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 23, 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 November 5, 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. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. remove this sentence if not SQC and IJ. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 5, 2021, the situation of immediate jeopardy to potential health and safety cited at F745 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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. However, due to the extended survey the new NATCEP loss date is November 5, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Crest View Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 5, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

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

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 11/05/2021

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 On 11/1/21 to 11/5/21, 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 survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ at F745 began on 11/4/21, when R10 was discharged from the facility without appropriate nursing services and interventions in place prior to discharge. R10 required 24/7 supervision due to her mental illness and assistance with Activities of Daily Living (ADL). The administrator and DON were notified of the IJ on 11/4/21 at 3:50 p.m.. The IJ was removed on 11/5/21 at 3:45 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted from 11/4/21 to 11/5/21. The following complaints were found to be SUBSTANTIATED: H5018185C (MN78165) with a deficiency cited at F745. H5018181C (MN57836) was also SUBSTANTIATED, however due to actions taken by the facility prior to entrance, NO deficiencies were cited. The following complaints were found to be UNSUBSTANTIATED: H5018179C (MN78021), H5018182C (MN77657), and H5018184C (MN77442). H5018183C (MN78022) and H5018186C (MN78211) were also UNSUBSTANTIATED, however a related deficiency was cited at F609.	F 000		

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

Electronically Signed | 12/02/2021

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F 000	Continued From page 1 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 609 SS=D	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 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	F 609		12/8/21

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F 609	Continued From page 2 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: Based on interview and record review, the facility failed to report allegations of abuse involving 3 of 3 residents (R1, R2 and R12) to the State Agency (SA) immediately but no later than 2 hours. Findings include: Review of the 10/27/21, report to the State Agency (SA) at 12:27 a.m., identified on 10/26/21 at 3:30 p.m., R2 was observed by nurse touching R1's waist and tummy while whispering into R1's ear as she sat in chair in the lounge area. R2 had taken R1's walker away from R1. The nurse intervened and redirected R2 away from R1. Action taken to protect the resident was to immediately separate the 2 residents and initiate 15 minute checks. R2's Admission Record printed 11/2/21, indicated R2 had the following diagnosis: dementia with behavioral disturbance, major depressive disorder, anxiety disorder, and seizures. R2's admission MDS dated 10/8/21, identified cognitive deficit, no behaviors, and required 2 staff extensive assist with cares, needed total assist with transfers. R2 took scheduled pain medication, a daily antipsychotic and antidepressant medication. R2 was receiving occupational and physical therapy. R2's care plan 10/27/21, identified R2 had	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. Nursing staff and other departmental staff were 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	

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F 609	Continued From page 3 behavior problem related to unwanted sexual advances towards other residents, impulsive behaviors/self transfers, taking things that do not belong to him especially walkers, refusing adaptive equipment, and wandering into other resident rooms. The identified goal was resident safety and the safety of others will not be interrupted related to behaviors. Staff to administer medications as ordered. Staff to assist to ambulate as needed when restless. Resident may be placed on 1:1 or 15 minute checks as needed. Review of R2's progress notes identified: 10/26/21 at 2:54 p.m., identified R2 was noted to be leaning on a chair where another resident was sitting, started to touch resident inappropriately, talking in residents left ear, and then took her walker away. R2 also took another residents walker away and when staff tried to redirect him he became impulsive. There was no indication that the incident had been reported to administration. Additional note at 6:17 p.m., identified R2 had been restless and agitated during the shift. R2 was stubborn and difficult to settle in one place. R2 had needed 1:1 related to fall risk. 10/27/21 at 10:13 a.m., identified R2 had been witnessed touching another resident inappropriately in the lounge. The other resident was visibly distressed by the incident. Residents were separated and family, provider, and supervisor aware. Additional note at 11:08 a.m., identified that nursing assistant reported that R2 had taken another residents wheelchair and walker, staff returned the walker to the other resident. R2 had been assisted to sit in a chair and 1:1 initiated.	F 609	staff of this requirement. Audits of progress notes to ensure supervisor notification will be conducted daily by DON/ADON 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.	

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F 609	Continued From page 4 R1's Admission Record printed 11/2/21, indicated R1 had diagnoses of dementia, diabetes, and major depressive disorder. R1's annual Minimum Data Set (MDS) dated 10/11/21, indicated R1 had diagnoses of brain dysfunction, dementia, and depression. R1 required physical assistance of one-person for transfers and required the use of a walker. R1's Care Area Assessment (CAA) dated 10/11/21, indicated R1 had triggered for cognitive loss/dementia, falls, and psychotropic drug use that would be care planned with a referral for psychiatric services. R1's care plan dated 11/2/21, indicated R1 was a vulnerable adult related to compromised health, decline in independence, and her diagnoses. R1's care plan directed staff to follow the Vulnerable Adult policy and procedure, and observe for changes in mood or behavior. R1's care plan further indicated R1 required assist of one staff with all grooming needs, showering, dressing, toileting, and wheelchair mobility. Review of R1's progress notes identified: 10/26/21 at 3:17 p.m., identified R1 was sitting in the lounge this afternoon when a male resident came and took her walker away, started to touch her inappropriately and was talking in R1's ear. The male resident was redirected and moved away from R1. There was no indication the incident had been reported. 10/27/21 at 11:53 a.m., identified writer witnessed R1 being inappropriately touched in the lounge area by another resident. The other resident removed R1's walker and touched her thighs, abdomen, and was whispering in her ear. The note identified R1 was dressed and there were no	F 609		

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F 609	Continued From page 5	F 609		

injuries, however, R1 was resistant and was visibly distressed. R1 was unable to move as the aggressor had taken R1's walker. Staff immediately separated the residents and assigned a 1:1 staff to the aggressor.
10/27/21 at 4:47 p.m., the director of nurses identified she had been updated by the nurse on 10/26/21, via phone that R1 had been inappropriately touched by a resident on waist, thigh, and abdomen in the common area and had her walker taken away and incident had been reported to the SA.

During interview on 11/1/21, at 11:15 a.m. with the administrator identified her expectation for staff was that all concerns of abuse be reported immediately to the supervisor or DON to ensure timely reporting to the SA.

Interview on 11/1/21, at 11:30 a.m. with the director of nursing (DON) identified she found out about the incident between R1 and R2 when reviewing the resident progress on 10/26/21, at around 9:00 p.m. The DON further stated she had completed a report to the SA on 10/27/21, at 12:27 a.m. The DON confirmed the report should have been submitted immediately within two hours of the incident occurring. The DON revealed the staff had failed to report the incident immediately to her or another supervisor.

