DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

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

RE: CCN: 245018
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 27, 2021, we notified you a remedy was imposed. On January 4, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 26, 2021 be discontinued as of January 4, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2022

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

Re: Reinspection Results
Event ID: 8GG212, 5QXY12, and QQN012

Dear Administrator:

On January 4, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 26, 2021, November 5, 2021, and December 9, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 17, 2021

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

RE: CCN: 245018
Cycle Start Date: October 7, 2021

Dear Administrator:

On October 27, 2021, we informed you of imposed enforcement remedies.

On October 26, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 26, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 26, 2021.

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.

As we notified you in our letter of October 27, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 26, 2021.

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.

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

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

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, 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 April 7, 2022 (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/ 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 10/26/2021

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 Surveyor: 43087 On 10/25/21, through 10/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5018175C (MN77776) with deficiencies cited at F600, F609, and F610. H5018176C (MN77762) with deficiencies cited at F600, F609, and F610. H5018177C (MN77615) with deficiencies cited at F600, F609, and F610. H5018178C (MN77724) with deficiencies cited at F600, F609, and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		12/8/21

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

Electronically Signed | 11/26/2021

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 600	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Surveyor: 43087 Based on interview and document review, the facility failed to supervise residents to prevent resident on resident physical abuse as resident-to-resident altercations initiated by R4 against 3 of 4 residents (R1, R2, and R3) and by R6 against 1 of 4 residents (R5) on the memory care unit. The facility also failed to take appropriate corrective action to prevent further resident on resident altercations leaving residents vulnerable to ongoing abuse. Findings include: R4's ALTERCATIONS WITH R1, R2, and R3 R1's quarterly Minimum Data Set (MDS) dated 7/13/21, indicated R1 had severely impaired cognition with diagnoses of dementia without behavioral disturbance and depression. R1's care plan dated 7/12/21, indicated R1 was a vulnerable adult and staff should follow vulnerable adult policies and procedures.	F 600	It is the policy of Crest View Lutheran Home that no employee, visitor, or volunteer of a nursing home shall physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a resident. Any nursing home employee, visitor or volunteer who becomes aware of abuse, mistreatment, neglect, or misappropriation shall immediately report to the Campus Administrator or designee. Facility policies on Abuse and Neglect were reviewed and revised as necessary by the Administrator, DON, facility Nurse Managers and Nurse Consultant. Education on policies was provided by DON/Designee to the entire Interdisciplinary Management team on 10/28/2021-10/29/2021. This education was provided to ensure residents are kept free from abuse and neglect, and to ensure allegations or suspicion of abuse and neglect are thoroughly investigated and documented with appropriate and timely reporting; to ensure effective communication between nursing, direct	

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F 600	Continued From page 2 R1's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R2's annual MDS dated 10/7/21, indicated R2 had severely impaired cognition with diagnoses of Alzheimer's disease, anxiety, depression, and psychotic disorder. R2's care plan indicated R2 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R2's care plan dated 8/23/21 also indicated R2 could become verbally or physically aggressive with other residents with an intervention of decreasing environmental stimuli. R2's PN dated 10/12/21, indicated R2 was hit on the shoulder by another resident (R5). R2's PN dated 10/25/21, indicated on 10/12/21 R2 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R3's quarterly MD dated 9/13/21, indicated R3 had severely impaired cognition with diagnoses of dementia with behavioral disturbance, depression, and psychotic disorder. R3's care plan lacked acknowledgement R3 was a vulnerable adult and lacked interventions to keep R3 safe from being a victim of abuse.	F 600	care staff, and healthcare providers regarding physical and verbal abuse; ensure that nursing staff contacts the resident's primary care physician at the time of an acute change in condition that requires the plan of care to be revised to meet the resident's needs in a timely manner; ensure that all facility staff respond professionally to medical and psychiatric emergencies; ensure that all staff are thoroughly trained and educated upon hire and yearly as required on the above. The above education was also provided to all facility staff at mandatory meetings on 11/16/2021 by nursing leadership. Audits to ensure that all new facility staff are educated on the above during orientation will be conducted by the Nurse Educator and/DON/designee weekly for 3 months and then monthly for 1 year. For all residents in the facility are deemed to be at risk for abuse or neglect. Care Plans for all residents will be reviewed to ensure proper interventions are in place to prevent abuse and neglect. Care Plans for R1, R2, R3, R4, R5 and R6 and an additional 10 random resident care plans will be audited by the DON and/ or designees weekly for 12 weeks and then monthly for 12 months to ensure compliance. Audit results from new staff audits and resident care plan audit findings will be reported at monthly QAPI meetings for review and revisions as necessary. The Administrator is responsible for overall compliance of each part of this plan of correction	

