DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TMS6

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00005 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) CREST VIEW LUTHERAN HOME (L1)245018 1. Initial 2. Recertification (L4) 4444 RESERVOIR BOULEVARD NORTHEAST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55421 935840400 (L2)(L5) COLUMBIA HEIGHTS, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital 05 HHA 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 10/16/2014 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 122 (L18) _1. Acceptable POC 8. Patient Room Size 5. Life Safety Code __ 9. Beds/Room Not in Compliance with Program 122 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: **A*** 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)122 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Mandatory DOPNA is rescinded. 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Becky Wong, HFE NE II Anne Kleppe, Enforcement Specialist 10/24/2014 10/27/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: ____ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 01/01/1967 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 09/23/2014 (L32) (L33)DETERMINATION APPROVAL



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,

Are Klegge

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



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,

Dre Klegge

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



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,

Dire Klegge

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

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 245018	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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) Dat	e (Y4) Item		(Y5) Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0225	Correc Comple 09/23/2	eted	F0226	Correction Completed 09/23/2014		ID Prefix	F0253		Correction Completed 09/23/2014
Reg. # LSC	483.13(c)(1)(ii)-(i	ii), (c)(2) -		483.13(c)				483.15(h)(2)		
ID Prefix	F0274	Correc Comple 09/23/2	eted	F0282	Correction Completed 09/23/2014		ID Prefix	F0312		Correction Completed 09/23/2014
Reg. # LSC	483.20(b)(2)(ii)		Reg. # LSC	483.20(k)(3)(ii)			Reg. # LSC	483.25(a)(3)		- -
ID Prefix	F0323	Correc Comple 09/23/2	eted	F0329	Correction Completed 09/23/2014		ID Prefix	F0353		Correction Completed 09/23/2014
	483.25(h)			483.25(I)				483.30(a)		_
	402 EE/b)	Correc Comple 09/23/2	eted 2014 ID Prefix	F0431 483.60(b), (d), (e)	Correction Completed 09/17/2014		_			Correction Completed
ID Prefix Reg. # LSC			eted ID Prefix Reg. #				_			
	D. D.	den de Bro	Participant							
Reviewed I		viewed By D/AK	Date: 11/07/20		of Surveyor:		30	951	Date: 10/1	6/2014
Reviewed I	By Re	viewed By	Date:	Signature	of Surveyor:				Date:	
Followup t	so Survey Compl 8/14/20				Uncorrected Defi d Deficiencies (CI				YES	NO

State Form: Revisit Report							
(Y1) Provider / Supplier / CLIA / Identification Number 00005	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/16/2014				
Name of Facility		Street Address, City, State, Zip Code					
CREST VIEW LUTHERAN HOME	Ξ	4444 RESERVOIR BOULEVARI	D NORTHEAST				

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).

COLUMBIA HEIGHTS, MN 55421

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) I	Date
- 3	Correction Completed 09/23/2014 4658.0400 Subp.	- 3	Correction Completed 09/23/2014 Rule 4658.0405 Subp.	ID Prefix Reg. #	20800 MN Rule 4658.0510 Su	Correction Completed 09/23/2014
ID Prefix 20830 Reg. # MN Rule	Correction Completed 09/23/2014 2 4658.0520 Subp.	ID Prefix 20 Reg. # MN LSC	Correction Completed 09/23/2014 Rule 4658.0520 Subp. :	ID Prefix	MN Rule 4658.0725 Su	Correction Completed 09/23/2014
<u> </u>	Correction Completed 09/23/2014 Statute 144A.04 Su		Correction Completed 09/23/2014 Rule 4658.1315 Subp.	ID Prefix Reg. #	21610 MN Rule 4658.1340 St	
	Correction Completed 09/23/2014 4658.1415 Subp.		Correction Completed 09/23/2014 St. Statute 626.557 Sul	ID Prefix Reg. #	22000 MN St. Statute 626.55	
Reg. #	Correction Completed	Reg. #	Correction Completed	ID Prefix Reg. # LSC		
Reviewed By State Agency	Reviewed By GD/AK	Date: 11/07/2014	Signature of Surveyor:	30	Date: 10/10	5/2014
	Reviewed By Completed on: /14/2014 SIT REPORT (5/99)	Date:	Signature of Surveyor: Check for any Uncorrected Def Uncorrected Deficiencies (C			NO

CREST VIEW LUTHERAN HOME

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 245018	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 10/24/2014
Name of Facility	Street Address, City, State, Zip Code	

CREST VIEW LUTHERAN HOME

Street Address, City, State, Zip Code
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).

Completed O9/23/2014 ID Prefix Completed O9/23/2014 ID Prefix Completed O9/23/2014 ID Prefix Completed O9/23/2014 ID Prefix Completed	rrection
ID Prefix	
Reg. # NFPA 101	mpleted
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ID Prefix	rrection impleted
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Reg. # Reg. # Reg. #	
LSC LSC LSC	
Reviewed By Reviewed By Date: Signature of Surveyor: Date:	
State Agency PS/AK 10/24/2014 28120 10/24/20)14
Reviewed By — Reviewed By Date: Signature of Surveyor: Date:	
Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of	
8/15/2014 Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES No.	0

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 / (Y2) Multiple Construction (Y3) Date Identification Number
--

Name of Facility

CREST VIEW LUTHERAN HOME

Street Address, City, State, Zip Code
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	()	(5)	Date
Reg. #	NFPA 101 K0027	Correction Completed 10/13/2014	ID Prefix Reg. # NF LSC KC	FPA 101	Correction Completed 10/21/2014	D "			
Reg. #			Reg. #		Correction Completed	Reg. #			Correction Completed -
Reg. #			Reg. #		Correction Completed				Correction Completed
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #	(Correction Completed	ID Prefix			Correction Completed
Reg. #			ID Prefix Reg. #	(Correction Completed	Reg. #			Correction Completed
Reviewed E State Agend Reviewed E CMS RO	су	PS/AK Reviewed By	Date: 10/24/2014 Date:	Signature of Surv		28120		Date: 10/24 Date:	./2014
	o Survey Co 9/25	mpleted on: 5/2014		Check for any Uncorr Uncorrected Defici				YES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: EHVW22



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,

Are Klegge

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

ID: TMS6

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

PART I	- TO BE COMPI	LETED BY T	THE STAT	E SURVEY AGENCY	Fac	cility ID: 00005
MEDICARE/MEDICAID PROVIDER NO. (L1) 245018	CILITY AN HOME		4. TYPE OF ACTION: 1. Initial	2 (L8) 2. Recertification		
2.STATE VENDOR OR MEDICAID NO.	(L4) 4444 RESEI	RVOIR BOUL	EVARD NO	ORTHEAST	3. Termination	4. CHOW
(L2) 935840400 (L5) COLUMBIA HEIGHTS, MN (L6) 55421					5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 08/14/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):	A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	<u>s:</u>
To (b):		equirements		2. Technical Personnel	6. Scope of Service	ces Limit
12.Total Facility Beds 122 (L18)	-	e Based On: cceptable POC		3. 24 Hour RN4. 7-Day RN (Rural SI		
13.Total Certified Beds 122 (L17)		npliance with Properties and/or Appli		5. Life Safety Code * Code: B	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN			1	15. FACILITY MEETS		
18 SNF 18/19 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
122						
(L37) (L38) (L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	CABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE	Date:			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Magdalene Jares, HFE NE II		09/15/2014	(L19)	Anne Kleppe, Enforce	ment Specialist	_ 09/19/2014 (L20)
PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	(220)
19. DETERMINATION OF ELIGIBILITY		IPLIANCE WITI	H CIVIL		ancial Solvency (HCFA-2572)	
1. Facility is Eligible to Participate	RIGI	HTS ACT:		 Ownership/Contr Both of the Abov 	ol Interest Disclosure Stmt (Ho e:	CFA-1513)
2. Facility is not Eligible						
(L21)						
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L3	30)
OF PARTICIPATION BEGINNIN	IG DATE	ENDING DA	TE	VOLUNTARY 0	<u>INVOLUNTA</u>	ARY
01/01/1967				01-Merger, Closure	05-Fail to Me	et Health/Safety
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburs	***************************************	et Agreement
25. LTC EXTENSION DATE: 27. ALTERNAT	TIVE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
A. Suspensi	on of Admissions:			04-Other Reason for Withdrawal	07-1 TOVIDET S	Status Change
(L27) P. Possind	Suspension Date:	(L44)			00-Active	
B. Reschiu	Suspension Date.	(1.45)				
		(L45)		20 DELCENTA		
28. TERMINATION DATE:	29. INTERMEDIARY	CARRIER NO.		30. REMARKS		
	03001					
(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	LOE ADDDOVAL	DATE			
		OFAPPROVAL	_DAIR			
(L32)	52. DETERMINATION	OF APPROVAL	_	DETERMINATION APP		



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,

Dire Klegge

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

DRIVE DAY

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TATEMENT OF I	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		SURVEY PLETED
		245018	B. WING		08/1	4/2014
	VIDER OR SUPPLIER	ме		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225 SS=D All TI be min his record in the street of the s	s your allegation of appartment's acceptrom of the first per used as verification of the first per used as verification of the facility of the facility must need to find a finding entered a finding entered and a finding entered at a finding entered and a finding entered	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with , (c)(2) - (4) PORT DIVIDUALS ot employ individuals who have of abusing, neglecting, or not by a court of law; or have red into the State nurse aide g abuse, neglect, mistreatment cappropriation of their property; owledge it has of actions by a st an employee, which would for service as a nurse aide registry	テージーンとは多りなる	It is the policy of Crest View Home to follow all federal, local guidelines, laws, regul statues. This plan of correction is no construed as an admission practice by the facility adm employees, agents, or other deficiencies does not construct agreement with citations. The preparation, submission implementation of this plan correction will serve as our allegation of compliance. F 225 It is the policy of Crest View that all alleged violations on eglect or abuse are investigation.	state, and ations, and ations, and of deficient of itute on, and of credible w Luthera of mistrea	nt als. : n Home tment,

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.

If continuation sheet Page 1 of 54

1944 - 1998 Common Statistica (n. 1998) 1994 (1994)