The facility's letter titled VA Policy and Reporting Requirements dated 10/27/21, indicated concerns regarding not filing vulnerable adult concerns timely to the supervisor, DON, and administrator which caused delay in reporting to state agency. The facility letter further indicated resident to resident incidents must be reported immediately because the facility had two hours to report to the

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F 609	Continued From page 6 state agency. Review of the 11/2/21, SA report filed at 7:45 p.m., identified family member reported that R12 had reported during care conference that on Saturday morning 10/30/21 an unknown male nursing assistant (NA) was rough with her during cares. Suspected pool staff not working in facility pending investigation. R12's admission Minimum Data Set (MDS) dated 10/5/21, indicated R12 had intact cognition. The MDS indicated R12 required extensive assistance with dressing and limited assistance with toileting and transfers with one staff member. R12's Care Area Assessment (CAA) dated 10/11/21, indicated R12 triggered for activities of daily living (ADLs) deficit. R12's care plan dated 10/1/21, indicated R12 required one staff assistance with activities of daily living (ADL) for dressing, grooming, and bathing. The care plan indicated R12 was a vulnerable adult. Interventions included following the vulnerable adult policy and procedure. R12's progress note dated 11/2/21 at 9:42 p.m., identified R12's daughter had reported that R12 had reported to her during care conference that on 10/30/21, during cares R12 had requested to use the bathroom before getting dressed. Nursing assistant (NA)-C told R12 he was going to just change R12 while in bed. R12 had reported the NA-C was "rough" and she felt like he was treating her like a rag doll and she felt scared. During an interview on 11/4/21, at 2:11 p.m. with registered nurse (RN)-A who was also R12's family member, stated during R12's care	F 609		

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conference on 11/2/21, R12 stated a male, pool nursing assistant (NA) was rude and rushed R12 during morning cares the previous weekend.

During an interview on 11/4/21, at 2:53 p.m. with R12 stated during morning cares the previous weekend, a male NA "tossed me around like a rag doll". R12 further stated the NA was rough and rude and R12 did not want NA providing cares for her again. R12's identified she had reported the incident to the day time nurse when she came in to take her vitals.

During an interview on 11/4/21, at 3:26 p.m. social services director (SSD) identified during R12's care conference on 11/2/21, R12 reported a male, pool NA was rough with her during cares the previous weekend. SSD stated an unknown occupational therapist (OT), RN-A and another unknown family member, were present at R12's care conference which ended around 4:30 p.m. SSD revealed the allegation of abuse should have been immediately reported to the director of nursing (DON) or administrator who then would report to the SA within two hours.

During an interview on 11/5/21, at 2:03 p.m. the DON identified if a resident reported rough cares to staff, the staff should report the incident to a nurse or supervisor immediately, and they should report the incident immediately to the DON. The DON stated on 11/2/21, around 7:30 p.m. registered nurse (RN)-B gave her a grievance form that R12 filled out with the assistance of her family member of the allegation of rough cares. The DON stated she had reported to the SA immediately upon receiving the grievance. The DON further stated staff who were present at R12's care conference should have reported

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F 609	Continued From page 8 R12's concerns about rough cares immediately. The facility Resident Protection Plan, revised 1/21, indicated an incident or suspected incident of mistreatment or abuse must be immediately reported to the administrator or designee. The policy indicated the administrator or designee would report an allegation of abuse no later than 2 hours after the allegation was made.	F 609		
F 745 SS=J	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically related social services prior to discharge for 1 of 1 resident (R10). This resulted in an immediate jeopardy (IJ) for R10 when she was discharged home alone, upon request of her family member (FM)-A without appropriate discharge plans in place to a potentially unsafe environment. The immediate jeopardy began on 10/22/21, when R10 was discharged from the facility without appropriate nursing services and interventions in place prior to discharge. R10 required 24/7 supervision due to her mental illness and assistance with Activities of Daily Living (ADL). The administrator was notified of the immediate jeopardy on 11/4/21, at 3:50 p.m. The immediate jeopardy was removed on 11/5/21, at 3:45 p.m. but noncompliance remained at the lower scope and severity level of	F 745	Discharge Policy and Procedure updated to include the appropriate notifications including NHIR if coordinated discharge does not occur. R10 is currently not a resident in the facility. Hennepin County police department were contacted on 11/04/21 to conduct a well check for R10. Police Officer called back and stated that welfare check was completed for resident. Police Officer has no concern at this time. SW placed call to Brittney, ILS worker (612-230-1982) to check status of resident. Brittney stated that she sees R10 twice per week. All residents in the facility with a discharge anticipated back into the community have the potential to be affected. Recent	12/8/21

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F 745	Continued From page 9 a D, no actual harm with potential for more than minimal harm. Findings include: R10's 10/17/21, admission Minimum Data Set (MDS) identified she was admitted to the facility from a local hospital with diagnoses of schizoaffective disorder of the bipolar type (mental illness causing hallucinations and delusions), anxiety disorder, depression, high blood pressure, chronic kidney disease, and alcohol abuse. R10 was cognitively intact although she was noted to have disorganized thinking and difficulty focusing. R10 required extensive assistance of 1 staff for bed mobility, toileting, and was able to walk, transfer and perform personal hygiene with supervision. R22 required limited assistance of 1 staff for dressing. R10's Care Area Assessment (CAA) identified R10 had a impaired balance during transitions and maintaining a sitting balance. R10 had noted delirium, dementia, behavioral symptoms, falls, and psychotropic drug use. R10's 9/30/21 through 10/6/21, local hospital records identified R10's History and Physical (H&P) noted R10 was admitted with paranoia psychosis. She was brought to the hospital via ambulance (EMS) from home for potential decompensated schizophrenia and increased paranoia. Upon admission she appeared delusional, paranoid, was anxious, restless, and was showing erratic behavior, showed confusion, and had impaired judgement. R10 would give repetitive sentences and questions, hallucinated, was exhibiting name calling and verbal insults. She was diagnosed with paranoia and psychosis. R10 had concerns of someone placed a bomb in	F 745	discharges to be reviewed at this morning□s IDT meeting. Any future discharges will be discussed at daily (M-F) Clinical meeting (Campus Admin, Care Center Admin, DON, LPN, Director of SS, Director of Health Info, ADON) to ensure appropriateness and policy procedure followed. On 11/04/21 at 5:45pm IDT (Campus Admin, Care Center Admin, DON, LPN, Director of SS, Director of Health Info, ADON, Dir Life Enrich, Director Champlain Services, Dir of HR.) and available Licensed Nursing Staff were in-serviced to review policies Transfer/Discharge, Leave against Medical Advice and Leave of Absence. Discharge planning for all admitted residents will be conducted with the goal of ensuring a safe discharge for the resident to a community of their choice. All SW re-educated to appropriate DC to community and setting up services prior to any discharge. Policy updated to reflect SW or designee MUST ensure care and services are established before dc for the safety of the resident. Any nursing or SW staff not currently working was re-educated to these changes prior to their next shift. An audit has been developed to monitor the date of anticipated discharge, IDT meeting related to discharge to confirm discharge address, necessary equipment (DME) required, medications, transportation, community services, physician notification with orders and	

