Electronically delivered
June 13, 2019

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

RE: Project Number H5018125C

Dear Administrator:

On May 24, 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. In addition, at the time of the May 24, 2019 abbreviated survey the Minnesota Department of Health completed an investigation of complaint number H5018125C. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 12, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 12, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a

formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 12, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Crest View Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 12, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 24, 2019 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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: https://mdhprovidercontent.web.health.state.mn.us/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.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 05/24/2019

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 On 5/24/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5018125C 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively evaluate	F 689	F689	7/5/19

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

Electronically Signed | 06/21/2019

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 689	Continued From page 1 causative factors of falls, and failed to ensure interventions were implemented as recommended to reduce the risk for falls, for 2 of 3 residents (R1, R2) who experienced multiple falls in the facility. R2 sustained actual harm, a nose fracture and abraisions, as a result of falling. Findings include: R2's Admission Record dated 5/24/19, included diagnoses of restlessness, agitation and other psychotic disorder not due to a substance or known physiological condition. R2's quarterly Minimum Data Set (MDS) assessment dated 2/14/19, indicated R2 required limited assistance of one staff with transfers, walking in the corridor and locomotion on the unit. The MDS indicated R2 required supervision of one staff with walking in the room, and indicated R2 displayed no behaviors and did not wander. A quarterly MDS dated 5/15/19, indicated R2 required limited assistance of one staff for walking in room, had no behaviors, and exhibited wandering one to three days during the assessment review period. Each of these MDS's indicated R2 had severely impaired cognition. A facility assessment, Balance During Transitions and Functional Range of Motion dated 2/18/19, indicated R2 was unsteady when moving from a seated to standing position, walking with assistive device, moving on and off the toilet, and during transfers surface to surface. R2's care plan dated 11/27/18, identified a potential alteration in safety, with falls related to confusion and psychotropic medication use. The	F 689	It is the Policy of Crest View Lutheran Home to provide a resident environment that remains as free of accident hazards as is possible, and that each resident receives the adequate supervision and assistance devices to prevent accidents. Residents R1 and R2 no longer reside in the facility, and therefore will not benefit from changes in policy and practice related to falls. For all other residents that this practice may have affected, a whole-house assessment for every resident's fall risk will be completed in order to ensure that appropriate interventions are in place to prevent and/or limit falls. In addition, the Falls Program policies and procedures for Crest View Lutheran Home were both reviewed and updated by an interdisciplinary team on 6/21/2019. These policies detail the procedure for assessing all resident's fall risk, completing post fall assessments after each resident fall, and conducting a newly revised fall team huddle form. In addition, the new Falls Program policies and procedures detail the process for an interdisciplinary team reviewing all falls and ensuring appropriate interventions are put in place. Nurse Supervisors and LPN Coordinators will be responsible for completing an incident review and analysis report for each fall in order to ensure documentation for fall prevention interventions are in place and clearly documented. All staff will be re-educated on the Falls	

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F 689	Continued From page 2 care plan directed staff to assist R2 with activities of daily living (ADL's) per resident need and per request. In addition, the care plan directed staff to ensure R2 wore non skid footwear during transfers/ambulation, and indicated R2 had problems with forgetting his walker. Further, the care plan indicated staff were to keep R2's call light within reach, and to remind R2 when/how to use it for assistance. A Care Area Assessment (CAA) for falls dated 11/19/18, indicated R2 had impaired balance during transitions, was on antipsychotic medications which put him at risk for falls, and had impaired cognition. A Fall Risk Evaluation dated 5/12/19, indicated R2 had a fall risk score of 22 indicating R2 was at high risk for falls. Review of documentation related to R2's fall history and interventions, indicated interventions were recommended, but not always implemented, and not all falls were evaluated to determine root cause: -3/7/19, at 12:10 p.m. R2 had a fall without injury in the dining room. An interdisciplinary team (IDT) note dated 3/8/19, indicated R2 was independent with ambulation with use of a walker, and felt it it would be a good idea for Physical therapy (PT) to evaluate for ambulation/transfers to determine need/benefit of a walking program. Orders were received that same day from R2's physician, for PT to evaluate and treat. On 3/14/19, PT had screened R2 and recommended supervision for ambulation, and for nursing to cue R2 to always use the rolling walker when ambulating.	F 689	Program policies and procedures by July 5th. Audits have been put in place to monitor falls assessments, appropriate fall interventions, communication between nursing staff and therapy staff, and fall documentation. These audits will be completed weekly for four weeks, and then scheduled routinely 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: 7/5/2019	

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F 689	Continued From page 3	F 689		

-4/5/19, at 10:44 a.m. R2 was found laying on the floor in the hallway. R2 could not identify what had happened. Documentation indicated R2 wore gripper socks and the floor was clean and dry but did not indicate whether R2 had been using his walker, or whether staff had been providing supervision. On 4/8/19, orthostatic blood pressures were obtained following the fall. An IDT note dated 4/8/19, indicated the nurse practitioner (NP) was updated and had been in to the facility that day to see R2. The note further included, "NP was requested to review blood pressure (BP) medication to determine if this may have contributed to his fall. Resident (res) has a history of standing up quickly and starting to ambulate quickly. Low BP may have contributed. NP stated she will review res vitals and medications during visit today."

-4/20/19, at 8:30 p.m. a progress note included, "CNA (certified nursing assistant) saw resident laying on his back, on the floor of resident's room, between bed A and B. Resident stated that he was getting out of bed and sat on the floor and layed down." Vital signs were noted as stable, neurological assessment was noted as intact and range of motion was documented as within normal limits. An immediate intervention was identified as providing the call light to resident, and ensuring it was within resident reach.

-On 4/22/19, an IDT note indicated the resident's 4/20/19 fall had been reviewed, "Res. transfers independently. Res. currently has a low bed. Res. team sheets/care plan [TS/CP] will be updated to keep res. bed at appropriate height for res. to stand up from when transferring for res. safety."

-5/6/19, social service note indicated R2 had

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F 689	Continued From page 4 been seen by a clinical psychologist and the psychologist documented R2 had reported he was "tired all the time and this is causing anxiousness." The psychologist's recommendation included: "Gradual Dose Reduction [GDR] of Zyprexa to increase energy and ability to participate in programming . If further questions arise associated with psych medications [meds], psychiatry referral may be appropriate." -5/6/19, at 6:45 a.m. a progress note included, "CNA saw resident laying on his back, on the floor of resident's room, by his bed. Res observed laying down on his left side. Res stated when he was trying to stand up he lost his balance. He stated it was dark and he could not see." The note indicated an immediate intervention had been implemented. "Writer reminded resident of the use of call-light. Day supervisor updated and recommendation for night light." A subsequent IDT note from 5/6/19 included: "Reviewed res. fall. Maintenance will be updated to request a night light in room. Writer will update res. NP of fall and request res. weight loss be reviewed. Pharmacist is in facility today and will review res. medications for risk of increased falls and weight loss." Documentation indicated the NP had been updated on 5/6/19. The notes indicated the NP was updated of the of fall and continued weight loss and had given new orders to discontinue morning (AM) Olanzapine and in one week, to decrease bedtime (HS) olanzapine to 5 milligram (mg), to decrease Sinemet to three times daily (TID) and had given orders for several laboratory tests to be conducted. A nurse had documented she'd updated maintenance with the request to place a night light in R2's room.	F 689		

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F 689	Continued From page 5	F 689		

-5/14/19, at 10:45 a.m. a progress note included, "Resident was walking with walker into dining room after getting up from chair in television [TV] room. Had gripper socks on. Fell sideways into wall. Small abrasion on elbow." The note further indicated R2 had stated he hit his head and elbow however, the vital signs were stable and R2 denied pain. There was no documentation to indicate level of staff supervision for R2 at the time of the fall.

-On 5/15/19, an IDT note indicated R2 had been using a walker and was wearing gripper socks at the time of the fall. The note included, "Writer will check unit to determine if res. has shoes in his room. Res. also wears glasses, staff will be educated to remind res. to wear glasses. Res. will be provided with a string to wear glasses around neck to have them with him at all times. Res. family requested for res. to be on a walking program to work on steadiness, strength and speed of walking. Res. was starting on a walking program." There was no documentation to indicate level of staff supervision for R2 at the time of the fall.

-5/15/19, at 11:19 p.m. note indicated "Resident was observed on the floor in his bedroom, laying on the right lateral side of his body, in the entry way to his bedroom and bathroom bleeding from his right nostril. Resident stated he got up from his bed and was walking out the door without his walker and lost his balance. Writer assessed resident and observed heavy bleeding from his right nostril. Writer cleaned some of the blood off resident's face and forehead before calling 911 due to the fact that the resident appeared disoriented and could not stay seated up right, along with heavy bleeding." Resident was taken

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F 689	Continued From page 6	F 689		

to the hospital for further observation and medical evaluation.

The medical record and fall investigation lacked documentation to indicate whether staff had been asked when they had last seen and assisted R2 in the room.

-5/16/19, at 1:17 a.m. note indicated resident returned from the hospital emergency room and report was received by the writer was told that resident had a fractured nose. On 5/16/19, at 7:28 a.m. the note indicated after R2 had returned to the facility he was noted with further injuries which included abrasions on the forehead and small abrasion on both elbows and the vital signs were stable. On 5/16/19, an IDT progress note indicated R2 had been seen by the primary physician to evaluate medications and labs. Also the consultant pharmacist was going to evaluate medications and another maintenance request would be filled out for a night light to be placed at bedside along with walker. Another note on 5/16/19, indicated new orders had been received for Seroquel (psychotic medication) 50 mg twice daily (BID), to increase the resident's Sinemet back to original dose from 2 weeks ago, and to have therapy evaluate and treat for weakness and stiffness as resident was currently using a wheelchair for locomotion on unit related to unsteady gate, weakness and fractured nose.

-5/16/19, at 10:45 a.m. a progress note included, "The nurse had been called to the dining room by the NA who reported R2 had slid onto his buttocks when attempting to get up from the wheelchair he was using at lunch. Nurse also indicated staff had sat with R2 1:1 for the rest of the shift.