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245018	B. WING		08/	14/2014
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP COI 4444 RESERVOIR BOULEVARD NOR COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	prevent further pot investigation is in provent further pot investigation is in provention in the administrator representative and with State law (includent, and if the appropriate correct the state appropriate correct this REQUIREMED by: Based on intervier facility failed to eninjuries of unknow resident altercation to the State agency of 5 residents (R6) Findings include: R64 was involved altercation and the the SA nor was the Safety measures resident. R64 reported in a p.m. another residence and the other me, how come, it area and added, it area and added, it is a simple state of the state and added, it is a simple state of the state and added, it is a simple state of the state and added, it is a simple state of the s	oughly investigated, and must ential abuse while the progress. Investigations must be reported in or his designated. It to other officials in accordance uding to the State survey and y) within 5 working days of the alleged violation is verified tive action must be taken. ENT is not met as evidenced where alleged violations involving in source and resident to missing were immediately reported by (SA) and administrator for 3 4, R23, R177). In a resident to resident to reported to be report thoroughly investigated were not put in place for either interview on 8/11/14, at 6:30 dent had slapped his face is complaining too much. R64 in resident "never apologized to hurt!" and pointed to his check 'Right there he did that." R64		For Posidonts P6/L R23 ar	T on 09/15/1 ee of abusive ducated on A gpolicies and 09/19/14 related to porting was iplinary team f policies by be complete rds of practic	4 to huse
	was aware of the	d in the dining room and staff incident. Inimum Data Set (MDS) dated				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245018	B. WING		08/14/2014
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 554	CODE ORTHEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C	ORRECTION (X5) ON SHOULD BE COMPLETION BE APPROPRIATE DATE
F 225	7/8/14 identified Ri Mental Status (BIN level) score of fifte On 8/11/14, at 7:50 indicated he was a Review of the Res 3/7/14, revealed the p.m. in the dining another resident a reported he had so jaw. R64 and the a interviewed on 3/1 did not indicate who responsible party Progress Note pro 1/10/14, at 11:37 altercation between had occurred in the a.m. and there was provided of a thorother residents or interviewed and infor possible injury further documents measures taken finvolved in the incon 8/14/14, at 2:0 reviewed the facili interpreting the pilecause it was fabuse or intent to reported." The ac should have been R23 was involved resident altercation.	64 had a Brief Interview for MS - test to determine cognition en indicating intact cognition. 5 p.m. the administrator tware of the situation. General Marchael Report dated the incident occurred at 5:00 from. The report indicated pproached a nurse and portily slapped R64 on the left alleged perpetrator were 0/14. The incident report forminen SA, physician or had been notified. Evided by the facility dated a.m. indicated a verbal en R64 and another resident for the dining room (DR) at 11:20 as no further documentation ough investigation including staff in the DR that had been either was evidence of follow up ation with identified safety or R64 and the other resident cident. Do p.m. the administrator ity's policy and indicated irst not considered physical that had been either was evident was not diministrator verified the incident called into the SA. If in verbal abuse and resident to an and the incident was not A immediately nor was it		roles and responsibilition and procedures on A Reporting and Increated to ensure reporting all allegeneglect and abuse completed weekly for 2 months, and ensure continued for staff knowledgenegoting maltrea abuse will be comweeks, monthly for randomly to ensure compliance. The will be reported to Committee for recommendation	ed maltreatment, . This audit will be of for 4 weeks, monthly then randomly to compliance. Audits ge on identifying and tment, neglect, and apleted weekly for 4 or 2 months, and then are continued results of these audits to the QA/QI view and further a. Jursing or designee will or compliance.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 4444 RESERVOIR BOULEVARD NOT COLUMBIA HEIGHTS, MN 5542	ODE RTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	Crest View Luthera 6/18/14, at 3:24 p.r to his room with sta started yelling and the hell out of this rout of this room, I'll facility put R23 on safety. Crest View Luthera 7/20/14, at 1:31 p.r grabbed his arm in and assisted R23 t No bruising, no rec practitioner update. Crest View Luthera 8/2/14, at 2:36 p.m was holding and hi hallway per staff removed R23's room redness, no bruising R23 stated "I'm fin safety checks indicated R23's diadementia and Parl the MDS indicated During interview of administrator confresident to resider him but was not readministrator state reported to the SA and the SA	un Home Progress Note dated m. indicated R23 walked back aff to go to bed. Roommate threatening R23 by stating "get room now, if you don't get him will him." After incident the fifteen minutes checks for his an Home Progress Note dated m. indicated R23's roommate the hallway. Staff separated to the living area immediately. Incess noted on arm, nurse d. an Home Progress Note dated m. indicated R23's roommate itting to R23's thigh in the export. Staff separated and mate to the front desk. No not hands and thigh noted. e", supervisor updated and cated per policy. S dated 3/15/14, indicated was three which indicated was three which indicated bas. In addition the MDS agnoses included Alzheimer's, kinson's disease. Furthermore		25		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245018	B. WING			08/1	14/2014
	PROVIDER OR SUPPLIER	ME .		4	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	and followed the far R177 was found wi origin and was not SA, and the Investi submitted timely to Incident Report dat "Discoloration on le elbow. At 9:40 a.m. found a purple and discoloration on the measuring 11 Cent another red discolo 3 cm by 1/2 cm wit discoloration of the Resident can't expl wandering behavio down when walking Physician, Respon and Administrator r a.m." Incident Rep later to the SA on 7 The Investigative F currently resides of Diagnoses include disturbances and A and receives assis living [ADLs]. Resim mobility, and is abl assistive devices. I score of 4 of 15, w deficits. On the mo- observed with a lat 5.5 cm on resident happened, this res	the facility did incident reports cility policy. th a large bruise of unknown reported immediately to the gative Report was not the SA. ed 7/12/14, for R177 read of the hand with open area on left writer assessed resident and red and black long front of resident left hand imeters [cm] by 5 1/2 cm, oration on the elbow measuring hopen area in the red elbow measuring 1 cm. lain. Has history [Hx] of realisting with head facing g and bumping into things. sible party, DON, Supervisor, notified on 7/12/14, at 9:40 ort was submitted two days		225			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE S COMPLI	
		245018	B. WING			08/14	/2014
	PROVIDER OR SUPPLIER	ME		44	REET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHEAS DLUMBIA HEIGHTS, MN 55421	ST	
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F 225	notified immediate due to the facility's bruise that is large Report was submi 7/28/14, eleven we had been discove On 8/4/14, at 2:08 staff are trained to immediately after stated he decided not, and would go administrator also the abuse policy a updating. In addit R177's bruise wa of the bruise and investigative repofive working days administrator furt R177's report wa The facility's Abu Rev. 10/12, directincident of mistretincluding injuries misappropriation reported to the A 2) The administrinitial report of the to the SA immed The follow up invito the SA within the report."	ely. The bruise was reported by policy of reporting an unknown or in size." The Investigative tited to the SA untimely on priking days after the incident red. It p.m. the administrator stated of call the administrator an incident. The administrator if the incident is reportable or by the regulation. The stated the team has discussed and stated the policy needed ion the administrator stated is reportable because of the size also stated he did know orts were to be reported within of incident to the SA. The her stated he did not know why is submitted late to the SA. See Investigation Policy dated ted: "1) An incident or suspected ted: "1) An incident or suspected ted: "1) An incident or suspected incident, neglect, or abuse, of unknown source, and of property must be immediately dministrator or designee. The state of the submitted in accordance with law. The restigative notes will be submitted to working days of the initial	d d	2225 F 226			
F 22 SS=	D ABUSE/NEGLE	CT, ETC POLICIES		، خدر			
	The facility must	develop and implement written					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245018	B. WING _		08/14/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEA COLUMBIA HEIGHTS, MN 55421	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 226	policies and proced mistreatment, negliand misappropriation of the policy to immediate state Agency (SA) potential allegation altercations, injurie elopement for 3 of Findings include: The facility's Abuse Rev. 10/12, directed 1) An incident or simistreatment, neglight of unknown source property must be in Administrator or decent and the SA immedian of the SA immedian of the SA within 5 in report." In addition, the policy source, and misappet the policy investig Administrator or decent and the policy and the policy in the same policy of the policy and misappet the policy in the policy and misappet the policy in the policy and misappet the policy in t	dures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced w and document review, the element the abuse prevention ely notify the administrator, the and thoroughly investigate s of resident to resident es of unknown origin and 5 residents (R64, R23, R177). el Investigation Policy dated ed: uspected incident of lect, or abuse, including injuries e, and misappropriation of mmediately reported to the esignee. tor or designee will make an incident or suspected incident, tely in accordance with law. stigative notes will be submitted working days of the initial icy indicated "Suspected or es of resident mistreatment, including injuries of unknown opropriation of property will be gated and documented by the esignee. Suspected or	F 22	It is the policy of Crest Vie Home that all alleged viol mistreatment, neglect or investigated and reported appropriate entities in a to For Residents R64, R23, a of care were reviewed by 09/15/14 to ensure each of abusive environments All staff members were environments Abuse Prohibition and Reported by the interdisciple on 90/15/14. A review of post the Medical Director will be to ensure current standards are in place. Staff members trained as it relates to their roles and responsibilities reaches and procedures on 09/17/16	ations of abuse are d to the imely manner. Ind R177, plans IDT on resident is free ducated on eporting on 09/17/14- Plated to orting was inary team olicies by completed s of practice s were respective garding the orting policy
		esignee. Suspected of es must also be reported to		1	l

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B, WING			4/2014	
	PROVIDER OR SUPPLIE		4	TREET ADDRESS, CITY, STATE, ZIP C 444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 5542	RTHEAST		
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F 226	respective agence enforcement, phy representative. To routinely and oper R64 was involved altercation and the SA nor was the Safety measures resident. Progress Note por 1/10/14, at 11:37 altercation between had occurred in a.m. and there we provided of a the other residents of interviewed and for possible injurt further document measures taken involved in the interviewed in the interviewed on 3/7/14, revealed p.m. in the dining another resident reported he had jaw. R64 and the interviewed on 3/14 did not indicate responsible part R64 reported in p.m. another rebecause R64 we reported the other, how come,	ies such as state agencies, law ysician, families, and/or he subject of abuse shall be enly discussed." In a resident to resident to resident the incident was not reported to the report thoroughly investigated. It was not put in place for either arovided by the facility dated around an another resident the dining room (DR) at 11:20 was no further documentation brough investigation including or staff in the DR that had been neither was evidence of follow up by In addition, there was no station with identified safety for R64 and the other resident	F 226	A Reporting and Investoreated to ensure time reporting all alleged in neglect and abuse. The completed weekly for for 2 months, and the ensure continued confor staff knowledge of reporting maltreatment abuse will be compleweeks, monthly for 2 randomly to ensure a compliance. The result will be reported to the Committee for review recommendation. The Director of Nursibe responsible for compliance of Correction:	eliness of maltreatment, his audit will be a 4 weeks, moren randomly to mpliance. Audit on identifying a ted weekly for a months, and to continued alts of these audit of these audit of the wand further sing or designe ompliance.	enthly ots and and 4 then	

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	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245018	B. WING		08/1	4/2014
	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 226	was aware of the i R64's quarterly MI had a BIMS score cognition. On 8/11/14 at 7:55 indicated he was a On 08/14/14, at 2: reviewed the facili interpreting the po "Because it was fi abuse or intent to reported." The ad should have been R23 was involved resident altercatio reported to the SA thoroughly investic Crest View Luther 6/18/14, at 3:24 p to his room with s started yelling and the hell out of this out of this room, I facility put R23 or safety. Crest View Luther 7/20/14, at 1:31 p grabbed his arm i and assisted R23	In the dining room and staff neident. OS dated 7/8/14, identified R64 of fifteen indicating intact of p.m. the administrator aware of the situation. On p.m. the administrator ty's policy and identified not dicy correctly and indicated rest not considered physical harm the incident was not ministrator verified the incident called into the SA. In verbal abuse and resident to an and the incident was not ministrator verified the incident called into the SA. In verbal abuse and resident to an and the incident was not ministrator verified the incident to an and the incident was not a mediately nor was it gated. The transport of the transport of the state of the state of the living area immediately. The transport of the living area immediately.	F 226			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245018	B. WING		08/	14/2014
	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421			
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F 226	Crest View Luthers 8/2/14, at 2:36 p.m was holding and hallway per staff removed R23's room redness, no bruisin R23 stated "I'm fin safety checks indicated and parkinson's designation loss. In R23's diagnoses is and Parkinson's designation on the submitted time and followed the fill reduced in the submitted timely the lincident Report designation on the loss. In R23's annual MDS and resident to resident to resident in the submitted timely the lincident Report designation on the loss of	an Home Progress Note dated in. indicated R23's roommate itting to R23's thigh in the eport. Staff separated and inmate to the front desk. No ing to hands and thigh noted. Itelligible in the early supervisor updated and cated per policy. So dated 3/15/14, indicated R23's incree which indicated severe addition, the MDS indicated included Alzheimer's, dementia isease. In 8/14/14, at 11:16 a.m. the firmed facility policy and intercation were reported to eported to the SA. The ed "The incidents were not a because no harm was caused out it and also verified when no it the facility did incident reports acility policy. With a large bruise of unknown it reported immediately to the stigative Report was not	F 2	226		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER /IEW LUTHERAN HC			STREET ADDRESS, CITY, STATE, ZIF 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 55	CODE NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	Resident can't exp wandering behavid down when walkin Physician, Respor and Administrator a.m." Incident Rep later to the SA on The Investigative currently resides of Diagnoses included disturbances and and receives assis living [ADLs]. Res mobility, and is ab assistive devices. score of 4 of 15, v deficits. On the m observed with a la 5.5 cm on resider happened, this re- communicate the notified immediated due to the facility's bruise that is large Report was subm 7/28/14, eleven w had been discove On 8/4/14, at 2:08 staff are trained to immediately after stated he decided not, and would go administrator also the abuse policy a updating. In addit R177's bruise wa	plain. Has Hx [history] of our walking with head facing g and bumping into things. Insible party, DON, Supervisor, notified on 7/12/14, at 9:40 our was submitted two days 7/14/14. Report for R177 read "Resident on the secure memory care unit. It dementia with behavioral Alzheimer's. Resident needs at of 1 with all activities of daily ident is independent with old to ambulate without any Resident has a BIMS cognitive orning of 7/12/14, R177 was arge bruise measuring 11 cm x and sident was not able to source. Family and physician ely. The bruise was reported as policy of reporting an unknowner in size." The Investigative itted to the SA untimely on orking days after the incident		226		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		245018	B. WING			08/-	14/2014	
• ··	PROVIDER OR SUPPLIER		·	444	REET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHEA: DLUMBIA HEIGHTS, MN 55421	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE	
F 253	five working days administrator furth R177's report was 483.15(h)(2) HOU MAINTENANCE S The facility must p maintenance serv	ts were to be reported within of incident to the SA. The er stated he did not know why submitted late to the SA. SEKEEPING & SERVICES		226	F 253 It is the policy of Crest Vie	w Luthe	ran	
	maintenance services anitary, orderly, anitary, and ordered anitary, anitar	ices necessary to maintain a and comfortable interior. ENT is not met as evidenced ation and interview, the facility ousekeeping and maintenance ry to maintain a sanitary e provided for 16 of 114 R49, R5, R3, R188, R187, R78, R62, R14, R7, R2, R64, R23) ronmental concerns. R3 and R188's bathrooms were room observations on 8/11/14, to receive the cracks of the tiles or or. In was observed during room 8/11/14, to have rust and dark ebris buildup on the floor behind			Home that services provide maintain a clean and sanisituation for all residents. Crest View Lutheran Home For Residents R172, R49, R5 R187, R78, R81, R124, R62, and R23, rooms were cleaned thoroughly by housekeeping included the removal of old up in corners of the room and frames. These rooms were cleaned both the Administrator and Environmental Services by S	ded and tary living residing ne. , R3, R18 R14, R7, ed g staff; the wax builted door observed Director	at 38, R2, nis Id-	

