

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,

Mitig

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

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,

M. Ping

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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.

M. Ping

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			11		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		COM	E SURVEY PLETED
		245018	B. WING				C 05/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE	11/	05/2021
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F 000	INITIAL COMMEN	TS	F 0	00			
	survey was conduct was found to be NC requirements of 42 Requirements for L The survey resulted to resident health a began on 11/4/21, v from the facility with services and interved discharge. R10 req her mental illness a Daily Living (ADL). were notified of the The IJ was remove The above findings quality of care, and conducted from 11/ The following comp SUBSTANTIATED: a deficiency cited a (MN57836) was also due to actions take entrance, NO defici The following comp UNSUBSTANTIATE H5018182C (MN77 (MN77442). H5018 H5018186C (MN78	blaints were found to be H5018185C (MN78165) with t F745. H5018181C so SUBSTANTIATED, however n by the facility prior to iencies were cited. blaints were found to be ED: H5018179C (MN78021), 7657), and H5018184C H83C (MN78022) and					
	deficiency was cited	d at F609.					
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TI	TLE		(X6) DATE
Electron	ically Signed						12/02/2021

Electronically Signed

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

PRINTED: 12/03/2021

		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING			C 11/05/2021	
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F 000 F 609 SS=D	The facility's plan or as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificat Upon receipt of an onsite revisit of you validate that substar regulations has been Reporting of Alleger CFR(s): 483.12(c)(§483.12(c) In respon neglect, exploitation must: §483.12(c)(1) Ensu involving abuse, ne mistreatment, inclu- source and misapp are reported immed hours after the allege that cause the allege serious bodily injury the events that cau- abuse and do not re the administrator of officials (including to adult protective seri- for jurisdiction in lon accordance with St procedures. §483.12(c)(4) Repo	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ir facility may be conducted to untial compliance with the en attained. d Violations 1)(4) onse to allegations of abuse, n, or mistreatment, the facility are that all alleged violations eglect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established					12/8/21

If continuation sheet Page 2 of 20

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HO	ME		4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	AST	
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F 609	accordance with Si Survey Agency, with incident, and if the appropriate correct This REQUIREME by: Based on interview failed to report alle 3 residents (R1, R2	age 2 entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced w and record review, the facility gations of abuse involving 3 of 2 and R12) to the State Agency but no later than 2 hours.	F 60	It is the policy of Crest View Luthe Home that all alleged violations inv abuse, neglect, exploitation or mistreatment, including injuries or	volving	
	Findings include: Review of the 10/2 Agency (SA) at 12: at 3:30 p.m., R2 wa R1's waist and tum ear as she sat in cl taken R1's walker intervened and red Action taken to pro immediately separa 15 minute checks. R2's Admission Re R2 had the followin behavioral disturba	7/21, report to the State 27 a.m., identified on 10/26/21 as observed by nurse touching my while whispering into R1's hair in the lounge area. R2 had away from R1. The nurse lirected R2 away from R1. tect the resident was to ate the 2 residents and initiate cord printed 11/2/21, indicated ng diagnosis: dementia with ance, major depressive isorder, and seizures.		unknown source, and misappropri resident property, are reported immediately but no later than 2 ho the allegation is made, if the event cause the allegation involve abuse result in serious bodily injury, or no than 24 hours if the events that ca allegation do not involve abuse an result in serious bodily injury, to th administrator of the facility and to officials (including to the State Sur Agency and adult protective servic where state law provides for jurisd long-term care facilities) in accord with State law through established procedures. Nursing staff and other departmer were re-educated on the VA Policy Reporting Requirements by Nover	ation of urs after s that e or ot later use the d do not e other vey ses iction in ance	
	cognitive deficit, no staff extensive ass assist with transfer medication, a daily antidepressant me occupational and p	dication. R2 was receiving		16th, 2021. For all other residents this deficier practice could have affected the 2 report will be reviewed daily by DON/designee for indications of a that were not already reported. An electronic alert statement has bee to routinely used computer applica (Paycom and Point Click Care) to	it 4-hour buse n added itions	

Facility ID: 00005

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED	
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F 609	behavior problem re advances towards of behaviors/self trans belong to him espe- adaptive equipment resident rooms. The safety and the safe interrupted related to administer medicati to ambulate as nee may be placed on 1 needed. Review of R2's prog 10/26/21 at 2:54 p.r be leaning on a chas sitting, started to to talking in residents walker away. R2 als walker away and with he became impulsive that the incident has administration. Add identified R2 had be during the shift. R2 settle in one place. fall risk. 10/27/21 at 10:13 a witnessed touching inappropriately in the was visibly distress were separated and supervisor aware. A identified that nursin had taken another in walker, staff returner	elated to unwanted sexual other residents, impulsive sfers, taking things that do not cially walkers, refusing t, and wandering into other e identified goal was resident ty of others will not be to behaviors. Staff to ions as ordered. Staff to assist ded when restless. Resident 1:1 or 15 minute checks as gress notes identified: m., identified R2 was noted to air where another resident was uch resident inappropriately, left ear, and then took her so took another residents hen staff tried to redirect him ve. There was no indication d been reported to itional note at 6:17 p.m., een restless and agitated was stubborn and difficult to R2 had needed 1:1 related to u.m., identified R2 had been	F 6	staff of this requirement. Audits of progress notes supervisor notification wil daily by DON/ADON at o rounds and brought to ID and results shared at QA The Director of Nursing v responsible for compliant	l be conducted r before clinical T as needed, PI. vill be		