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F 689	Continued From page 7 -An Interdisciplinary Communication Form dated 5/16/19, revealed an order was written for PT to evaluate and treat R2 related to leg/knee weakness. On 5/17/19, a progress note by PT indicated a therapist had attempted to evaluate R2 who had refused. The note further indicated PT would attempt to evaluate again on Monday 5/20/19. On 5/17/19, an IDT progress note included R2 had order to be seen by therapy, and since resident fall from the wheelchair 5/16/19, maintenance was requested to place auto-lock brakes on the wheelchair. Note also indicated the NP had been requested to reinstate Olanzapine which had been decreased two weeks prior as staff had reported an increase in behavior during the evening shift. Further, the note indicated the consultant pharmacist was again requested to review R2's medications due to frequent falls. The medical record lacked documentation the consultant pharmacist had reviewed R2's medications falling the falls as indicated in the progress note from 5/17/19. -5/18/19, at 1:30 a.m. a progress note included, "During 2nd check, resident was found laying on the floor between the end of the bed and the furniture chest of his roommate. Resident was bleeding from cut on his head. Resident was very resistive to care. Range of motion [ROM] was done, resident was helped up with 4 assist and helped in the shower chair, resident obtained a cut on the front of his head on right side, pressure applied to stop the bleeding, site was cleansed and steri-strip applied. Resident remain impulsive trying to jump up from his chair, swing at staff when trying to stop him from falling." A follow up	F 689		

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 05/24/2019

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 689	Continued From page 8	F 689		

note indicated the writer had contacted a physician about the cut on the head and was told to monitor and update the provider with any changes.

-5/19/19, at 6:09 p.m. a progress note included, "Resident fell in the dining room during dinner time when he impulsively got up from his wheelchair to walk out the dining room. Resident landed on his abdomen and hands, while holding his head/face up. No injury was observed on resident. Writer reminded resident to ask for help whenever he feels he wants to get up to go some place. Resident should be closely monitored when sitting up in his wheelchair."

-5/19/19, at 6:41 p.m. a progress note included, "Resident was observed laying on the floor in his room by NAR who went to check on him...[R2] was very agitated and restless while getting him off the floor." Documentation indicated R2's vital signs were stable, no new injury was noted, and the NP was notified. The NP had "advised to give an additional 5 mg Olanzapine tonight, one time only."

-5/20/19, IDT note indicated resident's multiple falls over the weekend had been discussed and NP was going to be updated on resident's combative behavior and to see if she could address resident's pain with additional pain medications if appropriate due to possible pain from broken nose. The notes identified R2's Zyprexa had recently been increased and R2 was placed on a 1:1 for 48 hours. The medical record lacked documentation of the interdisciplinary team discussing and analyzing each of the three falls separately as the falls happened at different times and locations.

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 05/24/2019

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

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F 689	Continued From page 9	F 689		

-5/20/19, at 3:00 p.m. progress note indicated R2 had been seen by the NP and the NP was again updated on condition and continuing falls. The NP gave new orders for Tylenol, to taper Sinemet, and to discontinue after taper. The note indicated R2 was on 1:1.

-5/20/19, at 10:46 p.m. note indicated "NA doing one on one with resident called the nurse to come to the resident room and reported resident was on the floor. NA stated resident was trying to use the bathroom and as she was trying to calm him down to wait for another NA to come resident got combative, pushed NA and fell on the floor from bed. When the nurse got in the room she observed resident was lying on the floor face down and was crawling. The writer attempted to ask resident to stop crawling so they could help to assist him off the floor but he was not following commands. Resident was unsteady after getting up with staff assistance and asked to use the toilet but did not go. R2 noted to have an indwelling foley catheter." The documentation indicated the resident did not comprehend how to use the call light even though it was explained, and indicated R2's speech was slurred and non-sensical. The medical record lacked notation of a fall analysis and interventions put in place were things that had been put in place before the fall.

-5/21/19, at 6:23 a.m. progress note included, "Resident was one on one on this shift, he was restless, agitated, confused, swinging his arms at staff, resistive to cares, he pulled his night gown, brief and catheter off during the shift. He kept trying to get on the floor, so a floor mat was placed by his bedside." Although R2 had the

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 05/24/2019

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 689	Continued From page 10	F 689		

above noted increase in behaviors, the medical record lacked documentation the physician or NP had been notified of the change in condition on the night shift on 5/21/19.

-5/21/19, at 9:15 a.m. a change of condition note indicated the resident presented as confused, disoriented, lethargic, appeared to be hallucinating, grabbed things in the air and had pulled the catheter out the previous night. The note indicted the Tylenol which had been prescribed the previous day by the NP was not effective and the NP had given orders to send R2 to the emergency department for evaluation.

On 5/24/19, between 2:01 p.m. and 2:39 p.m., each of the above identified falls was reviewed with the director of nursing (DON). The DON stated to her knowledge R2 "was independent with ambulation in the unit and in his room." When asked about the PT recommendation for R2 to be supervised with ambulation and the other assessments which indicated R2 was not steady, the DON stated, "I don't know." The DON stated R2 was impulsive and would get up and start to walk at times. When asked when the IDT team discussed R2's multiple falls if staff who were present, or who had witnessed the falls, had been interviewed about the moments leading up to the falls, after the falls, and what R2 had been doing or what cares had been provided, the DON stated, "I don't know." When asked about the 5/14/19 incident when R2 had sustained an injury ambulating in the hallway with walker if staff had been asked why they were not walking with R2 at the time per the PT recommendation for R2 to be supervised to ambulate the DON stated "if the recommendation stands and is current the staff should have been with him. Sometimes the

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 05/24/2019

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 689	Continued From page 11	F 689		

resident gets up and starts going and staff don't get to him on time. You know how those units are." The DON also acknowledged some of the interventions put in place were not appropriate as R2 had severe cognitive impairment: such as a resident who was severely cognitively impaired being asked to use the call light, or for the resident to alert staff when he wanted to get up. When asked if R2 had been put on the walking program as an intervention for the 5/14/19 fall, the DON stated she thought so and was going to provide the documentation. The DON also reiterated PT had attempted to see R2 on 5/17/19, which was a Friday however, R2 continued to have multiple falls during that weekend "it would have been nice to be seen soon for all these falls." When asked why PT had not re-approached R2 until 5/20/19, the DON stated it was because R2 was in the long term care unit, and stated it usually took a few days before the resident was seen by PT. The DON further stated staff should have contacted the medical provider when R2 exhibited increased behaviors, including pulling out his catheter, and when his cognition deteriorated and his speech was observed to be slurred. The DON also verified the consultant pharmacist had last reviewed R2's medications on 5/6/19, and had not reviewed the medications despite the IDT notes indicating the pharmacist was going to be requested to review the medications after some of the falls as an intervention. The DON stated the IDT had reviewed each fall and had thought the falls were related to the resident's impulsivity and medications changes. The DON stated R2's hospital admitting diagnosis, was chronic anemia, and that R2 had been found to have an infection.

On 5/24/19. at 3:04 p.m. PT-A stated she had

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 05/24/2019

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 689	Continued From page 12	F 689		

attempted to conduct an evaluation for R2 on 5/17/19, however R2 had refused. PT-A said she had re-attempted on Monday 5/20/19. PT-A stated it was normal for a resident with dementia to refuse at times, but they always re-approached. PT-A stated, "It was to our understanding he had leg/knee weakness. We did not know the evaluation was ordered due to falls. If there was a concern with gait and strengthening to prevent falls, a therapist could have seen him on the weekend. Because this was not communicated, we thought we would re-attempt on Monday." At 3:10 p.m. that same day, PT-B stated R2 had been seen multiple times by therapy and was resistive but did eventually work with therapy. PT-B stated this was due to dementia. When asked about the therapy recommendation dated 3/14/19, regarding R2 being supervised for ambulation, and nursing to cue R2 to always use the rolling walker when ambulating, both PT's stated staff were to continue with those recommendations. They verified R2 was supposed to use the walker and staff were supposed to be with him, because at times R2 would leave the walker and walk off due to his cognitive impairment.

On 5/31/19, at 11:49 a.m. via telephone, family member (FM)-A stated he felt R2's falls had happened due to R2 not being provided adequate supervision. FM-A also stated, "The falls have taken a toll on him and now he just sits there. I liked when he was able to walk around. If someone had supervised him maybe he would be okay now. He had strokes in the past and this caused him not to be very steady. He was impulsive however, staff were supposed to be with him when he was on the move to make sure he was okay."

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 05/24/2019

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 689	Continued From page 13	F 689		

R2's ambulation program directed staff to assist with structure ambulation with walker 100-300 feet [ft], three times a day, to encourage resident to slow down when walking fast, and to remind him to focus on his stride. The documentation revealed in five days and 15 attempts, R2 had ambulated 2 times, had been documented to have refused 3 times and 9 times staff had documented "not applicable." The medical record lacked documentation the facility had followed up to make sure the walking program was effective and being implemented.

R1's admission Minimum Data Set (MDS) dated 4/11/19, indicated she was severely cognitively impaired, required extensive assitance from two staff for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. The MDS further indicated R1 had a history of falls prior to admission and had sustained a fall with injury since admission to the facility. The Care Area Assessment dated 4/16/19, lacked a rationale for the care plan decisions.

A Fall Risk Evaluation dated 4/5/19, indicated R1 had an altered level of consciousness, had no falls in the past three months and was chair bound. The assessment indicated an fall risk score of 13 and indicated a score over ten must include interventions to prevent falls. Interventions identified on the assessment included gripper socks.

R1's care plan dated 4/22/19, identified an alteration in self care and an alteration in safety related to dementia. The care plan directed staff to provide auto lock brakes on her wheel chair, place dycem on the seat of the wheel chair,

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 05/24/2019

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 689	Continued From page 14	F 689		

provide a stuffed animal to hold when restless and offer to ambulate in hallway when restless.
An undated facility document titled Willow Team 3 identified R1 as a high fall risk and directed staff to keep her where she could be monitored and Dycem in wheel chair.

An Order Recap Report dated 5/24/19, identified the following orders:

Dilaudid 1 milligram (mg) by mouth every hour as needed for anxiety and 1 mg every 6 hours for pain.
Zyprexa 7.5 mg by mouth every three hours for delirium.
Haldol 2 mg by mouth four times daily and every two hours as needed for delirium/unable to settle

During observation on 5/24/19, at approximately 10:30 a.m. R1 was lying on her back in bed. She had a large hematoma on the right side of her forehead, bruising on her upper lip and bruising to her right temple. At 10:42 a.m. nursing assistant (NA)-A and NA-B entered R1's room to assist her out of bed. NA-A and NA-B assisted R1 to stand and transfer to her wheel chair without the use of a transfer belt.

During interview at 10:46 a.m. NA-B stated they usually used a transfer belt. NA-B stated R1 fell frequently and stated R1 used to have a fall mat but it was removed because she would walk and it was a tripping hazard. NA-B stated staff watched R1 closely and R1 had dycem in her chair. NA-B further stated staff placed a pillow in front of her in the wheel chair to keep her from rising but "she hates it."

