	**F 329** It is the policy of Crest View Lutheran Home that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose or for excessive duration; or without adequate monitoring; or without adequate indication for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination or the reasons above. For Resident # 45, and AIMS was competed on 8/13/2014 while the surveyors were still present in the building. The score was 0. Corresponding updates have been made to care assignment sheets, care plans and communicated to the resident and/or designated decision maker.	

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F 329	Continued From page 26 indicated R45 had received an antipsychotic medication in the last seven days. Adverse consequences of antipsychotic medications included tardive dyskinesia (persistent involuntary movements), excessive sedation and hallucinations. The Minimum Data Set (MDS) dated 5/14/14, indicated R45 had a diagnoses of persistent mental disorder. The MDS dated 5/14/14, further indicated R45 had disorganized thinking. MDS also acknowledged the use of an antipsychotic medication in the past seven days. The Physician's Order dated 7/17/14, directed staff to administer Abilify (an antipsychotic medication) 2.5 milligrams (mg) by mouth at bedtimes for emotionally disturbing delusions. The Medication Administration Record (MAR) for August 2014 indicated R45 received Abilify each day at bedtime. The Crest View Treatment Administration Record (TAR) directed staff to conduct behavior monitoring, delusional statements, each shift. A review of the assessment records for R45 lacked a record that an Abnormal Involuntary Movement Scale (AIMS- a rating scale used to measure involuntary movements known as tardive dyskinesia) had been completed to monitor for adverse medication side effects. On 8/13/14, at 2:05 p.m. the assistant director of nursing (ADON) verified the AIMS assessment had not been completed for R45. The ADON explained, "She [R45] went to the hospital a while back and unfortunately we can't locate an AIMS assessment for this resident."	F 329	For all other residents who may be affected by this, a whole house audit of antipsychotic medications was completed on 9/16/2014 confirming that all AIMs assessments were completed and appropriate. The policy on psychotropic medications and monitoring was reviewed on 9/15/2014. 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 psychotropic medication and monitoring policy and procedures 09/17/14-09/19/14. Audits on residents with psychotropic medications and AIMS assessments will be completed weekly for 4 weeks, monthly for 2 months and randomly thereafter to ensure compliance The Director of Nursing or designee will be responsible for compliance. Date of Correction: 09/23/14	

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F 329	Continued From page 27 On 8/14/14, at 3:40 p.m. the director of nursing (DON) stated an AIMS assessment was completed for residents using psychotropic medications upon admission and every three months thereafter. The CREST VIEW LUTHERAN HOME ASSESSMENT PROTOCOL POLICY AND PROCEDURES dated 3/14, stated data will be collected by a licensed nurse. The data will be used by the MDS coordinator to accurately complete the resident's MDS. The policy also stated the MDS assessments will be scheduled on PointClickCare (PCC) in the TAR. The nurse assigned the assessment on their shift will complete the assessment and sign off in the TAR that it was completed. Although the policy addressed the assessment, the policy did not indicate who was responsible to oversee that the assessments were completed timely and appropriately.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353	**F 353** It is the policy of Crest View Lutheran Home to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	

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F 353	Continued From page 28 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient qualified nursing staff was available to meet the needs of residents observed/interviewed (R91, R103, R49, R35, R14, R81, R113, R5, R57, R12) as well as family members and staff who voiced concerns regarding lack of staff to assure resident needs were met timely. This had the potential to affect 114 of 122 residents that resided at the facility. Findings include: Stage 1 family interviews: On 8/12/14, at 8:57 a.m. during interview when asked if family member (F)-A felt there was enough staff available to make sure your family member get the care and assistance they need without having to wait a long time, F-A stated "Sometimes you have to wait for a little long during visit." On 8/11/14, at 5:48 p.m. during interview when asked if F-B felt there was enough staff available to make sure your family member get the care and assistance they need without having to wait a long time F-B stated "No, they need more help"	F 353	The nursing schedule was reviewed, and staffing ratios were noted to be well within industry standards. This was evidenced by a 4-star rating (out of a possible 5 stars) on the Minnesota Nursing Home Report Card. The plan includes the designation of a "charge nurse" on each shift and RN coverage in the building 24 hours a day. The Director of Nursing or designee will review average case mix levels daily to ensure adequate staffing is scheduled to meet resident needs as of 9/11/2014. Per Resident Council conversations, the PM shift was noted to have longer wait times for call-light responses. The Staffing Coordinator and Nursing Supervisors were re-educated on 9/17/2014 – 9/19/2014 that the nursing assistants on the floor that are scheduled from 3:00p – 9:00p will now be scheduled until 11:00p if they are needed for additional HS cares.	

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F 353	Continued From page 29 F-B further stated the only time there was enough staff was when the nursing students were at the facility with their instructor and that's when F-B felt there was enough help there. When asked which shifts F-B thought did not have enough help, F-B was not sure and commented the resident had not had any accidents that F-B knew of. Stage 1 Resident interview: R91's quarterly Minimum Data Set (MDS) dated 6/24/14, indicated cognition was moderately impaired and required extensive to total physical assistance of two staff with dressing and personal hygiene and used a wheelchair for mobility. On 8/11/14, at 2:56 p.m. during interview when asked if R91 felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R91 stated "I think they do not have enough staff. They admit new people today. I had to holler I'm done, I'm done, I told the trained medication aide [TMA]-A I waited for twenty minutes and he cleaned me up and took me off the bed pan. They must have gotten busy..." On 8/13/14, at 10:30 a.m. resident indicated to surveyor she had to use the bed pan really bad. When surveyor asked her to put the call light on, and she reported "it's too early." Surveyor then told resident she would tell the nurse, when surveyor approached licensed practical nurse (LPN)-G who stated "I knew you were going to tell me that." -At 11:50 a.m. after surveyor was walked out of another resident ' s room observed R91's call light was still on and approached the resident. R91 indicated she still had to use the toilet at that	F 353	Staff education will be done on the new schedule, writing their names on the white communication boards located in each hallway, and proper follow up with resident council concerns. Staff education will occur between 9/17/14 – 9/19/14. For other residents who may be affected by this practice the daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing levels, designation of charge nurse, to ensure an RN is on the schedule, and/or to ensure adequate staffing is present. The nursing staffing/ratios were reviewed by the interdisciplinary team on 9/15/2014. A review of practices/protocols 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 Staff	