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F 600	Continued From page 3 R3's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R4's quarterly MDS dated 7/19/21, indicated R4 had severely impaired cognition with diagnoses of dementia. R4's MDS also indicated R4 had delirium with inattention and disorganized thinking; R4 ambulated without the use of a walker or wheelchair. R4's care plan dated 4/22/21, indicated R4 was a vulnerable adult and interventions were staff to follow the vulnerable adult policy and procedures. R4's care plan dated 4/22/21, indicated R4 exhibited behaviors toward others with interventions including administering medications per orders and being mindful of escalating behaviors between R4 and others; noting if R4 became verbally aggressive towards others she could become physically aggressive. R4's PN dated 10/12/21, indicated R4 had increasing behaviors on the [day] shift, hitting other residents and staff. R4's PN dated 10/25/21, indicated on 10/12/21 R4 had increased agitation and hit three other residents. The PN also indicated the DON spoke to the nurse practitioner (NP) who reported reducing R4's antidepressant. The PN indicated the other residents were placed on 15-minute checks but there was no indication R4 was monitored more closely for aggression toward any other residents.	F 600		

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F 600	Continued From page 4	F 600		

R4's Associated Clinics of Psychology (ACP) note dated 10/15/21, indicated R4 had a history of verbal and physical aggression toward other residents:
-- 8/6/21 - R4 struck other residents within a couple of weeks [of 8/6/21]; PRN Gabapentin added but it was not used by staff so discontinued.
-- 1/11/10- R4 showed aggression to roommate and one other resident; staff were considering moving her off the locked memory care unit. There were no recommended changes in her care.

During an interview on 10/25/21, at 1:52 p.m. nursing assistant (NA)-A stated she observed the R4 hit R1, R2, and R3 on 10/12/21. NA-A further stated it started about two weeks prior when R4 woke up one morning and didn't want to change her clothes and was more agitated, which she reported to the nurse (licensed practical nurse [LPN]-A); R4 became combative later on that day with the staff. NA-A stated every day she worked, R4 showed aggression to R3 almost daily by calling her names or hitting R3. NA-A stated she reported it every time to the nurse. NA-A stated on one day (she was unsure of the day) she observed R2 and R4 get into an argument in the television room and then they started hitting one another; NA-A separated them and reported this to the nurse. On 10/12/21, NA-A said it was different because R4 was very aggressive and hit three different residents:
-- R4 used vulgar language against R3 in the morning and then punched her in the back with a closed fist
-- R4 slapped R1 in the face with her house shoe right after lunch
-- R4 hit and slapped R2 in the afternoon

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F 600	Continued From page 5	F 600		

NA-A stated she told the nurse (LPN-B) after each episode. NA-A stated she was asked to write a statement about what she saw on 10/12/21, but no one interviewed her or talked to her about the different events.

During an interview on 10/26/21, at 2:40 p.m. LPN-B stated NA-A reported to her in the afternoon R4 hit residents R1, R2, and R3. LPN-B stated she informed the supervisor (Sup)-A that afternoon. LPN-B also stated R4 often showed aggressive verbal behaviors before but was unsure if she hit anyone.

R6's ALTERCATION WITH R5

R5's significant change MDS dated 9/26/21, indicated R5 had severely impaired cognition with diagnoses of dementia without behavioral disturbances and depression. R5's care plan lacked acknowledgement R5 was a vulnerable adult and lacked interventions to keep R5 safe from being a victim of abuse.

R5's PN dated 10/17/21, indicated while sitting in the television room, another resident slapped R5 on the arm.

R5's progress noted (PN) dated 10/25/21, indicated on R5 slapped by another resident; the residents were separated and 15-minute checks were implemented. The PN further indicated there was no injury. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others.

R6's quarterly change MDS dated 8/31/21, indicated R6 had severely impaired cognition with

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F 600	Continued From page 6	F 600		

diagnoses of Alzheimer's disease and depression. R6's MDS also indicated R6 was mobile via wheelchair with assistance of one. R6's care plan dated 6/7/21, indicated R6 was a vulnerable adult and staff should follow vulnerable adult policies and procedures.