At 10:49 a.m., after R1 was seated in the wheel

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 05/24/2019

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 689	Continued From page 15	F 689		

chair, NA-B placed a pillow on her lap and pushed it down so it was partially tucked under the arm rests, even though she had just stated R1 hated it. R1 was then escorted to the dining room. At 10:55 a.m. R1 sat in her wheel chair at the dining room table with her head down and her eyes closed. At 11:04 a.m. R1 remained at the table with head down and eyes closed. She was observed to startle and flinch every few seconds. At this time a bruise was noted under her right eye socket.

At 12:15 p.m. R1 was in her wheel chair leaning far forward over the pillow in her lap and appeared to be asleep. At 12:18 p.m. NA-B and NA-C assisted R1 back to bed, again transferring her without a transfer belt.

A review of facility incident reports and correlating Progress Notes identified the following:

4/5/19, R1 stood up in the hallway near the nurses station, bent over in an attempt of picking something off the floor and "thumped" over hitting her head on the floor. A Progress Note dated 4/6/19, indicated R1 had a hematoma on the left side of her head with swelling that went down to the left side of her eye. A Progress Note dated 4/8/19, indicated the interdisciplinary team (IDT) reviewed the fall. Care plan updated to walk R1 when restless, give her a stuffed animal to hold and move to locked unit due to smaller environment. A facility document titled Fall Team huddle Form dated 4/5/19, indicated R1 had been assisted to the toilet at 4:30 p.m. and indicated there was nothing on the floor for R1 to pick up.

5/7/18, R1 was noted on the floor next to her wheel chair. A Progress Note dated 5/8/19,

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 05/24/2019

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 689	Continued From page 16	F 689		

indicated IDT discussed fall. R1 slipped out of chair, Dycem applied to wheel chair. Team felt this was an appropriate intervention at that time.

5/8/19, R1 found kneeling on the floor next to her bed. A Progress Note dated 5/8/19, indicated at 8:20 a.m. R1 was found kneeling on the floor next to her bed. NA stated she was just in the room and R1 had been sleeping. Skin tear noted to R1's right elbow measuring 1.4 centimeters (cm) x 1.6 cm. R1 unable to use call light. Brief was soiled at time of fall and last changed during overnight shift. on 5/9/19, IDT discussed R1's fall and determined R1 would be placed on early riser list and request sent to therapy for walking program evaluation. A fall Team Huddle Form indicated R1 was restless, had a soiled brief and wanted to get up and indicated R1 would benefit from a walking program.

An incident report dated 5/10/19, indicated R1 was found on the floor by her bed. A Progress Noted dated 5/10/19, indicated therapy staff ad been working with R1 in her room and did not notify nursing staff when they left.
A Fall Team Huddle Worksheet dated 5/10/19, indicated R1 fell in her room after working with physical therapy. Therapy did not communicate to nursing after working with R1. Intervention indicated staff to work on effective communication.

5/11/19, Fall incident report incomplete, no information. A Progress Note dated 5/11/19, indicated R1 was observed lying on the floor by her bed facing the window. 5/13/19, Writer spoke to nurse working at the time of the fall. Nurse stated R1 had gotten up in the morning at approximately 8:30 a.m. was given medications

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 05/24/2019

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 689	Continued From page 17	F 689		

and fell asleep in chair so she was laid down by the nurse and sleeping soundly. R1 to be placed on 15 minute checks.

5/14/19, Writer was alerted by floor nurse that R1 had a large purple bruise on the right side of her face 12 cm x 6 cm, including the eye lids which were swollen. Hospice nurse evaluated and felt R1 may have ben restless in bed and bumped her head on the night stand next to head of bed or other object. Night stand was moved and hospice delivering a floor mat.

A Progress Note dated 5/15/19, indicated IDT reviewed bruise. The note indicated the nightstand would be moved from next to the bed and floor fall mat would be moved since R1 was ambulatory and may increase risk for falls.

5/17/19, R1 found sitting on the floor near a table in the dining room. A Progress Note dated 5/17/19, indicated R1 was found sitting on the floor by the table in the dining room. 5/20/19, R1 discussed by IDT regarding fall. Zyprexa had been increased since this fall, hope is that medication change will help with restlessness.

During interview on 5/24/19, at 12:21 p.m. licensed practical nurse (LPN)-A stated R1 was on hospice. LPN-A stated When R1 sat in the bed or the wheel chair she would lean over and sometimes would stand up quickly. LPN- A stated staff would provide one to one assistance sometimes. LPN-A further stated sometimes R1 was very weak and didn't want to do anything and sometimes she was strong. LPN-A stated the bruise on R1's face was not from a fall but stated she did fall often. LPN-A stated the staff tried to offer food, sat with her and tried to keep an eye

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 05/24/2019

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 689	Continued From page 18 on her every 15 minutes when up in wheel chair. During interview on 5/24/19, at 1:31 p.m. the director of nursing (DON) was asked how the IDT determined appropriate interventions for R1's falls. The DON stated R1's medications were looked at in depth, but was unsure if any changes were made. Regarding the fall on 5/7/19, the DON stated she was thinking R1 slid to the floor. In regard to the fall on 5/8/19, she stated R1 was found on the floor at 8:20 a.m. and stated, "Im looking for a reason to think she's and early riser." In regard to the fall on 5/8/19, the DON stated, "you should talk to (another staff), she's really the champion on this." However, the nurse the DON identified was not in the facility during the survey. The DON stated she was not sure why the intervention for the fall on 5/11/19, had been put in place. The DON stated she would review the falls further, however no further information was provided. At 2:31 p.m. the hospice RN and hospice social worker (SW) were interviewed. The hospice RN stated when she met R1 she was upstairs on the transitional care unit and she had no bruises. The hospice RN stated when R1 was moved downstairs she had two falls, both when she slipped out of her wheel chair. She stated the bad bruises happened beginning on the weekend and stated R1's children had taken a picture and sent it to the guardian who in turn sent it to the hospice team to see if they were aware. The hospice RN stated they had not been aware of the bruising and stated when she saw it she could not believe how much it was. She stated R1's right eye was swollen shut and it hurt. She stated R1 then had a fall out of bed without a face strike. The hospice RN stated she felt it was the night stand so the	F 689		

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 05/24/2019

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

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F 689	Continued From page 19	F 689		

night stand was moved. She stated she talked to the supervisor and told her when R1 first admitted to the facility she was in a reclining wheel chair but the facility felt it was a restraint because R1 could walk so it was removed. She stated after the second fall she asked if hospice could make a negotiated risk with the family but the supervisor said the facility did not do that. She stated hospice also offered a concave mattress and were told that was also a restraint and could not use it but stated she had seen staff putting blankets under the sheet and creating a concave mattress. The hospice RN stated she talked with the facility about the falls but it was her bringing it up to them and asking them what they could do. She stated R1 was in the room with the door shut when she saw her and said initially the nurse would take R1 everywhere with her. She said everything she suggested to the facility she was told no. She stated herself and the DON were worried because R1 had so many falls. The hospice nurse further stated after the second fall, one of the NA's approached her and asked her to come and asked if had seen R1. She stated "it was breath taking."(referring to the facial bruising). She stated the NA said to her she needed to do something, she was in pain. The hospice RN stated she did not think R1's medications were contributing to her falls and stated the facility had expressed concerns about the use of the Haldol but stated, we had to stop the up and down." She stated "to me, she is sedated now" but is peaceful and stated when R1 first admitted to the facility the family did not want her on a lot of medication so they backed off but she told them R1 needed to be sedated and stated, "I felt like that was our only option." In regard to collaborating with hospice to find the root cause of R1's falls, the hospice RN stated

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	245018	A. BUILDING _____ B. WING _____	C 05/24/2019

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

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F 689	Continued From page 20 she thought the facility discussed it amongst themselves but did not collaborate with hospice. She stated after the second fall she felt the facility knew how concerned she was and stated, "it was the worst fall to the face she had ever seen." Shen then stated again the sedation was intentional. A facility policy titled Transfer Belts dated 4/19, indicated transfer belts are use when transferring residents and when assisting residents to stand or walk to minimize and prevent when possible injury to residents and staff. A facility policy titled Incident/Accident and Fall Reporting dated 6/17, indicated all incidents, accidents and unusual occupancies that involve residents are investigated for causal factors and prevention of reoccurrence.	F 689		

Electronically delivered
June 13, 2019

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

Re: State Nursing Home Licensing Orders - Project Number H5018125C

Dear Administrator:

The above facility was surveyed on May 24, 2019 through May 24, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5018125C. 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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/24/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found NOT to be in compliance with the MN state licensure. The following complaint(s) were found to be	2 000		

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2 000	Continued From page 1 substantiated: H5018125C was found not to be in compliance at the time of the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively evaluate causative factors of falls, and failed to ensure interventions were implemented as recommended to reduce the risk for falls, for 2 of 3 residents (R1, R2) who experienced multiple falls in the facility. R2 sustained actual harm, a nose fracture and abraisions, as a result of falling.	2 830	Corrected	7/5/19

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2 830	Continued From page 2 Findings include: R2's Admission Record dated 5/24/19, included diagnoses of restlessness, agitation and other psychotic disorder not due to a substance or known physiological condition. R2's quarterly Minimum Data Set (MDS) assessment dated 2/14/19, indicated R2 required limited assistance of one staff with transfers, walking in the corridor and locomotion on the unit. The MDS indicated R2 required supervision of one staff with walking in the room, and indicated R2 displayed no behaviors and did not wander. A quarterly MDS dated 5/15/19, indicated R2 required limited assistance of one staff for walking in room, had no behaviors, and exhibited wandering one to three days during the assessment review period. Each of these MDS's indicated R2 had severely impaired cognition. A facility assessment, Balance During Transitions and Functional Range of Motion dated 2/18/19, indicated R2 was unsteady when moving from a seated to standing position, walking with assistive device, moving on and off the toilet, and during transfers surface to surface. R2's care plan dated 11/27/18, identified a potential alteration in safety, with falls related to confusion and psychotropic medication use. The care plan directed staff to assist R2 with activities of daily living (ADL's) per resident need and per request. In addition, the care plan directed staff to ensure R2 wore non skid footwear during transfers/ambulation, and indicated R2 had problems with forgetting his walker. Further, the care plan indicated staff were to keep R2's call light within reach, and to remind R2 when/how to	2 830		