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	245018	A. BUILDING ______ B. WING ______	08/14/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 30 time nursing assistant (NA)-J was observed going to residents room and transfer resident. -At 1:30 p.m. surveyor approached resident when asked about waiting for the bed pan earlier she stated " I don't like it of course. " Resident further stated she often waited and one time she had waited for forty five minutes to get off the bed pad "my son was here and he couldn't stand it so he reported it. Often it is thirty minutes to get off. It's not right to wait that long." R103's annual MDS dated 5/24/14, indicated cognition was intact and required extensive physical assistance of one staff with dressing and personal hygiene. In addition, the MDS indicated R103 used a wheelchair for mobility and was not steady with transitions and walking and required someone to stabilize him. On 8/11/14, at approximately 6:55 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated "No" he went on to stated he had not been walked for a week how because there was no enough help and he had told the staff he was going home if they were not able to walk him. R103 further stated he had pain on his left leg and toes and walking helped at times and at times the aides or staff would come to room and tell him "I will be right back" and the staff would never even come back or come back one hour later. R49's admission 60 day quarterly MDS dated 7/17/14, indicated cognition was moderately	F 353	policy and procedures on 9/17/2014 – 9/19/2014. Staffing pattern audits and white board audits will be completed weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. Resident council meeting minutes will be audited monthly at the end of each month to ensure old news is followed up on. Call light audits remain ongoing. 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: 09/23/14	

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F 353	Continued From page 31 impaired and required limited to extensive assistance of one two staff with dressing, toileting, eating, transfers and personal hygiene. On 8/11/14, at 2:33 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated "Sometimes very short, staff have to rush in because they have to help someone else. Sometimes they come in and say I will be back in a minute and it turns into ten minutes because they have someone else to help. On weekends it seems to be short of help on all shifts, sometimes during the week depending on when staff goes home, like at 1 p.m. I have a very sensitive bottom and sometimes it breaks out. It's either itchy or its wear a diaper." R35's admission MDS dated 7/24/14, indicated cognition was intact and required extensive physical assistance of one staff with dressing, toileting and personal hygiene. On 8/11/14, at 4:06 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time "Have to go down the hall and use toilet there because wheelchair won't go through door too wide, have to wait ten minutes to get help to go to bathroom, and then you can tell staff by their faces is not happy to take me to the bathroom; they make you wait so long when you put your light on, the night people have a big picnic here, have to wait a half hour to get help; "always late on giving meds here thirty to forty five minutes. Most of the times have to wait; have to wait for pain medications; meals	F 353		

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F 353	Continued From page 32 are never on time." On 8/12/14, 9:54 a.m. R35 was observed still in bed when approached resident indicated he was still waiting to get up and had been waiting since 7:30 a.m. R35 stated "Not the best place to be. I wait for every morning for dressing change, that's what I wait for, nurse changes dressing and says can't change dressing any earlier they say because nurse has to pass medications first. " Resident further stated "sometimes I don't get up till 10:45 to 11:00 a.m. It's the pits." R14's quarterly MDS dated 6/23/14, indicated cognition was intact was independent with toileting and required personal hygiene. On 8/11/14, at 3:18 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated "No." but indicated she had never had any accidents but had to wait at times for assistance. R81's quarterly MDS dated 5/2/14, indicated cognition was intact and required extensive physical assistance of one to two staff with dressing, toileting, transfers and personal hygiene. On 8/12/14, at 10:54 a.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated "I was in bed today and I needed helped, I hollered and called, except this little one. It took forever to get some help. I waited and waited and	F 353		

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F 353	Continued From page 33 finally I fell asleep." R113's quarterly MDS dated 5/13/14, indicated cognition was intact and required extensive physical assistance of one to two staff with dressing, toileting, transfers and personal hygiene. In addition, MDS indicated R113 used a wheelchair for mobility. On 8/11/14, at 7:02 p.m. R113 was observed seated on her electric wheelchair parked right outside her room. When surveyor approached resident she broke down started to cry shaking with anger as she wiped tears off her cheeks. Resident told surveyor "Good luck" when surveyor told her she was going to find someone to help her. Resident also indicated she had put her light on for over forty minutes and nobody had responded to the light and she had decided to come out of her room to the hallway but they was no body either in the hallway to ask. Surveyor walked up to the Aspen Unit nursing station approached one of the nursing assistant (NA) coming out of another room who indicated R113 was assigned to another NA who was in a room assisting another resident at the time. As surveyor returned to the station to wait for the staff R113 was overheard down the hallway rising her voice in frustration as she was conversing with intern administrator who after talking to R113 walked the opposite way as surveyor approached R113 again. R113 further stated to surveyor she had been keeping call light logs of waiting times and at times it took put to two hours for staff to respond to her call lights. Staff interviews On 8/13/14, at 9:18 a.m. when asked what the	F 353		