R6's draft PN dated 10/16/21, indicated R6 became agitated and hit another resident's arm while watching television; R6 was transported to her room where she was toileted and calmed down; she was brought back "to sit next to her."

During an interview on 10/26/21, at 12:00 p.m. RN-B stated on 10/16/21, R5 and R6 were sitting in the television room close to each other when R6 exhibited signs of agitation and then reached out and slapped R5 on the arm. RN-B stated they took R6 to her room where she was toileted and then able to calm down. RN-B stated she called the supervisor but did not recall the supervisor's name.

During an interview on 10/26/21, at 3:30 p.m. the administrator and director of nursing verified their policy indicated staff working on the shift during the alleged abuse should be interviewed and staff on those shifts were not interviewed except those that were witnesses. They did not interview any residents but did skin assessments on all residents on 10/13/21, the day after R4 hit three other residents. They did not interview other staff who worked on 10/16/21 when R6 hit R5, nor did they interview residents or do any skin assessment on the other residents. They also acknowledged a root cause analysis should be completed that examined possible causes leading up to the abuse and actions taken to reduce chances of recurring abuse. They stated

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

(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 600	Continued From page 7 they discussed the abuse in the interdisciplinary team (IDT) meetings and considered interventions then. IDT meeting notes dated 9/15/21, 9/22/21, 9/29/21, 10/6/21, and 10/20/21, indicated lack of information or discussion about the allegations of abuse with any of the involved residents; no root causes or actions were documented. No additional IDT meeting notes were provided. The facility's Resident Protection Plan policy dated January 21, indicated abuse was defined as the "willful infliction of injury"; willful was defined as the "individual acted deliberately, not that the individual must have intended to inflict injury or harm." The policy also indicated any reports of abuse, including injuries of unknown origin would be investigated and the investigation would include at least the following: interviews of staff having contact with the resident during the relevant shifts of the alleged incident and a "root cause analysis of all circumstances surrounding the incident."	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		12/8/21

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 10/26/2021

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 609	Continued From page 8 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 43087 Based on interview and document review, the facility failed to ensure the State agency (SA) was notified within two hours of allegations of physical abuse and neglect, following resident to resident altercations initiate by R4 against 3 of 4 residents (R1, R2, and R3) and by R6 against 1 of 4 residents (R5) on the memory care unit. Findings include: R4's ALTERCATIONS WITH R1, R2, and R3 R1's quarterly Minimum Data Set (MDS) dated 7/13/21, indicated R1 had severely impaired cognition with diagnoses of dementia without behavioral disturbance and depression. R1's care plan dated 7/12/21, indicated R1 was a vulnerable adult and staff should follow vulnerable	F 609	It is the policy of Crest View Lutheran Home that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries or unknown source, and misappropriation of resident property, are reported immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	

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 10/26/2021

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 609	Continued From page 9 adult policies and procedures. R1's late entry progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The SA record, printed 10/19/21, indicated the allegation of abuse toward R1 occurred on 10/12/21 around 2:36 p.m. and was reported to the SA on 10/18/21 around 2:28 p.m., more than two hours after the allegation. R2's annual MDS dated 10/7/21, indicated R2 had severely impaired cognition with diagnoses of Alzheimer's disease, anxiety, depression, and psychotic disorder. R2's care plan indicated R2 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R2's PN dated 10/12/21, indicated R2 was hit on the shoulder by another resident (R5). R2's PN dated 10/17/21, staff found two pink/red marks on R2's inner upper right thigh. The SA record, printed 10/19/21, indicated the allegation of abuse toward R1 occurred on 10/12/21 around 2:40 p.m. and was reported to the SA on 10/18/21 around 2:28 p.m., more than two hours after the allegation. R3's quarterly MD dated 9/13/21, indicated R3 had severely impaired cognition with diagnoses of dementia with behavioral disturbance, depression, and psychotic disorder. R3's care plan lacked acknowledgement R3 was a	F 609	On 10/18/2021 VA report was filed for R1, R2 by DON. On 10/27-10/29 available staff were re-educated on this requirement. Further nursing staff and other departmental staff will be re-educated on the VA Policy and Reporting Requirements by November 16th, 2021. For all other residents this deficient practice could have affected the 24-hour report will be reviewed daily by DON/designee for indications of abuse that were not already reported. An electronic alert statement has been added to routinely used computer applications (Paycom and Point Click Care) to remind staff of this requirement. Audits of progress notes to ensure supervisor notification will be conducted daily at or before clinical rounds and brought to IDT as needed, and results shared at QAPI. The Director of Nursing will be responsible for compliance.	