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2 830	Continued From page 3 use it for assistance. A Care Area Assessment (CAA) for falls dated 11/19/18, indicated R2 had impaired balance during transitions, was on antipsychotic medications which put him at risk for falls, and had impaired cognition. A Fall Risk Evaluation dated 5/12/19, indicated R2 had a fall risk score of 22 indicating R2 was at high risk for falls. Review of documentation related to R2's fall history and interventions, indicated interventions were recommended, but not always implemented, and not all falls were evaluated to determine root cause: -3/7/19, at 12:10 p.m. R2 had a fall without injury in the dining room. An interdisciplinary team (IDT) note dated 3/8/19, indicated R2 was independent with ambulation with use of a walker, and felt it it would be a good idea for Physical therapy (PT) to evaluate for ambulation/transfers to determine need/benefit of a walking program. Orders were received that same day from R2's physician, for PT to evaluate and treat. On 3/14/19, PT had screened R2 and recommended supervision for ambulation, and for nursing to cue R2 to always use the rolling walker when ambulating. -4/5/19, at 10:44 a.m. R2 was found laying on the floor in the hallway. R2 could not identify what had happened. Documentation indicated R2 wore gripper socks and the floor was clean and dry but did not indicate whether R2 had been using his walker, or whether staff had been providing supervision. On 4/8/19, orthostatic blood pressures were obtained following the fall. An IDT note dated 4/8/19, indicated the nurse practitioner	2 830		

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2 830	Continued From page 4 (NP) was updated and had been in to the facility that day to see R2. The note further included, "NP was requested to review blood pressure (BP) medication to determine if this may have contributed to his fall. Resident (res) has a history of standing up quickly and starting to ambulate quickly. Low BP may have contributed. NP stated she will review res vitals and medications during visit today." -4/20/19, at 8:30 p.m. a progress note included, "CNA (certified nursing assistant) saw resident laying on his back, on the floor of resident's room, between bed A and B. Resident stated that he was getting out of bed and sat on the floor and layed down." Vital signs were noted as stable, neurological assessment was noted as intact and range of motion was documented as within normal limits. An immediate intervention was identified as providing the call light to resident, and ensuring it was within resident reach. -On 4/22/19, an IDT note indicated the resident's 4/20/19 fall had been reviewed, "Res. transfers independently. Res. currently has a low bed. Res. team sheets/care plan [TS/CP] will be updated to keep res. bed at appropriate height for res. to stand up from when transferring for res. safety." -5/6/19, social service note indicated R2 had been seen by a clinical psychologist and the psychologist documented R2 had reported he was "tired all the time and this is causing anxiousness." The psychologist's recommendation included: "Gradual Dose Reduction [GDR] of Zyprexa to increase energy and ability to participate in programming . If further questions arise associated with psych medications [meds], psychiatry referral may be appropriate."	2 830		

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2 830	Continued From page 5 -5/6/19, at 6:45 a.m. a progress note included, "CNA saw resident laying on his back, on the floor of resident's room, by his bed. Res observed laying down on his left side. Res stated when he was trying to stand up he lost his balance. He stated it was dark and he could not see." The note indicated an immediate intervention had been implemented. "Writer reminded resident of the use of call-light. Day supervisor updated and recommendation for night light." A subsequent IDT note from 5/6/19 included: "Reviewed res. fall. Maintenance will be updated to request a night light in room. Writer will update res. NP of fall and request res. weight loss be reviewed. Pharmacist is in facility today and will review res. medications for risk of increased falls and weight loss." Documentation indicated the NP had been updated on 5/6/19. The notes indicated the NP was updated of the of fall and continued weight loss and had given new orders to discontinue morning (AM) Olanzapine and in one week, to decrease bedtime (HS) olanzapine to 5 milligram (mg), to decrease Sinemet to three times daily (TID) and had given orders for several laboratory tests to be conducted. A nurse had documented she'd updated maintenance with the request to place a night light in R2's room. -5/14/19, at 10:45 a.m. a progress note included, "Resident was walking with walker into dining room after getting up from chair in television [TV] room. Had gripper socks on. Fell sideways into wall. Small abrasion on elbow." The note further indicated R2 had stated he hit his head and elbow however, the vital signs were stable and R2 denied pain. There was no documentation to indicate level of staff supervision for R2 at the time of the fall.	2 830		

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2 830	Continued From page 6 -On 5/15/19, an IDT note indicated R2 had been using a walker and was wearing gripper socks at the time of the fall. The note included, "Writer will check unit to determine if res. has shoes in his room. Res. also wears glasses, staff will be educated to remind res. to wear glasses. Res. will be provided with a string to wear glasses around neck to have them with him at all times. Res. family requested for res. to be on a walking program to work on steadiness, strength and speed of walking. Res. was starting on a walking program." There was no documentation to indicate level of staff supervision for R2 at the time of the fall. -5/15/19, at 11:19 p.m. note indicated "Resident was observed on the floor in his bedroom, laying on the right lateral side of his body, in the entry way to his bedroom and bathroom bleeding from his right nostril. Resident stated he got up from his bed and was walking out the door without his walker and lost his balance. Writer assessed resident and observed heavy bleeding from his right nostril. Writer cleaned some of the blood off resident's face and forehead before calling 911 due to the fact that the resident appeared disoriented and could not stay seated up right, along with heavy bleeding." Resident was taken to the hospital for further observation and medical evaluation. The medical record and fall investigation lacked documentation to indicate whether staff had been asked when they had last seen and assisted R2 in the room. -5/16/19, at 1:17 a.m. note indicated resident returned from the hospital emergency room and report was received by the writer was told that resident had a fractured nose. On 5/16/19, at	2 830		

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2 830	Continued From page 7 7:28 a.m. the note indicated after R2 had returned to the facility he was noted with further injuries which included abrasions on the forehead and small abrasion on both elbows and the vital signs were stable. On 5/16/19, an IDT progress note indicated R2 had been seen by the primary physician to evaluate medications and labs. Also the consultant pharmacist was going to evaluate medications and another maintenance request would be filled out for a night light to be placed at bedside along with walker. Another note on 5/16/19, indicated new orders had been received for Seroquel (psychotic medication) 50 mg twice daily (BID), to increase the resident's Sinemet back to original dose from 2 weeks ago, and to have therapy evaluate and treat for weakness and stiffness as resident was currently using a wheelchair for locomotion on unit related to unsteady gate, weakness and fractured nose. -5/16/19, at 10:45 a.m. a progress note included, "The nurse had been called to the dining room by the NA who reported R2 had slid onto his buttocks when attempting to get up from the wheelchair he was using at lunch. Nurse also indicated staff had sat with R2 1:1 for the rest of the shift. -An Interdisciplinary Communication Form dated 5/16/19, revealed an order was written for PT to evaluate and treat R2 related to leg/knee weakness. On 5/17/19, a progress note by PT indicated a therapist had attempted to evaluate R2 who had refused. The note further indicated PT would attempt to evaluate again on Monday 5/20/19. On 5/17/19, an IDT progress note included R2 had order to be seen by therapy, and since resident fall from the wheelchair 5/16/19,	2 830		

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2 830	Continued From page 8 maintenance was requested to place auto-lock brakes on the wheelchair. Note also indicated the NP had been requested to reinstate Olanzapine which had been decreased two weeks prior as staff had reported an increase in behavior during the evening shift. Further, the note indicated the consultant pharmacist was again requested to review R2's medications due to frequent falls. The medical record lacked documentation the consultant pharmacist had reviewed R2's medications falling the falls as indicated in the progress note from 5/17/19. -5/18/19, at 1:30 a.m. a progress note included, "During 2nd check, resident was found laying on the floor between the end of the bed and the furniture chest of his roommate. Resident was bleeding from cut on his head. Resident was very resistive to care. Range of motion [ROM] was done, resident was helped up with 4 assist and helped in the shower chair, resident obtained a cut on the front of his head on right side, pressure applied to stop the bleeding, site was cleansed and steri-strip applied. Resident remain impulsive trying to jump up from his chair, swing at staff when trying to stop him from falling." A follow up note indicated the writer had contacted a physician about the cut on the head and was told to monitor and update the provider with any changes. -5/19/19, at 6:09 p.m. a progress note included, "Resident fell in the dining room during dinner time when he impulsively got up from his wheelchair to walk out the dining room. Resident landed on his abdomen and hands, while holding his head/face up. No injury was observed on resident. Writer reminded resident to ask for help whenever he feels he wants to get up to go some place. Resident should be closely monitored	2 830		

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2 830	Continued From page 9 when sitting up in his wheelchair." -5/19/19, at 6:41 p.m. a progress note included, "Resident was observed laying on the floor in his room by NAR who went to check on him...[R2] was very agitated and restless while getting him off the floor." Documentation indicated R2's vital signs were stable, no new injury was noted, and the NP was notified. The NP had "advised to give an additional 5 mg Olanzapine tonight, one time only." -5/20/19, IDT note indicated resident's multiple falls over the weekend had been discussed and NP was going to be updated on resident's combative behavior and to see if she could address resident's pain with additional pain medications if appropriate due to possible pain from broken nose. The notes identified R2's Zyprexa had recently been increased and R2 was placed on a 1:1 for 48 hours. The medical record lacked documentation of the interdisciplinary team discussing and analyzing each of the three falls separately as the falls happened at different times and locations. -5/20/19, at 3:00 p.m. progress note indicated R2 had been seen by the NP and the NP was again updated on condition and continuing falls. The NP gave new orders for Tylenol, to taper Sinemet, and to discontinue after taper. The note indicated R2 was on 1:1. -5/20/19, at 10:46 p.m. note indicated "NA doing one on one with resident called the nurse to come to the resident room and reported resident was on the floor. NA stated resident was trying to use the bathroom and as she was trying to calm him down to wait for another NA to come resident got combative, pushed NA and fell on the floor from	2 830		

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	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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2 830	Continued From page 10 bed. When the nurse got in the room she observed resident was lying on the floor face down and was crawling. The writer attempted to ask resident to stop crawling so they could help to assist him off the floor but he was not following commands. Resident was unsteady after getting up with staff assistance and asked to use the toilet but did not go. R2 noted to have an indwelling foley catheter." The documentation indicated the resident did not comprehend how to use the call light even though it was explained, and indicated R2's speech was slurred and non-sensical. The medical record lacked notation of a fall analysis and interventions put in place were things that had been put in place before the fall. -5/21/19, at 6:23 a.m. progress note included, "Resident was one on one on this shift, he was restless, agitated, confused, swinging his arms at staff, resistive to cares, he pulled his night gown, brief and catheter off during the shift. He kept trying to get on the floor, so a floor mat was placed by his bedside." Although R2 had the above noted increase in behaviors, the medical record lacked documentation the physician or NP had been notified of the change in condition on the night shift on 5/21/19. -5/21/19, at 9:15 a.m. a change of condition note indicated the resident presented as confused, disoriented, lethargic, appeared to be hallucinating, grabbed things in the air and had pulled the catheter out the previous night. The note indicted the Tylenol which had been prescribed the previous day by the NP was not effective and the NP had given orders to send R2 to the emergency department for evaluation. On 5/24/19, between 2:01 p.m. and 2:39 p.m.,	2 830		