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F 353	Continued From page 34 staffing patterns was for nurses on the floor LPN-C "We are supposed to have two nurses on Linden during the day, we have two nurses during the days and evenings, pretty much have two nurses, but if someone calls in, the nurse was not replaced but instead would have TMA, supervisors, one nurse but was very rarely." On 8/13/14, at 7:10 a.m. LPN-D stated there was one nurse for the Evergreen and Willow units, one nurse for Linden and Aspen on nights and a supervisor. LPN-D stated there were scheduled medications at midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m. LPN-D stated together with giving PRN's and the paperwork the night was kept busy. LPN-D further stated breaks were usually taken while working on the computer and management expected the staff to take meal break but when there was emergency full code, overtime for no meal break was approved. On 8/13/14, at 7:10 a.m. NA-A stated during the night the laundry aide was pulled mostly if someone had called in and then the night shift did not have to work short. NA-A indicated there was one NA for each of the units and the float NA went between the units to help with cares and stay for the other NA's to go for break. On 8/13/14, at 1:48 p.m. TMA-A stated the carts were heavy at times and residents would ask for as needed (PRN) pain medication for pain. TMA-A indicated residents would ask for ask for PRN's when in the middle of sometimes and had to tell the residents to give him a couple minutes. TMA-A also stated Evergreen has two carts, Linden had a lot of PRN's and at times the medication times would go into "pink" as medications cannot be passed timely. TMA-A	F 353		

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F 353	Continued From page 35 further stated taking breaks was difficult and had taken only a fifteen minute break during the shift and had given some residents morning medications not until 10:45 a.m. which were supposed to be given at 8:00 a.m. On 8/14/14, at 1:30 p.m. an interview with the staffing coordinator (SC), director of nursing (DON) and administrator was conducted. When asked how the facility determined the staffing pattern for the facility SC stated was according to the census. Both DON and administrator indicated staffing was adjusted according to the census and when asked if the acuity or the needs of the residents in the various units was looked at when adjusting the staffing with the census both indicated again that this was reviewed "As a team." When asked if staffing was tracked and trended with incidents such as falls among other things for patterns and how it had been addressed administrator stated We track that using the event logs and if we see a trend we will make necessary adjustments but have not seen any trends." When asked who did the staffing when SC was not at the facility, SC stated supervisors did staffing and again she was on call if they had any questions but during the week when she was at the facility she handled all the sick calls and found the replacement. When asked if the facility used pool staff SC stated the facility had not used pool for ten years. When asked if facility had any employee injuries in the last three months, SC stated they were none that had happened at the facility but one of the employees was hurt at home and was not a work related. When asked how many open positions SC indicated there was a few nursing assistant positions and would	F 353		

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F 353	Continued From page 36 provide the information. In addition, DON stated there were two positions a day and evening part-time and had two offers. When asked how often orientation was ran SC and DON both indicated once a month and at time twice depending on the need. When DON was asked if staff had brought her concerns about the workloads, DON stated "Occasionally when we are busy but not had a staffing concern for a long time." SC added staff would usually come to her first and have not come recently for a long time. When asked if staffing concerns had been discussed at the quality assurance meetings DON indicated it had not been brought up. When asked what the facility fall statistics was administrator provided a copy which indicated the facility had one hundred and eight four falls in the last months. When asked if the falls had been track or trended with the units administrator indicated these were discussed in the interdisciplinary team meetings (IDT) and thought no trends had been identified but other it would have been brought up. Call light logs and audits were requested and the administrator stated the current facility system was not able to track that and indicated would provide call light audits that had been completed by various staff in different departments including the chaplain. Review of the undated Open Nar [nursing assistant registered] position list revealed the facility had four part-time 6:30 a.m. to 3:00 p.m. positions, three part-time 3:00 p.m. to 9:00 p.m. positions and one part-time every other weekend 11:30 p.m. to 7:30 a.m. position open currently at the facility.	F 353		

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F 353	Continued From page 37 Review of the Call Light Audit forms dated 10/1/13, through 7/28/14, revealed the Call Light Audit form did not consistently provide follow up and indicated resident needs had been fulfilled on numerous times, the audits were mostly completed at the start to mid-week and a few times on Thursdays through Saturdays which was inconsistent. In addition, the audits revealed the staff would on some occasions indicate the audits were not reflective of the trends. The audits noted the NA's were observed by the nurse during the audits, NA's were still in the dining room (DR) when call lights had taken time to be answered, and the staff would comment the number of NA's on the floor during the shift. The audit further stated the NA's were busy when the call lights had been on for a some time and some of the audits were incomplete with the dates completed. Review of the random schedules dated 2/1/14, going forward revealed the following: On 2/1/14: - AM Shift one NA position was blank but was penciled on Aspen, one call in which was replaced by rehab NA with changed to seven instead of six thirty, rehab NA was cut and was not replaced "No Rehab." -PM Shift TMA on Aspen was moved to Willow "No 8 PM TMA", Evergreen TMA hours were changed from 4:00 to 8:00 p.m. to 9:00 to 11:00 p.m. "No 4 PM TMA" Census was 121. On 3/1/14: - AM Shift one Linden NA was cut. - PM shift Aspen TMA was changed to be NA on Linden and Willow 4-8 PM TMA was cut. Census was 118.	F 353		

