DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 11, 2019

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

RE: Project Number H5018122C

Dear Administrator:

On April 10, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 6, 2019

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

RE: Project Number H5018122C, H5018123C

Dear Administrator:

On February 26, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is April 7, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 26, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by August 26, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 02/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted on 2/25/19 to 2/26/19, to investigate complaint(s) #H5018123C and H5018122C. Crest View Lutheran Home is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. H5018122C substantiated at F684 H5018123C Not substantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		4/4/19

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

Electronically Signed | 03/15/2019

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

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F 684	Continued From page 1 Based on observation, interview and document review the facility failed to ensure physician orders were followed for 2 of 3 residents (R1 and R2) reviewed for quality of care. Findings include: Weights and fluid restriction: R1's diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), arthritis, peripheral vascular disease (PVD) and hypertension obtained from the quarterly Minimum Data Set (MDS) dated 12/25/18. In addition, the MDS indicated R1 had intact cognition, did not refuse cares and required extensive physical assistance of one to two staff with dressing and transfers. R1's care plan dated 1/6/19, indicated R1 had an alteration in respiratory status related to diagnoses of congestive heart failure, COPD and obesity. The care plan directed staff to observe and report to the physician any signs of increased respiratory distress and to observe for symptoms of CHF exacerbation. The care plan did not address R1 was on a fluid restriction and was on daily weights as noted on the physician orders. On 2/25/19, at 2:44 p.m. licensed practical nurse (LPN)-A went to R1's room. LPN-A attempted to weigh R1 in the bed however, the scale was not working. During this observation R1 was was using oxygen and R1's face and both legs appeared to have edema. On 2/26/19, at 9:07 a.m. R1 was observed lying in her bed and the breakfast tray was on the bedside table in front of her. R1 had consumed 480 milliters (ml) of beverages. When asked if	F 684	F684 It is the Policy of Crest View Lutheran Home to follow physician's orders related to weights monitoring and fluid restrictions. Resident R1 signed a Risks and Benefits form for her frequent refusals to be weighed. In addition, she was given a new wheelchair that better fits on the weight scale. The consultant Registered Dietician reviewed her plan of care and made diet recommendations on 3/6/2019. The Director of Nursing revised her fluid restriction order in her chart to for better clarity. Resident R2 was re-weighed on 3/14/2019. His primary care physician has been notified of his recent weight loss. The consultant Registered Dietician reviewed his plan of care and made diet recommendations on 3/13/2019. For all other residents that this practice may have affected, a whole-house audit will be completed for every resident to ensure any weight losses have been reported to their respective primary physician. Every resident on a fluid restriction will also be reviewed to ensure orders are clear and compliance with the restriction is being followed. In addition, the Weights Monitoring Policy and Procedure along with the Fluid Restriction Policy and Procedure for Crest View Lutheran Home were both reviewed and updated by an interdisciplinary team on	

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F 684	Continued From page 2 she knew what fluid restriction she was on R1 stated "I don't know. I know am not supposed to have the water pitcher." When asked about being weighed, R1 stated staff had told her a while back the bed had a scale and with her shortness of breath and not feeling well she did not like to get out of her bed most of the time. R1's physician orders dated 12/18/18, indicated R1 had the following orders: --Bumetanide (Bumex a water pill) 4 milligram (mg) by mouth two times a day for heart failure --Fluid restriction: total of 2000 ml per day. Document the total intake per shift every shift --Record daily a.m. weight with same clothes every day and notify the nurse practitioner (NP)/physician (MD) if weight is up more than 2 pounds in one day or 5 pounds in one week from their admission weight or patient has signs or symptoms of CHF such as worsening dyspnea or leg edema. During review of the medical record it was revealed R1 had missing weights on 12/20/18, 12/22/18-12/27/18, 12/29/18, 12/31/18, 1/1/19, 1/4-1/7/19, 1/9-1/10/19, 1/12-1/18/19, 1/21-1/23/19, 1/25/19, 1/27-1/29/19, 1/31/19, 2/3/19, 2/7/19, 2/9-2/11/19, 2/13-2/16/19, 2/18/19. During a review of the medication administration record and treatment administration records from 12/19/18, through 2/19/19, it was revealed in the documentation R1 was consuming more than 2000 ml of fluids over the recommended amount, per staff documentation. On 2/25/19, at 2:36 p.m. LPN-A stated she was	F 684	3/15/2019. These policies detail the procedure for documenting and monitoring resident weights and fluid intake, notifying the physician of changes, and tracking non-compliance. All staff will be re-educated on these policies and procedures by April 4th. Audits have been put in place to monitor weights and fluid restrictions. This will ensure documentation is done accurately, and that notifications to physicians are being completed. These audits will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing, based on the audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 4/4/2019	