If continuation sheet Page 4 of 20

		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
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F 609	R1's Admission Rei R1 had diagnoses of major depressive d R1's annual Minimu 10/11/21, indicated dysfunction, demer required physical as transfers and requir Care Area Assessm indicated R1 had tri loss/dementia, falls that would be care psychiatric services R1's care plan date vulnerable adult rel decline in independ R1's care plan direc Vulnerable Adult po observe for change care plan further into one staff with all gro dressing, toileting, a Review of R1's prop 10/26/21 at 3:17 p.1 the lounge this afte came and took her her inappropriately The male resident v away from R1. The incident had been r 10/27/21 at 11:53 a R1 being inappropr area by another res removed R1's walk abdomen, and was	cord printed 11/2/21, indicated of dementia, diabetes, and isorder. um Data Set (MDS) dated R1 had diagnoses of brain ntia, and depression. R1 ssistance of one-person for red the use of a walker. R1's nent (CAA) dated 10/11/21, iggered for cognitive s, and psychotropic drug use planned with a referral for s. ed 11/2/21, indicated R1 was a ated to compromised health, lence, and her diagnoses. cted staff to follow the blicy and procedure, and es in mood or behavior. R1's dicated R1 required assist of ooming needs, showering, and wheelchair mobility. gress notes identified: m., identified R1 was sitting in rnoon when a male resident walker away, started to touch and was talking in R1's ear. was redirected and moved re was no indication the	F	609				

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391		
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		245018	B. WING				C 05/2021		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CREST	/IEW LUTHERAN HOI	ME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421						
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F 609	injuries, however, F visibly distressed. F aggressor had take immediately separa assigned a 1:1 staf 10/27/21 at 4:47 p.r identified she had b 10/26/21, via phone inappropriately touct thigh, and abdomen her walker taken av reported to the SA. During interview on the administrator id staff was that all co immediately to the s timely reporting to t Interview on 11/1/2 director of nursing (about the incident b reviewing the reside around 9:00 p.m. T had completed a re 12:27 a.m. The DC have been submitte hours of the incider revealed the staff f immediately to her The facility's letter t Requirements date regarding not filing timely to the superv which caused delay The facility letter fur resident incidents n	A1 was resistant and was A1 was unable to move as the en R1's walker. Staff ated the residents and f to the aggressor. m., the director of nurses been updated by the nurse on that R1 had been ched by a resident on waist, n in the common area and had way and incident had been 11/1/21, at 11:15 a.m. with lentified her expectation for incerns of abuse be reported supervisor or DON to ensure	F	609					

If continuation sheet Page 6 of 20

	MENT OF HEALTH		FORM	APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE	E SURVEY
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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F 609	Continued From pa	ae 6	F 6	sna			
1 000	state agency.	geo	10	103			
	Beview of the 11/2/	21, SA report filed at 7:45					
	p.m., identified fami	ily member reported that R12					
		g care conference that on 10/30/21 an unknown male					
	nursing assistant (N	NA) was rough with her during					
	cares. Suspected p pending investigation	ool staff not working in facility on.					
	10/5/21, indicated F	inimum Data Set (MDS) dated R12 had intact cognition. The required extensive assistance					
	with dressing and li	mited assistance with toileting one staff member. R12's Care					
	Area Assessment (CAA) dated 10/11/21,					
	indicated R12 trigge (ADLs) deficit.	ered for activities of daily living					
		ted 10/1/21, indicated R12					
		ssistance with activities of r dressing, grooming, and					
	bathing. The care p	plan indicated R12 was a					
		terventions included following t policy and procedure.					
		e dated 11/2/21 at 9:42 p.m.,					
		ughter had reported that R12 during care conference that					
		cares R12 had requested to					
		before getting dressed. Nursing Id R12 he was going to just					
		n bed. R12 had reported the and she felt like he was					
		ag doll and she felt scared.					
	During an interview	on 11/4/21, at 2:11 p.m. with					
	registered nurse (R	N)-A who was also R12's ted during R12's care					

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PRINTED: 12/03/2021

CENTER STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI		RINTED: 12/03/2021 FORM APPROVED MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED
		245018	B. WING			C 11/05/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	_	
CREST \	IEW LUTHERAN HO	ME			444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	conference on 11/2, nursing assistant (N during morning care During an interview R12 stated during m weekend, a male N rag doll". R12 furthe and rude and R12 of cares for her again. reported the incider she came in to take During an interview social services direct R12's care conferent a male, pool NA wa the previous weeke occupational therap unknown family me care conference wh SSD revealed the a have been immedia nursing (DON) or a report to the SA with During an interview DON identified if a n to staff, the staff shin nurse or supervisor report the incident i DON stated on 11/2 registered nurse (R form that R12 filled family member of th The DON stated shi immediately upon re DON further stated	 All 2 stated a male, pool VA) was rude and rushed R12 es the previous weekend. A on 11/4/21, at 2:53 p.m. with morning cares the previous IA "tossed me around like a er stated the NA was rough did not want NA providing . R12's identified she had nt to the day time nurse when e her vitals. A on 11/4/21, at 3:26 p.m. ctor (SSD) identified during nce on 11/2/21, R12 reported as rough with her during cares end. SSD stated an unknown pist (OT), RN-A and another ember, were present at R12's nich ended around 4:30 p.m. allegation of abuse should ately reported to the director of dministrator who then would 	F 6	09			