Event ID:TMS611

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245018	B. WING		08/14/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	ORTHEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETION DATE
F 274	bathroom door. R81, R124, R64 a during room observations on 8 black debris build very sticky to walk had a dark brown the toilet. A tour of the facili 10:05 a.m. with thousekeeping an (HMS). The admiall the findings lis "the corners are eve can use a ma around the toilets HMS both agreed in cleaning the room observations on 8 black debris build very sticky to walk had a dark brown the toilet. A tour of the facili 10:05 a.m. with the housekeeping an (HMS). The admiall the findings lis "the corners are eve can use a ma around the toilets HMS both agreed in cleaning the room on 8/14/14, main was indicated the 483.20(b)(2)(ii) C	and R62's rooms were observed revations on 8/11/14, to have in the floor upon entrance to the orners of the room. R9's rooms were observed revations on 8/11/14, to have ck debris buildup on the floors in the corners of the rooms. Observed during room of the corners, the floor was con and the base of the toilet substance around the base of the administrator and different maintenance supervisor inistrator and the HMS verified ted above. The HMS stated that easy to clean with a scraper and chine to clean behind and in the different maintenance policy was requested ere was no policy. COMPREHENSIVE ASSESS		The policy and procedures Resident Room Cleaning the Administrator and Environmental Service by the interdisciplinary 9/15/2014. Staff memory trained as it relates to roles and responsibility Resident Room Cleaning procedure on 9/17/2000 Resident room cleanling completed weekly for for 2 months, and the ensure continued compresults will be reported Committee for review recommendation. The Director of Environg designee will be recompliance. Date of Correction: O	Director of s and reviewed y team by abers were their respective ies regarding the applicy and policy and policy and policy and policy will be 4 weeks, monthly a randomly to appliance. The ed to the QA/QI y and further
SS=D	AFTER SIGNIFIC A facility must coassessment of a	CANT CHANGE Induct a comprehensive It resident within 14 days after the			

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245018	B. WING		08/14/2014
	DER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	CODE ORTHEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
faci that res pur me res itse imp inte one req car Thi by: Ba rev cor of: cor fir Or roc no ob dir ov me tee dis Or me fitt	there has been dent's physical pose of this secans a major dendent's status the dent's status the dementing standard reventions, that area of the resuires interdiscipe plan, or both. SREQUIREME sed on observation, the facility inprehensive as a residents (R5 incerns.) dings include: 8/13/14, at 8:4 in and lying in able to responserved turning bection started year to surveyor and the open. During the were noted to coloration before the status of the status o	or should have determined, in a significant change in the or mental condition. (For stion, a significant change cline or improvement in the stat will not normally resolve or intervention by staff or by dard disease-related clinical has an impact on more than sident's health status, and olinary review or revision of the	F 2	It is the policy of Crest Home that a comprehe assessment of a reside completed within 14 d determination has bee there is a significant chresident's physical or resident's physical o	ensive nt to be ays of when the an made that hange in a mental condition. The dentist on r residents this use audit will be te Services any and use on 9/11/14. In has been annual and assessments as usessments. On-Site visits ter Disciplinary view of new Director will be Staff members

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245018	B. WING				14/2014
	PROVIDER OR SUPPLIE			44	REET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTH DLUMBIA HEIGHTS, MN 55421	EAST	1
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	D PREFI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 274	"I would like to he indicated dental the quarterly care facility and F-A he dental protocols party. During review of notes the following review of notes the following raised 1 Centime hyperkeratotic [a is due to the correct accumulation of mucosa on his recommissure [a jert place where two or unite] and he throughout." The limited exam halesion, R57 was dentist indicated initial exam and a Dated 11/16/1 and during the Millimeters (mmmucosa near coin size from lassifibroma" The dentist was safedue to poor cool exam due to he indicated R57 recooperated for to reevaluate the R57's annual Market S7's annual Market	page 14 ave him seen by the dentist." F-A had not been brought up during e conference meetings by the ad not thought of asking about as she was R57's responsible the Apple Tree Dental progress ng were revealed: 2, indicated R57 had a "firm eter (cm) nodule with white a rather common skin condition. It atinual production and skin cells on the sin surface] ight buccal mucosa near oint, seam, suture, or closure; the both bodies or parts of a body meet avy plaque was noted e progress note indicated a d been completed to evaluate the d he needed to reschedule R57's prophylaxis appointment. 2, indicated R57 had been seen visit a raised lesion measuring 6 h) by 7 mm on R57's "right buccal formissure. Lesion has decreased t visit, likely a cheek bite and progress note also indicated the ely unable to complete cleaning operation and was unable to do eavy plaque on teeth. The dentist exam which R57 had not and dentist had limited exam dor ne lesion on his right cheek. Minimum Data Set (MDS) dated cant change MDS dated 3/9/14,		274	Resident dental, vision and positists will be audited weekly weeks, monthly for 2 month randomly to ensure continu compliance. Results from the will be reported to the QA/committee for review and for recommendations. Director of Health Informated designee will be responsible compliance. Date of compliance: 09/23	for 4 ns, and the ned nese audits QI further tion or e for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING _			/14/2014	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	ORTHEAST 21		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 274	three dental sectic concerns which ir or loosely fitting futeeth or tooth fragobyious cavity or bleeding gums, mor difficulty with calso indicated R5 memory issues. In addition, the da Assessment (CA completed on 7/1 The care plan da alteration in self-with oral care twi care plan did not be seen by the d R57's diagnoses diabetes mellitus malignant neopla cerebrovascular Admission Reco When interviewed registered nurses coordinator stated doing the dental the dental assessment was after looking at the nurses usual mouth but there	ange MDS dated 6/28/14, all ons were left blank of any dental neluded but not limited to broken ull or partial denture, no natural gments, abnormal mouth tissue, loose natural teeth, inflamed or nouth or facial pain, discomfort hewing. MDS dated 6/28/14, 7 had both short and long term ental section Care Area A) did not trigger for CAA 0/14. Itted 7/10/14, identified R57 with care and directed staff to assist ce daily and as needed. The address how often R57 was to	nt	74			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245018	B. WING			08/1	14/2014
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	/EACH DESIGIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
F 274	licensed practical as though the Ora new to the facility with new admit inf the quarterly and a verified the Oral Ir lacking in the chall on 8/14/14, at 4:0 (DON) stated she have brought to the had not been see and the oral asse and completed in assessments where the thing is seen to be provided accordance with care.	on 8/13/14, at 2:31 p.m. nurse (LPN)-A stated she felt I Inspection Assessment was and indicated the form came ormation packet and not with annual assessments. LPN respection Assessment was rt. 23 p.m. the director of nursing expected the MDS nurse to re facility's attention that R57 respected the MDS nurse to re facility's attention that R57 respected the MDS nurse to re facility's attention that R57 respected the MDS. ERVICES BY QUALIFIED CARE PLAN respectively of the facility I by qualified persons in reach resident's written plan of		274	F 282 It is the policy of Crest View L Home that services provided arranged by the facility must provided by qualified persons accordance with each resider plan of care.	or be s in	
	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:				For Resident's # 127 and # 5, plan was reviewed and revise interdisciplinary team on 09/Corresponding updates have made to care assignment she	ed by the 15/2014 been	e . 4.
	Falls:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245018	B. WING	 -	08/14/2014
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD NO COLUMBIA HEIGHTS, MN 554	CODE ORTHEAST
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION E APPROPRIATE DATE
F 282	During observation at 8:47 a.m. nursin NA-F are gathering up before breakfast NA-E began to ware height and lowered position. R127 proafter verbal cueing sounding) while Nunderneath R127 to roll to the other as the two NA's proceed the bed (no bed a lark sister and as the two NA-E removed old brief new brief and as they could apply continued clothing athered dirty line ready for breakfarno bed alarm ware line and as a sounding as she alarm was lying rolled up. RN-C at 3:32 RN-C at 15 p.m. C and a sounding as she alarm was lying rolled up. RN-C at 3:32 RN-C at 15 p.m. C a	n of morning cares on 8/13/14, ag assistant (NA)-E and another g supplies to get R127 cleaned st. After gathering the supplies, sh R127 face. E raised the bed to a workable d the head of the bed to a flat acceded to roll to the right side g from NA-E, (no bed alarm A-E placed a white soaker pad NA-E gave R127 verbal cues side (no bed alarm sounding), laced the soaker pad completely the soaker pad was in place, eeded to lift the resident up in larm sounding). E removed R127's brief and tres, then asked R127 to roll to E performed the peri cares and the NA-E proceeded to apply a sed R127 to roll side to side so new brief. After that staff g R127, lowered the bed, en and supplies, and got R127 st. During the entire observation	d	was reviewed and interdisciplinary te review of policies of Director will be concurrent standards place. Staff memberelates to their responsibilities responsibilities responsibilities respolicy and proceded 09/19/14. Care plan audits woweekly for 4 week months, then rand compliance with reaching QA/QI Committee further recommensions are provided if individuals.	prehensive care plans revised by the am on 09/15/14. A by the Medical mpleted to ensure of practice are in pers were trained as it spective roles and garding the care plan tures on 09/17/14- vill be completed as, monthly for 2 domly to ensure results reported to the efor review and andations. Further and staff education will licated by audits. ursing or designee will r compliance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245018	B. WING			/14/2014	
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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	R127 was to have care plan.	nis bed properly and confirmed a bed alarm on his bed per	F 282				
	high risk for falls, r impairment, impair antipsychotic and incontinence and c interventions inclu side rails x2, sens ensure brakes loc	lated 7/9/14, identified him as a elated to weakness, balance red cognition, poor judgment, antidepressant use, depression. The care plan ded safety devices such as 1/2 or alarm on bed, secured unit, ked on bed and wheelchair d reorient resident as needed.					
	confirmed that bed and stated "he is a	n 8/13/14, at 3:22 p.m. RN-C d alarm was to be on R127's a high risk for falls." RN-C was to be in bed per care plan.					
	confirmed care pla	n 8/13/14, at 3:22 p.m. LPN-H an and R127 was to have bed due to being high risk for falls.					
	confirmed that R1	n 8/14/14, at 8:54 a.m. NA-F 27 was to have a bed alarm on ed that R127 did not have one evious day.					
	confirmed that R1	on 8/14/14, at 8:54 a.m. NA-E 27 was to have a bed alarm on ed that R127 did not have one evious day.					
	Oral care: R5 was not provid	ded assistance with oral cares.					
	During observation	on on 8/13/14, at 8:08 a.m. NA-D orning cares and R5 is refusing)				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		245018	B. WING	-			/14/2014
	ROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	to let her wash her wishes of refusal a body with assistar -At 8:12 a.m. NA-I and began to was then her buttocks -At 8:13 a.m. NA-I clean brief on R5 on her pants. R5 with getting dress -At 8:16 a.m. R5 NA-E proceeded transfer lift) and transfer lift and tran	r up. NA-D granted R5 her and begins to dress R5's upper nee from NA-E. D and NA-E removes R5's brief h R5's peri area in the front and area. D and NA-E proceed to apply a and then assist her with putting is not providing any assistance ed or personal hygiene. stated "get me up" NA-D and to get Hoyer lift (mechanical ransferred R5 to her wheelchair. D shaved R5's facial hair, while ng her hair, R5 was made or wheelchair and was taken that 8:25 a.m. and oral cares or provided to R5 during this ated 7/14/14, indicated staff to ares twice a day and as needed on 8/13/14, at 2:25 p.m. NA-F s was not done and had not R5. on 8/13/14, at 2:25 p.m. NA-E was not done and was not dote an	е	282			
	During interview of nursing (DON	on 8/14/14, at 4:21 p.m. directo I) indicated she expected staff to))				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245018	B. WING			_08/	14/2014
	PROVIDER OR SUPPLIER	ME		4444	EET ADDRESS, CITY, STATE, ZIP CODE 4 RESERVOIR BOULEVARD NORTHE LUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	offer oral cares eve to do it themselves wrong."	eryday if the resident is unable and stated "not doing it is	F 2	82			
. F 312 SS=D	And Procedure, rewill ensure the resiappropriate care reresidents highest possible. 483.25(a)(3) ADL	olicy titled Care Plan Policy vised on 10/12, indicated staff dent is receiving the equired to maintain or attain the evel of practicable function CARE PROVIDED FOR SIDENTS		312	F 312		` .
	daily living receive	unable to carry out activities of s the necessary services to rition, grooming, and personal			It is the policy of Crest V Home to ensure that a r unable to carry out activ living receives the neces maintain good nutrition personal and oral hygie	esident w vities of dassary servi , groomin	ho is aily ces to
	by: Based on observareview, the facility with oral care for frequired assistant cares and R5 is re NA-D granted R5 begins to dress R from NA-EAt 8:12 a.m. NA-	ation, interview, and document failed to provide assistance of 1 resident (R5) who se with dental hygiene. In on 8/13/14, at 8:08 a.m. (NA)-D began routine morning efusing to let her wash her up. her wishes of refusal and 5's upper body with assistance D and NA-E removes R5's brief h R5's peri area in the front and area.			For Resident # 127 a new Assessment was comple 09/10/2014. For reside Oral Assessment was comple 11/2014. Correspond have been made to care sheets, care plans and complete the care plans are pla	w Safety Feted on nt # 5 a no mpleted oing update assignme	ew on es ent