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2 830	Continued From page 11 each of the above identified falls was reviewed with the director of nursing (DON). The DON stated to her knowledge R2 "was independent with ambulation in the unit and in his room." When asked about the PT recommendation for R2 to be supervised with ambulation and the other assessments which indicated R2 was not steady, the DON stated, "I don't know." The DON stated R2 was impulsive and would get up and start to walk at times. When asked when the IDT team discussed R2's multiple falls if staff who were present, or who had witnessed the falls, had been interviewed about the moments leading up to the falls, after the falls, and what R2 had been doing or what cares had been provided, the DON stated, "I don't know." When asked about the 5/14/19 incident when R2 had sustained an injury ambulating in the hallway with walker if staff had been asked why they were not walking with R2 at the time per the PT recommendation for R2 to be supervised to ambulate the DON stated "if the recommendation stands and is current the staff should have been with him. Sometimes the resident gets up and starts going and staff don't get to him on time. You know how those units are." The DON also acknowledged some of the interventions put in place were not appropriate as R2 had severe cognitive impairment: such as a resident who was severely cognitively impaired being asked to use the call light, or for the resident to alert staff when he wanted to get up. When asked if R2 had been put on the walking program as an intervention for the 5/14/19 fall, the DON stated she thought so and was going to provide the documentation. The DON also reiterated PT had attempted to see R2 on 5/17/19, which was a Friday however, R2 continued to have multiple falls during that weekend "it would have been nice to be seen soon for all these falls." When asked why PT had	2 830		

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2 830	Continued From page 12 not re-approached R2 until 5/20/19, the DON stated it was because R2 was in the long term care unit, and stated it usually took a few days before the resident was seen by PT. The DON further stated staff should have contacted the medical provider when R2 exhibited increased behaviors, including pulling out his catheter, and when his cognition deteriorated and his speech was observed to be slurred. The DON also verified the consultant pharmacist had last reviewed R2's medications on 5/6/19, and had not reviewed the medications despite the IDT notes indicating the pharmacist was going to be requested to review the medications after some of the falls as an intervention. The DON stated the IDT had reviewed each fall and had thought the falls were related to the resident's impulsivity and medications changes. The DON stated R2's hospital admitting diagnosis, was chronic anemia, and that R2 had been found to have an infection. On 5/24/19. at 3:04 p.m. PT-A stated she had attempted to conduct an evaluation for R2 on 5/17/19, however R2 had refused. PT-A said she had re-attempted on Monday 5/20/19. PT-A stated it was normal for a resident with dementia to refuse at times, but they always re-approached. PT-A stated, "It was to our understanding he had leg/knee weakness. We did not know the evaluation was ordered due to falls. If there was a concern with gait and strengthening to prevent falls, a therapist could have seen him on the weekend. Because this was not communicated, we thought we would re-attempt on Monday." At 3:10 p.m. that same day, PT-B stated R2 had been seen multiple times by therapy and was resistive but did eventually work with therapy. PT-B stated this was due to dementia. When asked about the therapy recommendation dated 3/14/19,	2 830		

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2 830	Continued From page 13 regarding R2 being supervised for ambulation, and nursing to cue R2 to always use the rolling walker when ambulating, both PT's stated staff were to continue with those recommendations. They verified R2 was supposed to use the walker and staff were supposed to be with him, because at times R2 would leave the walker and walk off due to his cognitive impairment. On 5/31/19, at 11:49 a.m. via telephone, family member (FM)-A stated he felt R2's falls had happened due to R2 not being provided adequate supervision. FM-A also stated, "The falls have taken a toll on him and now he just sits there. I liked when he was able to walk around. If someone had supervised him maybe he would be okay now. He had strokes in the past and this caused him not to be very steady. He was impulsive however, staff were supposed to be with him when he was on the move to make sure he was okay." R2's ambulation program directed staff to assist with structure ambulation with walker 100-300 feet [ft], three times a day, to encourage resident to slow down when walking fast, and to remind him to focus on his stride. The documentation revealed in five days and 15 attempts, R2 had ambulated 2 times, had been documented to have refused 3 times and 9 times staff had documented "not applicable." The medical record lacked documentation the facility had followed up to make sure the walking program was effective and being implemented. R1's admission Minimum Data Set (MDS) dated 4/11/19, indicated she was severely cognitively impaired, required extensive assitance from two staff for bed mobility, transfers and toileting and	2 830		

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2 830	Continued From page 14 was frequently incontinent of bowel and bladder. The MDS further indicated R1 had a history of falls prior to admission and had sustained a fall with injury since admission to the facility. The Care Area Assessment dated 4/16/19, lacked a rationale for the care plan decisions. A Fall Risk Evaluation dated 4/5/19, indicated R1 had an altered level of consciousness, had no falls in the past three months and was chair bound. The assessment indicated an fall risk score of 13 and indicated a score over ten must include interventions to prevent falls. Interventions identified on the assessment included gripper socks. R1's care plan dated 4/22/19, identified an alteration in self care and an alteration in safety related to dementia. The care plan directed staff to provide auto lock brakes on her wheel chair, place dycem on the seat of the wheel chair, provide a stuffed animal to hold when restless and offer to ambulate in hallway when restless. An undated facility document titled Willow Team 3 identified R1 as a high fall risk and directed staff to keep her where she could be monitored and Dycem in wheel chair. An Order Recap Report dated 5/24/19, identified the following orders: Dilaudid 1 milligram (mg) by mouth every hour as needed for anxiety and 1 mg every 6 hours for pain. Zyprexa 7.5 mg by mouth every three hours for delirium. Haldol 2 mg by mouth four times daily and every two hours as needed for delirium/unable to settle During observation on 5/24/19, at approximately	2 830		

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2 830	Continued From page 15 10:30 a.m. R1 was lying on her back in bed. She had a large hematoma on the right side of her forehead, bruising on her upper lip and bruising to her right temple. At 10:42 a.m. nursing assistant (NA)-A and NA-B entered R1's room to assist her out of bed. NA-A and NA-B assisted R1 to stand and transfer to her wheel chair without the use of a transfer belt. During interview at 10:46 a.m. NA-B stated they usually used a transfer belt. NA-B stated R1 fell frequently and stated R1 used to have a fall mat but it was removed because she would walk and it was a tripping hazard. NA-B stated staff watched R1 closely and R1 had dycem in her chair. NA-B further stated staff placed a pillow in front of her in the wheel chair to keep her from rising but "she hates it." At 10:49 a.m., after R1 was seated in the wheel chair, NA-B placed a pillow on her lap and pushed it down so it was partially tucked under the arm rests, even though she had just stated R1 hated it. R1 was then escorted to the dining room. At 10:55 a.m. R1 sat in her wheel chair at the dining room table with her head down and her eyes closed. At 11:04 a.m. R1 remained at the table with head down and eyes closed. She was observed to startle and flinch every few seconds. At this time a bruise was noted under her right eye socket. At 12:15 p.m. R1 was in her wheel chair leaning far forward over the pillow in her lap and appeared to be asleep. At 12:18 p.m. NA-B and NA-C assisted R1 back to bed, again transferring her without a transfer belt. A review of facility incident reports and correlating Progress Notes identified the following:	2 830		

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2 830	Continued From page 16 4/5/19, R1 stood up in the hallway near the nurses station, bent over in an attempt of picking something off the floor and "thumped" over hitting her head on the floor. A Progress Note dated 4/6/19, indicated R1 had a hematoma on the left side of her head with swelling that went down to the left side of her eye. A Progress Note dated 4/8/19, indicated the interdisciplinary team (IDT) reviewed the fall. Care plan updated to walk R1 when restless, give her a stuffed animal to hold and move to locked unit due to smaller environment. A facility document titled Fall Team huddle Form dated 4/5/19, indicated R1 had been assisted to the toilet at 4:30 p.m. and indicated there was nothing on the floor for R1 to pick up. 5/7/18, R1 was noted on the floor next to her wheel chair. A Progress Note dated 5/8/19, indicated IDT discussed fall. R1 slipped out of chair, Dycem applied to wheel chair. Team felt this was an appropriate intervention at that time. 5/8/19, R1 found kneeling on the floor next to her bed. A Progress Note dated 5/8/19, indicated at 8:20 a.m. R1 was found kneeling on the floor next to her bed. NA stated she was just in the room and R1 had been sleeping. Skin tear noted to R1's right elbow measuring 1.4 centimeters (cm) x 1.6 cm. R1 unable to use call light. Brief was soiled at time of fall and last changed during overnight shift. on 5/9/19, IDT discussed R1's fall and determined R1 would be placed on early riser list and request sent to therapy for walking program evaluation. A fall Team Huddle Form indicated R1 was restless, had a soiled brief and wanted to get up and indicated R1 would benefit from a walking program. An incident report dated 5/10/19, indicated R1	2 830		

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2 830	Continued From page 17 was found on the floor by her bed. A Progress Noted dated 5/10/19, indicated therapy staff ad been working with R1 in her room and did not notify nursing staff when they left. A Fall Team Huddle Worksheet dated 5/10/19, indicated R1 fell in her room after working with physical therapy. Therapy did not communicate to nursing after working with R1. Intervention indicated staff to work on effective communication. 5/11/19, Fall incident report incomplete, no information. A Progress Note dated 5/11/19, indicated R1 was observed lying on the floor by her bed facing the window. 5/13/19, Writer spoke to nurse working at the time of the fall. Nurse stated R1 had gotten up in the morning at approximately 8:30 a.m. was given medications and fell asleep in chair so she was laid down by the nurse and sleeping soundly. R1 to be placed on 15 minute checks. 5/14/19, Writer was alerted by floor nurse that R1 had a large purple bruise on the right side of her face 12 cm x 6 cm, including the eye lids which were swollen. Hospice nurse evaluated and felt R1 may have ben restless in bed and bumped her head on the night stand next to head of bed or other object. Night stand was moved and hospice delivering a floor mat. A Progress Note dated 5/15/19, indicated IDT reviewed bruise. The note indicated the nightstand would be moved from next to the bed and floor fall mat would be moved since R1 was ambulatory and may increase risk for falls. 5/17/19, R1 found sitting on the floor near a table in the dining room. A Progress Note dated 5/17/19, indicated R1 was found sitting on the	2 830		

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2 830	Continued From page 18	2 830		

floor by the table in the dining room. 5/20/19, R1 discussed by IDT regarding fall. Zyprexa had been increased since this fall, hope is that medication change will help with restlessness.