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F 353	Continued From page 38 On 3/2/14: - AM Shift one NA hours on Aspen were cut from eight to six hours; rehab NA was cut "No Rehab" and moved to Evergreen and one NA from Linden was moved to Evergreen. -PM Shift Aspen TMA was moved to Linden as NA and Willow TMA was cut. Census was 119. On 4/4/14: - AM Shift rehab NA was cut "No rehab NAR" moved to Evergreen; one NA was moved to Willow from Linden; laundry NA was cut and moved to Aspen and one NA was cut on Evergreen. Census was 140. On 5/11/14: - AM Shift rehab NA was moved to Evergreen "No Rehab." Census was 119. On 6/9/14: - AM shift one NA was moved from Linden to Evergreen to work as a TMA not replaced. Census was 115. On 7/6/14: - AM Shift rehab NA was moved to Evergreen "No Rehab" and one Linden NA was cut. -PM shift Willow and Aspen had only one TMA instead of two for four hours as other TMA had called in and was not replaced. Census was 115. On 8/3/14: - AM Shift one NA was cut on Linden and one NA on Willow hours were cut to six instead of eight hours. -Night shift the house float NA was moved to Willow and night laundry NA was also moved to Evergreen neither were replaced. Census was 116.	F 353		

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F 353	Continued From page 39 Review of multiple random daily schedules revealed the facility shifted staff from unit to unit frequently without regard to the duties that needed to be replaced such as filling NA slots with TMA's. In addition, review of the daily schedules dated 2/1/14, through 8/12/14, revealed there was a lot of staff replaced daily and at times the facility would replace a licensed practical nurse (LPN) with a TMA such as on 8/11/14. A review of the resident council meeting minutes and responses from 9/18/13, through 7/16/14, revealed the following: - On 9/18/13, the minute's new business concerns: "A resident mentioned that call lights are not being answered." Resident had stated "he waited for 45 minutes before receiving assistance." - A minutes on 10/16/13, the minutes indicated the subject of call lights and/or staffing was not discussed. - The minutes on 12/18/13, minute's new business indicated two residents had brought up "nurses are never available to help with her needs." In addition another resident had indicated "Help is unavailable during breaks or meals mentioned that the aides and nurses were involved in other procedures at meals and might not be easily found during meals." - The minutes on 1/14/14, old business indicated, "There was no old business." - The minutes on 3/19/14, new business "Nursing: A resident shared a concern about call lights not being answered promptly. [DON] happened to be walking by and informed the group that this problem was being addressed as a priority."	F 353		

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F 353	Continued From page 40 - The minutes on 4/14 (no actual day documented), indicated the minutes from the previous meeting were reviewed and approved and "There was no Old Business so the group proceeded to New Business." - The minutes for 7/16/14, new business indicated, "Nursing: concerns are still simmering for the lack of responding to call light on all shifts with second shift being the most challenging. [LPN-A] responded to the group's questions and offered a solution. In the future the shift personnel will have their names posted on the white board in the hallway for residents to view and record when such incidents occur. It was also suggested by residents and supported by [LPN-A] that the nurses should be responding should the NAR's be involved with other residents." Although the subject of call lights had been brought up on several meetings the concern was never addressed or reviewed by the facility to look at the staffing patterns to ensure resident needs were met in a timely manner. The Crest View Lutheran Home Staffing Plan Policy and Procedures revised 04/13, indicated "The staffing coordinator on a daily basis complete all staffing for the Nursing Department for twenty-four hours, seven days a week nursing coverage. Staffing is based on and reflects consideration of the needs of resident population along with case mix in determining the composition of the nursing staff. The Director of Nursing adjusts station staffing according to case mix levels on a regular basis. The schedule is done ahead to cover two pay periods for all nursing staff. 1. The Director of Nursing is scheduled to work is full time. 2. One full time MDS coordinator is scheduled for	F 353		

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F 353	Continued From page 41 80 hours per pay period Monday through Friday. 3. In the absence of Director of Nursing, the responsibility for continuum and supervision of nursing care is delegated to the RN supervisor. 4. The staffing coordinator is scheduled to work full time, Monday-Friday. 5. At least 1 RN/ADON supervisor and 1 LPN coordinator are scheduled Monday through Friday on the 6:30 a.m. to 3:00 p.m. shift and 1 RN Supervisor is scheduled Saturday and Sunday from 6:30 a.m. to 3:00 p.m., along with 4 other licensed nurses (RN's and /or LPN's). One full time RN supervisor is scheduled from 2:30 p.m. to 11:00 p.m. and 1 RN full time Night Supervisor is scheduled from 10:30 p.m. to 7:00 a.m. every day. The RN Supervisors are responsible for emergency calls to The Boulevard, Columbia Village, and Royce Place. 6. Licensed nurses (RN's and LPN's), TMA's and NA's are scheduled for twenty-four (24) hour coverage, seven days a week by the Staffing Coordinator. Staffing is done on a monthly basis. 7. There is a full time TMA scheduled 7 days a week on the 6:00 a.m. to 2:30 p.m. shift and 2 part time TMA's for heavier med passes from 6 AM-10 AM. There are 3 part time TMA's from 4-8 p.m. 7 days a week. 8. The Director of Nursing and Staffing Coordinator work closely together to staff according to census. 9. On Evergreen the ratio is typically 1 NAR to 8 residents; on Willow typically 1 NAR to 8 Residents; on Aspen typically 1 NAR to 8 Residents; On Linden it is typically 1 NAR to 8 Residents (if Linden is full) 10. At a minimum 2 RN's or LPN's are scheduled from 10:30 p.m. to 7:00 a.m. One RN Supervisor is on duty. 11. At minimum, 5 NA/R's are scheduled on the	F 353		