Event ID:TMS611

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BUILD	ING	
		245018	B. WING		08/14/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 4444 RESERVOIR BOULEVA COLUMBIA HEIGHTS, MN	ARD NORTHEAST N 55421
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION (X5) ACTION SHOULD BE TO THE APPROPRIATE IENCY) (X5) COMPLETION DATE
F 312	-At 8:13 a.m. NAclean brief on R5 on her pants. R5 with getting dress -At 8:16 a.m. R5 NA-E proceeded transfer lift) and t -At 8:22 a.m. NANA-E was combic comfortable in he down to breakfas was not offered time. R5's quarterly Mi 7/14/14, indicate and R5 required of daily living successful locomotion, toile R5's care plan, to assist with oran eeded. During interview verified oral care been offered to R5 are normally ask her During interview verified oral care offered to R5 are offered to R5 are offered to R5 are offered to R5 are we get her up."	D and NA-E proceed to apply a and then assist her with putting is not providing any assistance sed or personal hygiene. stated "get me up" NA-D and to get Hoyer lift (mechanical ransferred R5 to her wheelchair. D shaved R5's facial hair, while ng her hair, R5 was made er wheelchair and was taken at 8:25 a.m. and oral cares or provided to R5 during this shammad between the state of the second that it is a second to the second that it is and the second that it is and the second that it is and the second that it is a second that it is a second to the second that it is and the second that it is a second that it is not that it is not the second that it is not that it is not the second that it is not the second that it is not that it is not the second that it is n	e	be completed weel basis. Results will be QA/QI Committee further recommensystem revision and be provided if indicate.	be completed on I. Is who may be actice, audits on an oral care will kly on an on-going be reported to the for review and dations. Further d staff education will cated by audits. Irsing or designee will compliance.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245018	B. WING		08/14/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4444 RESERVOIR BOULEVARD NORT COLUMBIA HEIGHTS, MN 55421	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLÉTION
F 312	of nursing (DON) i offer oral cares ev unable to do it the is wrong." Review of facility p And Procedure, re will ensure the res	ndicated she expected staff to eryday if the resident was mselves and stated "not doing it policy titled Care Plan Policy vised on 10/12, indicated staff ident is receiving the	F 31:	2	
F 323 SS=D	residents highest l possible. 483.25(h) FREE C HAZARDS/SUPEI	RVISION/DEVICES	F 32	F 323 It is the policy of Crest View	
	environment rema	ensure that the resident lins as free of accident hazards deach resident receives sion and assistance devices to		Home that each resident radequate supervision and prevent accidents.	eceives
	by: Based on observinterview, the facifall safety measur	ENT is not met as evidenced ation, interview and document lity failed to ensure consistent es were in place to minimize the f 3 residents (R127).		For Resident # 127 a new a for Fall Risk and Physical D completed on 9/10/2014. Corresponding updates ha made to care assignment splans and communicated tresident and/or designated maker.	ve been sheets, care to the
	During observation the following was - At 8:47 a.m. nu another NA-F gat cleaned up before	on of morning cares on 8/13/14, observed: rsing assistant (NA)-E and hered supplies to get R127 be breakfast. After gathering the gan to wash R127's face.		For other residents who maffected by this practice a comprehensive record rev completed by October 29, review updates will be manappropriate for each reside	iew of will be 2013. After de as

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245018	B. WING			08/-	14/2014
	PROVIDER OR SUPPLIER	ME		44	REET ADDRESS, CITY, STATE, ZIP CODE 144 RESERVOIR BOULEVARD NORTHE OLUMBIA HEIGHTS, MN 55421	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	- At 8:53 a.m. NAheight and lowered position. R127 proafter verbal cueing sounding) while Naunderneath R127, cues to roll to the sounding) as the transport completely under in place, the two National resident up in the At 8:57 a.m. NAheasked R127 to rol continued to do perceeded to ask could apply new by putting a new grathered dirty line ready for breakfast no bed alarm was At 3:15 p.m. reg R127's room to greathing treatm that he was missing proceeded by loowent on the left sound the help to the bottom cabing alarm started sound the night stand row had not had it on R127's care plan At 3:32 RN-C are plan R127 was to have care plan.	E raised the bed to a workable of the head of the bed to a flat ceeded to roll to the right side of the man to the right side of from NA-E, (no bed alarm A-E placed a white soaker pad then NA-E gave R127 verbal other side (no bed alarm wo NA's placed the soaker pad R127. After the soaker pad was IA's proceeded to lift the bed (no bed alarm sounding). E performed peri care and then I to the left side as NA-E eri cares on his back side. NA-E R127 to roll side to side so they wrief. After that, staff continued gown on R127, lowered the bed, an and supplies and got R127 st. During the entire observation is sounding. In the sounding istered nurse (RN)-C went into five him a nebulizer treatment ent), after refusal, R127 stated ng his glasses. RN-C king around in R127's. She ther ide of his bed and opened up et of his night stand and the bed anding as she opened the night larm was lying in the bottom of olled up. RN-C confirmed R127 all day and went to check	d	323	The policy and procedure related Falls was reviewed by the interdisciplinary team on 9/15 review of policies by the Market Director will be completed current standards of practiplace. Staff members were relates to their respective responsibilities regarding that and hazards policy and procedure of the procedure of the procedure. The results were ported to the QA/QI Conceview and further recommendated to the procedure of the pro	dedical to ensurice are in e trained roles and the accide ocedures ted week months continued vill be mmittee in mendation designed	e as it ents ly and d

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
		245018	B. WING			08/14	1/2014
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 323	high risk for falls, rimpairment, impairment, impairment, impairment, impairment, impairment, impairment, incontinence and rinterventions incluing 1/2 side rails x2, sunit, ensure brake wheelchair during as needed. R127's re-admissional dated 7/22/14, incontinent, incontinent, incontinent, incontinent, incontinent, incontinent, impairment, incontinent, incontinent, impairment, incontinence and rinterventions incluinterventions incluintervent	related to weakness, balance red cognition, poor judgment, antidepressant use, depression. The care plan ded safety devices whoch were ensor alarm on bed, secured s were locked on bed and transfer, and reorient resident ion Minimum Data Set (MDS) licated R127 had fallen since	F	323			
	During interview of confirmed that be and stated "he is verified bed alarm." During interview of confirmed care platerm on his bed. During interview of confirmed that R his bed and verified.	ne and had no injury. on 8/13/14, at 3:22 p.m. RN-C d alarm was to be on R127's a high risk for falls." RN-C n was to be in bed per care plan. on 8/13/14, at 3:22 p.m. LPN-H an and R127 was to have bed due to being high risk for falls. on 8/14/14, at 8:54 a.m. NA-F 127 was to have a bed alarm on ed that R127 did not have one					
F 3	confirmed that R his bed and verif on his bed the pr the needed assis injury from falls. 29 483.25(I) DRUG UNNECESSAR	on 8/14/14, at 8:54 a.m. NA-E 127 was to have a bed alarm on ied that R127 did not have one evious day. R127 did not receive stive device to minimize potential	9	F 32	9		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	COMPLETED
		245018	B. WING		08/14/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 554	IORTHEAST 421
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE
F 329	unnecessary drug drug when used in duplicate therapy) without adequate indications for its adverse conseque should be reduced combinations of the Based on a compresident, the facility who have not use given these drugs therapy is necess as diagnosed and record; and reside drugs receive grabehavioral intervecontraindicated, in drugs. This REQUIREM by: Based on intervifacility failed to material for 1 of 5 resider antipsychotic meanings include. The Crest View indicated R45's dementia with design in the contraint of the contra	s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose dor discontinued; or any ne reasons above. The reasons above. The residents of a ty must ensure that residents of antipsychotic drugs are not any ences antipsychotic drug ary to treat a specific condition of documented in the clinical ents who use antipsychotic dual dose reductions, and entions, unless clinically on an effort to discontinue these ences and document review, the nonitor for adverse side effects ats (R45) who received dications.		drugs. An unnecess when used in exce excessive duration adequate monitor adequate indication presence of advers which indicate the reduced or discont combination or the For Resident # 45, competed on 8/13 surveyors were stibuilding. The scor Corresponding up made to care assignlans and communication or the state of the second competed on 8/13 surveyors were stibuilding. The scor Corresponding up made to care assignlans and communication and communication in excession and communication in excession and communication in excession and communication	sident's drug ree from unnecessary sary drug is any drug ssive dose or for a; or without ing; or without on for its use, or in the se consequences dose should be tinued; or any e reasons above. and AIMS was 3/2014 while the ill present in the re was 0. dates have been gnment sheets, care