During interview on 5/24/19, at 12:21 p.m. licensed practical nurse (LPN)-A stated R1 was on hospice. LPN-A stated When R1 sat in the bed or the wheel chair she would lean over and sometimes would stand up quickly. LPN- A stated staff would provide one to one assistance sometimes. LPN-A further stated sometimes R1 was very weak and didn't want to do anything and sometimes she was strong. LPN-A stated the bruise on R1's face was not from a fall but stated she did fall often. LPN-A stated the staff tried to offer food, sat with her and tried to keep an eye on her every 15 minutes when up in wheel chair.

During interview on 5/24/19, at 1:31 p.m. the director of nursing (DON) was asked how the IDT determined appropriate interventions for R1's falls. The DON stated R1's medications were looked at in depth, but was unsure if any changes were made. Regarding the fall on 5/7/19, the DON stated she was thinking R1 slid to the floor. In regard to the fall on 5/8/19, she stated R1 was found on the floor at 8:20 a.m. and stated, "Im looking for a reason to think she's and early riser." In regard to the fall on 5/8/19, the DON stated, "you should talk to (another staff), she's really the champion on this." However, the nurse the DON identified was not in the facility during the survey. The DON stated she was not sure why the intervention for the fall on 5/11/19, had been put in place. The DON stated she would review the falls further, however no further information was provided.

At 2:31 p.m. the hospice RN and hospice social

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2 830	Continued From page 19 worker (SW) were interviewed. The hospice RN stated when she met R1 she was upstairs on the transitional care unit and she had no bruises. The hospice RN stated when R1 was moved downstairs she had two falls, both when she slipped out of her wheel chair. She stated the bad bruises happened beginning on the weekend and stated R1's children had taken a picture and sent it to the guardian who in turn sent it to the hospice team to see if they were aware. The hospice RN stated they had not been aware of the bruising and stated when she saw it she could not believe how much it was. She stated R1's right eye was swollen shut and it hurt. She stated R1 then had a fall out of bed without a face strike. The hospice RN stated she felt it was the night stand so the night stand was moved. She stated she talked to the supervisor and told her when R1 first admitted to the facility she was in a reclining wheel chair but the facility felt it was a restraint because R1 could walk so it was removed. She stated after the second fall she asked if hospice could make a negotiated risk with the family but the supervisor said the facility did not do that. She stated hospice also offered a concave mattress and were told that was also a restraint and could not use it but stated she had seen staff putting blankets under the sheet and creating a concave mattress. The hospice RN stated she talked with the facility about the falls but it was her bringing it up to them and asking them what they could do. She stated R1 was in the room with the door shut when she saw her and said initially the nurse would take R1 everywhere with her. She said everything she suggested to the facility she was told no. She stated herself and the DON were worried because R1 had so many falls. The hospice nurse further stated after the second fall, one of the NA's approached her and asked her to come and asked if had seen R1. She stated "it	2 830		

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2 830	Continued From page 20 was breath taking."(referring to the facial bruising). She stated the NA said to her she needed to do something, she was in pain. The hospice RN stated she did not think R1's medications were contributing to her falls and stated the facility had expressed concerns about the use of the Haldol but stated, we had to stop the up and down." She stated "to me, she is sedated now" but is peaceful and stated when R1 first admitted to the facility the family did not want her on a lot of medication so they backed off but she told them R1 needed to be sedated and stated, "I felt like that was our only option." In regard to collaborating with hospice to find the root cause of R1's falls, the hospice RN stated she thought the facility discussed it amongst themselves but did not collaborate with hospice. She stated after the second fall she felt the facility knew how concerned she was and stated, "it was the worst fall to the face she had ever seen." Shen then stated again the sedation was intentional. A facility policy titled Transfer Belts dated 4/19, indicated transfer belts are use when transferring residents and when assisting residents to stand or walk to minimize and prevent when possible injury to residents and staff. A facility policy titled Incident/Accident and Fall Reporting dated 6/17, indicated all incidents, accidents and unusual occupancies that involve residents are investigated for causal factors and prevention of reoccurrence.	2 830		

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2 830	Continued From page 21	2 830		

Based on interview and document review, the facility failed to comprehensively evaluate causative factors of falls, and failed to ensure interventions were implemented as recommended to reduce the risk for falls, for 2 of 3 residents (R1, R2) who experienced multiple falls in the facility. R2 sustained actual harm, a nose fracture and abraisions, as a result of falling.

Findings include:

R2's Admission Record dated 5/24/19, included diagnoses of restlessness, agitation and other psychotic disorder not due to a substance or known physiological condition.

R2's quarterly Minimum Data Set (MDS) assessment dated 2/14/19, indicated R2 required limited assistance of one staff with transfers, walking in the corridor and locomotion on the unit. The MDS indicated R2 required supervision of one staff with walking in the room, and indicated R2 displayed no behaviors and did not wander. A quarterly MDS dated 5/15/19, indicated R2 required limited assistance of one staff for walking in room, had no behaviors, and exhibited wandering one to three days during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 22 assessment review period. Each of these MDS's indicated R2 had severely impaired cognition. A facility assessment, Balance During Transitions and Functional Range of Motion dated 2/18/19, indicated R2 was unsteady when moving from a seated to standing position, walking with assistive device, moving on and off the toilet, and during transfers surface to surface. R2's care plan dated 11/27/18, identified a potential alteration in safety, with falls related to confusion and psychotropic medication use. The care plan directed staff to assist R2 with activities of daily living (ADL's) per resident need and per request. In addition, the care plan directed staff to ensure R2 wore non skid footwear during transfers/ambulation, and indicated R2 had problems with forgetting his walker. Further, the care plan indicated staff were to keep R2's call light within reach, and to remind R2 when/how to use it for assistance. A Care Area Assessment (CAA) for falls dated 11/19/18, indicated R2 had impaired balance during transitions, was on antipsychotic medications which put him at risk for falls, and had impaired cognition. A Fall Risk Evaluation dated 5/12/19, indicated R2 had a fall risk score of 22 indicating R2 was at high risk for falls. Review of documentation related to R2's fall history and interventions, indicated interventions were recommended, but not always implemented, and not all falls were evaluated to determine root cause: -3/7/19, at 12:10 p.m. R2 had a fall without injury	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 23 in the dining room. An interdisciplinary team (IDT) note dated 3/8/19, indicated R2 was independent with ambulation with use of a walker, and felt it it would be a good idea for Physical therapy (PT) to evaluate for ambulation/transfers to determine need/benefit of a walking program. Orders were received that same day from R2's physician, for PT to evaluate and treat. On 3/14/19, PT had screened R2 and recommended supervision for ambulation, and for nursing to cue R2 to always use the rolling walker when ambulating. -4/5/19, at 10:44 a.m. R2 was found laying on the floor in the hallway. R2 could not identify what had happened. Documentation indicated R2 wore gripper socks and the floor was clean and dry but did not indicate whether R2 had been using his walker, or whether staff had been providing supervision. On 4/8/19, orthostatic blood pressures were obtained following the fall. An IDT note dated 4/8/19, indicated the nurse practitioner (NP) was updated and had been in to the facility that day to see R2. The note further included, "NP was requested to review blood pressure (BP) medication to determine if this may have contributed to his fall. Resident (res) has a history of standing up quickly and starting to ambulate quickly. Low BP may have contributed. NP stated she will review res vitals and medications during visit today." -4/20/19, at 8:30 p.m. a progress note included, "CNA (certified nursing assistant) saw resident laying on his back, on the floor of resident's room, between bed A and B. Resident stated that he was getting out of bed and sat on the floor and layed down." Vital signs were noted as stable, neurological assessment was noted as intact and range of motion was documented as within normal limits. An immediate intervention was	2 830		

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	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 24 identified as providing the call light to resident, and ensuring it was within resident reach. -On 4/22/19, an IDT note indicated the resident's 4/20/19 fall had been reviewed, "Res. transfers independently. Res. currently has a low bed. Res. team sheets/care plan [TS/CP] will be updated to keep res. bed at appropriate height for res. to stand up from when transferring for res. safety." -5/6/19, social service note indicated R2 had been seen by a clinical psychologist and the psychologist documented R2 had reported he was "tired all the time and this is causing anxiousness." The psychologist's recommendation included: "Gradual Dose Reduction [GDR] of Zyprexa to increase energy and ability to participate in programming . If further questions arise associated with psych medications [meds], psychiatry referral may be appropriate." -5/6/19, at 6:45 a.m. a progress note included, "CNA saw resident laying on his back, on the floor of resident's room, by his bed. Res observed laying down on his left side. Res stated when he was trying to stand up he lost his balance. He stated it was dark and he could not see." The note indicated an immediate intervention had been implemented. "Writer reminded resident of the use of call-light. Day supervisor updated and recommendation for night light." A subsequent IDT note from 5/6/19 included: "Reviewed res. fall. Maintenance will be updated to request a night light in room. Writer will update res. NP of fall and request res. weight loss be reviewed. Pharmacist is in facility today and will review res. medications for risk of increased falls and weight loss." Documentation indicated the NP had been updated on 5/6/19. The notes indicated the NP	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 25	2 830		

was updated of the of fall and continued weight loss and had given new orders to discontinue morning (AM) Olanzapine and in one week, to decrease bedtime (HS) olanzapine to 5 milligram (mg), to decrease Sinemet to three times daily (TID) and had given orders for several laboratory tests to be conducted. A nurse had documented she'd updated maintenance with the request to place a night light in R2's room.

-5/14/19, at 10:45 a.m. a progress note included, "Resident was walking with walker into dining room after getting up from chair in television [TV] room. Had gripper socks on. Fell sideways into wall. Small abrasion on elbow." The note further indicated R2 had stated he hit his head and elbow however, the vital signs were stable and R2 denied pain. There was no documentation to indicate level of staff supervision for R2 at the time of the fall.

-On 5/15/19, an IDT note indicated R2 had been using a walker and was wearing gripper socks at the time of the fall. The note included, "Writer will check unit to determine if res. has shoes in his room. Res. also wears glasses, staff will be educated to remind res. to wear glasses. Res. will be provided with a string to wear glasses around neck to have them with him at all times. Res. family requested for res. to be on a walking program to work on steadiness, strength and speed of walking. Res. was starting on a walking program." There was no documentation to indicate level of staff supervision for R2 at the time of the fall.