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F 353	Continued From page 42 11:00 p.m. to 7:30 a.m. shift. One NA/R is scheduled 11:00 p.m. to 7:00 a.m. as House Float. One NAR floats and does personal laundry. 12. In-house pool on call staff are scheduled by the Staffing Coordinator to cover during vacations, mental health days, floating holidays, sick leave, leaves of absence (LOA), emergencies and holidays. 13. All nursing staff is required and scheduled to work every other weekend and every other holiday, unless specified otherwise. 14. All master schedules for nursing personnel on each shift are posted two weeks prior to the start of the new pay period, on the nursing bulletin board. Each schedule covers one pay period or 2 weeks. 15. The Daily Work Schedule for each station is completed prior to the next day and posted on the Staffing Coordinator's office door. 16. Staffing Coordinator will adjust productive nursing hours on a daily basis." Refer to F312. The facility failed to provide assistance with oral care for 1 of 1 resident (R5) who required assistance with dental hygiene. Refer to F412. The facility failed to ensure, follow up and facilitate necessary dental services for 2 of 3 residents (R57, R12) reviewed for dental concerns.	F 353		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each	F 412		

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	245018	A. BUILDING ______ B. WING ______	08/14/2014

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

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F 412	Continued From page 43 resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure, follow up and facilitate necessary dental services for 2 of 3 residents (R57, R12) reviewed for dental concerns. Findings include: R57 was not provided dental services. On 8/13/14, at 8:45 a.m. R57 was observed in his room and lying in bed. R57 was non-verbal was not able to respond to any questions. R57 was observed turning his head to the opposite direction started yelling loud then turned his head over to surveyor as he continued to yell and his mouth open. During observation a few of R57's teeth were noted to have a yellow brown discoloration before he closed his mouth again. On 8/12/14, at 9:00 a.m. during interview family member (F)-A stated R57's dentures were not fitting, were on a mechanical soft diet, and were tube fed. When asked if R57 had teeth, gum, mouth sores and denture problems, FA-A stated "I would like to have him seen by the dentist." F-A indicated dental had not been brought up during the quarterly care conference meetings by the facility and F-A had not thought of asking about dental protocols as she was R57's financial	F 412	**F 412** It is Crest View Lutheran Homes policy that Crest View Lutheran Home obtains from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Resident #57 was seen by the dentist on 8/21/2014. Resident 12 She has an appointment to be seen on 9/18/2014. Corresponding updates have been made to care assignment sheets, care plans and communicated to the resident and/or designated decision maker.	

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F 412	Continued From page 44 representative and responsible party. During review of the Apple Tree Dental progress notes the following were revealed: - Dated 10/16/12, indicated R57 had a "firm raised 1 Centimeter (cm) nodule with white hyperkeratotic [a rather common skin condition. It is due to the continual production and accumulation of skin cells on the sin surface] mucosa on his right buccal mucosa near commissure [a joint, seam, suture, or closure; the place where two bodies or parts of a body meet or unite] and heavy plaque was noted throughout." The progress note indicated a limited exam had been completed to evaluate the lesion, R57 was unable to cooperate and the dentist indicated he needed to reschedule R57's initial exam and prophylaxis appointment. - Dated 11/16/12, indicated R57 had been seen and during the visit a raised lesion measuring 6 Millimeters (mm) by 7 mm on R57's "right buccal mucosa near commissure. Lesion has decreased in size from last visit, likely a cheek bite and fibroma..." The progress note also indicated the dentist was safely unable to complete cleaning due to poor cooperation and was unable to do exam due to heavy plaque on teeth. The dentist indicated R57 needed a full-mouth debridement (FMD) before exam which R57 had not cooperated for and dentist had limited exam done to reevaluate the lesion on his right cheek. R57's annual Minimum Data Set (MDS) dated 2/14/14, significant change MDS dated 3/9/14, and significant change MDS dated 6/28/14, all three dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue,	F 412	For all other residents this may affect, a whole house audit will be completed by the On-Site Services group for dental, podiatry and audiology visit compliance on 9/11/14. An Oral assessment form has been added to our quarterly, annual and significant change MDS assessments as well as the admission assessments. The policy for in house On-Site visits was reviewed by the Inter Disciplinary Team on 9/15/14. A review of new policies by the Medical Director will be completed on 9/16/14. Staff members will be trained on their roles regarding this mater on 9/17-19. Resident dental, vision and podiatry visits will be audited weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. Results from these audits will be reported to the QA/QI committee for review and further recommendations. Director of Health Information or designee will be responsible for compliance. Date of compliance: 09/23/14	

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F 412	Continued From page 45 obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. MDS dated 6/28/14, also indicated R57 had both short and long term memory issues. In addition, the dental section Care Area Assessment (CAA) did not trigger for CAA completed on 7/10/14. The care plan dated 7/10/14, identified R57 with alteration in self-care and directed staff to assist with oral care twice daily and as needed. The care plan did not address how often R57 was to be seen by the dentist. R57's diagnoses included multiple myeloma, diabetes mellitus type II, glaucoma, aphasia, malignant neoplasm of prostate, hemiplegia and cerebrovascular disease (CVD) obtained from Admission Record dated 8/14/14. When interviewed on 8/13/14, at 2:22 p.m. registered nurse (RN)-A who was also a MDS coordinator stated the nurses were responsible of doing the dental assessments and she expected the dental assessments to be done at least with each comprehensive MDS if not quarterly. RN-A went through the chart verified the oral assessment was lacking. RN-A further stated after looking at the hydration assessment thought the nurses usually would be looking at the R57's mouth but there was no documentation in the assessment about dental status. When interviewed on 8/13/14, at 2:31 p.m. licensed practical nurse (LPN)-A stated she felt as though the Oral Inspection Assessment was new to the facility and indicated the form came	F 412		