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RAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
RAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME CA 1D	AND PLAN O	r CORRECTION	DENTIFICATION NOTIFIES.	A. BUILD	ING	
CREST VIEW LUTHERAN HOME CAH ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG			245018	B. WING	— :	08/14/2014
CREST VIEW LUTHERAN HOME (X4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 26 indicated R45 had received an antipsychotic medication in the last seven days. Adverse consequences of antipsychotic medication in dual dual 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 a diagnoses of persistent mental disorder. The MDS dated 5/14/14, further indicated R45 had a diagnoses of persistent medication in the past seven days. The Physician's Order dated 7/17/14, directed staff to administer Ablifty (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 Ablifty 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 gardyerse medication so of the province of the provinc	NAME OF F	PROVIDER OR SUPPLIER				
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	CREST V	IEW LUTHERAN HO	ме			
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 mental disorder. The MDS dated 5/14/14, further indicated R45 had a diagnoses of persistent mental disorder. The MDS dated 5/14/14, further indicated R45 had diagnoses of persistent mental disorder. The MDS dated 5/14/14, further indicated R45 had of a diagnoses of persistent medication in the past seven days. The Physician's Order dated 7/17/14, directed staff to administer Ability (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 Ability 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.		CLIMMA DV ST	ATEMENT OF DEFICIENCIES	In In	PROVIDER'S PLAN OF C	CORRECTION (X5)
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. For all other residents who may be affected by this, a whole house audit of antipsychotic medications was completed by fint, all filt particularly antipsychotic medications was completed on 9/16/2014 confirming that all AIMs assessments were completed 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 who may be affected by this, a whole house audit of antipsychotic medications was completed by 1/6/2014 confirming that all AIMs assessments were completed to ensure completed on 9/16/2014 a review of policies by the Medical Director will be completed on 9/15/2014. A review	PREFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
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		indicated R45 had medication in the I consequences of a included tardive dy movements), excendilucinations. The Minimum Dat indicated R45 had mental disorder. Tindicated R45 had also acknowledge medication in the The Physician's C staff to administer medication) 2.5 m bedtimes for emo The Medication A August 2014 indicated at bedtime. The Administration Reconduct behavior statements, each A review of the aslacked a record to Movement Scale measure involunt tardive dyskinesis monitor for adversing (ADON) had not been contacted to the contacte	received an antipsychotic ast seven days. Adverse antipsychotic medications yskinesia (persistent involuntary essive sedation and a Set (MDS) dated 5/14/14, I a diagnoses of persistent the MDS dated 5/14/14, further disorganized thinking. MDS at the use of an antipsychotic past seven days. Order dated 7/17/14, directed Abilify (an antipsychotic nilligrams (mg) by mouth at attionally disturbing delusions. Idministration Record (MAR) for cated R45 received Abilify each he Crest View Treatment ecord (TAR) directed staff to monitoring, delusional shift. I seessment records for R45 that an Abnormal Involuntary (AIMS- a rating scale used to tary movements known as a) had been completed to ree medication side effects. O5 p.m. the assistant director of verified the AIMS assessment mpleted for R45. The ADON		For all other residents affected by this, a who antipsychotic medicate completed on 9/16/2 that all AIMs assessment completed and approach and monitoring was responsibilities regal psychotropic medical monitoring policy and policy and policy and monitoring policy and it relates to their resergives responsibilities regal psychotropic medical monitoring policy and 09/17/14-09/19/14. Audits on residents medications and AIM be completed week monthly for 2 mont thereafter to ensure the Director of Nurbe responsible for complete for comp	who may be ole house audit of cions was 014 confirming ents were priate. tropic medications reviewed on of policies by the be completed to ards of practice are pers-were trained as pective roles and raing the cition and of procedures with psychotropic MS assessments will ly for 4 weeks, his and randomly a compliance sing or designee will compliance.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		245018	B. WING			08/1	4/2014
	ROVIDER OR SUPPLIER	ME		444	REET ADDRESS, CITY, STATE, ZIP CODE 4 RESERVOIR BOULEVARD NORTHI DUMBIA HEIGHTS, MN 55421	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	(DON) stated an A completed for reside medications upon months thereafter. The CREST VIEW ASSESSMENT PEROCEDURES decollected by a licerused by the MDS complete the resident stated the MDS as on PointClickCare	p.m. the director of nursing IMS assessment was dents using psychotropic admission and every three	F3	29			
F 353 SS=F	complete the asset that it was complete the asset that it was complete addressed the asset indicate who was assessments were appropriately. 483.30(a) SUFFICE PER CARE PLANT The facility must be provide nursing a maintain the high and psychosocial determined by resindividual plans of the facility must numbers of each personnel on a 2-	essment and sign off in the TAR ted. Although the policy sessment, the policy did not responsible to oversee that the e completed timely and CIENT 24-HR NURSING STAFF IS mave sufficient nursing staff to not related services to attain or est practicable physical, mental, well-being of each resident, as sident assessments and	F	353	F 353 It is the policy of Crest Vie Home to have sufficient n provide nursing and relate attain or maintain the high practicable physical, ment psychosocial well-being or resident, as determined b assessments and individucare.	ursing staff ed services hest tal, and f each by resident	f to to

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTI	ION	(X3) DATE COMP	SURVEY
THE PERIOD		245018	B. WING			08/1	4/2014
NAME OF F	PROVIDER OR SUPPLIER		D. William	STREET ADDRES	SS, CITY, STATE, ZIP COD	DE	
	IEW LUTHERAN HO			COLUMBIA H	OIR BOULEVARD NORT EIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DESIGNATION)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	OVIDER'S PLAN OF CORR' CORRECTIVE ACTION SI REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	Except when waix section, licensed personnel. Except when waix section, the facilit nurse to serve as duty. This REQUIREM by: Based on observe review, the facilit qualified nursing needs of residen R103, R49, R35, as well as family concerns regard resident needs we potential to affect resided at the fact asked if family in Con 8/12/14, at 8 asked if family renough staff awarenber get the without having the without having the without having the saked if F-B fell to make sure your assistance.	ved under paragraph (c) of this nurses and other nursing ved under paragraph (c) of this y must designate a licensed a charge nurse on each tour of ENT is not met as evidenced vation, interview, and document y failed to ensure sufficient staff was available to meet the ts observed/interviewed (R91, R14, R81, R113, R5, R57, R12) members and staff who voiced ing lack of staff to assure vere met timely. This had the st 114 of 122 residents that cility.	e a	and standed well we evider possible well we evider possible with the bolirector eview ensure to mee 9/11/20 Per Res PM shift times for Staffing Superve 9/17/20 assistant schedule we schedule well well well well well well well w	arsing schedule wa affing ratios were within industry standard by a 4-star ratiole 5 stars) on the first the designation on each shift and building 24 hours a rof Nursing or designation of the start o	noted to be indards. This was ting (out of a Minnesota of a "charge RN coverage inday. The signee will levels daily to is scheduled in the Nursing cated on that the nursing cated on the	he ait

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		245018	B. WING			08/1	4/2014
	ROVIDER OR SUPPLIER	245016	5		EET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	
	TEW LUTHERAN HO	ME		4444	RESERVOIR BOULEVARD NORTHE LUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	staff was when the facility with their in felt there was enough which shifts F-B thelp, F-B was not resident had not hof.	the only time there was enough a nursing students were at the structor and that's when F-B ugh help there. When asked lought did not have enough sure and commented the ad any accidents that F-B knew interview:	F	S V E	taff education will be done of chedule, writing their names white communication boards each hallway, and proper followed the council concerns. Stateducation will occur between 19/19/14. For other residents who may affected by this practice the concerns of the council concerns.	located in ow up with ff 9/17/14 – be	
	6/24/14, indicated impaired and requassistance of two	nimum Data Set (MDS) dated cognition was moderately lired extensive to total physical staff with dressing and personal a wheelchair for mobility.			schedules will be reviewed by Director of Nursing or design posting to ensure appropriation of charge	y the ee before e staffing nurse, to	
	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 yo 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 to me that." -At 11:50 a.m. after surveyor was walked out of another resident's room observed R91's call				ensure an RN is on the sched to ensure adequate staffing The nursing staffing/ratios were reviewed by the interdiscipt on 9/15/2014. A review of practices/protocols by the Notice Director will be completed to current standards of practice place. Staff members were relates to their respective responsibilities regarding the	vere inary team Medical to ensure te are in trained as oles and	

The second s

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · - / ·	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING	·	08/14/2014	
	- OUR PLANTED OF PLANTED SERVICE		5	STREET ADDRESS, CITY, STATE, Z		\neg
	ROVIDER OR SUPPLIER		. :	4444 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 5	NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE COMPLETIC THE APPROPRIATE DATE	ON
F 353	Continued From p time nursing assis to residents room -At 1:30 p.m. surv asked about waiting stated " I don't lik further stated she had waited for for pad "my son was he reported it. Oft It's not right to was reported it. Oft It's not right to was stated assistant personal hygiene R103 used a whe steady with trans someone to stable on 8/11/14, at ap interview when a staff available to assistance you not time resident stated had not been was there was no end staff he was goir walk him. R103 if left leg and toes at times the aide	age 30 tant (NA)-J was observed going and transfer resident. eyor approached resident when a for the bed pan earlier she it of course. "Resident often waited and one time she ty five minutes to get off the bed here and he couldn't stand it so en it is thirty minutes to get off. it that long." DS dated 5/24/14, indicated act and required extensive oce of one staff with dressing and. In addition, the MDS indicated elechair for mobility and was not itions and walking and required itions and walking and required ed without having to wait a long ted "No" he went on to stated he liked for a week how because ough help and he had told the further stated he had pain on his and walking helped at times and its or staff would come to room		policy and procedures 9/19/2014. Staffing pattern audits audits will be complete weeks, monthly for 2 randomly to ensure cocompliance. Resident minutes will be audite end of each month to is followed up on. Call remain ongoing. The reported to the QA/Q review and further red The Director of Nursing be responsible for conducted to the Correction: Of the Date of Correct	and white board ed weekly for 4 months and then ntinued council meeting d monthly at the ensure old news light audits esults will be Committee for commendation.	
	would never eve	If be right back" and the staff in come back or come back one				
	R49's admission	n 60 day quarterly MDS dated ed cognition was moderately				

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BANGONIA SALAKATA - SANGONIA SANGONIA SANGANIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION 3		COMPLETED	
	•	245018	B. WING			08/14/2014	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	/EACH DEEIGIEN(ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDE DEFICIENCY)	ULD BE	COMPLETION DATE
F 353	impaired and requassistance of one toileting, eating, to toileting, eating, to to 8/11/14, at 2:3 asked if he felt that to make sure you need without have stated "Sometimes they a minute and it to they have some of the seems to be shown to make at 1 pubottom and some itchy or its wear at the seems to be shown to make sure you need without hat to make sure you need without hat you can apply to take mount of the seems to be shown to wait ten minuand then you can apply to take mount of the seems to be shown to wait ten minuand then you can apply to take mount of the seems to long who people have a behour to get help thirty to forty five.	tired limited to extensive two staff with dressing, cansfers and personal hygiene. 33 p.m. during interview when ere was enough staff available get the care and assistance you ing to wait a long time resident es very short, staff have to rush have to help someone else. Come in and say I will be back in the else to help. On weekends it into the minutes because the else to help. On weekends it into the first of help on all shifts, sometimes depending on when staff goes and I have a very sensitive etimes it breaks out. It's either a diaper." MDS dated 7/24/14, indicated eact and required extensive noe of one staff with dressing,	u , ou t free e	35			

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION			CONSTRUCTION		MPLETED
		245018	B. WING			/14/2014
AND FLAN OF GOTTLESTIGHT		44	REET ADDRESS, CITY, STATE, ZIP 144 RESERVOIR BOULEVARD NO OLUMBIA HEIGHTS, MN 554	ORTHEAST 21		
PRÉFIX	(EACH DEEICIEN	CYMUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 353	on 8/12/14, 9:54 bed when approastill waiting to get 7:30 a.m. R35 st wait for every mount of the cause nurse hecause nurse hesident further	a.m. R35 was observed still in ched resident indicated he was up and had been waiting since ated "Not the best place to be. I rning for dressing change, that's urse changes dressing and says as to pass medications first."	F 353			
	cognition was in	act was independent with				
	On 8/11/14, at 3 asked if he felt to make sure you need without ha stated "No." but accidents but he	:18 p.m. during interview when here was enough staff available u get the care and assistance you ving to wait a long time resident indicated she had never had any ad to wait at times for assistance.				
	cognition was in	MDS dated 5/2/14, indicated stact and required extensive nce of one to two staff with ng, transfers and personal				
	asked if he felt to make sure y need without he stated "I was in	10:54 a.m. during interview when there was enough staff available ou get the care and assistance your to wait a long time resident bed today and I needed helped, alled, except this little one. It took tome help. I waited and waited an	ou l			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING			08/14/2014		
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421	ST		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 353	finally I fell asleep.'	,7	F:	353				
	cognition was intac physical assistance dressing, toileting,	DS dated 5/13/14, indicated and required extensive of one to two staff with transfers and personal n, MDS indicated R113 used a bility.						
	seated on her elect outside her room. The sident she broke with anger as she	2 p.m. R113 was observed tric wheelchair parked right When surveyor approached down started to cry shaking wiped tears off her cheeks.						
	Resident told surve surveyor told her sto help her. Reside her light on for overesponded to the licome out of her rono body either in the walked up to the A approached one ocoming out of anowas assigned to a assisting another surveyor returned staff R113 was owher voice in frustrawith intern administrational walked the opposite R113 again. R113 had been keeping and at times it too respond to her care	he was going to find someone ant also indicated she had put ar forty minutes and nobody had ight and she had decided to om to the hallway but they was ne hallway to ask. Surveyor spen Unit nursing station of the nursing assistant (NA) ther room who indicated R113 nother NA who was in a room resident at the time. As to the station to wait for the erheard down the hallway rising attor who after talking to R113 te way as surveyor approached further stated to surveyor she call light logs of waiting times k put to two hours for staff to						
	Staff interviews On 8/13/14, at 9:1	8 a.m. when asked what the						