Facility ID: 00005

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
			A. BUILDIN	G		С	
		245018	B. WING _			05/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CREST	IEW LUTHERAN HO	ME		4444 RESERVOIR BOULEVARD NORTHEA COLUMBIA HEIGHTS, MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI			
F 609	Continued From pa R12's concerns abo	ge 8 out rough cares immediately.	F 60	9			
F 745 SS=J	1/21, indicated an in of mistreatment or reported to the adm policy indicated the would report an alle 2 hours after the all	nt Protection Plan, revised ncident or suspected incident abuse must be immediately ninistrator or designee. The administrator or designee egation of abuse no later than legation was made. ally Related Social Service	F 74	5		12/8/21	
	maintain the highes and psychosocial w This REQUIREMEI by: Based on interview facility failed to prov services prior to dis (R10). This resulted for R10 when she w upon request of her without appropriate potentially unsafe e The immediate jeop when R10 was disc without appropriate interventions in place required 24/7 super illness and assistant Living (ADL). The a	becal services to attain or st practicable physical, mental vell-being of each resident. NT is not met as evidenced v and document review, the vide medically related social scharge for 1 of 1 resident d in an immediate jeopardy (IJ) vas discharged home alone, r family member (FM)-A discharge plans in place to a environment. Dardy began on 10/22/21, charged from the facility nursing services and ce prior to discharge. R10 rvision due to her mental nee with Activities of Daily administrator was notified of ardy on 11/4/21, at 3:50 p.m. Dardy was removed on		Discharge Policy and Procedure to include the appropriate notifica including NHIR if coordinated disc does not occur. R10 is currently not a resident in f facility. Hennepin County police departme contacted on 11/04/21 to conduct check for R10. Police Officer call and stated that welfare check was completed for resident. Police Officer has no concern at the SW placed call to Brittney, ILS we (612-230-1982) to check status of resident. Brittney stated that she se R10 twice per week. All residents in the facility with a co anticipated back into the communication.	tions charge the ent were a well ed back s his time. orker f sees lischarge		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED
		245018	B. WING		())5/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		JJ/2021
CREST V	VIEW LUTHERAN HON	ME		4444 RESERVOIR BOULEVARD COLUMBIA HEIGHTS, MN 55	NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
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		F 74	 discharges to be reviewe morning s IDT meeting. discharges will be discuss Clinical meeting (Campus Center Admin, DON, LPN Director of Health Info, Al appropriateness and polit followed. On 11/04/21 at 5:45pm IE Admin, Care Center Adm Director of SS, Director o ADON, Dir Life Enrich, Di Champlain Services, Dir available Licensed Nursir in-serviced to review polit Transfer/Discharge, Leav Medical Advice and Leav Discharge planning for al residents will be conducte of ensuring a safe discha 	Any future sed at daily (M-F) s Admin, Care J, Director of SS, DON) to ensure cy procedure DT (Campus in, DON, LPN, f Health Info, irector of HR.) and ng Staff were cies re against e of Absence. I admitted ed with the goal	
	and maintaining a s delirium, dementia, and psychotropic du R10's 9/30/21 throu records identified R (H&P) noted R10 w psychosis. She was ambulance (EMS) f decompensated scl paranoia. Upon adr delusional, paranoio was showing erratio and had impaired ju repetitive sentences	I balance during transitions Sitting balance. R10 had noted behavioral symptoms, falls, rug use. Igh 10/6/21, local hospital 10's History and Physical as admitted with paranoia brought to the hospital via rom home for potential hizophrenia and increased nission she appeared d, was anxious, restless, and behavior, showed confusion, udgement. R10 would give s and questions, hallucinated, e calling and verbal insults.		 resident to a community of All SW re-educated to ap community and setting up any discharge. Policy up SW or designee MUST e services are established safety of the resident. Ar staff not currently working re-educated to these chatheir next shift. An audit has been develot the date of anticipated dismeeting related to discharge address, neces (DME) required, medicating 	of their choice. propriate DC to o services prior to dated to reflect nsure care and before dc for the ny nursing or SW g was nges prior to oped to monitor scharge, IDT rge to confirm ssary equipment	

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		AND HUMAN SERVICES			FORM	12/03/2021 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED			
		245018	B. WING			C 05/2021			
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE						
CREST \	/IEW LUTHERAN HOI	ME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421						
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 745	her kitchen while he social history identii and required a 4 wh required standby as psychologolical (psi function testing was if she had been drin consultant prescrib- potential alcohol wi R10 was previously 8/30/21, for manag- hallucinations, and instructions identifier recommended 24-H discharge and was walker, standby ass supervision for all m summary discharge required skilled car R10's 10/22/21, car risk for elopment re awareness evidence disorientation, at tim placed on her left for attempt 10/13/21. F ADLs related to we assist with ambulat walker and dressing assistance of 1 with R10 was at risk for medication use, be her safety needs. R10's 10/21/21, Me Record (MAR) indic (antidepressant and	er floor was being redone. Her fied she lived at home alone heeled walker for mobility. She ssist of 1 staff. A ych) consult identified her liver s high, although it was unclear nking lately. The psychiatric ed Ativan (benzodiazepine) for thdrawal and seizure activity. y hospitalized from 8/8/21 to ement of seizures, auditory suicidal ideation. Discharge ed physical therapy (PT) nour supervision upon a fall risk, required a rolling sistance, and required nobility. R10's after visit e instructions identified R10 e and occupational therapy. re plan identified she was at elated to poor safety sed by aimless wandering and mes. R10 had a WanderGuard ower leg due to an elopment R10 required assistance with akness. She required stand by ion and use of her 4 wheeled g. She required extensive staff n bed mobility and transfers. falls related to psychoactive ing unsteady and unaware of	F 745	reason for discharge and all process will be conveyed to physician on or The audit was completed daily x 10 currently weekly x 4 weeks then mo The results of the audits will be rep to the QAPI committee for future recommendations. The audit will be completed by the Administrator or h designee. The Administrator will be responsib compliance.	der.) days, onthly. oorted e ner				