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 10/26/2021

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 609	Continued From page 10	F 609		

vulnerable adult and lacked interventions to keep R3 safe from being a victim of abuse.

R3's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks.

The SA record, printed 10/19/21, indicated the allegation of abuse toward R1 occurred on 10/12/21 around 2:36 p.m. and was reported to the SA on 10/13/21 around 10:43 a.m., more than two hours after the allegation.

R4's quarterly MDS dated 7/19/21, indicated R4 had severely impaired cognition with diagnoses of dementia. R4's care plan dated 4/22/21, indicated R4 was a vulnerable adult and interventions were staff to follow the vulnerable adult policy and procedures.

R4's PN dated 10/25/21, indicated on 10/12/21 R4 had increased agitation and hit three other residents.

R6's ALTERCATION WITH R5

R5's significant change MDS dated 9/26/21, indicated R5 had severely impaired cognition with diagnoses of dementia without behavioral disturbances and depression. R5's care plan lacked acknowledgement R5 was a vulnerable adult and lacked interventions to keep R5 safe from being a victim of abuse.

R5's progress noted (PN) dated 10/25/21, indicated on R5 slapped by another resident; 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 10/26/2021

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 609	Continued From page 11	F 609		

residents were separated and 15-minute checks were implemented. The PN further indicated there was no injury.

R6's quarterly change MDS dated 8/31/21, indicated R6 had severely impaired cognition with diagnoses of Alzheimer's disease and depression. R6's care plan dated 6/7/21, indicated R6 was a vulnerable adult and staff should follow vulnerable adult policies and procedures.

R6's PN dated 10/16/21, indicated R6 became agitated and hit another resident's arm while watching television.

The SA record, printed 10/19/21, indicated the allegation of abuse toward R1 occurred on 10/16/21 around 2:30 p.m. and was reported to the SA on 10/16/21 around 5:32 p.m., more than two hours after the allegation.

During an interview on 10/26/21, at 3:30 p.m. the administrator stated she reported the allegations of abuse toward R1, R2, and R3 by R4 was reported to her the morning after the abuse was witnessed on 10/12/21; she filed a report related to the abuse toward R3 on 10/13/21 but included the fact R1 and R2 were also abused. The administrator also stated she was contacted by the SA on 10/18/21 and requested to complete a separate abuse report for R1 and R2; she filed the additional reports and now understands each incident of abuse requires a separate report. The administrator noted the allegation of abuse toward R5 by R6 was reported when she knew about it but acknowledged staff witnessed the abuse and it should be reported within two hours of the allegation.

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 10/26/2021

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 609	Continued From page 12 The facility's Resident Protection Plan policy dated January 2021, indicated abuse was defined as the "willful infliction of injury"; willful was defined as the "individual acted deliberately, not that the individual must have intended to inflict injury or harm." The policy also indicated any reports of abuse or injuries of unknown origin would be immediately to the to the administrator who would report to the SA within two hours after the allegation was made.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 43087 Based on interview and document review, the facility failed to thoroughly investigate allegations	F 610	It is the policy of Crest View Lutheran Home that a root cause investigation and analysis will be completed. The information gathered is given to	12/8/21

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 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 13 of physical abuse and neglect, following resident to resident altercations initiate by R4 against 3 of 4 residents (R1, R2, and R3) and by R6 against 1 of 4 residents (R5) on the memory care unit. The facility also failed to take appropriate corrective action to prevent further resident-to-resident altercations. Findings include: R4's ALTERCATIONS WITH R1, R2, and R3 R1's quarterly Minimum Data Set (MDS) dated 7/13/21, indicated R1 had severely impaired cognition with diagnoses of dementia without behavioral disturbance and depression. R1's care plan dated 7/12/21, indicated R1 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R1's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R2's annual MDS dated 10/7/21, indicated R2 had severely impaired cognition with diagnoses of Alzheimer's disease, anxiety, depression, and psychotic disorder. R2's care plan indicated R2 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R2's care plan dated 8/23/21 also indicated R2 could become verbally or physically aggressive with other residents with an intervention of decreasing environmental stimuli.	F 610	administration. The investigation will include: Who was involved, Residents statements, Resident s roommate statements (if applicable) , Involved staff and witness statements of events, a description of the resident s behavior and environment at the time of the incident, injuries present, observation of resident and staff behaviors during the investigation, environmental considerations 10/28-10/29 The VA policy and Reporting Requirements were reviewed by the Administrator and education was provided by nursing leadership to Interdisciplinary Management Team. All facility nurses were given additional training on all of the above in more detail after the all-staff meetings. This information was presented by the Administrator and the DON. Care Plans for R1, R2, R3, R4, R5 and R6 were reviewed to ensure that interventions were in place to help protect them from resident to resident altercations. For all other residents in the facility that are identified as at risk for resident to resident altercations and their care plans will be reviewed to ensure interventions are in place to help protect them from resident to resident altercations as well by 12-8-2021. The Administrator is responsible for overall compliance of each part of this plan of correction	