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F 684	Continued From page 3	F 684		

not the assigned unit manager however, she had heard R1 refused to be weighed among other care and treatments. LPN-A reviewed R1's medical record and verified there was no risk and benefits provided to R1 for refusing to be weighed. LPN-A also verified R1's fluid restriction was not being followed and staff documented R1 was consuming more fluids daily than the recommended 2000 ml. LPN-A stated R1 had heart failure and COPD "staff should weigh her and if they are not able they should be documenting the reason and the fluid restriction is not being followed according to the documentation."
-At 2:37 p.m. LPN-A stated she was going to call the assigned unit manager to get accurate information regarding R1. At 2:39 p.m. LPN-A stated after being on the phone with LPN-B regarding the bed scale on R1's bed, "we were renting it and [LPN-B] stated the scale is broken." LPN-A explained that R1 could be weighed with the Hoyer but that one wasn't working and indicated [LPN-B] had requested a special wheelchair from therapy and had not gotten that either. [LPN-B] said she had not done a risk and benefits for the resident refusing weights. "I did not know the Hoyer scale was not working." LPN-A acknowledged the facility should have a way to weigh R1 since she did not get out of bed.

On 2/25/19, at 2:51 p.m. LPN-A stated "I asked the aide and she said the Hoyer scale is not working. Am taking the number and will call the company because the Hoyer is new and they have warranty I think."

Weights:
R2's diagnoses included heart failure, muscle

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F 684	Continued From page 4	F 684		

weakness, hypertension and hemiplegia and hemiparesis, obtained from the 5 day MDS dated 1/5/19. In addition, the MDS indicated R2 had intact cognition, did not refuse cares and required extensive physical assistance of one staff with dressing and transfers.

R2's care plan dated 12/19/18, indicated R2 had an alteration in nutrition related to congestive heart failure and hypertension. The care plan directed staff to monitor for changes in weight per the physician order.

R1's physician orders dated 12/18/18, indicated R1 had the following orders:
--Furosemide (Lasix a water pill) 20 mg 2 tablets by mouth one time a day for heart failure
-- daily weights in am. call physician if weight increases by 2 pounds in 24 hours or 5 pounds in 7 days from admission weight. One time a day

During review of the medical record it was revealed R2 had missing weights on 12/18/18 to 12/20/18, 12/22/18, 12/26/18, 1/2/19, 1/6/19, 1/11/19, 1/23/19, 1/25-1/26/19, 2/2/19, 2/6/19, 2/12/19, and 2/21/19.

During further review of the medical record, it was revealed the physician had not been notified of weight increase/gains for the following dates:
12/24/18 to 12/25/18, 2.6 pounds (lbs)
12/27/18 to 12/28/19, 2.5 lbs
12/28/18, to 12/29/18, 3.2 lbs
1/8/19 to 1/9/19 8.2 lbs
1/17/19 to 1/18/19, 7.3 lbs
1/19/19 to 1/20/19, 10.6 lbs
2/17/19 to 2/18/19, 2.6 lbs
2/19/19 to 2/20/19, 3.2 lbs

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F 684	Continued From page 5 On 2/25/19, at 12:59 p.m. LPN-A reviewed the medical record and verified the physician was not notified of the weight increase. LPN-A stated if the documentation was not there then they were going to have to do education with the nurses as they were supposed to follow physician orders. LPN-A stated when nurses chart the "code 9" in the MAR's and TAR's they were supposed to write a nurse note. When asked what documentation the nurses had noted for missing the weights, LPN-A stated the documentation had statements such as "NAR did not chart weight before leaving" ""weight not done this shift." "staff was told to weigh resident and did not.", among others. LPN-A stated if the weights were off, the nurses were supposed to have the aides re-check it again to make sure it was accurate. On 2/25/19, at 2:48 p.m. LPN-C stated the aides were supposed to get the weights and the nurse entered the weight. LPN-C stated she would check the previous date weight and if there was a discrepancy she would have the aides re-check it. LPN-C further stated the nurse was supposed to document if a resident refused to be weighed and if it was a continuous problem she would report to the supervisors and the Nurse Practitioner would be notified. On 2/26/19, at 9:00 a.m. the director of nursing (DON) stated "I realize it is a physician order and we will be looking at our equipment and we knew the bed scale had stopped working about a month or two ago. Our Hoyer's work and don't work some days. It's very touchy." When asked if the nurses were supposed to chart why the weights were not done as ordered by the physician, the DON stated "I have seen the staff ask to weigh her but she refuses. I don't have	F 684		