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245018	B. WING			C 11/05/2021	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI	ИЕ			444 RESERVOIR BOULEVARD NORTHEAS OLUMBIA HEIGHTS, MN 55421	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	medication), leveting medication), Name schizophrenia), and R10's October 2022 indicated R10 had a required a memory R10's progress note 1) 10/10/21 at 4:57 at the facility from the required transfer of documented she ha 2) 10/11/21 at 2:18 met with R10 in her to another nursing h called them herself. She stated before h nurse at home who machine. She report related to seizures, she had not indicate factor to the SW. R staff with her walke and used a wheeled other ambulation. F contact person for e 3) 10/14/21 at 10:44 door alarm after go nursing sitting in the delivery person (un WanderGuard alert R10 was "confused 4) 10/15/21, R10 wa after her elopment a was called and a m from FM-A was rect 5) 10/17/21 at 10:35	acetam (anti-seizure nda (used for Alzheimer's and d Seroquel (anti-psychotic). 1, Order Summary report an order for WanderGuard and care/locked unit. es identified on: p.m., staff noted R10 arrived he local hospital via EMS. She 1 assist by staff. Staff ad "slight forgetfulness". p.m., the social worker (SW) room. R10 wanted to transfer home. She reported she had , but they had no openings. her hospitalization she had a regulated her medication rted she was in the hospital but documentation showed ed her mental illness was a 10 transfers with assist of 1 r to the bathroom as needed hair propelled by staff for all R10's FM-A was her immediate emergencies. 4 p.m., R10 set off the front ing outside. R10 was found by e passenger seat of a car of a known to R10). R10's red staff she left the facility. I at times and forgetful". as moved to another room as a safety precaution. FM-A ressage left, but no return call	F 7	45			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245018	B. WING	ì			C 05/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	VIEW LUTHERAN HOI	ME			4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	 wanted to go home 6) 10/18/21 at 4:47 elopment was revie WanderGuard alarr staff checked the fr was placed in mem elopements. R10 w behaviors and wam 7) 10/21/21 at 12:33 she spoke with FM- discharged "as sood discharge the next R10's independent nurse to restart her noted PT and OT w The SW would ensite discharge order for further documentat SW was following fr was appropriate for discharging to, or if services and home safety. 8) 10/22/21 at 1:34, progress note identi home escorted by F documentation was notes. Interview on 11/2/2 mental health care R10 was not a good dementia. During a once took a hammed dispensing device. spoken to another fr prior to R10 being of concerned if R10 ref	 p.m., staff documented R10's p.m., staff documented R10's p.m., staff documented R10's p.m., staff documented R10 on and it had sounded, and ront area of the building. R10 on are to prevent further vas noted to have exit seeking ted to return home. 6 p.m., the SW documented -A. FM-A wanted R10 on as possible". R10 was to day. FM-A was to contact living skills (ILS) worker and r services. The social worker vas requested by the resident. Sure this request was on the the physician to sign. No tion was made identifying the facility policy by ensuring R10 r discharge, where she was f she had the appropriate atmosphere conducive to her p.m., the discharge summary tified R10 was discharged to 	F	745			

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING				C)5/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	IEW LUTHERAN HOI	ME			444 RESERVOIR BOULEVARD NORTHEAS	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	made aware of R10 facility until after R2 concerned R10 did supervision needed issues and mental I discharged to home home care. R10's occupational 10/10/21 to 10/22/2 performed a SLUM University Mental S minute) clinician-ad screening for Alzhe or mild neurocognit 12/30, indicating R3 recommended R10 upon discharge. R1 apartment/condo by received help for gr medication, and scl R10's bathroom wa a shower chair and they were "unsure of situation]". FM-A wa needed". Interview on 11/2/27 nurse practitioner (I admitted to the faci elopement from the door and entering the car. R10 had not kr concerned as she w discharge orders fro advised her to sign	D's sudden discharge by the 22 was home. The MHCC was not have the appropriate d for someone with memory health diagnoses to be e and required skilled nursing therapy (OT) notes from 21, identified staff had S test (The Saint Louis Status Examination: a brief (7 dministered method of imer's other types of dementia tive impairment). R10 scored 10 had dementia and have 24-hour supervision 10 was noted to live in an y herself and reported she roceries, managing heduling (appointments). as reported to be equipped with grab bars. OT staff remarked of the validity of this [home as reported to help "as 1 at 4:00 p.m., with R10's NP)-A identified R10 was lity and had attempted e facility by exiting out the front he car of male delivery driver's nown this driver. NP-A was was not involved with R10's	F	745			