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 10/26/2021

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 610	Continued From page 14	F 610		

R2's PN dated 10/12/21, indicated R2 was hit on the shoulder by another resident (R4).

R2's PN dated 10/25/21, indicated on 10/12/21 R2 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others.

R3's quarterly MD dated 9/13/21, indicated R3 had severely impaired cognition with diagnoses of dementia with behavioral disturbance, depression, and psychotic disorder. R3's care plan lacked acknowledgement R3 was a vulnerable adult and lacked interventions to keep R3 safe from being a victim of abuse.

R3's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others.

R4's quarterly MDS dated 7/19/21, indicated R4 had severely impaired cognition with diagnoses of dementia. R4's MDS also indicated R4 had delirium with inattention and disorganized thinking; R4 ambulated without the use of a walker or wheelchair. R4's care plan dated 4/22/21, indicated R4 was a vulnerable adult and interventions were staff to follow the vulnerable adult policy and procedures. R4's care plan dated 4/22/21, indicated R4 exhibited behaviors toward

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 10/26/2021

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 610	Continued From page 15	F 610		

others with interventions including administering medications per orders and being mindful of escalating behaviors between R4 and others; noting if R4 became verbally aggressive towards others she could become physically aggressive.

R4's PN dated 10/12/21, indicated R4 had increasing behaviors on the [day] shift, hitting other residents and staff.

R4's PN dated 10/25/21, indicated on 10/12/21 R4 had increased agitation and hit three other residents. The PN also indicated the DON spoke to the nurse practitioner (NP) who reported reducing R4's antidepressant. The PN indicated the other residents were placed on 15-minute checks but there was no indication R4 was monitored more closely for aggression toward any other residents.

R4's Associated Clinics of Psychology (ACP) note dated 10/15/21, indicated R4 had a history of verbal and physical aggression toward other residents:
-- 8/6/21 - R4 struck other residents within a couple of weeks [of 8/6/21]; PRN Gabapentin added but it was not used by staff so discontinued.
-- 1/11/10- R4 showed aggression to roommate and one other resident; staff were considering moving her off the locked memory care unit. There were no recommended changes in her care.

During an interview on 10/25/21, at 1:52 p.m. nursing assistant (NA)-A stated she observed R4 hit R1, R2, and R3 on 10/12/21. NA-A further stated it started about two weeks prior when R4 woke up one morning and didn't want to change

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 10/26/2021

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 610	Continued From page 16	F 610		

her clothes and was more agitated, which she reported to the nurse (licensed practical nurse [LPN]-A); R4 became combative later on that day with the staff. NA-A stated every day she worked, R4 showed aggression to R3 almost daily by calling her names or hitting R3. NA-A stated she reported it every time to the nurse. NA-A stated on one day (she was unsure of the day) she observed R2 and R4 get into an argument in the television room and then they started hitting one another; NA-A separated them and reported this to the nurse. On 10/12/21, NA-A said it was different because R4 was very aggressive and hit three different residents:
-- R4 used vulgar language against R3 in the morning and then punched her in the back with a closed fist
-- R4 slapped R1 in the face with her house shoe right after lunch
-- R4 hit and slapped R2 in the afternoon
NA-A stated she told the nurse (LPN-B) after each episode. NA-A stated she was asked to write a statement about what she saw on 10/12/21, but no one interviewed her or talked to her about the different events.

During an interview on 10/26/21, at 2:40 p.m. LPN-B stated NA-A reported to her in the afternoon R4 hit residents R1, R2, and R3. LPN-B stated she informed the supervisor (Sup)-A that afternoon. LPN-B also stated R4 often showed aggressive verbal behaviors before but was unsure if she hit anyone.