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F 684	Continued From page 6 documentation. We will have to come up with a policy on how to address that." The DON also stated nurses needed to follow the orders and call the physician with any weight gains if any. When asked about the fluid restriction, the DON stated she was the only one who put the order to document on each shift the amount of fluid intake for residents on restrictions. "I am not sure who is putting them in and causing a lot of confusion. I will go through today and make sure they are straightened out. Am surprised the dietician did not catch that."	F 684		

Electronically delivered
March 6, 2019

Administrator
Crest View Lutheran Home
4444 Reservoir Boulevard Northeast
Columbia Heights, MN 55421

Re: State Nursing Home Licensing Orders - Project Numbers H5018122C, H5018123C

Dear Administrator:

The above facility was surveyed on February 25, 2019 through February 26, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 2/25/19 to 2/26/19, surveyors of this Department's staff, visited the above provider and conducted an abbreviated standard survey to investigate complaint(s) #H5018123C and H5018122C.The following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and

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2 000	Continued From page 1 mail or email to: Minnesota Department of Health Susanne Reuss, Supervisor 85 East 7th St. St. Paul, MN susanne.reuss@state.mn.us During the survey complaint H5018122C was found to be substantiated at State tag 0830 (4658.0520 Subp 1) - Adequate and Proper Nursing Care PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		4/4/19

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2 830	Continued From page 2 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure physician orders were followed for 2 of 3 residents (R1, R2) reviewed for quality of care. Findings include: Weights and fluid restriction: R1's diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), arthritis, peripheral vascular disease (PVD) and hypertension obtained from the quarterly Minimum Data Set (MDS) dated 12/25/18. In addition, the MDS indicated R1 had intact cognition, did not refuse cares and required extensive physical assistance of one to two staff with dressing and transfers. R1's care plan dated 1/6/19, indicated R1 had an alteration in respiratory status related to diagnoses of congestive heart failure, COPD and obesity. The care plan directed staff to observe and report to the physician any signs of increased respiratory distress and to observe for symptoms of CHF exacerbation. The care plan did not address R1 was on a fluid restriction and was on daily weights as noted on the physician orders. On 2/25/19, at 2:44 p.m. licensed practical nurse (LPN)-A went to R1's room. LPN-A attempted to weigh R1 in the bed however, the scale was not working. During this observation R1 was was using oxygen and R1's face and both legs	2 830	No Plan of Correction Needed to be Submitted For State Statutes/Rules	

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2 830	Continued From page 3 appeared to have edema. On 2/26/19, at 9:07 a.m. R1 was observed lying in her bed and the breakfast tray was on the bedside table in front of her. R1 had consumed 480 milliters (ml) of beverages. When asked if she knew what fluid restriction she was on R1 stated "I don't know. I know am not supposed to have the water pitcher." When asked about being weighed, R1 stated staff had told her a while back the bed had a scale and with her shortness of breath and not feeling well she did not like to get out of her bed most of the time. R1's physician orders dated 12/18/18, indicated R1 had the following orders: --Bumetanide (Bumex a water pill) 4 milligram (mg) by mouth two times a day for heart failure --Fluid restriction: total of 2000 ml per day. Document the total intake per shift every shift --Record daily a.m. weight with same clothes every day and notify the nurse practitioner (NP)/physician (MD) if weight is up more than 2 pounds in one day or 5 pounds in one week from their admission weight or patient has signs or symptoms of CHF such as worsening dyspnea or leg edema. During review of the medical record it was revealed R1 had missing weights on 12/20/18, 12/22/18-12/27/18, 12/29/18, 12/31/18, 1/1/19, 1/4-1/7/19, 1/9-1/10/19, 1/12-1/18/19, 1/21-1/23/19, 1/25/19, 1/27-1/29/19, 1/31/19, 2/3/19, 2/7/19, 2/9-2/11/19, 2/13-2/16/19, 2/18/19. During a review of the medication administration record and treatment administration records from 12/19/18, through 2/19/19, it was revealed in the	2 830		