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING				C 05/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDEST	/IEW LUTHERAN HOI	ME		4	444 RESERVOIR BOULEVARD NORTHEAS	т	
CREST				С	COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	determine if R10 was but acknowledged s facility to do so. NP cognitive impairment diagnoses, she req place prior to discha home care with 24- risk of injury and pr assumed the facility appropriate cares a to R10's discharge had not occurred. R10's 10/29/21, PT care was 10/22/21, instruction included health nursing serv program. Interview on 11/3/21 director (MD) identif follow the discharge procedure and ensitive were in place prior ensure their safety Interview on 11/3/21 worker (SW)-A ider a "quick discharge, attempted to elope with an unknown m SW-A agreed R10 f and required placer WanderGuard. SW home care agencie coordinator, primar upon R10's dischar she would take care	as appropriate for discharge, she felt pressured by the -A stated R10 had known nt and with her mental health uired supportive services in arge, to include at a minimum hour supervision to reduce the ovide appropriate care. NP-A	F 7	745			

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245018	B. WING				C 05/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	/IEW LUTHERAN HOI	ME		4	444 RESERVOIR BOULEVARD NORTHEAS	т	
ONLOT				С	COLUMBIA HEIGHTS, MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	done at IDT. SW-A responsibility to ensi in place prior to disc 11/4/21 at 9:25 a.m conversation with F upset R10 was mov SW-A stated did no fit" for R10 who req her memory issues hard time following on "tangents". SW- home care agencie coordinator, primary living skills (ILS) we she would take care that "should have h chronic mental hea should have ensure place. SW-A was un recommendations f ordered. SW-A stat little more research services, she would R10's actual needs filed a Vulnerable A was not with living w R10, 24 hours per c ensure safe and ap Interview on 11/3/2" supervisor stated R only came to her ho at a time. R10 had but that staff only pu The ILS supervisor was safe to be hom advanced care suc 24-hour supervisior	agreed it was the facilities sure cares and services were charge. Follow up interview on a with SW-A stated her only FM-A was when FM-A became wed down to memory care unit. of feel the facility was a "right juired more assistance with and mental health. R10 had a conversations and would go -A did not contact any outside es, case managers, care y physician, or independent orkers because FM-A stated e of it. She stated now realized and a red flag" as R10 had lth illness and dementia and e needed services were in	F	745			

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING				C 05/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	VIEW LUTHERAN HOI	ME			444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	π	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	refused services to R10 was a "liability" not safe at home. L 9:07 a.m., the ILS s ILS worker (ILS-A) adult report becaus nursing agency filed and was awaiting d reports. Interview on 11/3/2" therapist assistant of recommended have on her cognitive tes 12/30 indicating der Recommendations based on the visits the facility as they of able to be at home Interview on 11/3/2" identified R10 requi garbage, laundry, s companion-type penurse or other thera the present time. IL her own at this time issues and her histo decreased physical Interview on 11/3/2" health case manag visits were over the monthly. She review on R10's mental health thera stated R10's mental down" with 2 recent	R10 because the agency felt ' as they determined she was ater interview on 11/4/21 at supervisor stated neither the or herself filed a vulnerable be the previous home care d 3 prior to her hospitalization eterminations from those 1 at 1:45 p.m., with physical (PTA)-A identified therapy e 24-hour supervision based sting with a SLUM score of mentia upon discharge. for 24-hour supervision was therapy had with R10 while in questioned her safety to be alone. 1 at 2:00 p.m., with ILS-A ired additional support with upervision"Maybe a rson". R10 does not have a apies provided in her home at .S-A felt R10 was not safe on a due to significant memory ory of wandering and	F	745			

Facility ID: 00005

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		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245018	B. WING	i			C)5/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	IEW LUTHERAN HO	ME			444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	т	
	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 745	Continued From no	200 17		745			
1 /43	Continued From pa	-	F	745			
		0 had not seen a psychiatrist pitalized. During her					
		R10 she would stop					
		confused, and "not clear" of					
	what happening in t	the moment.					
	Interview on 11/4/2	1 at 8:54 a.m., with R10's					
		cian (MD)-B identified he last					
		er admission to the facility. Edical history, hospitalization,					
		ehavior, in his expert medical					
	opinion, R10 was n	ot safe to be home alone and					
		upervision and care. R10					
	the facility.	en discharged to home from					
		1 at 1:30 p.m., with the for Disability Inclusion					
		hager stated she was not					
	notified of R10's dis	scharge and was not contacted					
	by the facility regard occurring to assist	ding the discharge prior to it					
		DI-A stated she does not feel					
	the resident was cu	irrently safe to be home alone.					
		A was never actively involved					
	in R10's care and d medication set up c	loes not want to help with or administration.					
		1 at 1:00 p.m., with the director					
		lentified R10's discharge was					
		terdisciplinary (IDT) meeting ay before she was discharged,					
	-	arding R10's needed care was					
	not brought forth. F	M-A pushed facility staff to do					
		'. The DON stated FM-A					
		plan and organize services for n transferred to memory care					
		ed out the front door and got in					
		n delivery driver. R10					