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F 412	Continued From page 46 with new admit information packet and not with the quarterly and annual assessments. LPN verified the Oral Inspection Assessment was lacking in the chart. On 8/13/14, at 2:53 p.m. the medical records and admission coordinator approached surveyor stated initially when R57 was admitted at the facility the family daughter had signed the initial dental consent which the facility usually would fax to Apple Tree Dental. Then after the initial visit with the dentist Apple Tree Dental would come up with a treatment plan and send it to the family who would sign it and return it to Apple Tree Dental who would put the residents normally on rotating schedules. Medical records and admission coordinator further stated she had spoken with someone at Apple Tree Dental who indicated the office had sent several consents paperwork to the daughter but she had not responded thus explaining why R57 had not been seen since 11/12/12. She indicated her department was responsible for scheduling appointments but missing dental follow up had not been brought up to her attention to check with Apple Tree Dental to facilitate obtaining the consent from the daughter. When interviewed on 8/14/14, at 2:17 p.m. via conference call Apple Tree Dental mobile care coordinator stated another daughter had been sent three consents but had not responded. When asked why the facility had not been updated about the failed attempts she indicated she was not sure and was not working at her current job and had looked at R57's record and had not found any information of the facility being contacted. When asked if she expected the facility to have followed up to see what was going	F 412		

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F 412	Continued From page 47 on she indicated she would not answer even after surveyor indicated a different daughter was the financial and responsible party. On 8/14/14, at 2:26 p.m. after concern had been brought to the facility attention three Proposed Dental Treatment for R57 were provided dated 11/19/12, 2/1/13, and 3/4/13, which had been sent to a different daughter who was not the responsible party and financial representative who was listed in R57's chart. On 8/14/14, at 4:03 p.m. the director of nursing (DON) stated she expected the MDS nurse to have brought to the facility attention R57 had not been seen by the dentist since 11/12/12, and the oral assessment had not been identified and completed in the last three comprehensive assessments when reviewing the MDS. R12's dentures were misplaced and R12 did not receive new dentures. On 8/11/14, at 6:54 p.m. R12 was observed with no upper dentures in her mouth. R12 stated "I have no upper dentures; they were lost in the hospital in February [2014]." R12 also stated, "I really would like dentures." R12 further stated she liked to eat nuts but could not eat the nuts without the dentures. On 1/21/14, a Physician's Order noted the diet as modified diabetic diet regular texture and thin consistency. The resident was a diabetic. The admission Individual Resident Care Plan dated 1/21/14, indicated under dental status, that R12 was admitted with own teeth and upper dentures.	F 412		

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F 412	Continued From page 48	F 412		

The Nutrition Assessment Form dated 1/23/14, indicated R12 had upper dentures and bottom own teeth. The word "good" was crossed out where it had stated "good condition."

The quarterly MDS dated 4/30/14, revealed R12 scored an 11 on the Brief Interview for Mental Status (BIMS - a test to determine the cognition level of a resident) which indicated moderately impaired cognition. The Oral/Dental Status was left blank on the MDS.

The care plan dated 5/13/14, indicated R12 was independent with oral cares with set up from staff and the care plan lacked evidence of any form of dental status.

The nurse practitioner's (NPs) note dated 7/14/14, in the section depicted as eyes, nose and throat (ENT)/Mouth read: "moist mucous membranes, no upper teeth."

The Care Conference Summary form dated 8/12/14, noted the section of dental was left blank for when R12 was last seen by a dentist and the there was no mention of referring R12 to the dentist at that time for denture fitting.

On 8/13/14, at 7:57 a.m. director of social service (DSS) stated R12 had not been seen by a dentist since admission to the facility. DSS stated she knew R12 wanted dentures, and possibly thought a consent form for R12 to see the dentist was filled out. DSS verified there were no Physician Orders for R12 to see the dentist. DSS also stated dental came to the facility and the health unit coordinator (HUC) notified the dental office to obtain orders. DSS further stated every care

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F 412	Continued From page 49 conference dental was offered to the resident(s) and she had created the new form so all services for residents would be offered and in addition dental as of a few months ago was being offered to residents upon admission. DSS verified R12's last care conference dated 8/12/14, dental was left blank and indicated "I will talk to her (R12) today." Dental policy was requested on 8/14/14, at approximately 3:30 p.m. but was not provided.	F 412		
F 431 SS=E	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	F 431	**F 431** It is the policy of Crest View Lutheran Home to 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.	

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F 431	Continued From page 50 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 medication and treatment carts was locked on the Aspen Unit. In addition, the facility failed to remove expired medications and stock medical supplies available for use for residents in 2 of 4 medication storage rooms/carts. Findings include: Aspen Unit: A Medication cart (which held biologicals and medications such as anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication) was left unlock and unsupervised. On 8/14/14, at 7:19 a.m. the key lock to the medication cart was observed to be fully extended in the unlocked position on the Aspen unit. - At 7:20 a.m. both trained medication aide (TMA)-A and licensed practical nurse (LPN)-B were observed walking off the unit almost at the same time to the Linden Unit with TMA-A pulling a cart. As they walked off the unit past the fire door, a nursing student instructor was observed	F 431	For the lab items that were expired, they were immediately disposed of and new supplies were ordered. For the expired insulin that had been found, the insulin was discarded and new supply ordered. For all other residents that this may affect, a whole house audit of medication expiration, lab supply expiration was completed on09/17/2014. The policy on expired medications and medication storage were reviewed/created by the Inter Disciplinary Team on 09/15/14 and were updated to reflect the deficiencies received. 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 expired medication and medication cart security policy and procedures 09/17/14-09/19/14.	