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2 830	Continued From page 4 documentation R1 was consuming more than 2000 ml of fluids over the recommended amount, per staff documentation. On 2/25/19, at 2:36 p.m. LPN-A stated she was not the assigned unit manager however, she had heard R1 refused to be weighed among other care and treatments. LPN-A reviewed R1's medical record and verified there was no risk and benefits provided to R1 for refusing to be weighed. LPN-A also verified R1's fluid restriction was not being followed and staff documented R1 was consuming more fluids daily than the recommended 2000 ml. LPN-A stated R1 had heart failure and COPD "staff should weigh her and if they are not able they should be documenting the reason and the fluid restriction is not being followed according to the documentation." -At 2:37 p.m. LPN-A stated she was going to call the assigned unit manager to get accurate information regarding R1. At 2:39 p.m. LPN-A stated after being on the phone with LPN-B regarding the bed scale on R1's bed, "we were renting it and [LPN-B] stated the scale is broken." LPN-A explained that R1 could be weighed with the Hoyer but that one wasn't working and indicated [LPN-B] had requested a special wheelchair from therapy and had not gotten that either. [LPN-B] said she had not done a risk and benefits for the resident refusing weights. "I did not know the Hoyer scale was not working." LPN-A acknowledged the facility should have a way to weigh R1 since she did not get out of bed. On 2/25/19, at 2:51 p.m. LPN-A stated "I asked the aide and she said the Hoyer scale is not working. Am taking the number and will call the company because the Hoyer is new and they have warranty I think."	2 830		

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2 830	Continued From page 5 Weights: R2's diagnoses included heart failure, muscle weakness, hypertension and hemiplegia and hemiparesis, obtained from the 5 day MDS dated 1/5/19. In addition, the MDS indicated R2 had intact cognition, did not refuse cares and required extensive physical assistance of one staff with dressing and transfers. R2's care plan dated 12/19/18, indicated R2 had an alteration in nutrition related to congestive heart failure and hypertension. The care plan directed staff to monitor for changes in weight per the physician order. R1's physician orders dated 12/18/18, indicated R1 had the following orders: --Furosemide (Lasix a water pill) 20 mg 2 tablets by mouth one time a day for heart failure -- daily weights in am. call physician if weight increases by 2 pounds in 24 hours or 5 pounds in 7 days from admission weight. One time a day During review of the medical record it was revealed R2 had missing weights on 12/18/18 to 12/20/18, 12/22/18, 12/26/18, 1/2/19, 1/6/19, 1/11/19, 1/23/19, 1/25-1/26/19, 2/2/19, 2/6/19, 2/12/19, and 2/21/19. During further review of the medical record, it was revealed the physician had not been notified of weight increase/gains for the following dates: 12/24/18 to 12/25/18, 2.6 pounds (lbs) 12/27/18 to 12/28/19, 2.5 lbs 12/28/18, to 12/29/18, 3.2 lbs 1/8/19 to 1/9/19 8.2 lbs 1/17/19 to 1/18/19, 7.3 lbs 1/19/19 to 1/20/19, 10.6 lbs	2 830		

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2 830	Continued From page 6 2/17/19 to 2/18/19, 2.6 lbs 2/19/19 to 2/20/19, 3.2 lbs On 2/25/19, at 12:59 p.m. LPN-A reviewed the medical record and verified the physician was not notified of the weight increase. LPN-A stated if the documentation was not there then they were going to have to do education with the nurses as they were supposed to follow physician orders. LPN-A stated when nurses chart the "code 9" in the MAR's and TAR's they were supposed to write a nurse note. When asked what documentation the nurses had noted for missing the weights, LPN-A stated the documentation had statements such as "NAR did not chart weight before leaving" ""weight not done this shift." "staff was told to weigh resident and did not.", among others. LPN-A stated if the weights were off, the nurses were supposed to have the aides re-check it again to make sure it was accurate. On 2/25/19, at 2:48 p.m. LPN-C stated the aides were supposed to get the weights and the nurse entered the weight. LPN-C stated she would check the previous date weight and if there was a discrepancy she would have the aides re-check it. LPN-C further stated the nurse was supposed to document if a resident refused to be weighed and if it was a continuous problem she would report to the supervisors and the Nurse Practitioner would be notified. On 2/26/19, at 9:00 a.m. the director of nursing (DON) stated "I realize it is a physician order and we will be looking at our equipment and we knew the bed scale had stopped working about a month or two ago. Our Hoyer's work and don't work some days. It's very touchy." When asked if the nurses were supposed to chart why the weights were not done as ordered by the	2 830		

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2 830	Continued From page 7 physician, the DON stated "I have seen the staff ask to weigh her but she refuses. I don't have documentation. We will have to come up with a policy on how to address that." The DON also stated nurses needed to follow the orders and call the physician with any weight gains if any. When asked about the fluid restriction, the DON stated she was the only one who put the order to document on each shift the amount of fluid intake for residents on restrictions. "I am not sure who is putting them in and causing a lot of confusion. I will go through today and make sure they are straightened out. Am surprised the dietician did not catch that." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents on daily weights and on fluid restriction are receiving the necessary services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure daily weights are complated as ordered by the physician; fluid restriction is followed and the physician is notified of weight increases. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		