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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MIST SEPRECIBED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) FROM IT AND INFORMATION OF LSO IDENTIFYING INFORMATION INFORMATION (EACH OFFICIENCY MIST SEPRECIBED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) 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, petry much have two nurses, but if someone calls in, the nurse was not replaced but instead would have TMA, supervisors, one nurse for the Evergreen and Willow units, one nurse for the Evergreen and Willow units, one nurse for the Evergreen and Willow units, one nurse for the Inden and Aspen on nights and a supervisor. LPN-D stated there were scheduled medications at midnight, 200 a.m., 4:00 a.m., and 6:00 a.m. LPN-D stated together with giving PEN'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 tut when there was one more 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 he 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 ask for ERN's when in the middle of sometimes and had to tell the residents to give him a couple minutes. TMA-A landstated Evergreen has two carts, Lunden had a lot of PRN's when in the middle of sometimes and had to tell the residents of the ning and the most the carts were heavy at times and residents would ask for ask for ask for PRN's when in the middle of sometimes and had to tell the residents.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
CREST VIEW LUTHERAN HOME 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421 PREPAIR TAGS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL PREVENTED TO THE APPROPRIATE DEPOCATION OF LOST DETAILS OF TAGS OF THE APPROPRIATE DEPOCATION OF LOST DETAILS OF TAGS OF TA			245018	B. WING			4/2014
PREFIX TAG FEACH CORRECTIVE ACTION SYNOLD BE PRECEDED BY FILL PREFIX TAG FOR STREEPENCH TO THE APPROPRIATE CROSS-REFERENCE CROSS-REFE			ME		4444 RESERVOIR BOULEVARD NORTH COLUMBIA HEIGHTS, MN 55421	HEAST	
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION
medication times would go into "pink" as medications cannot be passed timely. TMA-A	F 353	staffing patterns will LPN-C "We are sul Linden during the of the days and even nurses, but if some replaced but instead supervisors, one in On 8/13/14, at 7:1 one nurse for the lone nurse for Linden de 1:00 a.m. LPN-PRN's and the particular busy. LPN-D furth taken while working management exportable but when the overtime for no moderation on NA for each of went between the stay for the other On 8/13/14, at 1:1 were heavy at time as needed (PRN) TMA-A indicated PRN's when in the totell the resider TMA-A also state Linden had a lot medication times	as for nurses on the floor pposed to have two nurses on day, we have two nurses during ings, pretty much have two eone calls in, the nurse was not ad would have TMA, urse but was very rarely." O a.m. LPN-D stated there was Evergreen and Willow units, en and Aspen on nights and a constant stated there were scheduled dhight, 2:00 a.m., 4:00 a.m., N-D stated together with giving perwork the night was kept er stated breaks were usuallying on the computer and ected the staff to take meal here was emergency full code, eal break was approved. If a.m. NA-A stated during the aide was pulled mostly if led in and then the night shift dieshort. NA-A indicated there was of the units and the float NA equits to help with cares and NA's to go for break. He p.m. TMA-A stated the carts have and residents would ask for ask for pain medication for pain. The residents would ask for ask for the middle of sometimes and had ask to give him a couple minutes and Evergreen has two carts, of PRN's and at times the swould go into "pink" as		53		

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	OOTHIE OTTO	245018	B. WING			08/	14/2014
	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHE DLUMBIA HEIGHTS, MN 55421	AST	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	iX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 353	Continued From p further stated takin taken only a fifteer and had given somedications not u supposed to be gi On 8/14/14, at 1:3 staffing coordinate (DON) and admin asked how the fact pattern for the fact the census. Both indicated staffing census and when of the residents in	age 35 ng breaks was difficult and had n minute break during the shift ne residents morning ntil 10:45 a.m. which were ven at 8:00 a.m. 0 p.m. an interview with the or (SC), director of nursing istrator was conducted. When cility determined the staffing cility SC stated was according to DON and administrator was adjusted according to the asked if the acuity or the needs of the various units was looked at		353			
	indicated again the team." When ask trended with incic things for pattern addressed admir	he staffing with the census both hat this was reviewed "As a hed if staffing was tracked and dents such as falls among other is and how it had been histrator stated We track that logs and if we see a trend we will adjustments but have not seen					
	not at the facility staffing and againg questions but due the facility she had found the replaceused pool staff spool for ten year employee injuries stated they were facility but one of home and was replaced.	o did the staffing when SC was SC stated supervisors did In she was on call if they had any ring the week when she was at andled all the sick calls and ement. When asked if the facility SC stated the facility had not use is in the last three months, SC in one that had happened at the of the employees was hurt at not a work related. When asked positions SC indicated there was sistant positions and would	y d				and Dagge 36 of the

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
		245018	B. WING			08/1	4/2014
	PROVIDER OR SUPPLIE			44	TREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421		
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F 353	provide the informathere were two part-time and had often orientation indicated once a depending on the When DON was concerns about "Occasionally what staffing concern would usually occame recently for staffing concern quality assurant not been brough When asked what administrator programments in the staffing concern quality had one last months. With track or trended indicated these interdisciplinary no trends had been brough the staffing concern facility and indicated what been brough the staffing concern facility is and indicated what been compartments in the staffing consistent regisfacility had four positions, three positions, three positions and controlled the staffing controlled the staf	mation. In addition, DON stated ositions a day and evening d two offers. When asked how was ran SC and DON both month and at time twice e need. asked if staff had brought her the workloads, DON stated then we are busy but not had a for a long time." SC added staff ome to her first and have not or a long time. When asked if s had been discussed at the see meetings DON indicated it had	d d	353			net Page 37 of

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Mary Marketti (M. 1988) (M

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245018	B. WING _			/14/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 4444 RESERVOIR BOULEVARD N COLUMBIA HEIGHTS, MN 55	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 353	Review of the Call 10/1/13, through 7 Audit form did not and indicated resignation resignation of the staff would on some were not reflective the NA's were when call lights ha and the staff would on some work of the NA's were when call lights ha and the staff would	Light Audit forms dated 1/28/14, revealed the Call Light consistently provide follow up dent needs had been fulfilled on the audits were mostly start to mid-week and a few as through Saturdays which was lidition, the audits revealed the ne occasions indicate the audits of the trends. The audits noted served by the nurse during the still in the dining room (DR) ad taken time to be answered, d comment the number of NA's the shift. The audit further	F 35	53			
	stated the NA's whad been on for a audits were income Review of the rangoing forward rev On 2/1/14: - AM States but was penciled replaced by rehabilities and for the states of six third not replaced "No-PM Shift TMA" "No 8 PM TMA", changed from 4:0 p.m. "No 4 PM TI Census was 121. On 3/1/14: - AM States of the states of t	ere busy when the call lights some time and some of the applete with the dates completed. dom schedules dated 2/1/14, ealed the following: Shift one NA position was blank on Aspen, one call in which was a NA with changed to seven try, rehab NA was cut and was Rehab." on Aspen was moved to Willow Evergreen TMA hours were to to 8:00 p.m. to 9:00 to 11:00 MA" Shift one Linden NA was cut. Shift Aspen TMA was changed to and Willow 4-8 PM TMA was					

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA iDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING				3/14/2014
	PROVIDER OR SUPPLIER	ME		44	REET ADDRESS, CITY, STATE, ZIP 44 RESERVOIR BOULEVARD NO DLUMBIA HEIGHTS, MN 554	ORTHEAST	
(X4) ID PREFIX TAG	(EACH DEEICIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 353	On 3/2/14: - AM S were cut from eight cut "No Rehab" a one NA from Linde -PM SI Linden as NA and Census was 119. On 4/4/14: - AM S rehab NAR" moved moved to Willow cut and moved to Evergreen. Census was 140.	hift one NA hours on Aspen at to six hours; rehab NA was and moved to Evergreen and en was moved to Evergreen. Hift Aspen TMA was moved to Willow TMA was cut. Shift rehab NA was cut "No ed to Evergreen; one NA was from Linden; laundry NA was Aspen and one NA was cut on		353			
	Evergreen "No Ricensus was 119. On 6/9/14: - AM size Linden to Evergre replaced. Census was 115. On 7/6/14: - AM Evergreen "No RicutPM shift Willo instead of two fo called in and was Census was 115.	shift one NA was moved from een to work as a TMA not Shift rehab NA was moved to ehab" and one Linden NA was w and Aspen had only one TMA r four hours as other TMA had s not replaced.					
	and one NA on Ninstead of eight -Ni	ght shift the house float NA was v and night laundry NA was also reen neither were replaced.					

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			CONCERNICATION	(X3) DATE SURVEY		
STATEMENT	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	COMPLETED		
AND PLAN OF	CORRECTION	BEITTE STATE OF THE STATE OF TH	A. BUILD	,, , , , ,				
		245018	B. WING				14/2014	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	ACT		
CDEST V	IEW LUTHERAN HO	ME			44 RESERVOIR BOULEVARD NORTHE. DLUMBIA HEIGHTS, MN 55421	401		
CREST			10		PROVIDER'S PLAN OF CORRECT	ION	(X5)	
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F 353	Continued From p	age 39	F	353				
	Review of multiple revealed the facilit frequently without needed to be replay with TMA's. In add schedules dated 2 revealed there wa and at times the factical nurse (L. 8/11/14. A review of the reand responses for revealed the folloron 9/18/13, the concerns: "A resi are not being answaited for 45 min assistance." - A minutes on 10 the subject of caldiscussed. - The minutes of business indicate "nurses are never needs." In additing "Help is unavailad mentioned that the involved in other not be easily four the minutes of "There was no control to the minutes	e random daily schedules by shifted staff from unit to unit regard to the duties that aced such as filling NA slots dition, review of the daily 2/1/14, through 8/12/14, as a lot of staff replaced daily acility would replace a licensed PN) with a TMA such as on sident council meeting minutes om 9/18/13, through 7/16/14, wing: minute's new business dent mentioned that call lights swered." Resident had stated "he autes before receiving 0/16/13, the minutes indicated all lights and/or staffing was not a 12/18/13, minute's new bed two residents had brought up are available to help with her on another resident had indicate able during breaks or meals he aides and nurses were are procedures at meals and might and during meals." on 1/14/14, old business indicate bold business." on 3/19/14, new business dent shared a concern about cal answered promptly. [DON] walking by and informed the	d d,					
	group that this p	problem was being addressed as	5					

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STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
		245018	B. WING			08/14/	/2014
	ROVIDER OR SUPPLIER	ME		4.	TREET ADDRESS, CITY, STATE, ZIP CODE 444 RESERVOIR BOULEVARD NORTHEA OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	documented), indiprevious meeting and "There was no proceeded to New - The minutes for indicated, "Nursin for the lack of res with second shift [LPN-A] responde offered a solution will have their nar in the hallway for when such incide by residents and nurses should be involved with a Although the sub brought up on se never addressed look at the staffir needs were met The Crest View Policy and Proce "The staffing concomplete all staffor twenty-four hocourage. Staffing consideration of along with case composition of the Nursing adjusts mix levels on a done ahead to nursing staff. 1. The Director full time in the process of the	cated the minutes from the were reviewed and approved of Old Business so the group of Business." 7/16/14, new business gronding to call light on all shifts being the most challenging. In the future the shift personner mes posted on the white board residents to view and record nts occur. It was also suggested supported by [LPN-A] that the responding should the NAR's other residents." ject of call lights had been over all meetings the concern was or reviewed by the facility to not patterns to ensure resident in a timely manner. Lutheran Home Staffing Planer and the Name of the Nursing Department ours, seven days a week nursing is based on and reflects the needs of resident population mix in determining the he nursing staff. The Director of station staffing according to cast regular basis. The schedule is cover two pay periods for all	g n see is	353			
	2. One full time	MDS coordinator is scheduled f	UI			tinuation shee	Page 41 of 54