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F 745	Continued From page 10 her kitchen while her floor was being redone. Her social history identified she lived at home alone and required a 4 wheeled walker for mobility. She required standby assist of 1 staff. A psychologolical (psych) consult identified her liver function testing was high, although it was unclear if she had been drinking lately. The psychiatric consultant prescribed Ativan (benzodiazepine) for potential alcohol withdrawal and seizure activity. R10 was previously hospitalized from 8/8/21 to 8/30/21, for management of seizures, auditory hallucinations, and suicidal ideation. Discharge instructions identified physical therapy (PT) recommended 24-hour supervision upon discharge and was a fall risk, required a rolling walker, standby assistance, and required supervision for all mobility. R10's after visit summary discharge instructions identified R10 required skilled care and occupational therapy. R10's 10/22/21, care plan identified she was at risk for elopment related to poor safety awareness evidenced by aimless wandering and disorientation, at times. R10 had a WanderGuard placed on her left lower leg due to an elopment attempt 10/13/21. R10 required assistance with ADLs related to weakness. She required stand by assist with ambulation and use of her 4 wheeled walker and dressing. She required extensive staff assistance of 1 with bed mobility and transfers. R10 was at risk for falls related to psychoactive medication use, being unsteady and unaware of her safety needs. R10's 10/21/21, Medication Administration Record (MAR) indicated R10 took trazodone (antidepressant and sedative medication), Abilify (anti-psychotic), Depakote (anti-seizure medication), gabapentin (anti-seizure	F 745	reason for discharge and all processes will be conveyed to physician on order. The audit was completed daily x 10 days, currently weekly x 4 weeks then monthly. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the Administrator or her designee. The Administrator will be responsible for compliance.	

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medication), levetiracetam (anti-seizure medication), Namenda (used for Alzheimer's and schizophrenia), and Seroquel (anti-psychotic).

R10's October 2021, Order Summary report indicated R10 had an order for WanderGuard and required a memory care/locked unit.

R10's progress notes identified on:
1) 10/10/21 at 4:57 p.m., staff noted R10 arrived at the facility from the local hospital via EMS. She required transfer of 1 assist by staff. Staff documented she had "slight forgetfulness".
2) 10/11/21 at 2:18 p.m., the social worker (SW) met with R10 in her room. R10 wanted to transfer to another nursing home. She reported she had called them herself, but they had no openings. She stated before her hospitalization she had a nurse at home who regulated her medication machine. She reported she was in the hospital related to seizures, but documentation showed she had not indicated her mental illness was a factor to the SW. R10 transfers with assist of 1 staff with her walker to the bathroom as needed and used a wheelchair propelled by staff for all other ambulation. R10's FM-A was her immediate contact person for emergencies.
3) 10/14/21 at 10:44 p.m., R10 set off the front door alarm after going outside. R10 was found by nursing sitting in the passenger seat of a car of a delivery person (unknown to R10). R10's WanderGuard alerted staff she left the facility. R10 was "confused at times and forgetful".
4) 10/15/21, R10 was moved to another room after her elopment as a safety precaution. FM-A was called and a message left, but no return call from FM-A was received.
5) 10/17/21 at 10:33 a.m., R10 used a phone at the nurse's station to call 911 because she

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wanted to go home.
6) 10/18/21 at 4:47 p.m., staff documented R10's elopment was reviewed. She had a WanderGuard alarm on and it had sounded, and staff checked the front area of the building. R10 was placed in memory care to prevent further elopements. R10 was noted to have exit seeking behaviors and wanted to return home.
7) 10/21/21 at 12:36 p.m., the SW documented she spoke with FM-A. FM-A wanted R10 discharged "as soon as possible". R10 was to discharge the next day. FM-A was to contact R10's independent living skills (ILS) worker and nurse to restart her services. The social worker noted PT and OT was requested by the resident. The SW would ensure this request was on the discharge order for the physician to sign. No further documentation was made identifying the SW was following facility policy by ensuring R10 was appropriate for discharge, where she was discharging to, or if she had the appropriate services and home atmosphere conducive to her safety.
8) 10/22/21 at 1:34, p.m., the discharge summary progress note identified R10 was discharged to home escorted by FM-A. No further documentation was made in R10's progress notes.

Interview on 11/2/21 at 2:45 p.m. with R10's mental health care coordinator (MHCC) identified R10 was not a good historian related to her dementia. During a hallucination, she and had once took a hammer to her medication dispensing device. The MHCC stated she had spoken to another family member of R10 (FM-B) prior to R10 being discharged. FM-B was concerned if R10 remined in the facility her "trust fund would be eaten up". The MHCC was not

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made aware of R10's sudden discharge by the facility until after R22 was home. The MHCC was concerned R10 did not have the appropriate supervision needed for someone with memory issues and mental health diagnoses to be discharged to home and required skilled nursing home care.

R10's occupational therapy (OT) notes from 10/10/21 to 10/22/21, identified staff had performed a SLUMS test (The Saint Louis University Mental Status Examination: a brief (7 minute) clinician-administered method of screening for Alzheimer's other types of dementia or mild neurocognitive impairment). R10 scored 12/30, indicating R10 had dementia and recommended R10 have 24-hour supervision upon discharge. R10 was noted to live in an apartment/condo by herself and reported she received help for groceries, managing medication, and scheduling (appointments). R10's bathroom was reported to be equipped with a shower chair and grab bars. OT staff remarked they were "unsure of the validity of this [home situation]". FM-A was reported to help "as needed".

Interview on 11/2/21 at 4:00 p.m., with R10's nurse practitioner (NP)-A identified R10 was admitted to the facility and had attempted elopement from the facility by exiting out the front door and entering the car of male delivery driver's car. R10 had not known this driver. NP-A was concerned as she was not involved with R10's discharge planning process or the interdisciplinary team meetings. NP-A received discharge orders from the social worker who advised her to sign them. NP-A was hesitant as she had not performed an evaluation herself to

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determine if R10 was appropriate for discharge, but acknowledged she felt pressured by the facility to do so. NP-A stated R10 had known cognitive impairment and with her mental health diagnoses, she required supportive services in place prior to discharge, to include at a minimum home care with 24-hour supervision to reduce the risk of injury and provide appropriate care. NP-A assumed the facility had facilitated the appropriate cares and services be in place prior to R10's discharge and was "upset" to learn this had not occurred.