Facility ID: 00005

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	-	AND HUMAN SERVICES			FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245018	B. WING _			C 05/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST	/IEW LUTHERAN HOI	ME		4444 RESERVOIR BOULEVARD NORTHEA COLUMBIA HEIGHTS, MN 55421	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 745	"moderate" cognitiv difficulty holding a c unaware of recomm R10 to have 24-hou R10 had prior ment admission, but unsu she required. The D R10's physician to D discharge so the M services would pote discharge was appr facility was response place and policies a ensure the safety a Interview on 11/5/2' administrator identi provide a safe discl discharge was "quie together" and ensure before discharge. T not have enough do agreed there was li physician. The adm communication need therapy, nursing, ph the administrator. D begin upon admisss discharge plans. The would beneficial if t included in the IDT Review of the Augur and Procedures ide of the SW to coordi to coordinate comm residents upon disc	ve impairment and had conversation. The DON was nendations from the OT for ur supervision. The DON knew tal health services before her ure of what kind of services DON's expectation was for the be contacted with requests for D could decide what care and entially be needed and if the ropriate. The DON agreed the sible to ensure services were in and procedures followed to nd care of a resident. 1 at 3:56 p.m., with the fied she felt the facility failed to harge for R10 because the ck" and the team "did not pull re R10 had services in place The administrator felt R10 did ocumentation of her needs and ttle to no involvement of R10's ninistrator stated eds to be improved between hysicians, social services, and Discharge planning should ion. The SW was to coordinate he administrator agreed it herapy and the physician were meetings.	F 74			

If continuation sheet Page 19 of 20

		AND HUMAN SERVICES				FORM	12/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245018	B. WING	i			05/2021
NAME OF I	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CREST \	IEW LUTHERAN HO	ME			4444 RESERVOIR BOULEVARD NORTHEAS COLUMBIA HEIGHTS, MN 55421	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	through interview a facility reviewed an procedures, review	age 19 n. when it could be verified nd document review, the d revised policies and ed other resident's medical by, and educated staff to those staff to those	F	745			



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

· Juig

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

Minnesc	ota Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00005	B. WING		C 11/0) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	/IEW LUTHERAN HO	ME 4444 RES	ERVOIR BO	ULEVARD NORTHEAST		
	Ι		A HEIGHTS,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y and identify the date	TS: 11/5/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 12/02/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 22

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	COM	E SURVEY PLETED	
		00005	D. WING		11/	/05/2021	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
CREST	IEW LUTHERAN HO	ME	SERVOIR BOU BIA HEIGHTS, I	JLEVARD NORTHEAST MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	ige 1	2 000				
	SUBSTANTIATED: a licensing order is (MN57836) was als due to actions take entrance, NO licens The following comp UNSUBSTANTIATI H5018182C (MN77 H5018183C (MN78 (MN78211) were al	plaints were found to be H5018185C (MN78165) with sued at 1475. H5018181C so SUBSTANTIATED, however n by the facility prior to sing orders were issued. Dalaints were found to be ED: H5018179C (MN78021), 7657), H5018184C (MN77442) 8022) and H5018186C so UNSUBSTANTIATED, icensing order was issued at					
	documenting the S Orders using Feder have been assigne statutes/rules for N tag number appear "ID Prefix Tag." Th compliance is listed of Deficiencies" col Comply" portion of column also include violation of the state "This Rule is not m the surveyor ' s find Method of Correction Correction. You have agreed to receipt of State lice the Minnesota Dep Informational Bullet <https: www.health<br="">on/infobulletins/ib14</https:>	bartment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned s in the far-left column entitled e state statute/rule out of d in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following lings are the Suggested on and Time Period for o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at n.state.mn.us/facilities/regulati 4_1.html> The State licensing ed on the attached Minnesota					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	E SURVEY PLETED
		00005	B. WING))5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	/IEW LUTHERAN HO		ERVOIR BO	ULEVARD NORTHEAST , MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	is necessary for Sta enter the word "CC available for text. Y electronic State lice heading completion be corrected prior t the Minnesota Dep is enrolled in ePOC	Although no plan of correction ate Statutes/Rules, please ORRECTED" in the box You must then indicate in the ensure process, under the in date, the date your orders will to electronically submitting to artment of Health. The facility C and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. .R ON EACH PAGE.				
21475	MN Rule 4658.100 General Requireme	5 Subp. 1 Social Services: ents	21475			12/8/21
	home must have an department or prog related social servin nursing home must collaborate with our who is in need of a	Il requirements. A nursing n organized social services gram to provide medically ces to each resident. A t make referrals to or tside resources for a resident dditional mental health, or financial services.				
	by: Based on interview facility failed to pro- services prior to dis (R10). This resulted for R10 when she w	ent is not met as evidenced vand document review, the vide medically related social scharge for 1 of 1 resident d in an immediate jeopardy (IJ) was discharged home alone, r family member (FM)-A		Discharge Policy and Proced to include the appropriate not including NHIR if coordinated does not occur. R10 is currently not a residen facility.	ifications discharge	