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245018	B. WING		08	/14/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, Z 4444 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 5	NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 353	80 hours per pay p 3. In the absence of responsibility for conursing care is del- 4. The staffing coofull time, Monday-F 5. At least 1 RN/AI coordinator are solon the 6:30 a.m. to 3 licensed nurses (Fitime RN supervisor to 11:00 p.m. and is scheduled from day. The RN Superemergency calls to Village, and Royce 6. Licensed nurses NA's are schedule coverage, seven of Coordinator. Staffi 7. There is a full time TMA's for AM-10 AM. There p.m. 7 days a wee 8. The Director of Coordinator work according to cens 9. On Evergreen tresidents; on Willage, on Asp Residents; On Lin Residents (if Linda 10. At a minimum from 10:30 p.m. to is on duty.	eriod Monday through Friday. of Director of Nursing, the continuum and supervision of egated to the RN supervisor. rdinator is scheduled to work friday. ON supervisor and 1 LPN neduled Monday through Friday 3:00 p.m. shift and 1 RN duled Saturday and Sunday 8:00 p.m., along with 4 other N's and /or LPN's). One full r is scheduled from 2:30 p.m. 1 RN full time Night Supervisor 10:30 p.m. to 7:00 a.m. every rvisors are responsible for The Boulevard, Columbia Place. Is (RN's and LPN's), TMA's and d for twenty-four (24) hour ays a week by the Staffing and is done on a monthly basis. TMA scheduled 7 days a a.m. to 2:30 p.m. shift and 2 r heavier med passes from 6 are 3 part time TMA's from 4-8 k. Nursing and Staffing closely together to staff us. he ratio is typically 1 NAR to 8 ow typically 1 NAR to 8 en typically 1 NAR to 8 den it is typically 1 NAR to 8		353		

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STATEMENT OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRE	ECTION	IDENTIFICATION NUMBER:	A. BUILD	NG			
	:	245018	B. WING			08/1	4/2014
NAME OF PROVIDE		ME		444	EET ADDRESS, CITY, STATE, ZIP CODE 4 RESERVOIR BOULEVARD NORTHEA LUMBIA HEIGHTS, MN 55421	IST	
		ATEMENT OF DEFICIENCIES	ID	$\overline{}$	PROVIDER'S PLAN OF CORRECT	ON	(X5) COMPLETION
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11:00 sched Float 12. Ir the S vacar sick lemen 13. A work holid 14. A each	duled 11:00 p . One NAR flot on-house pool of the staffing Coord tions, mental leave, leaves regencies and all nursing states every other very other very other staffing staffing shift are poses a new pay	a.m. shift. One NA/R is .m. to 7:00 a.m. as House bats and does personal laundry. on call staff are scheduled by inator to cover during health days, floating holidays, of absence (LOA),		353			
wee 15. com Staf 16. nurs Ref ass who Septimber 15. com Staf 16. nurs Ref ass who septimber 15. com F 412 SS=D SE The an \$48	ks. The Daily Wo pleted prior to fing Coordina Staffing Coordina Staffing Coordina Staffing Coordina Staffing Coordina Staffing Coordina er to F312. The istance with of orequired ass fer to F412. The and facilitate is a residents (Rincerns. B.55(b) ROUT RVICES IN N e nursing facilioutside resou 83.75(h) of the overed under the	rk Schedule for each station is the next day and posted on the tor's office door. dinator will adjust productive a daily basis." The facility failed to provide a daily basis. The facility failed to provide a daily basis. The facility failed to ensure, follow the facility failed to ensure, follow the facility failed to ensure, follow the facility failed to ensure for 2 for R12) reviewed for dental The facility failed to ensure.		= 412			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT!FICATION NÜMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING			08/14/2014	
	PROVIDER OR SUPPLIER	ME		444	REET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHEA DLUMBIA HEIGHTS, MN 55421	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETION	
F 412	resident; must, if n making appointme transportation to an must promptly refe damaged dentures This REQUIREME by: Based on observareview, the facility facilitate necessar	ecessary, assist the resident in nts; and by arranging for nd from the dentist's office; and er residents with lost or	F	412	It is Crest View Lutheran Home that Crest View Lutheran Home from an outside resource, in a with §483.75(h) of this part, rothe extent covered under the plan); and emergency dentals meet the needs of each reside if necessary, assist the resider making appointments; and by for transportation to and from dentist's office; and must prove refer residents with lost or day dentures to a dentist.	e obtains ccordance cutine (to State services to ent; must, at in arranging a the mptly	
	On 8/13/14, at 8:4 room and lying in not able to respon observed turning I direction started y over to surveyor a mouth open. Durit teeth were noted i discoloration beformember (F)-A stafitting, were on a stube fed. When a mouth sores and "I would like to ha indicated dental hithe quarterly care facility and F-A ha	ded dental services. 5 a.m. R57 was observed in his bed. R57 was non-verbal was id to any questions. R57 was his head to the opposite elling loud then turned his head is he continued to yell and his no observation a few of R57's to have a yellow brown re he closed his mouth again. 30 a.m. during interview family ited R57's dentures were not mechanical soft diet, and were sked if R57 had teeth, gum, denture problems, FA-A stated we him seen by the dentist." F-A and not been brought up during a conference meetings by the ad not thought of asking about as she was R57's financial			Resident #57 was seen by the 8/21/2014. Resident 12 She happointment to be seen on 9 Corresponding updates have made to care assignment she plans and communicated to resident and/or designated of maker.	nas an /18/2014. been eets, care the	

	TO TOTT MEDIONITE	A MEDIOTAD OFFICE				111D 110.	0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		SURVEY PLETED
		245018	B. WING	i		08/1	14/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HO	ME		i	444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	ST 	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 412	representative and During review of th notes the following - Dated 10/16/12, is raised 1 Centimete hyperkeratotic [a raised to the contine accumulation of sk mucosa on his right commissure [a join place where two be or unite] and heavy throughout." The plimited exam had be lesion, R57 was undentist indicated he initial exam and proportion of the product of the pr	responsible party. e Apple Tree Dental progress were revealed: ndicated R57 had a "firm or (cm) nodule with white ather common skin condition. It ual production and in cells on the sin surface] at buccal mucosa near tt, seam, suture, or closure; the odies or parts of a body meet		412	For all other residents this may whole house audit will be comp the On-Site Services group for d podiatry and audiology visit comon 9/11/14. An Oral assessment has been added to our quarterly annual and significant change N assessments as well as the adm assessments. The policy for in house On-Site was reviewed by the Inter Discite Team on 9/15/14. A review of policies by the Medical Director completed on 9/16/14. Staff m will be trained on their roles rethis mater on 9/17-19. Resident dental, vision and poor visits will be audited weekly for weeks, monthly for 2 months, a randomly to ensure continued compliance. Results from these will be reported to the QA/QI committee for review and furtirecommendations. Director of Health Information designee will be responsible for compliance. Date of compliance: 09/23/14	leted by lental, inpliance it form y, /IDS ission visits plinary new r will be embers garding diatry r 4 and ther e audits her	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, · ·	TIPLE CONSTRUCTION NG		MPLETED
		245018	B. WING			3/14/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 4444 RESERVOIR BOULEV. COLUMBIA HEIGHTS, M	ARD NORTHEAST IN 55421	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 412	bleeding gums, m or difficulty with ch also indicated R57 memory issues. In addition, the de Assessment (CAA completed on 7/16	oose natural teeth, inflamed or outh or facial pain, discomfort newing. MDS dated 6/28/14, 7 had both short and long term ontal section Care Area A) did not trigger for CAA 0/14.	F	412		
	alteration in self-o	ed 7/10/14, identified R57 with care and directed staff to assist ce daily and as needed. The address how often R57 was to entist.				
	R57's diagnoses diabetes mellitus malignant neopla cerebrovascular Admission Recor When interviewe registered nurse coordinator state doing the dental the dental asses each compreher went through the assessment was after looking at the nurses usual mouth but there	included multiple myeloma, type II, glaucoma, aphasia, ism of prostate, hemiplegia and disease (CVD) obtained from	nt			
	licensed practice	ed on 8/13/14, at 2:31 p.m. al nurse (LPN)-A stated she felt ral Inspection Assessment was ty and indicated the form came				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		MPLETED	
		245018	B. WING			/14/2014
	ROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, S 4444 RESERVOIR BOULI COLUMBIA HEIGHTS,	EVARD NORTHEAST MN 55421	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE DED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 412	the quarterly and a verified the Oral In lacking in the char On 8/13/14, at 2:5 admission coordin stated initially whe facility the family dental consent wh to Apple Tree Den with the dentist Ap with a treatment p who would sign it Dental who would rotating schedules admission coordin spoken with some indicated the offic paperwork to the responded thus e seen since 11/12/department was rappointments but not been brought Apple Tree Denta consent from the When interviewed conference call A coordinator states sent three consecutive who was not sure current job and had not found an contacted. When	ormation packet and not with innual assessments. LPN spection Assessment was t. 3 p.m. the medical records and ator approached surveyor n R57 was admitted at the aughter had signed the initial ich the facility usually would fax tal. Then after the initial visit ple Tree Dental would come up lan and send it to the family and return it to Apple Tree put the residents normally on s. Medical records and nator further stated she had cone at Apple Tree Dental who e had sent several consents daughter but she had not explaining why R57 had not been 12. She indicated her esponsible for scheduling missing dental follow up had up to her attention to check with it to facilitate obtaining the		412		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION		B. WING			08	/14/2014	
	ROVIDER OR SUPPLIER	245018 ME	B. WING	STRE 4444	EET ADDRESS, CITY, STATE, ZIP COI RESERVOIR BOULEVARD NOR' LUMBIA HEIGHTS, MN 55421	DE THEAST	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	RECTION SHOULD BE	(X5) COMPLETION DATE	
TAG	REGULATORT OR	LOO IDENTIFY THE MAN OF THE PARTY.	-	-	DEFICIENCY)			
F 412	on she indicated surveyor indicated financial and responsible party who was listed in On 8/14/14, at 2:2 brought to the fact Dental Treatment 11/19/12, 2/1/13, sent to a different responsible party who was listed in On 8/14/14, at 4: (DON) stated she have brought to the been seen by the oral assessment completed in the	the would not answer even after a different daughter was the onsible party. 26 p.m. after concern had been ility attention three Proposed for R57 were provided dated and 3/4/13, which had been daughter who was not the and financial representative R57's chart. 23 p.m. the director of nursing expected the MDS nurse to he facility attention R57 had not deducted and last three comprehensive		412				
	assessments when R12's dentures we receive new den On 8/11/14, at 6 no upper dentur have no upper dentur have no upper dentur have no upper dentures would like	en reviewing the MDS. vere misplaced and R12 did not	ne					
	modified diabet consistency. The admission dated 1/21/14.	hysician's Order noted the diet a ic diet regular texture and thin e resident was a diabetic. Individual Resident Care Plan indicated under dental status, that ted with own teeth and upper		_			beet Page 48.0	