-5/15/19, at 11:19 p.m. note indicated "Resident was observed on the floor in his bedroom, laying on the right lateral side of his body, in the entry way to his bedroom and bathroom bleeding from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 26 his right nostril. Resident stated he got up from his bed and was walking out the door without his walker and lost his balance. Writer assessed resident and observed heavy bleeding from his right nostril. Writer cleaned some of the blood off resident's face and forehead before calling 911 due to the fact that the resident appeared disoriented and could not stay seated up right, along with heavy bleeding." Resident was taken to the hospital for further observation and medical evaluation. The medical record and fall investigation lacked documentation to indicate whether staff had been asked when they had last seen and assisted R2 in the room. -5/16/19, at 1:17 a.m. note indicated resident returned from the hospital emergency room and report was received by the writer was told that resident had a fractured nose. On 5/16/19, at 7:28 a.m. the note indicated after R2 had returned to the facility he was noted with further injuries which included abrasions on the forehead and small abrasion on both elbows and the vital signs were stable. On 5/16/19, an IDT progress note indicated R2 had been seen by the primary physician to evaluate medications and labs. Also the consultant pharmacist was going to evaluate medications and another maintenance request would be filled out for a night light to be placed at bedside along with walker. Another note on 5/16/19, indicated new orders had been received for Seroquel (psychotic medication) 50 mg twice daily (BID), to increase the resident's Sinemet back to original dose from 2 weeks ago, and to have therapy evaluate and treat for weakness and stiffness as resident was currently using a wheelchair for locomotion on unit related to unsteady gate, weakness and fractured nose.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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) COMPLETE DATE
2 830	Continued From page 27 -5/16/19, at 10:45 a.m. a progress note included, "The nurse had been called to the dining room by the NA who reported R2 had slid onto his buttocks when attempting to get up from the wheelchair he was using at lunch. Nurse also indicated staff had sat with R2 1:1 for the rest of the shift. -An Interdisciplinary Communication Form dated 5/16/19, revealed an order was written for PT to evaluate and treat R2 related to leg/knee weakness. On 5/17/19, a progress note by PT indicated a therapist had attempted to evaluate R2 who had refused. The note further indicated PT would attempt to evaluate again on Monday 5/20/19. On 5/17/19, an IDT progress note included R2 had order to be seen by therapy, and since resident fall from the wheelchair 5/16/19, maintenance was requested to place auto-lock brakes on the wheelchair. Note also indicated the NP had been requested to reinstate Olanzapine which had been decreased two weeks prior as staff had reported an increase in behavior during the evening shift. Further, the note indicated the consultant pharmacist was again requested to review R2's medications due to frequent falls. The medical record lacked documentation the consultant pharmacist had reviewed R2's medications falling the falls as indicated in the progress note from 5/17/19. -5/18/19, at 1:30 a.m. a progress note included, "During 2nd check, resident was found laying on the floor between the end of the bed and the furniture chest of his roommate. Resident was bleeding from cut on his head. Resident was very resistive to care. Range of motion [ROM] was	2 830		

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	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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) COMPLETE DATE
2 830	Continued From page 28	2 830		

done, resident was helped up with 4 assist and helped in the shower chair, resident obtained a cut on the front of his head on right side, pressure applied to stop the bleeding, site was cleansed and steri-strip applied. Resident remain impulsive trying to jump up from his chair, swing at staff when trying to stop him from falling." A follow up note indicated the writer had contacted a physician about the cut on the head and was told to monitor and update the provider with any changes.

-5/19/19, at 6:09 p.m. a progress note included, "Resident fell in the dining room during dinner time when he impulsively got up from his wheelchair to walk out the dining room. Resident landed on his abdomen and hands, while holding his head/face up. No injury was observed on resident. Writer reminded resident to ask for help whenever he feels he wants to get up to go some place. Resident should be closely monitored when sitting up in his wheelchair."

-5/19/19, at 6:41 p.m. a progress note included, "Resident was observed laying on the floor in his room by NAR who went to check on him...[R2] was very agitated and restless while getting him off the floor." Documentation indicated R2's vital signs were stable, no new injury was noted, and the NP was notified. The NP had "advised to give an additional 5 mg Olanzapine tonight, one time only."

-5/20/19, IDT note indicated resident's multiple falls over the weekend had been discussed and NP was going to be updated on resident's combative behavior and to see if she could address resident's pain with additional pain medications if appropriate due to possible pain from broken nose. The notes identified R2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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) COMPLETE DATE
2 830	Continued From page 29 Zyprexa had recently been increased and R2 was placed on a 1:1 for 48 hours. The medical record lacked documentation of the interdisciplinary team discussing and analyzing each of the three falls separately as the falls happened at different times and locations. -5/20/19, at 3:00 p.m. progress note indicated R2 had been seen by the NP and the NP was again updated on condition and continuing falls. The NP gave new orders for Tylenol, to taper Sinemet, and to discontinue after taper. The note indicated R2 was on 1:1. -5/20/19, at 10:46 p.m. note indicated "NA doing one on one with resident called the nurse to come to the resident room and reported resident was on the floor. NA stated resident was trying to use the bathroom and as she was trying to calm him down to wait for another NA to come resident got combative, pushed NA and fell on the floor from bed. When the nurse got in the room she observed resident was lying on the floor face down and was crawling. The writer attempted to ask resident to stop crawling so they could help to assist him off the floor but he was not following commands. Resident was unsteady after getting up with staff assistance and asked to use the toilet but did not go. R2 noted to have an indwelling foley catheter." The documentation indicated the resident did not comprehend how to use the call light even though it was explained, and indicated R2's speech was slurred and non-sensical. The medical record lacked notation of a fall analysis and interventions put in place were things that had been put in place before the fall. -5/21/19, at 6:23 a.m. progress note included, "Resident was one on one on this shift, he was	2 830		

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	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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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2 830	Continued From page 30	2 830		

restless, agitated, confused, swinging his arms at staff, resistive to cares, he pulled his night gown, brief and catheter off during the shift. He kept trying to get on the floor, so a floor mat was placed by his bedside." Although R2 had the above noted increase in behaviors, the medical record lacked documentation the physician or NP had been notified of the change in condition on the night shift on 5/21/19.

-5/21/19, at 9:15 a.m. a change of condition note indicated the resident presented as confused, disoriented, lethargic, appeared to be hallucinating, grabbed things in the air and had pulled the catheter out the previous night. The note indicted the Tylenol which had been prescribed the previous day by the NP was not effective and the NP had given orders to send R2 to the emergency department for evaluation.

On 5/24/19, between 2:01 p.m. and 2:39 p.m., each of the above identified falls was reviewed with the director of nursing (DON). The DON stated to her knowledge R2 "was independent with ambulation in the unit and in his room." When asked about the PT recommendation for R2 to be supervised with ambulation and the other assessments which indicated R2 was not steady, the DON stated, "I don't know." The DON stated R2 was impulsive and would get up and start to walk at times. When asked when the IDT team discussed R2's multiple falls if staff who were present, or who had witnessed the falls, had been interviewed about the moments leading up to the falls, after the falls, and what R2 had been doing or what cares had been provided, the DON stated, "I don't know." When asked about the 5/14/19 incident when R2 had sustained an injury ambulating in the hallway with walker if staff had been asked why they were not walking with R2 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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) COMPLETE DATE
2 830	Continued From page 31	2 830		

the time per the PT recommendation for R2 to be supervised to ambulate the DON stated "if the recommendation stands and is current the staff should have been with him. Sometimes the resident gets up and starts going and staff don't get to him on time. You know how those units are." The DON also acknowledged some of the interventions put in place were not appropriate as R2 had severe cognitive impairment: such as a resident who was severely cognitively impaired being asked to use the call light, or for the resident to alert staff when he wanted to get up. When asked if R2 had been put on the walking program as an intervention for the 5/14/19 fall, the DON stated she thought so and was going to provide the documentation. The DON also reiterated PT had attempted to see R2 on 5/17/19, which was a Friday however, R2 continued to have multiple falls during that weekend "it would have been nice to be seen soon for all these falls." When asked why PT had not re-approached R2 until 5/20/19, the DON stated it was because R2 was in the long term care unit, and stated it usually took a few days before the resident was seen by PT. The DON further stated staff should have contacted the medical provider when R2 exhibited increased behaviors, including pulling out his catheter, and when his cognition deteriorated and his speech was observed to be slurred. The DON also verified the consultant pharmacist had last reviewed R2's medications on 5/6/19, and had not reviewed the medications despite the IDT notes indicating the pharmacist was going to be requested to review the medications after some of the falls as an intervention. The DON stated the IDT had reviewed each fall and had thought the falls were related to the resident's impulsivity and medications changes. The DON stated R2's hospital admitting diagnosis, was chronic anemia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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) COMPLETE DATE
2 830	Continued From page 32 and that R2 had been found to have an infection. On 5/24/19. at 3:04 p.m. PT-A stated she had attempted to conduct an evaluation for R2 on 5/17/19, however R2 had refused. PT-A said she had re-attempted on Monday 5/20/19. PT-A stated it was normal for a resident with dementia to refuse at times, but they always re-approached. PT-A stated, "It was to our understanding he had leg/knee weakness. We did not know the evaluation was ordered due to falls. If there was a concern with gait and strengthening to prevent falls, a therapist could have seen him on the weekend. Because this was not communicated, we thought we would re-attempt on Monday." At 3:10 p.m. that same day, PT-B stated R2 had been seen multiple times by therapy and was resistive but did eventually work with therapy. PT-B stated this was due to dementia. When asked about the therapy recommendation dated 3/14/19, regarding R2 being supervised for ambulation, and nursing to cue R2 to always use the rolling walker when ambulating, both PT's stated staff were to continue with those recommendations. They verified R2 was supposed to use the walker and staff were supposed to be with him, because at times R2 would leave the walker and walk off due to his cognitive impairment. On 5/31/19, at 11:49 a.m. via telephone, family member (FM)-A stated he felt R2's falls had happened due to R2 not being provided adequate supervision. FM-A also stated, "The falls have taken a toll on him and now he just sits there. I liked when he was able to walk around. If someone had supervised him maybe he would be okay now. He had strokes in the past and this caused him not to be very steady. He was impulsive however, staff were supposed to be	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 33 with him when he was on the move to make sure he was okay." R2's ambulation program directed staff to assist with structure ambulation with walker 100-300 feet [ft], three times a day, to encourage resident to slow down when walking fast, and to remind him to focus on his stride. The documentation revealed in five days and 15 attempts, R2 had ambulated 2 times, had been documented to have refused 3 times and 9 times staff had documented "not applicable." The medical record lacked documentation the facility had followed up to make sure the walking program was effective and being implemented. R1's admission Minimum Data Set (MDS) dated 4/11/19, indicated she was severely cognitively impaired, required extensive assitance from two staff for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. The MDS further indicated R1 had a history of falls prior to admission and had sustained a fall with injury since admission to the facility. The Care Area Assessment dated 4/16/19, lacked a rationale for the care plan decisions. A Fall Risk Evaluation dated 4/5/19, indicated R1 had an altered level of consciousness, had no falls in the past three months and was chair bound. The assessment indicated an fall risk score of 13 and indicated a score over ten must include interventions to prevent falls. Interventions identified on the assessment included gripper socks. R1's care plan dated 4/22/19, identified an alteration in self care and an alteration in safety related to dementia. The care plan directed staff	2 830		