If continuation sheet 3 of 22

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		00005	B. WING		11/05/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
CREST V	IEW LUTHERAN HO			ULEVARD NORTHEAST	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION (X5)
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21475	Continued From pa	ge 3	21475		
21475	without appropriate potentially unsafe e The immediate jeop when R10 was disc without appropriate interventions in plac required 24/7 super illness and assistan Living (ADL). The a the immediate jeop The immediate jeop The immediate jeop 11/5/21, at 3:45 p.m remained at the low a D, no actual harm minimal harm. Findings include: R10's 10/17/21, add (MDS) identified sh from a local hospita schizoaffective disc (mental illness caus delusions), anxiety blood pressure, chr alcohol abuse. R10 although she was n thinking and difficul extensive assistance	discharge plans in place to a anvironment. bardy began on 10/22/21, charged from the facility nursing services and ce prior to discharge. R10 rvision due to her mental ace with Activities of Daily dministrator was notified of ardy on 11/4/21, at 3:50 p.m. bardy was removed on h. but noncompliance ver scope and severity level of a with potential for more than mission Minimum Data Set e was admitted to the facility	21475	 Hennepin County police depart contacted on 11/04/21 to condu- check for R10. Police Officer of and stated that welfare check w completed for resident. Police Officer has no concern a SW placed call to Brittney, ILS (612-230-1982) to check status resident. Brittney stated that sh twice per week. All residents in the facility with a anticipated back into the comm the potential to be affected. Rea discharges to be reviewed at th morning s IDT meeting. Any f discharges will be discussed at Clinical meeting (Campus Adm Center Admin, DON, LPN, Dire Director of Health Info, ADON) appropriateness and policy pro- followed. On 11/04/21 at 5:45pm IDT (Ca Admin, Care Center Admin, DC Director of SS, Director of Heal ADON, Dir Life Enrich, Director Services, Dir of HR.) and avail Licensed Nursing Staff were in- review policies Transfer/Discha against Medical Advice and Lea Absence. Discharge planning f 	alled back vas tt this time. worker of e sees R10 a discharge unity have cent is uture daily (M-F) in, Care ctor of SS, to ensure cedure mpus N, LPN, th Info, Champlain able serviced to rge, Leave ave of
	R10's Care Area As R10 had a impaired and maintaining a s	sistance of 1 staff for dressing. sessment (CAA) identified d balance during transitions sitting balance. R10 had noted behavioral symptoms, falls, rug use.		admitted residents will be cond the goal of ensuring a safe disc the resident to a community of choice. All SW re-educated to a DC to community and setting u prior to any discharge. Policy u reflect SW or designee MUST of	harge for their appropriate p services pdated to
	R10's 9/30/21 throu	igh 10/6/21, local hospital		and services are established be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00005		LE CONSTRUCTION	(X3) DATE : COMPL	LETED
				11/05/2021	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CREST VIEW LUTHERAN HO					
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES		-	OBBECTION	(X5)
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21475 Continued From pa	age 4	21475			
records identified F (H&P) noted R10 w psychosis. She wa ambulance (EMS) decompensated so paranoia. Upon ad delusional, parano was showing errati and had impaired j repetitive sentence was exhibiting nam She was diagnose R10 had concerns her kitchen while h social history ident and required a 4 w required standby a psychologolical (ps function testing wa if she had been dri consultant prescrib potential alcohol w R10 was previousl 8/30/21, for manag hallucinations, and instructions identifi recommended 24- discharge and was walker, standby as supervision for all summary discharg required skilled ca	R10's History and Physical vas admitted with paranoia s brought to the hospital via from home for potential chizophrenia and increased mission she appeared id, was anxious, restless, and c behavior, showed confusion, udgement. R10 would give as and questions, hallucinated, ne calling and verbal insults. d with paranoia and psychosis. of someone placed a bomb in er floor was being redone. Her ified she lived at home alone heeled walker for mobility. She		AG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
						C 11/05/2021	
		00005					
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	/IEW LUTHERAN HO	ME	SERVOIR BOU	ILEVARD NORTHEAST MN 55421			
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21475	Continued From pa	age 5	21475				
	walker and dressin assistance of 1 with R10 was at risk for	tion and use of her 4 wheeled Ig. She required extensive staff h bed mobility and transfers. falls related to psychoactive ing unsteady and unaware of					
	Record (MAR) indi (antidepressant an (anti-psychotic), De medication), gabap medication), levetir medication), Name	edication Administration cated R10 took trazodone d sedative medication), Abilify epakote (anti-seizure pentin (anti-seizure racetam (anti-seizure enda (used for Alzheimer's and d Seroquel (anti-psychotic).					
		1, Order Summary report an order for WanderGuard and care/locked unit.					
	at the facility from the required transfer of documented she here 2) 10/11/21 at 2:18 met with R10 in here to another nursing called them herself. She stated before a nurse at home who	tes identified on: ' p.m., staff noted R10 arrived the local hospital via EMS. She f 1 assist by staff. Staff ad "slight forgetfulness". p.m., the social worker (SW) r room. R10 wanted to transfer home. She reported she had f, but they had no openings. her hospitalization she had a p regulated her medication brted she was in the hospital					
	she had not indicat factor to the SW. F staff with her walke and used a wheelc other ambulation. F contact person for	, but documentation showed ted her mental illness was a 210 transfers with assist of 1 er to the bathroom as needed thair propelled by staff for all R10's FM-A was her immediate emergencies. 4 p.m., R10 set off the front					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00005			11/05/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
CREST	/IEW LUTHERAN HOI		ERVOIR BOU IA HEIGHTS, N	LEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
21475	door alarm after go nursing sitting in the delivery person (un WanderGuard alert R10 was "confused 4) 10/15/21, R10 wa after her elopment a was called and a m from FM-A was rece 5) 10/17/21 at 10:33 the nurse's station t wanted to go home 6) 10/18/21 at 4:47 elopment was revie WanderGuard alarr staff checked the fr was placed in mem elopements. R10 w behaviors and want 7) 10/21/21 at 12:30 she spoke with FM- discharged "as soo discharge the next R10's independent nurse to restart her noted PT and OT w The SW would ens discharge order for further documentati SW was following fi was appropriate for discharging to, or if services and home safety. 8) 10/22/21 at 1:34, progress note ident home escorted by F	ing outside. R10 was found by e passenger seat of a car of a known to R10). R10's ed staff she left the facility. at times and forgetful". as moved to another room as a safety precaution. FM-A essage left, but no return call eived. 3 a.m., R10 used a phone at to call 911 because she p.m., staff documented R10's ewed. She had a m on and it had sounded, and ont area of the building. R10 ory care to prevent further as noted to have exit seeking ted to return home. 6 p.m., the SW documented -A. FM-A wanted R10 n as possible". R10 was to day. FM-A was to contact living skills (ILS) worker and services. The social worker vas requested by the resident. ure this request was on the the physician to sign. No ion was made identifying the acility policy by ensuring R10 discharge, where she was she had the appropriate atmosphere conducive to her	21475			
STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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			A. BUILDING	· · · · · · · · · · · · · · · · · · ·		С
		00005	B. WING		11/05/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	IEW LUTHERAN HO	ME	SERVOIR BOU BIA HEIGHTS, I	ILEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21475	Continued From pa	age 7	21475			
	mental health care R10 was not a good dementia. During a once took a hamme dispensing device. spoken to another to prior to R10 being of concerned if R10 re fund would be eate made aware of R10 facility until after R2 concerned R10 did supervision needed issues and mental	1 at 2:45 p.m. with R10's coordinator (MHCC) identified d historian related to her hallucination, she and had er to her medication The MHCC stated she had family member of R10 (FM-B) discharged. FM-B was emined in the facility her "trust n up". The MHCC was not D's sudden discharge by the 22 was home. The MHCC was not have the appropriate d for someone with memory health diagnoses to be e and required skilled nursing				
	10/10/21 to 10/22/2 performed a SLUM University Mental S minute) clinician-ac screening for Alzhe or mild neurocognit 12/30, indicating R recommended R10 upon discharge. R1 apartment/condo by received help for gr medication, and sc R10's bathroom wa a shower chair and they were "unsure of	therapy (OT) notes from 21, identified staff had S test (The Saint Louis Status Examination: a brief (7 dministered method of simer's other types of dementia tive impairment). R10 scored 10 had dementia and have 24-hour supervision 10 was noted to live in an y herself and reported she roceries, managing heduling (appointments). as reported to be equipped with grab bars. OT staff remarked of the validity of this [home as reported to help "as	1			
	nurse practitioner (1 at 4:00 p.m., with R10's NP)-A identified R10 was lity and had attempted				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00005			· · ·		(X3) DATE SURVEY COMPLETED C 11/05/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
		4444 BE		ILEVARD NORTHEAST		
CREST	IEW LUTHERAN HO		BIA HEIGHTS,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21475	Continued From pa	age 8	21475			
	door and entering t car. R10 had not ki concerned as she discharge planning interdisciplinary tea discharge orders fr advised her to sign she had not perforn determine if R10 w but acknowledged facility to do so. NF cognitive impairme diagnoses, she req place prior to disch home care with 24- risk of injury and pr assumed the facilit appropriate cares a	e facility by exiting out the front the car of male delivery driver's nown this driver. NP-A was was not involved with R10's process or the am meetings. NP-A received om the social worker who them. NP-A was hesitant as med an evaluation herself to as appropriate for discharge, she felt pressured by the P-A stated R10 had known int and with her mental health juired supportive services in large, to include at a minimum -hour supervision to reduce the rovide appropriate care. NP-A y had facilitated the and services be in place prior and was "upset" to learn this	5			
	care was 10/22/21. instruction included	noted indicated R10's end of PT discharge plans and R10 return home with home rices and a home exercise				
	director (MD) ident follow the discharg procedure and ens were in place prior	1 at 9:56 a.m. with the medical ified the facility needed to e planning process, policy, and ure all cares and services to discharging a resident to and ability to live alone.				
	worker (SW)-A ider a "quick discharge. attempted to elope	1, at 9:57 a.m. the social ntified R10's daughter initiated " SW-A indicated R10 did while residing in the facility nale whom she did not know.				