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		& MEDICAID SERVICES	()(0) 14111	TIDLE (CONSTRUCTION	(X3) DAT	E SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		MPLETED
		245018	B. WING				/14/2014
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTH		
CREST V	IEW LUTHERAN HO	ME			LUMBIA HEIGHTS, MN 55421	ILAG I	
(X4) ID PREFIX TAG	/EACH DEEICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 412	Continued From p	age 48	F	412			
	indicated R12 had	essment Form dated 1/23/14, upper dentures and bottom and "good" was crossed out d "good condition."					
	scored an 11 on the Status (BIMS - a to level of a resident	S dated 4/30/14, revealed R12 ne Brief Interview for Mental est to determine the cognition which indicated moderately n. The Oral/Dental Status was MDS.					
	independent with	ed 5/13/14, indicated R12 was oral cares with set up from staff					
	dental status. The nurse practition 7/14/14, in the se	lacked evidence of any form of oner's (NPs) note dated ction depicted as eyes, nose 'Mouth read: "moist mucous upper teeth."					
	8/12/14, noted the for when R12 was there was no me	ence Summary form dated e section of dental was left bland is last seen by a dentist and the ntion of referring R12 to the see for denture fitting.	k				
	(DSS) stated R1 since admission knew R12 wante a consent form f filled out. DSS voorders for R12 t stated dental caunit coordinator	57 a.m. director of social service 2 had not been seen by a dentist to the facility. DSS stated she d dentures, and possibly though or R12 to see the dentist was erified there were no Physician o see the dentist. DSS also me to the facility and the health (HUC) notified the dental office SS further stated every care	nt				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(· -)	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245018	B. WING		08/14/2014	
1	PROVIDER OR SUPPLIER VIEW LUTHERAN HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHE COLUMBIA HEIGHTS, MN 55421	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 412	conference dental and she had create for residents would dental as of a few to residents upon a last care conference left blank and indicated ay."	was offered to the resident(s) ed the new form so all services if the offered and in addition months ago was being offered admission. DSS verified R12's ce dated 8/12/14, dental was cated "I will talk to her (R12) requested on 8/14/14, at	F 412			
F 43°	approximately 3:3: 1 483.60(b), (d), (e) 2 LABEL/STORE D	Dp.m. but was not provided. DRUG RECORDS, RUGS & BIOLOGICALS Employ or obtain the services of	F 43	¹ F 431	:	
	a licensed pharma of records of rece controlled drugs in accurate reconcili records are in ord controlled drugs in reconciled. Drugs and biologicabeled in accordaprofessional princiappropriate accessinstructions, and applicable. In accordance with facility must store locked compartments.	acist who establishes a system ipt and disposition of all a sufficient detail to enable an ation; and determines that drug ler and that an account of all is maintained and periodically cals used in the facility must be ance with currently accepted ciples, and include the ssory and cautionary the expiration date when the State and Federal laws, the eall drugs and biologicals in the ents under proper temperature mit only authorized personnel to		It is the policy of Crest View Leading to employ or obtain the of a licensed pharmacist who establishes a system of recorreceipt and disposition of all drugs in sufficient detail to e accurate reconciliation; and that drug records are in order an account of all controlled of maintained and periodically	ne services ords of controlled nable an determines er and that drugs is	
	The facility must permanently affix	ne keys. provide separately locked, ked compartments for storage of	F			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	F CORRECTION	245018	B. WING			08/14/201	14	
	OD OLIDBUIED		D. 11.11	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER				44 RESERVOIR BOULEVARD NORTH	EAST		
CREST V	IEW LUTHERAN HC	ME		С	OLUMBIA HEIGHTS, MN 55421		<u></u>	
(X4) ID PREFIX TAG	/EACH DEELCIENC	ATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION OF STREET			(5) LETION ATE	
F 431	controlled drugs li Comprehensive D Control Act of 197 abuse, except wh package drug dist quantity stored is	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 clouse, except when the facility uses single unit backage drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			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.			
	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		е		For all other residents that affect, a whole house audit medication expiration, lab expiration was completed on09/17/2014.	of supply		
					The policy on expired med medication storage were reviewed/created by the library Team on 09/1 were updated to reflect the received.	nter 5/14 and		
			e g	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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STATEMENT	S FOR MEDICARE OF DEFICIENCIES FORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .		E SURVEY MPLETED	
		245018	B. WING			08/14/2014		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421					
(X4) ID PREFIX TAG	/EACH DEEICIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	seated across the bent over asleep. unlocked at that ti - At 7:21 a.m. TM. of the cart to start cart was open after was supposed to When interviewed director of nursing should be locked supervised.	art and R54 was observed cart near the wall with the head The cart still remained		431				
	room tour was conthe tour there wand used to screen the stool test kits with two with an expirit stored in a drawer also container which an expiration date expiration date of the culture of the culture stool kits were experienced in the culture stool with the culture stool kits were experienced in the culture stool kits were	on 8/12/14, at 3:38 p.m. LPN-E are swabs and the Hemoccult expired and confirmed that they sed because they are expired.						
	verified expired medication store more on the me indicated medic	medical supplies in the age room and stated "we focus dications not the kits" and ation room audits are done on a e DON verified supplies should	L				heet Page 520	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245018	B. WING			08/14	1/2014
	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	have been taken o confirmed she exp policy. Evergreen Unit me On 8/12/14, at app medication storage Evergreen Unit. A treat diabetes mell stored on the top of treatment/medicat on the pen of 7/10 -At 1:10 p.m. LPN expired twenty eig LPN-G verified the 7/10/14, which two had expired. LPN-the insulin on two insulin injection pet the insulin pen fro get rid of it then a locked medication. A Physician 's Or directed staff to in Aspart) per sliding times a day for diabeted with the condition of the cord (MAR) it is Novolog insulin a 8/12/14, from the On 8/14/14, at 3:5 should be discard	ut and disposed of and ected staff to follow the facility dication cart: roximately 1:00 p.m. was observed on the Novolog insulin pen (used to itus) for R43 was observed drawer of the ion cart with hand-written date /14. G stated the medication ht to thirty days after opening. date pen was opened was odays later since medication G also stated R43 had received separate occasions from that en on 8/12/14. LPN-G then took m the top drawer and said "I will and was observed going into the room. der dated 5/29/14, for R43 ject Novolog solution (Insuling scale subcutaneously three abetes. the Medication Administration was revealed R43 had received a 7:30 a.m. and 10:30 a.m. on outdated pen. 30 p.m. DON stated all insuling the detwenty eight days after being the days after being t		431			
	opened according recommendation	g to manufacturer's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245018	B. WING			08/1	4/2014
	PROVIDER OR SUPPLIER	ME		44	TREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	Diabetic Learning https://www.bd.corstore and handle is lose effectiveness The Receiving Medid not address mincluded the medic if they were to be unsupervised. In a address multi-use and disposing of elacked information	ickinson and Company)	F	431			
	discarded from the	e carts.					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				
		245018	B. WING	B. WING			5/2014
	ROVIDER OR SUPPLIER	ME		44	TREET ADDRESS, CITY, STATE, ZIP CODE 1444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ΚŒ	000	8		
M-ER-6 : 02	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TIPAGE OF THE CM VERIFICATION OF UPON RECEIPT CON-SITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE W	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.			Poc oh 9-16-14		
ENIT: 8-14-14	Minnesota Departitime of this survey Building 1 was fou compliance with the in Medicare/Medicate/Medic	N THE PLAN OF OR THE FIRE SAFETY K-TAGS) TO: espections Il Division Suite 145 01-5145, OR			SEP 1 5 2014 MN DEPT. OF PUBLIC SAFE STATE FIRE MARSHAL DIVIS		(X6) DATE
LABORATOR	RY DIBECTORS OF PROT	TIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	e (Center Administrator 9	11214	

Any deficiency statement ending with an asterisk () Genotes 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		MPLETED			
		245018	B. WING			08/	/15/2014
	F PROVIDER OR SUPPLIER			444	REET ADDRESS, CITY, STATE, ZIP CODE 44 RESERVOIR BOULEVARD NORTHEA DLUMBIA HEIGHTS, MN 55421	ST	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)		LD BE	(X5) COMPLETION DATE
K 00	THE PLAN OF CODEFICIENCY MUFOLLOWING INF 1. A description of to correct the defi 2. The actual, or part of the copressible for coprevent a reoccur. Crest View Luther	ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: f what has been, or will be, done		000			
	constructed in 19 Construction type of Type II (111) a basement. The building is fu facility has a con smoke detection open to the corri automatic fire de has a licensed of census of 118 at The requiremen NOT MET as ev NFPA 101 LIFE Patient room do patient can open using a key (S)	an addition in 1966. and is II (111). The 2007 edition is a 1-story building with a sully fire sprinkler protected. The applete fire alarm system with in the corridors and spaces dor, that is monitored for apacity of 122 beds and had a the time of the survey. The at 42 CFR Subpart 483.70(a) is a series in the survey.	y	K 04\$	It is the policy of Crest View Home to follow all state an regulations including but no the Life Safety Code.	d federa	at "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		COMPLETED		
		245018	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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
K 043	This STANDARD Based on observa has failed to maint accordance with L 18.2.2.4. This defi residents. Findings include: On facility tour bet on 08/15/2014, ob	is not met as evidenced by: tion and interview, the facility ain the door locks in ife Safety Code Section icient practice could affect the ween 9:15 AM and 11:00 AM servation revealed that there is ually unlock or manually relock	K 043	dates of medications and lal along with medication cart's be completed weekly on an basis to ensure compliance maintained. Results of the abrought to the QA/QI Commerciew and further recomm	o supplies security will on-going is udits will be nittee for endations. lesignee will ice.		
K 103 SS=D	This deficient pracadministrator at the NFPA 101 LIFE S. Interior walls and or Type II construction in the combustible of the c	tice was verified by the settime of the inspection. AFETY CODE STANDARD partitions in buildings of Type I ction are noncombustible or le materials. 19.1.6.3 is not met as evidenced by: sation and interview, the facility construction materials in the partitions not in accordance with Section 19.1.6.3. This deficient sect some residents.	K 103	Upon inspection on 8/15/20 View employees incorrectly there was no means of mar unlocking and manually reexit doors on the memory of Upon further inspection by Administrator and the Direct Environmental Services, the lock/unlock button for the memory care unit was located the nursing desk.	014, Crest v stated that hually locking the care unit. the ctor of e manual secure		

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO. 09			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING 01		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED			
		245018	B. WING			08/15/	2014		
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	eT.			
CREST V	IEW LUTHERAN HO	ме			44 RESERVOIR BOULEVARD NORTHEA: DLUMBIA HEIGHTS, MN 55421	31			
OHEO!			l in		PROVIDER'S PLAN OF CORRECTION	ON I	(X5) OMPLETION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE 10	DMPLÉTION DATE		
				400	To ensure the manual lock/unl	ock			
K 103	Continued From page 3		K	K 103 system is in full working order, Mayer					
	perimeter and interior walls of the gift shop are			Electric was contracted to inspect the					
	tramed with wood	framed with wood studs. There is also plywood sheathing above the ceiling in the gift shop.			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					
	Theis deficient practice was verified by the administrator at the time of the inspection.								
*1					care unit-by 9/23/2014.				
					All staff will be re-educated to	the			
					location and purpose of the m				
			1		lock/unlock button on 9/17/2	014 –			
					9/19/2014.				
					9/13/2014.				
					Manual Switch Audits will be	completed			
			T)		weekly for 4 weeks, monthly	for 2			
			1		months, and then randomly t	o ensure			
					compliance is maintained and	l the			
					manual lock/unlock button is	in proper			
					working order. Results from t	hese			
					audits will be brought to the	QA/QI			
					Committee for review and fu	rther			
					recommendations.				
	<u>a</u>				The Director of Environment	al Services			
					or designee will be responsib				
					compliance.				
					compliance.				
	1				1 25 100 10 10				
					Date of Correction: 09/23/14		5		
1	1		1		. (
1961									

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

		& MEDICAID SERVICES	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE SI	JRVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 02		- 2007 ADDITION	COMPLE	:IED
		245018	B. WING			08/15/	2014
	ROVIDER OR SUPPLIER	ME		444	REET ADDRESS, CITY, STATE, ZIP CODE 14 RESERVOIR BOULEVARD NORTHEA DLUMBIA HEIGHTS, MN 55421	ST	
(X4) ID PREFIX TAG	ACACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	К	000	K103		ie
	Minnesota Departitime of this survey Build 2 was found the requirements of Medicare/Medicaid 483.70(a), Life Sa edition of National (NFPA) Standard Chapter 18 New Forest View Luther with a partial base	d at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), Health Care. Fran Home is a 2-story building Franch, The building was			It is the policy of Crest View Home to follow all state and regulations including, but not the Life Safety Code. All into and partitions in the building construction are noncombulimited-combustible mater. Upon further inspection by Administrator and Director Environmental Services along.	d federal not limited to terior walls ng's ustible or rials. the	
	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.				Fire Marshal Supervisor on there was only one interior was framed with wood stuthan all of the walls within area. This was evidenced be drilled into the walls reveastuds. The wood-studded wall all shop and dining room are replaced with a metal studies an outside contractor by Some of the Completed by the Direct Environmental Services to further deficient practices. Results from these audits brought to the QA/QI Correview and further recommental services.	s/20/2014 r wall that ds, rather the gift sh by holes ding metal ong the gift a will be dded wall k d/23/2014. Ion audits wall ctor of ensure no s are obser will be mmittee fo	t op will oved.

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.

The Director of Environmental Services or designee will be responsible for compliance.

at iys 14

F5018026

Printed: 08/20/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - 2007 ADDITION

(X3) DATE SURVEY COMPLETED

245018

B. WING

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

	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	K 000					
	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.						
	25						
			TITLE	(X6) DATE			

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

Crest View Lutheran Home September 2, 2014 Page 2 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

Dire Klegge

Enclosures

cc: Original - Facility