R6's ALTERCATION WITH R5

R5's significant change MDS dated 9/26/21, indicated R5 had severely impaired cognition with

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 10/26/2021

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 610	Continued From page 17	F 610		

diagnoses of dementia without behavioral disturbances and depression. R5's care plan lacked acknowledgement R5 was a vulnerable adult and lacked interventions to keep R5 safe from being a victim of abuse.

R5's PN dated 10/17/21, indicated while sitting in the television room, another resident slapped R5 on the arm.

R5's progress noted (PN) dated 10/25/21, indicated on R5 slapped by another resident; the residents were separated and 15-minute checks were implemented. The PN further indicated there was no injury. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others.

R6's quarterly change MDS dated 8/31/21, indicated R6 had severely impaired cognition with diagnoses of Alzheimer's disease and depression. R6's MDS also indicated R6 was mobile via wheelchair with assistance of one. R6's care plan dated 6/7/21, indicated R6 was a vulnerable adult and staff should follow vulnerable adult policies and procedures.

R6's draft PN dated 10/16/21, indicated R6 became agitated and hit another resident's arm while watching television; R6 was transported to her room where she was toileted and calmed down; she was brought back "to sit next to her."

During an interview on 10/26/21, at 12:00 p.m. RN-B stated on 10/16/21, R5 and R6 were sitting in the television room close to each other when R6 exhibited signs of agitation and then reached out and slapped R5 on the arm. RN-B stated they took R6 to her room where she was toileted and

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 10/26/2021

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 610	Continued From page 18	F 610		

then able to calm down. RN-B stated she called the supervisor but did not recall the supervisor's name. RN-B stated no one followed up with her after she reported the altercation.

The investigative file lacked evidence RN-B was interviewed, other staff working the shift were interviewed, any residents were interviewed, or any resident assessments were conducted after the altercation. The investigative file included 15-minute check worksheets for R5 and R6 for 10/16/21 through 10/18/21.

During an interview on 10/26/21, at 3:30 p.m. the administrator and director of nursing verified their policy indicated staff working on the shift during the alleged abuse should be interviewed and staff on those shifts were not interviewed except those that were witnesses. They did not interview any residents but did skin assessments on all residents on 10/13/21, the day after R4 hit three other residents. They did not interview other staff who worked on 10/16/21 when R6 hit R5, nor did they interview residents or do any skin assessment on the other residents. They also acknowledged a root cause analysis should be completed that examined possible causes leading up to the abuse and actions taken to reduce chances of recurring abuse. They stated they discussed the abuse in the interdisciplinary team (IDT) meetings and considered interventions then. They stated supervisor A was no longer at the facility.

IDT meeting notes dated 9/15/21, 9/22/21, 9/29/21, 10/6/21, and 10/20/21, indicated lack of information or discussion about the allegations of abuse with any of the involved residents; no root causes or actions were documented. No

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 10/26/2021

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 610	Continued From page 19 additional IDT meeting notes were provided. The facility's Resident Protection Plan policy dated January 21, indicated abuse was defined as the "willful infliction of injury"; willful was defined as the "individual acted deliberately, not that the individual must have intended to inflict injury or harm." The policy also indicated any reports of abuse, including injuries of unknown origin would be investigated and the investigation would include at least the following: interviews of staff having contact with the resident during the relevant shifts of the alleged incident and a "root cause analysis of all circumstances surrounding the incident."	F 610		

Electronically delivered
November 17, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 8GG211

Dear Administrator:

The above facility was surveyed on October 25, 2021 through October 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: Surveyor: 43087 On 10/25/21, through 10/26/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5018175C (MN77776) with a licensing order issued at 1950. H5018176C (MN77762) with a licensing order issued at 1950. H5018177C (MN77615) with a licensing order issued at 1950. H5018178C (MN77724) with a licensing order issued at 1950. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21950	MN St. Statute 144A.13 Subd. 2 Complaints; Resident's Rights Subd. 2. Resident's rights. The administrator of a nursing home shall inform each resident in writing at the time of admission of the right to complain to the administrator about facility accommodations and services. A notice of the right to complain shall be posted in the nursing home. The administrator shall also inform each resident of the right to complain to the commissioner of health. This MN Requirement is not met as evidenced by: Surveyor: 43087 Based on interview and document review, the facility failed to thoroughly investigate allegations of physical abuse and neglect, following resident	21950	It is the policy of Crest View Lutheran Home that a root cause investigation and analysis will be completed. The information gathered is given to administration. The investigation will	12/8/21