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	00005	A. BUILDING: _____ B. WING _____	C 05/24/2019

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2 830	Continued From page 34 to provide auto lock brakes on her wheel chair, place dycem on the seat of the wheel chair, provide a stuffed animal to hold when restless and offer to ambulate in hallway when restless. An undated facility document titled Willow Team 3 identified R1 as a high fall risk and directed staff to keep her where she could be monitored and Dycem in wheel chair. An Order Recap Report dated 5/24/19, identified the following orders: Dilaudid 1 milligram (mg) by mouth every hour as needed for anxiety and 1 mg every 6 hours for pain. Zyprexa 7.5 mg by mouth every three hours for delirium. Haldol 2 mg by mouth four times daily and every two hours as needed for delirium/unable to settle During observation on 5/24/19, at approximately 10:30 a.m. R1 was lying on her back in bed. She had a large hematoma on the right side of her forehead, bruising on her upper lip and bruising to her right temple. At 10:42 a.m. nursing assistant (NA)-A and NA-B entered R1's room to assist her out of bed. NA-A and NA-B assisted R1 to stand and transfer to her wheel chair without the use of a transfer belt. During interview at 10:46 a.m. NA-B stated they usually used a transfer belt. NA-B stated R1 fell frequently and stated R1 used to have a fall mat but it was removed because she would walk and it was a tripping hazard. NA-B stated staff watched R1 closely and R1 had dycem in her chair. NA-B further stated staff placed a pillow in front of her in the wheel chair to keep her from rising but "she hates it."	2 830		

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2 830	Continued From page 35 At 10:49 a.m., after R1 was seated in the wheel chair, NA-B placed a pillow on her lap and pushed it down so it was partially tucked under the arm rests, even though she had just stated R1 hated it. R1 was then escorted to the dining room. At 10:55 a.m. R1 sat in her wheel chair at the dining room table with her head down and her eyes closed. At 11:04 a.m. R1 remained at the table with head down and eyes closed. She was observed to startle and flinch every few seconds. At this time a bruise was noted under her right eye socket. At 12:15 p.m. R1 was in her wheel chair leaning far forward over the pillow in her lap and appeared to be asleep. At 12:18 p.m. NA-B and NA-C assisted R1 back to bed, again transferring her without a transfer belt. A review of facility incident reports and correlating Progress Notes identified the following: 4/5/19, R1 stood up in the hallway near the nurses station, bent over in an attempt of picking something off the floor and "thumped" over hitting her head on the floor. A Progress Note dated 4/6/19, indicated R1 had a hematoma on the left side of her head with swelling that went down to the left side of her eye. A Progress Note dated 4/8/19, indicated the interdisciplinary team (IDT) reviewed the fall. Care plan updated to walk R1 when restless, give her a stuffed animal to hold and move to locked unit due to smaller environment. A facility document titled Fall Team huddle Form dated 4/5/19, indicated R1 had been assisted to the toilet at 4:30 p.m. and indicated there was nothing on the floor for R1 to pick up. 5/7/18, R1 was noted on the floor next to her wheel chair. A Progress Note dated 5/8/19,	2 830		

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2 830	Continued From page 36 indicated IDT discussed fall. R1 slipped out of chair, Dycem applied to wheel chair. Team felt this was an appropriate intervention at that time. 5/8/19, R1 found kneeling on the floor next to her bed. A Progress Note dated 5/8/19, indicated at 8:20 a.m. R1 was found kneeling on the floor next to her bed. NA stated she was just in the room and R1 had been sleeping. Skin tear noted to R1's right elbow measuring 1.4 centimeters (cm) x 1.6 cm. R1 unable to use call light. Brief was soiled at time of fall and last changed during overnight shift. on 5/9/19, IDT discussed R1's fall and determined R1 would be placed on early riser list and request sent to therapy for walking program evaluation. A fall Team Huddle Form indicated R1 was restless, had a soiled brief and wanted to get up and indicated R1 would benefit from a walking program. An incident report dated 5/10/19, indicated R1 was found on the floor by her bed. A Progress Noted dated 5/10/19, indicated therapy staff ad been working with R1 in her room and did not notify nursing staff when they left. A Fall Team Huddle Worksheet dated 5/10/19, indicated R1 fell in her room after working with physical therapy. Therapy did not communicate to nursing after working with R1. Intervention indicated staff to work on effective communication. 5/11/19, Fall incident report incomplete, no information. A Progress Note dated 5/11/19, indicated R1 was observed lying on the floor by her bed facing the window. 5/13/19, Writer spoke to nurse working at the time of the fall. Nurse stated R1 had gotten up in the morning at approximately 8:30 a.m. was given medications and fell asleep in chair so she was laid down by	2 830		

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2 830	Continued From page 37 the nurse and sleeping soundly. R1 to be placed on 15 minute checks. 5/14/19, Writer was alerted by floor nurse that R1 had a large purple bruise on the right side of her face 12 cm x 6 cm, including the eye lids which were swollen. Hospice nurse evaluated and felt R1 may have ben restless in bed and bumped her head on the night stand next to head of bed or other object. Night stand was moved and hospice delivering a floor mat. A Progress Note dated 5/15/19, indicated IDT reviewed bruise. The note indicated the nightstand would be moved from next to the bed and floor fall mat would be moved since R1 was ambulatory and may increase risk for falls. 5/17/19, R1 found sitting on the floor near a table in the dining room. A Progress Note dated 5/17/19, indicated R1 was found sitting on the floor by the table in the dining room. 5/20/19, R1 discussed by IDT regarding fall. Zyprexa had been increased since this fall, hope is that medication change will help with restlessness. During interview on 5/24/19, at 12:21 p.m. licensed practical nurse (LPN)-A stated R1 was on hospice. LPN-A stated When R1 sat in the bed or the wheel chair she would lean over and sometimes would stand up quickly. LPN- A stated staff would provide one to one assistance sometimes. LPN-A further stated sometimes R1 was very weak and didn't want to do anything and sometimes she was strong. LPN-A stated the bruise on R1's face was not from a fall but stated she did fall often. LPN-A stated the staff tried to offer food, sat with her and tried to keep an eye on her every 15 minutes when up in wheel chair.	2 830		

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2 830	Continued From page 38 During interview on 5/24/19, at 1:31 p.m. the director of nursing (DON) was asked how the IDT determined appropriate interventions for R1's falls. The DON stated R1's medications were looked at in depth, but was unsure if any changes were made. Regarding the fall on 5/7/19, the DON stated she was thinking R1 slid to the floor. In regard to the fall on 5/8/19, she stated R1 was found on the floor at 8:20 a.m. and stated, "Im looking for a reason to think she's and early riser." In regard to the fall on 5/8/19, the DON stated, "you should talk to (another staff), she's really the champion on this." However, the nurse the DON identified was not in the facility during the survey. The DON stated she was not sure why the intervention for the fall on 5/11/19, had been put in place. The DON stated she would review the falls further, however no further information was provided. At 2:31 p.m. the hospice RN and hospice social worker (SW) were interviewed. The hospice RN stated when she met R1 she was upstairs on the transitional care unit and she had no bruises. The hospice RN stated when R1 was moved downstairs she had two falls, both when she slipped out of her wheel chair. She stated the bad bruises happened beginning on the weekend and stated R1's children had taken a picture and sent it to the guardian who in turn sent it to the hospice team to see if they were aware. The hospice RN stated they had not been aware of the bruising and stated when she saw it she could not believe how much it was. She stated R1's right eye was swollen shut and it hurt. She stated R1 then had a fall out of bed without a face strike. The hospice RN stated she felt it was the night stand so the night stand was moved. She stated she talked to the supervisor and told her when R1 first admitted to the facility she was in a reclining wheel chair	2 830		

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2 830	Continued From page 39	2 830		

but the facility felt it was a restraint because R1 could walk so it was removed. She stated after the second fall she asked if hospice could make a negotiated risk with the family but the supervisor said the facility did not do that. She stated hospice also offered a concave mattress and were told that was also a restraint and could not use it but stated she had seen staff putting blankets under the sheet and creating a concave mattress. The hospice RN stated she talked with the facility about the falls but it was her bringing it up to them and asking them what they could do. She stated R1 was in the room with the door shut when she saw her and said initially the nurse would take R1 everywhere with her. She said everything she suggested to the facility she was told no. She stated herself and the DON were worried because R1 had so many falls. The hospice nurse further stated after the second fall, one of the NA's approached her and asked her to come and asked if had seen R1. She stated "it was breath taking."(referring to the facial bruising). She stated the NA said to her she needed to do something, she was in pain. The hospice RN stated she did not think R1's medications were contributing to her falls and stated the facility had expressed concerns about the use of the Haldol but stated, we had to stop the up and down." She stated "to me, she is sedated now" but is peaceful and stated when R1 first admitted to the facility the family did not want her on a lot of medication so they backed off but she told them R1 needed to be sedated and stated, "I felt like that was our only option." In regard to collaborating with hospice to find the root cause of R1's falls, the hospice RN stated she thought the facility discussed it amongst themselves but did not collaborate with hospice. She stated after the second fall she felt the facility knew how concerned she was and stated, "it was

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2 830	Continued From page 40 the worst fall to the face she had ever seen." Shen then stated again the sedation was intentional. A facility policy titled Transfer Belts dated 4/19, indicated transfer belts are use when transferring residents and when assisting residents to stand or walk to minimize and prevent when possible injury to residents and staff. A facility policy titled Incident/Accident and Fall Reporting dated 6/17, indicated all incidents, accidents and unusual occupancies that involve residents are investigated for causal factors and prevention of reoccurrence. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		