R10's 10/29/21, PT noted indicated R10's end of care was 10/22/21. PT discharge plans and instruction included R10 return home with home health nursing services and a home exercise program.

Interview on 11/3/21 at 9:56 a.m. with the medical director (MD) identified the facility needed to follow the discharge planning process, policy, and procedure and ensure all cares and services were in place prior to discharging a resident to ensure their safety and ability to live alone.

Interview on 11/3/21, at 9:57 a.m. the social worker (SW)-A identified R10's daughter initiated a "quick discharge." SW-A indicated R10 did attempted to elope while residing in the facility with an unknown male whom she did not know. SW-A agreed R10 required 24-hour supervision and required placement in memory care with a WanderGuard. SW-A did not contact any outside home care agencies, case managers, care coordinator, primary physician, or ILS workers upon R10's discharge. SW-A took FM-A's word she would take care of R10 discharge needs. SW-A agreed there was no discharge planning

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done at IDT. SW-A agreed it was the facilities responsibility to ensure cares and services were in place prior to discharge. Follow up interview on 11/4/21 at 9:25 a.m. with SW-A stated her only conversation with FM-A was when FM-A became upset R10 was moved down to memory care unit. SW-A stated did not feel the facility was a "right fit" for R10 who required more assistance with her memory issues and mental health. R10 had a hard time following conversations and would go on "tangents". SW-A did not contact any outside home care agencies, case managers, care coordinator, primary physician, or independent living skills (ILS) workers because FM-A stated she would take care of it. She stated now realized that "should have had a red flag" as R10 had chronic mental health illness and dementia and should have ensure needed services were in place. SW-A was unsure why the recommendations from OT and PT were not ordered. SW-A stated if she would have done "a little more research" and contacted the other services, she would have had a clear picture of R10's actual needs. SW-A stated she would have filed a Vulnerable Adult report if had known FM-A was not with living with or providing supervision to R10, 24 hours per day. SW agreed she failed to ensure safe and appropriate discharge occurred.

Interview on 11/3/21 at 11:23, with R10's ILS supervisor stated R10 had an ILS worker who only came to her home twice a week for 2 hours at a time. R10 had a mental health case manager but that staff only provided services via phone. The ILS supervisor stated she did not feel R10 was safe to be home alone and required advanced care such as a nursing home with 24-hour supervision. The ILS supervisor further stated the previous home care agency nurse

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refused services to R10 because the agency felt R10 was a "liability" as they determined she was not safe at home. Later interview on 11/4/21 at 9:07 a.m., the ILS supervisor stated neither the ILS worker (ILS-A) or herself filed a vulnerable adult report because the previous home care nursing agency filed 3 prior to her hospitalization and was awaiting determinations from those reports.

Interview on 11/3/21 at 1:45 p.m., with physical therapist assistant (PTA)-A identified therapy recommended have 24-hour supervision based on her cognitive testing with a SLUM score of 12/30 indicating dementia upon discharge. Recommendations for 24-hour supervision was based on the visits therapy had with R10 while in the facility as they questioned her safety to be able to be at home alone.

Interview on 11/3/21 at 2:00 p.m., with ILS-A identified R10 required additional support with garbage, laundry, supervision ..."Maybe a companion-type person". R10 does not have a nurse or other therapies provided in her home at the present time. ILS-A felt R10 was not safe on her own at this time due to significant memory issues and her history of wandering and decreased physical mobility.

Interview on 11/3/21 at 4:00 p.m. with mental health case manager (MHCM)-A identified her visits were over the phone and completed monthly. She reviewed medications and check in on R10's mental health. There was no current mental health therapist caring for R10. MHCM-A stated R10's mental health has been "up and down" with 2 recent hospitalizations as R10 had been more manic within the past few months.

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MHCM-A stated R10 had not seen a psychiatrist since she was hospitalized. During her conversations with R10 she would stop mid-sentence, was confused, and "not clear" of what happening in the moment.

Interview on 11/4/21 at 8:54 a.m., with R10's primary care physician (MD)-B identified he last saw R10 prior to her admission to the facility. Based on R10's medical history, hospitalization, and exit-seeking behavior, in his expert medical opinion, R10 was not safe to be home alone and required 24-hour supervision and care. R10 should not have been discharged to home from the facility.

Interview on 11/4/21 at 1:30 p.m., with the Community Access for Disability Inclusion (CADI)-A case manager stated she was not notified of R10's discharge and was not contacted by the facility regarding the discharge prior to it occurring to assist with appropriate arrangements. CADI-A stated she does not feel the resident was currently safe to be home alone. CADI-A stated FM-A was never actively involved in R10's care and does not want to help with medication set up or administration.

Interview on 11/5/21 at 1:00 p.m., with the director of nursing (DON) identified R10's discharge was discussed at the interdisciplinary (IDT) meeting on 10/21/21, the day before she was discharged, but information regarding R10's needed care was not brought forth. FM-A pushed facility staff to do a "quick discharge". The DON stated FM-A eluded she would plan and organize services for R10. R10 had been transferred to memory care after R10 had eloped out the front door and got in a car of an unknown delivery driver. R10

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 11/05/2021

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 745	Continued From page 18	F 745		

"moderate" cognitive impairment and had difficulty holding a conversation. The DON was unaware of recommendations from the OT for R10 to have 24-hour supervision. The DON knew R10 had prior mental health services before her admission, but unsure of what kind of services she required. The DON's expectation was for the R10's physician to be contacted with requests for discharge so the MD could decide what care and services would potentially be needed and if the discharge was appropriate. The DON agreed the facility was responsible to ensure services were in place and policies and procedures followed to ensure the safety and care of a resident.

Interview on 11/5/21 at 3:56 p.m., with the administrator identified she felt the facility failed to provide a safe discharge for R10 because the discharge was "quick" and the team "did not pull together" and ensure R10 had services in place before discharge. The administrator felt R10 did not have enough documentation of her needs and agreed there was little to no involvement of R10's physician. The administrator stated communication needs to be improved between therapy, nursing, physicians, social services, and the administrator. Discharge planning should begin upon admission. The SW was to coordinate discharge plans. The administrator agreed it would beneficial if therapy and the physician were included in the IDT meetings.

Review of the August 2019, Discharge Policies and Procedures identified it was the responsibility of the SW to coordinate discharge planning and to coordinate community services necessary for a residents upon discharge.