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F 431	Continued From page 51 to walk past the cart and R54 was observed seated across the cart near the wall with the head bent over asleep. The cart still remained unlocked at that time. - At 7:21 a.m. TMA-A returned and stood in front of the cart to start passing medication verified the cart was open after looking when asked if the cart was supposed to be left open TMA-A stated "No." When interviewed on 8/14/14, at 9:47 a.m. the director of nursing (DON) stated medication carts should be locked at all times when not supervised. Willow Unit: On 8/12/14, at 3:32 p.m. the medication storage room tour was conducted on Willow Unit. During the tour there was eighteen Hemoccult (a test used to screen the presence of blood in stools) stool test kits with an expiration date of 12/12 and two with an expiration date of 10/09 which were stored in a drawer in the medication room. The drawer also contained a cream colored plastic container which held fourteen culture swabs with an expiration date of 7/14, and one with a expiration date of 3/2013. During interview on 8/12/14, at 3:38 p.m. LPN-E verified the culture swabs and the Hemoccult stool kits were expired and confirmed that they should not be used because they are expired. During interview on 8/12/14, at 3:51 p.m. DON verified expired medical supplies in the medication storage room and stated "we focus more on the medications not the kits" and indicated medication room audits are done on a weekly basis. -At 4:15 p.m. the DON verified supplies should	F 431		

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F 431	Continued From page 52 have been taken out and disposed of and confirmed she expected staff to follow the facility policy. Evergreen Unit medication cart: On 8/12/14, at approximately 1:00 p.m. medication storage was observed on the Evergreen Unit. A Novolog insulin pen (used to treat diabetes mellitus) for R43 was observed stored on the top drawer of the treatment/medication cart with hand-written date on the pen of 7/10/14. -At 1:10 p.m. LPN-G stated the medication expired twenty eight to thirty days after opening. LPN-G verified the date pen was opened was 7/10/14, which two days later since medication had expired. LPN-G also stated R43 had received the insulin on two separate occasions from that insulin injection pen on 8/12/14. LPN-G then took the insulin pen from the top drawer and said "I will get rid of it then" and was observed going into the locked medication room. A Physician ' s Order dated 5/29/14, for R43 directed staff to inject Novolog solution (Insulin Aspart) per sliding scale subcutaneously three times a day for diabetes. During review of the Medication Administration Record (MAR) it was revealed R43 had received Novolog insulin at 7:30 a.m. and 10:30 a.m. on 8/12/14, from the outdated pen. On 8/14/14, at 3:30 p.m. DON stated all insulin should be discarded twenty eight days after being opened according to manufacturer's recommendations.	F 431		

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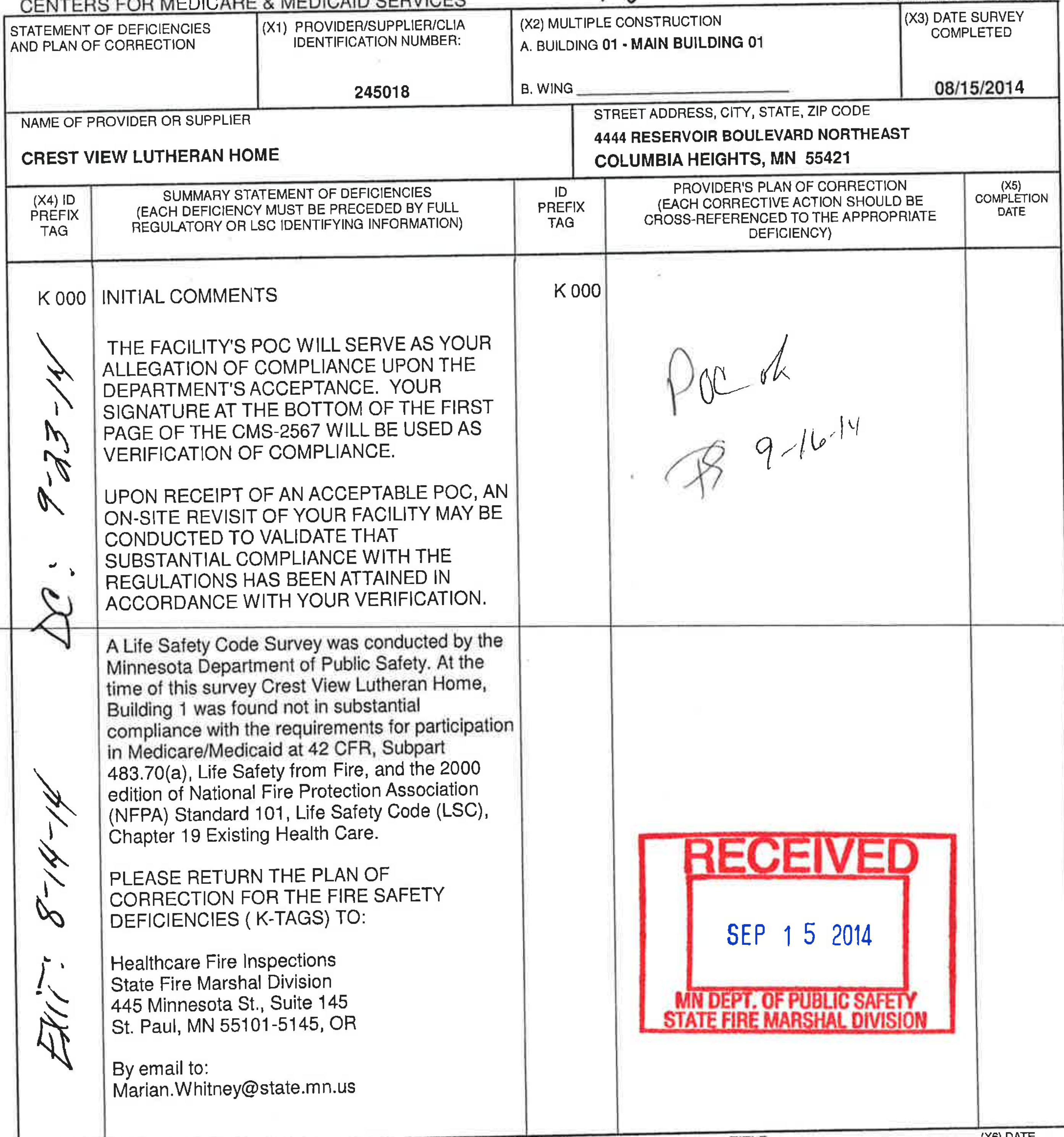
F 431	Continued From page 53 The BD (Becton Dickinson and Company) Diabetic Learning Center website at: https://www.bd.com/us/diabetes/page.aspx,to store and handle insulin, Novolog refillable pens lose effectiveness 28 days after opened. The Receiving Medications policy revised 5/13, did not address medication storage areas which included the medication and treatment carts and if they were to be locked when not at sight or unsupervised. In addition, the policy did not address multi-use medication expiration, labelling and disposing of expired medications. The policy lacked information of who was responsible to oversee and ensure expired medications were discarded from the carts.	F 431		