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21950	Continued From page 3 to resident altercations initiate by R4 against 3 of 4 residents (R1, R2, and R3) and by R6 against 1 of 4 residents (R5) on the memory care unit. The facility also failed to take appropriate corrective action to prevent further resident-to-resident altercations. Findings include: R4's ALTERCATIONS WITH R1, R2, and R3 R1's quarterly Minimum Data Set (MDS) dated 7/13/21, indicated R1 had severely impaired cognition with diagnoses of dementia without behavioral disturbance and depression. R1's care plan dated 7/12/21, indicated R1 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R1's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R2's annual MDS dated 10/7/21, indicated R2 had severely impaired cognition with diagnoses of Alzheimer's disease, anxiety, depression, and psychotic disorder. R2's care plan indicated R2 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R2's care plan dated 8/23/21 also indicated R2 could become verbally or physically aggressive with other residents with an intervention of decreasing environmental stimuli. R2's PN dated 10/12/21, indicated R2 was hit on	21950	include: Who was involved, Residents statements, Resident s roommate statements (if applicable) , Involved staff and witness statements of events, a description of the resident s behavior and environment at the time of the incident, injuries present, observation of resident and staff behaviors during the investigation, environmental considerations 10/28-10/29 The VA policy and Reporting Requirements were reviewed by the Administrator and education was provided by nursing leadership to Interdisciplinary Management Team. All facility nurses were given additional training on all of the above in more detail after the all-staff meetings. This information was presented by the Administrator and the DON. Care Plans for R1, R2, R3, R4, R5 and R6 were reviewed to ensure that interventions were in place to help protect them from resident to resident altercations. For all other residents in the facility that are identified as at risk for resident to resident altercations and their care plans will be reviewed to ensure interventions are in place to help protect them from resident to resident altercations as well by 12-8-2021. The Administrator is responsible for overall compliance of each part of this plan of correction	

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21950	Continued From page 4 the shoulder by another resident (R4). R2's PN dated 10/25/21, indicated on 10/12/21 R2 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R3's quarterly MD dated 9/13/21, indicated R3 had severely impaired cognition with diagnoses of dementia with behavioral disturbance, depression, and psychotic disorder. R3's care plan lacked acknowledgement R3 was a vulnerable adult and lacked interventions to keep R3 safe from being a victim of abuse. R3's progress noted (PN) dated 10/25/21, indicated on 10/12/21 R1 was "removed from immediate harm" and 15-minute checks were implemented. The PN further indicated a skin check was conducted with no bruises or marks. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R4's quarterly MDS dated 7/19/21, indicated R4 had severely impaired cognition with diagnoses of dementia. R4's MDS also indicated R4 had delirium with inattention and disorganized thinking; R4 ambulated without the use of a walker or wheelchair. R4's care plan dated 4/22/21, indicated R4 was a vulnerable adult and interventions were staff to follow the vulnerable adult policy and procedures. R4's care plan dated 4/22/21, indicated R4 exhibited behaviors toward others with interventions including administering medications per orders and being mindful of escalating behaviors between R4 and others;	21950		

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21950	Continued From page 5 noting if R4 became verbally aggressive towards others she could become physically aggressive. R4's PN dated 10/12/21, indicated R4 had increasing behaviors on the [day] shift, hitting other residents and staff. R4's PN dated 10/25/21, indicated on 10/12/21 R4 had increased agitation and hit three other residents. The PN also indicated the DON spoke to the nurse practitioner (NP) who reported reducing R4's antidepressant. The PN indicated the other residents were placed on 15-minute checks but there was no indication R4 was monitored more closely for aggression toward any other residents. R4's Associated Clinics of Psychology (ACP) note dated 10/15/21, indicated R4 had a history of verbal and physical aggression toward other residents: -- 8/6/21 - R4 struck other residents within a couple of weeks [of 8/6/21]; PRN Gabapentin added but it was not used by staff so discontinued. -- 1/11/10- R4 showed aggression to roommate and one other resident; staff were considering moving her off the locked memory care unit. There were no recommended changes in her care. During an interview on 10/25/21, at 1:52 p.m. nursing assistant (NA)-A stated she observed R4 hit R1, R2, and R3 on 10/12/21. NA-A further stated it started about two weeks prior when R4 woke up one morning and didn't want to change her clothes and was more agitated, which she reported to the nurse (licensed practical nurse [LPN]-A); R4 became combative later on that day with the staff. NA-A stated every day she worked,	21950		

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21950	Continued From page 6	21950		