The IJ which began on 11/4/21 was removed on

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F 745	Continued From page 19 11/5/21, at 3:45 p.m. when it could be verified through interview and document review, the facility reviewed and revised policies and procedures, reviewed other resident's medical records for accuracy, and educated staff to those changes.	F 745		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 5QXY11

Dear Administrator:

The above facility was surveyed on November 1, 2021 through November 5, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

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

Minnesota Department of Health

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 11/05/2021

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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 11/1/21 through 11/5/21, 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 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 12/02/21

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5018185C (MN78165) with a licensing order issued at 1475. H5018181C (MN57836) was also SUBSTANTIATED, however due to actions taken by the facility prior to entrance, NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5018179C (MN78021), H5018182C (MN77657), H5018184C (MN77442). H5018183C (MN78022) and H5018186C (MN78211) were also UNSUBSTANTIATED, however a related licensing order was issued at 1980. 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	2 000		

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2 000	Continued From page 2 you electronically. 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. 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		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide medically related social services prior to discharge for 1 of 1 resident (R10). This resulted in an immediate jeopardy (IJ) for R10 when she was discharged home alone, upon request of her family member (FM)-A	21475	Discharge Policy and Procedure updated to include the appropriate notifications including NHIR if coordinated discharge does not occur. R10 is currently not a resident in the facility.	12/8/21

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21475	Continued From page 3 without appropriate discharge plans in place to a potentially unsafe environment. The immediate jeopardy began on 10/22/21, when R10 was discharged from the facility without appropriate nursing services and interventions in place prior to discharge. R10 required 24/7 supervision due to her mental illness and assistance with Activities of Daily Living (ADL). The administrator was notified of the immediate jeopardy on 11/4/21, at 3:50 p.m. The immediate jeopardy was removed on 11/5/21, at 3:45 p.m. but noncompliance remained at the lower scope and severity level of a D, no actual harm with potential for more than minimal harm. Findings include: R10's 10/17/21, admission Minimum Data Set (MDS) identified she was admitted to the facility from a local hospital with diagnoses of schizoaffective disorder of the bipolar type (mental illness causing hallucinations and delusions), anxiety disorder, depression, high blood pressure, chronic kidney disease, and alcohol abuse. R10 was cognitively intact although she was noted to have disorganized thinking and difficulty focusing. R10 required extensive assistance of 1 staff for bed mobility, toileting, and was able to walk, transfer and perform personal hygiene with supervision. R22 required limited assistance of 1 staff for dressing. R10's Care Area Assessment (CAA) identified R10 had a impaired balance during transitions and maintaining a sitting balance. R10 had noted delirium, dementia, behavioral symptoms, falls, and psychotropic drug use. R10's 9/30/21 through 10/6/21, local hospital	21475	Hennepin County police department were contacted on 11/04/21 to conduct a well check for R10. Police Officer called back and stated that welfare check was completed for resident. Police Officer has no concern at this time. SW placed call to Brittney, ILS worker (612-230-1982) to check status of resident. Brittney stated that she sees R10 twice per week. All residents in the facility with a discharge anticipated back into the community have the potential to be affected. Recent discharges to be reviewed at this morning□s IDT meeting. Any future discharges will be discussed at daily (M-F) Clinical meeting (Campus Admin, Care Center Admin, DON, LPN, Director of SS, Director of Health Info, ADON) to ensure appropriateness and policy procedure followed. On 11/04/21 at 5:45pm IDT (Campus Admin, Care Center Admin, DON, LPN, Director of SS, Director of Health Info, ADON, Dir Life Enrich, Director Champlain Services, Dir of HR.) and available Licensed Nursing Staff were in-serviced to review policies Transfer/Discharge, Leave against Medical Advice and Leave of Absence. Discharge planning for all admitted residents will be conducted with the goal of ensuring a safe discharge for the resident to a community of their choice. All SW re-educated to appropriate DC to community and setting up services prior to any discharge. Policy updated to reflect SW or designee MUST ensure care and services are established before dc for	

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21475	Continued From page 4 records identified R10's History and Physical (H&P) noted R10 was admitted with paranoia psychosis. She was brought to the hospital via ambulance (EMS) from home for potential decompensated schizophrenia and increased paranoia. Upon admission she appeared delusional, paranoid, was anxious, restless, and was showing erratic behavior, showed confusion, and had impaired judgement. R10 would give repetitive sentences and questions, hallucinated, was exhibiting name calling and verbal insults. She was diagnosed with paranoia and psychosis. R10 had concerns of someone placed a bomb in her kitchen while her floor was being redone. Her social history identified she lived at home alone and required a 4 wheeled walker for mobility. She required standby assist of 1 staff. A psychologolical (psych) consult identified her liver function testing was high, although it was unclear if she had been drinking lately. The psychiatric consultant prescribed Ativan (benzodiazepine) for potential alcohol withdrawal and seizure activity. R10 was previously hospitalized from 8/8/21 to 8/30/21, for management of seizures, auditory hallucinations, and suicidal ideation. Discharge instructions identified physical therapy (PT) recommended 24-hour supervision upon discharge and was a fall risk, required a rolling walker, standby assistance, and required supervision for all mobility. R10's after visit summary discharge instructions identified R10 required skilled care and occupational therapy. R10's 10/22/21, care plan identified she was at risk for elopment related to poor safety awareness evidenced by aimless wandering and disorientation, at times. R10 had a WanderGuard placed on her left lower leg due to an elopment attempt 10/13/21. R10 required assistance with ADLs related to weakness. She required stand by	21475	the safety of the resident. Any nursing or SW staff not currently working was re-educated to these changes prior to their next shift. An audit has been developed to monitor the date of anticipated discharge, IDT meeting related to discharge to confirm discharge address, necessary equipment (DME) required, medications, transportation, community services, physician notification with orders and reason for discharge and all processes will be conveyed to physician on order. The audit was completed daily x 10 days, currently weekly x 4 weeks then monthly. The results of the audits will be reported to the QAPI committee for future recommendations. The audit will be completed by the Administrator or her designee. The Administrator will be responsible for compliance.	

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21475	Continued From page 5	21475		

assist with ambulation and use of her 4 wheeled walker and dressing. She required extensive staff assistance of 1 with bed mobility and transfers. R10 was at risk for falls related to psychoactive medication use, being unsteady and unaware of her safety needs.

R10's 10/21/21, Medication Administration Record (MAR) indicated R10 took trazodone (antidepressant and sedative medication), Abilify (anti-psychotic), Depakote (anti-seizure medication), gabapentin (anti-seizure medication), levetiracetam (anti-seizure medication), Namenda (used for Alzheimer's and schizophrenia), and Seroquel (anti-psychotic).

R10's October 2021, Order Summary report indicated R10 had an order for WanderGuard and required a memory care/locked unit.