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	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2014

NAME OF PROVIDER OR SUPPLIER: CREST VIEW LUTHERAN HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 4444 RESERVOIR BOULEVARD NORTHEAST, COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	K 000	POC ok 9-16-14	
DC: 9-23-14	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crest View Lutheran Home, Building 1 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us		RECEIVED SEP 15 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	
Exit: 8-14-14				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Care Center Administrator — (X6) DATE: 9/12/14

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.

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/15/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with an addition in 1968. Construction typed is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2	K 043	K043 It is the policy of Crest View Lutheran Home to follow all state and federal regulations including but not limited to the Life Safety Code.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	08/15/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 043	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the door locks in accordance with Life Safety Code Section 18.2.2.4. This deficient practice could affect the residents. Findings include: On facility tour between 9:15 AM and 11:00 AM on 08/15/2014, observation revealed that there is no means to manually unlock or manually relock the exit doors in the memory care unit. This deficient practice was verified by the administrator at the time of the inspection.	K 043	Audits on the medication expiration dates of medications and lab supplies along with medication cart security will be completed weekly on an on-going basis to ensure compliance is maintained. Results of the audits will be brought to the QA/QI Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 09/23/14	
K 103 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has combustible construction materials in the interior walls and partitions not in accordance with Life Safety Code Section 19.1.6.3. This deficient practice could affect some residents. Findings include: On facility tour between 9:15 AM and 11:00 AM on 08/15/2014, observation revealed that the	K 103	Upon inspection on 8/15/2014, Crest View employees incorrectly stated that there was no means of manually unlocking and manually re-locking the exit doors on the memory care unit. Upon further inspection by the Administrator and the Director of Environmental Services, the manual lock/unlock button for the secure memory care unit was located behind the nursing desk.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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	08/15/2014

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 103	Continued From page 3 perimeter and interior walls of the gift shop are framed with wood studs. There is also plywood sheathing above the ceiling in the gift shop. Theis deficient practice was verified by the administrator at the time of the inspection.	K 103	To ensure the manual lock/unlock system is in full working order, Mayer Electric was contracted to inspect the unit and ensure it is up to all fire inspection codes. Mayer Electric will have concluded its work with Crest View Lutheran Home's secure memory care unit by 9/23/2014. All staff will be re-educated to the location and purpose of the manual lock/unlock button on 9/17/2014 – 9/19/2014. Manual Switch Audits will be completed weekly for 4 weeks, monthly for 2 months, and then randomly to ensure compliance is maintained and the manual lock/unlock button is in proper working order. Results from these audits will be brought to the QA/QI Committee for review and further recommendations. The Director of Environmental Services or designee will be responsible for compliance. Date of Correction: 09/23/14	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING 02 - 2007 ADDITION B. WING	08/15/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Crest View Lutheran Home, Build 2 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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 type is II (111). The 2007 edition is of Type II (111) and is a 1-story building with a basement. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 122 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET. PoC ok TB 9-16-14	K 000	K103 It is the policy of Crest View Lutheran Home to follow all state and federal regulations including, but not limited to the Life Safety Code. All interior walls and partitions in the building's construction are noncombustible or limited-combustible materials. Upon further inspection by the Administrator and Director of Environmental Services along with State Fire Marshal Supervisor on 8/20/2014, there was only one interior wall that was framed with wood studs, rather than all of the walls within the gift shop area. This was evidenced by holes drilled into the walls revealing metal studs. The wood-studded wall along the gift shop and dining room area will be replaced with a metal studded wall by an outside contractor by 9/23/2014. On-going building inspection audits will be completed by the Director of Environmental Services to ensure no further deficient practices are observed. Results from these audits will be brought to the QA/QI Committee for review and further recommendations. The Director of Environmental Services or designee will be responsible for compliance.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution ... other safeguards provide sufficient protection to the patients. (See instructions.) Except for nu... following the date of survey whether or not a plan of correction is provided. For nursing home... days following the date these documents are made available to the facility. If deficiencies are... program participation.

Date of Correction: 09/23/14

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

F5018026

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 ______	08/15/2014

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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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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4677

September 2, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5018026

Dear Mr. Tobalsky:

The above facility was surveyed on August 11, 2014 through August 14, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosures
cc: Original - Facility