R4 showed aggression to R3 almost daily by calling her names or hitting R3. NA-A stated she reported it every time to the nurse. NA-A stated on one day (she was unsure of the day) she observed R2 and R4 get into an argument in the television room and then they started hitting one another; NA-A separated them and reported this to the nurse. On 10/12/21, NA-A said it was different because R4 was very aggressive and hit three different residents:
-- R4 used vulgar language against R3 in the morning and then punched her in the back with a closed fist
-- R4 slapped R1 in the face with her house shoe right after lunch
-- R4 hit and slapped R2 in the afternoon
NA-A stated she told the nurse (LPN-B) after each episode. NA-A stated she was asked to write a statement about what she saw on 10/12/21, but no one interviewed her or talked to her about the different events.

During an interview on 10/26/21, at 2:40 p.m. LPN-B stated NA-A reported to her in the afternoon R4 hit residents R1, R2, and R3. LPN-B stated she informed the supervisor (Sup)-A that afternoon. LPN-B also stated R4 often showed aggressive verbal behaviors before but was unsure if she hit anyone.

R6's ALTERCATION WITH R5

R5's significant change MDS dated 9/26/21, indicated R5 had severely impaired cognition with diagnoses of dementia without behavioral disturbances and depression. R5's care plan lacked acknowledgement R5 was a vulnerable adult and lacked interventions to keep R5 safe from being a victim of abuse.

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21950	Continued From page 7 R5's PN dated 10/17/21, indicated while sitting in the television room, another resident slapped R5 on the arm. R5's progress noted (PN) dated 10/25/21, indicated on R5 slapped by another resident; the residents were separated and 15-minute checks were implemented. The PN further indicated there was no injury. The documentation lacked any changes in the plan of care to prevent future incidents of physical altercations from others. R6's quarterly change MDS dated 8/31/21, indicated R6 had severely impaired cognition with diagnoses of Alzheimer's disease and depression. R6's MDS also indicated R6 was mobile via wheelchair with assistance of one. R6's care plan dated 6/7/21, indicated R6 was a vulnerable adult and staff should follow vulnerable adult policies and procedures. R6's draft PN dated 10/16/21, indicated R6 became agitated and hit another resident's arm while watching television; R6 was transported to her room where she was toileted and calmed down; she was brought back "to sit next to her." During an interview on 10/26/21, at 12:00 p.m. RN-B stated on 10/16/21, R5 and R6 were sitting in the television room close to each other when R6 exhibited signs of agitation and then reached out and slapped R5 on the arm. RN-B stated they took R6 to her room where she was toileted and then able to calm down. RN-B stated she called the supervisor but did not recall the supervisor's name. RN-B stated no one followed up with her after she reported the altercation. The investigative file lacked evidence RN-B was	21950		

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21950	Continued From page 8	21950		

interviewed, other staff working the shift were interviewed, any residents were interviewed, or any resident assessments were conducted after the altercation. The investigative file included 15-minute check worksheets for R5 and R6 for 10/16/21 through 10/18/21.

During an interview on 10/26/21, at 3:30 p.m. the administrator and director of nursing verified their policy indicated staff working on the shift during the alleged abuse should be interviewed and staff on those shifts were not interviewed except those that were witnesses. They did not interview any residents but did skin assessments on all residents on 10/13/21, the day after R4 hit three other residents. They did not interview other staff who worked on 10/16/21 when R6 hit R5, nor did they interview residents or do any skin assessment on the other residents. They also acknowledged a root cause analysis should be completed that examined possible causes leading up to the abuse and actions taken to reduce chances of recurring abuse. They stated they discussed the abuse in the interdisciplinary team (IDT) meetings and considered interventions then. They stated supervisor A was no longer at the facility.

IDT meeting notes dated 9/15/21, 9/22/21, 9/29/21, 10/6/21, and 10/20/21, indicated lack of information or discussion about the allegations of abuse with any of the involved residents; no root causes or actions were documented. No additional IDT meeting notes were provided.

The facility's Resident Protection Plan policy dated January 21, indicated abuse was defined as the "willful infliction of injury"; willful was defined as the "individual acted deliberately, not that the individual must have intended to inflict

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21950	Continued From page 9 injury or harm." The policy also indicated any reports of abuse, including injuries of unknown origin would be investigated and the investigation would include at least the following: interviews of staff having contact with the resident during the relevant shifts of the alleged incident and a "root cause analysis of all circumstances surrounding the incident." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure they comply with federal regulations and include timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21950		