R10's progress notes identified on:
1) 10/10/21 at 4:57 p.m., staff noted R10 arrived at the facility from the local hospital via EMS. She required transfer of 1 assist by staff. Staff documented she had "slight forgetfulness".
2) 10/11/21 at 2:18 p.m., the social worker (SW) met with R10 in her room. R10 wanted to transfer to another nursing home. She reported she had called them herself, but they had no openings. She stated before her hospitalization she had a nurse at home who regulated her medication machine. She reported she was in the hospital related to seizures, but documentation showed she had not indicated her mental illness was a factor to the SW. R10 transfers with assist of 1 staff with her walker to the bathroom as needed and used a wheelchair propelled by staff for all other ambulation. R10's FM-A was her immediate contact person for emergencies.
3) 10/14/21 at 10:44 p.m., R10 set off the front

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21475	Continued From page 6 door alarm after going outside. R10 was found by nursing sitting in the passenger seat of a car of a delivery person (unknown to R10). R10's WanderGuard alerted staff she left the facility. R10 was "confused at times and forgetful". 4) 10/15/21, R10 was moved to another room after her elopment as a safety precaution. FM-A was called and a message left, but no return call from FM-A was received. 5) 10/17/21 at 10:33 a.m., R10 used a phone at the nurse's station to call 911 because she wanted to go home. 6) 10/18/21 at 4:47 p.m., staff documented R10's elopment was reviewed. She had a WanderGuard alarm on and it had sounded, and staff checked the front area of the building. R10 was placed in memory care to prevent further elopements. R10 was noted to have exit seeking behaviors and wanted to return home. 7) 10/21/21 at 12:36 p.m., the SW documented she spoke with FM-A. FM-A wanted R10 discharged "as soon as possible". R10 was to discharge the next day. FM-A was to contact R10's independent living skills (ILS) worker and nurse to restart her services. The social worker noted PT and OT was requested by the resident. The SW would ensure this request was on the discharge order for the physician to sign. No further documentation was made identifying the SW was following facility policy by ensuring R10 was appropriate for discharge, where she was discharging to, or if she had the appropriate services and home atmosphere conducive to her safety. 8) 10/22/21 at 1:34, p.m., the discharge summary progress note identified R10 was discharged to home escorted by FM-A. No further documentation was made in R10's progress notes.	21475		

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21475	Continued From page 7 Interview on 11/2/21 at 2:45 p.m. with R10's mental health care coordinator (MHCC) identified R10 was not a good historian related to her dementia. During a hallucination, she and had once took a hammer to her medication dispensing device. The MHCC stated she had spoken to another family member of R10 (FM-B) prior to R10 being discharged. FM-B was concerned if R10 remined in the facility her "trust fund would be eaten up". The MHCC was not made aware of R10's sudden discharge by the facility until after R22 was home. The MHCC was concerned R10 did not have the appropriate supervision needed for someone with memory issues and mental health diagnoses to be discharged to home and required skilled nursing home care. R10's occupational therapy (OT) notes from 10/10/21 to 10/22/21, identified staff had performed a SLUMS test (The Saint Louis University Mental Status Examination: a brief (7 minute) clinician-administered method of screening for Alzheimer's other types of dementia or mild neurocognitive impairment). R10 scored 12/30, indicating R10 had dementia and recommended R10 have 24-hour supervision upon discharge. R10 was noted to live in an apartment/condo by herself and reported she received help for groceries, managing medication, and scheduling (appointments). R10's bathroom was reported to be equipped with a shower chair and grab bars. OT staff remarked they were "unsure of the validity of this [home situation]". FM-A was reported to help "as needed". Interview on 11/2/21 at 4:00 p.m., with R10's nurse practitioner (NP)-A identified R10 was admitted to the facility and had attempted	21475		

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elopement from the facility by exiting out the front door and entering the car of male delivery driver's car. R10 had not known this driver. NP-A was concerned as she was not involved with R10's discharge planning process or the interdisciplinary team meetings. NP-A received discharge orders from the social worker who advised her to sign them. NP-A was hesitant as she had not performed an evaluation herself to determine if R10 was appropriate for discharge, but acknowledged she felt pressured by the facility to do so. NP-A stated R10 had known cognitive impairment and with her mental health diagnoses, she required supportive services in place prior to discharge, to include at a minimum home care with 24-hour supervision to reduce the risk of injury and provide appropriate care. NP-A assumed the facility had facilitated the appropriate cares and services be in place prior to R10's discharge and was "upset" to learn this had not occurred.

R10's 10/29/21, PT noted indicated R10's end of care was 10/22/21. PT discharge plans and instruction included R10 return home with home health nursing services and a home exercise program.

Interview on 11/3/21 at 9:56 a.m. with the medical director (MD) identified the facility needed to follow the discharge planning process, policy, and procedure and ensure all cares and services were in place prior to discharging a resident to ensure their safety and ability to live alone.

Interview on 11/3/21, at 9:57 a.m. the social worker (SW)-A identified R10's daughter initiated a "quick discharge." SW-A indicated R10 did attempted to elope while residing in the facility with an unknown male whom she did not know.

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21475	Continued From page 9 SW-A agreed R10 required 24-hour supervision and required placement in memory care with a WanderGuard. SW-A did not contact any outside home care agencies, case managers, care coordinator, primary physician, or ILS workers upon R10's discharge. SW-A took FM-A's word she would take care of R10 discharge needs. SW-A agreed there was no discharge planning done at IDT. SW-A agreed it was the facilities responsibility to ensure cares and services were in place prior to discharge. Follow up interview on 11/4/21 at 9:25 a.m. with SW-A stated her only conversation with FM-A was when FM-A became upset R10 was moved down to memory care unit. SW-A stated did not feel the facility was a "right fit" for R10 who required more assistance with her memory issues and mental health. R10 had a hard time following conversations and would go on "tangents". SW-A did not contact any outside home care agencies, case managers, care coordinator, primary physician, or independent living skills (ILS) workers because FM-A stated she would take care of it. She stated now realized that "should have had a red flag" as R10 had chronic mental health illness and dementia and should have ensure needed services were in place. SW-A was unsure why the recommendations from OT and PT were not ordered. SW-A stated if she would have done "a little more research" and contacted the other services, she would have had a clear picture of R10's actual needs. SW-A stated she would have filed a Vulnerable Adult report if had known FM-A was not with living with or providing supervision to R10, 24 hours per day. SW agreed she failed to ensure safe and appropriate discharge occurred. Interview on 11/3/21 at 11:23, with R10's ILS supervisor stated R10 had an ILS worker who only came to her home twice a week for 2 hours	21475		

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at a time. R10 had a mental health case manager but that staff only provided services via phone. The ILS supervisor stated she did not feel R10 was safe to be home alone and required advanced care such as a nursing home with 24-hour supervision. The ILS supervisor further stated the previous home care agency nurse refused services to R10 because the agency felt R10 was a "liability" as they determined she was not safe at home. Later interview on 11/4/21 at 9:07 a.m., the ILS supervisor stated neither the ILS worker (ILS-A) or herself filed a vulnerable adult report because the previous home care nursing agency filed 3 prior to her hospitalization and was awaiting determinations from those reports.

Interview on 11/3/21 at 1:45 p.m., with physical therapist assistant (PTA)-A identified therapy recommended have 24-hour supervision based on her cognitive testing with a SLUM score of 12/30 indicating dementia upon discharge. Recommendations for 24-hour supervision was based on the visits therapy had with R10 while in the facility as they questioned her safety to be able to be at home alone.

Interview on 11/3/21 at 2:00 p.m., with ILS-A identified R10 required additional support with garbage, laundry, supervision ..."Maybe a companion-type person". R10 does not have a nurse or other therapies provided in her home at the present time. ILS-A felt R10 was not safe on her own at this time due to significant memory issues and her history of wandering and decreased physical mobility.

Interview on 11/3/21 at 4:00 p.m. with mental health case manager (MHCM)-A identified her visits were over the phone and completed

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monthly. She reviewed medications and check in on R10's mental health. There was no current mental health therapist caring for R10. MHCM-A stated R10's mental health has been "up and down" with 2 recent hospitalizations as R10 had been more manic within the past few months. MHCM-A stated R10 had not seen a psychiatrist since she was hospitalized. During her conversations with R10 she would stop mid-sentence, was confused, and "not clear" of what happening in the moment.

Interview on 11/4/21 at 8:54 a.m., with R10's primary care physician (MD)-B identified he last saw R10 prior to her admission to the facility. Based on R10's medical history, hospitalization, and exit-seeking behavior, in his expert medical opinion, R10 was not safe to be home alone and required 24-hour supervision and care. R10 should not have been discharged to home from the facility.

Interview on 11/4/21 at 1:30 p.m., with the Community Access for Disability Inclusion (CADI)-A case manager stated she was not notified of R10's discharge and was not contacted by the facility regarding the discharge prior to it occurring to assist with appropriate arrangements. CADI-A stated she does not feel the resident was currently safe to be home alone. CADI-A stated FM-A was never actively involved in R10's care and does not want to help with medication set up or administration.

Interview on 11/5/21 at 1:00 p.m., with the director of nursing (DON) identified R10's discharge was discussed at the interdisciplinary (IDT) meeting on 10/21/21, the day before she was discharged, but information regarding R10's needed care was not brought forth. FM-A pushed facility staff to do

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a "quick discharge". The DON stated FM-A eluded she would plan and organize services for R10. R10 had been transferred to memory care after R10 had eloped out the front door and got in a car of an unknown delivery driver. R10 "moderate" cognitive impairment and had difficulty holding a conversation. The DON was unaware of recommendations from the OT for R10 to have 24-hour supervision. The DON knew R10 had prior mental health services before her admission, but unsure of what kind of services she required. The DON's expectation was for the R10's physician to be contacted with requests for discharge so the MD could decide what care and services would potentially be needed and if the discharge was appropriate. The DON agreed the facility was responsible to ensure services were in place and policies and procedures followed to ensure the safety and care of a resident.

Interview on 11/5/21 at 3:56 p.m., with the administrator identified she felt the facility failed to provide a safe discharge for R10 because the discharge was "quick" and the team "did not pull together" and ensure R10 had services in place before discharge. The administrator felt R10 did not have enough documentation of her needs and agreed there was little to no involvement of R10's physician. The administrator stated communication needs to be improved between therapy, nursing, physicians, social services, and the administrator. Discharge planning should begin upon admission. The SW was to coordinate discharge plans. The administrator agreed it would beneficial if therapy and the physician were included in the IDT meetings.

Review of the August 2019, Discharge Policies and Procedures identified it was the responsibility of the SW to coordinate discharge planning and

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21475	Continued From page 13 to coordinate community services necessary for a residents upon discharge. The IJ which began on 11/4/21 was removed on 11/5/21, at 3:45 p.m. when it could be verified through interview and document review, the facility reviewed and revised policies and procedures, reviewed other resident's medical records for accuracy, and educated staff to those changes. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies and procedures to ensure medically related social services are provided to each resident throughout their stay and upon discharge and make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. The facility should identify other residents who are at risk for the deficient practice, review, re-educate staff to policies and procedures, and audit services to be provided by social services for a measurable amount of 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	21475		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated,	21980		12/8/21

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or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining

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21980	Continued From page 15 how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse involving 3 of 3 residents (R1, R2 and R12) to the State Agency (SA) immediately but no later than 2 hours. Findings include: Review of the 10/27/21, report to the State Agency (SA) at 12:27 a.m., identified on 10/26/21 at 3:30 p.m., R2 was observed by nurse touching R1's waist and tummy while whispering into R1's ear as she sat in chair in the lounge area. R2 had taken R1's walker away from R1. The nurse intervened and redirected R2 away from R1. Action taken to protect the resident was to immediately separate the 2 residents and initiate 15 minute checks. R2's Admission Record printed 11/2/21, indicated R2 had the following diagnosis: dementia with behavioral disturbance, major depressive disorder, anxiety disorder, and seizures. R2's admission MDS dated 10/8/21, identified cognitive deficit, no behaviors, and required 2 staff extensive assist with cares, needed total assist with transfers. R2 took scheduled pain medication, a daily antipsychotic and antidepressant medication. R2 was receiving occupational and physical therapy.	21980	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. Nursing staff and other departmental staff were 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	

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21980	Continued From page 16 R2's care plan 10/27/21, identified R2 had behavior problem related to unwanted sexual advances towards other residents, impulsive behaviors/self transfers, taking things that do not belong to him especially walkers, refusing adaptive equipment, and wandering into other resident rooms. The identified goal was resident safety and the safety of others will not be interrupted related to behaviors. Staff to administer medications as ordered. Staff to assist to ambulate as needed when restless. Resident may be placed on 1:1 or 15 minute checks as needed. Review of R2's progress notes identified: 10/26/21 at 2:54 p.m., identified R2 was noted to be leaning on a chair where another resident was sitting, started to touch resident inappropriately, talking in residents left ear, and then took her walker away. R2 also took another residents walker away and when staff tried to redirect him he became impulsive. There was no indication that the incident had been reported to administration. Additional note at 6:17 p.m., identified R2 had been restless and agitated during the shift. R2 was stubborn and difficult to settle in one place. R2 had needed 1:1 related to fall risk. 10/27/21 at 10:13 a.m., identified R2 had been witnessed touching another resident inappropriately in the lounge. The other resident was visibly distressed by the incident. Residents were separated and family, provider, and supervisor aware. Additional note at 11:08 a.m., identified that nursing assistant reported that R2 had taken another residents wheelchair and walker, staff returned the walker to the other resident. R2 had been assisted to sit in a chair and 1:1 initiated.	21980	(Paycom and Point Click Care) to remind staff of this requirement. Audits of progress notes to ensure supervisor notification will be conducted daily by DON/ADON 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.	

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21980	Continued From page 17 R1's Admission Record printed 11/2/21, indicated R1 had diagnoses of dementia, diabetes, and major depressive disorder. R1's annual Minimum Data Set (MDS) dated 10/11/21, indicated R1 had diagnoses of brain dysfunction, dementia, and depression. R1 required physical assistance of one-person for transfers and required the use of a walker. R1's Care Area Assessment (CAA) dated 10/11/21, indicated R1 had triggered for cognitive loss/dementia, falls, and psychotropic drug use that would be care planned with a referral for psychiatric services. R1's care plan dated 11/2/21, indicated R1 was a vulnerable adult related to compromised health, decline in independence, and her diagnoses. R1's care plan directed staff to follow the Vulnerable Adult policy and procedure, and observe for changes in mood or behavior. R1's care plan further indicated R1 required assist of one staff with all grooming needs, showering, dressing, toileting, and wheelchair mobility. Review of R1's progress notes identified: 10/26/21 at 3:17 p.m., identified R1 was sitting in the lounge this afternoon when a male resident came and took her walker away, started to touch her inappropriately and was talking in R1's ear. The male resident was redirected and moved away from R1. There was no indication the incident had been reported. 10/27/21 at 11:53 a.m., identified writer witnessed R1 being inappropriately touched in the lounge area by another resident. The other resident removed R1's walker and touched her thighs, abdomen, and was whispering in her ear. The note identified R1 was dressed and there were no injuries, however, R1 was resistant and was	21980		

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visibly distressed. R1 was unable to move as the aggressor had taken R1's walker. Staff immediately separated the residents and assigned a 1:1 staff to the aggressor.
10/27/21 at 4:47 p.m., the director of nurses identified she had been updated by the nurse on 10/26/21, via phone that R1 had been inappropriately touched by a resident on waist, thigh, and abdomen in the common area and had her walker taken away and incident had been reported to the SA.

During interview on 11/1/21, at 11:15 a.m. with the administrator identified her expectation for staff was that all concerns of abuse be reported immediately to the supervisor or DON to ensure timely reporting to the SA.

Interview on 11/1/21, at 11:30 a.m. with the director of nursing (DON) identified she found out about the incident between R1 and R2 when reviewing the resident progress on 10/26/21, at around 9:00 p.m. The DON further stated she had completed a report to the SA on 10/27/21, at 12:27 a.m. The DON confirmed the report should have been submitted immediately within two hours of the incident occurring. The DON revealed the staff had failed to report the incident immediately to her or another supervisor.

The facility's letter titled VA Policy and Reporting Requirements dated 10/27/21, indicated concerns regarding not filing vulnerable adult concerns timely to the supervisor, DON, and administrator which caused delay in reporting to state agency. The facility letter further indicated resident to resident incidents must be reported immediately because the facility had two hours to report to the state agency.

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21980	Continued From page 19 Review of the 11/2/21, SA report filed at 7:45 p.m., identified family member reported that R12 had reported during care conference that on Saturday morning 10/30/21 an unknown male nursing assistant (NA) was rough with her during cares. Suspected pool staff not working in facility pending investigation. R12's admission Minimum Data Set (MDS) dated 10/5/21, indicated R12 had intact cognition. The MDS indicated R12 required extensive assistance with dressing and limited assistance with toileting and transfers with one staff member. R12's Care Area Assessment (CAA) dated 10/11/21, indicated R12 triggered for activities of daily living (ADLs) deficit. R12's care plan dated 10/1/21, indicated R12 required one staff assistance with activities of daily living (ADL) for dressing, grooming, and bathing. The care plan indicated R12 was a vulnerable adult. Interventions included following the vulnerable adult policy and procedure. R12's progress note dated 11/2/21 at 9:42 p.m., identified R12's daughter had reported that R12 had reported to her during care conference that on 10/30/21, during cares R12 had requested to use the bathroom before getting dressed. Nursing assistant (NA)-C told R12 he was going to just change R12 while in bed. R12 had reported the NA-C was "rough" and she felt like he was treating her like a rag doll and she felt scared. During an interview on 11/4/21, at 2:11 p.m. with registered nurse (RN)-A who was also R12's family member, stated during R12's care conference on 11/2/21, R12 stated a male, pool nursing assistant (NA) was rude and rushed R12 during morning cares the previous weekend.	21980		

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21980	Continued From page 20 During an interview on 11/4/21, at 2:53 p.m. with R12 stated during morning cares the previous weekend, a male NA "tossed me around like a rag doll". R12 further stated the NA was rough and rude and R12 did not want NA providing cares for her again. R12's identified she had reported the incident to the day time nurse when she came in to take her vitals. During an interview on 11/4/21, at 3:26 p.m. social services director (SSD) identified during R12's care conference on 11/2/21, R12 reported a male, pool NA was rough with her during cares the previous weekend. SSD stated an unknown occupational therapist (OT), RN-A and another unknown family member, were present at R12's care conference which ended around 4:30 p.m. SSD revealed the allegation of abuse should have been immediately reported to the director of nursing (DON) or administrator who then would report to the SA within two hours. During an interview on 11/5/21, at 2:03 p.m. the DON identified if a resident reported rough cares to staff, the staff should report the incident to a nurse or supervisor immediately, and they should report the incident immediately to the DON. The DON stated on 11/2/21, around 7:30 p.m. registered nurse (RN)-B gave her a grievance form that R12 filled out with the assistance of her family member of the allegation of rough cares. The DON stated she had reported to the SA immediately upon receiving the grievance. The DON further stated staff who were present at R12's care conference should have reported R12's concerns about rough cares immediately. The facility Resident Protection Plan, revised 1/21, indicated an incident or suspected incident	21980		

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 11/05/2021

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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21980	Continued From page 21 of mistreatment or abuse must be immediately reported to the administrator or designee. The policy indicated the administrator or designee would report an allegation of abuse no later than 2 hours after the allegation was made. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure 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 measurable and determined amount of 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	21980		