PRINTED: 12/03/2021 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00005	B. WING			C 05/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	/IEW LUTHERAN HO	ME	SERVOIR BOU BIA HEIGHTS, I	LEVARD NORTHEAST		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLE
21475	Continued From pa	age 9	21475			
	and required place WanderGuard. SW home care agencie coordinator, primar upon R10's dischar she would take car SW-A agreed there done at IDT. SW-A responsibility to ensi in place prior to dis 11/4/21 at 9:25 a.m conversation with F upset R10 was mor SW-A stated did no fit" for R10 who rec her memory issues hard time following on "tangents". SW home care agencie coordinator, primar living skills (ILS) wo she would take car that "should have ensure place. SW-A was u recommendations ordered. SW-A stated little more research services, she would R10's actual needs filed a Vulnerable A was not with living R10, 24 hours per ensure safe and ap Interview on 11/3/2 supervisor stated F	required 24-hour supervision ment in memory care with a 4-A did not contact any outside es, case managers, care y physician, or ILS workers rge. SW-A took FM-A's word e of R10 discharge needs. was no discharge planning agreed it was the facilities sure cares and services were charge. Follow up interview on h. with SW-A stated her only FM-A was when FM-A became ved down to memory care unit. of feel the facility was a "right guired more assistance with a and mental health. R10 had a conversations and would go -A did not contact any outside es, case managers, care y physician, or independent orkers because FM-A stated e of it. She stated now realized had a red flag" as R10 had with illness and dementia and e needed services were in nsure why the from OT and PT were not ted if she would have done "a " and contacted the other d have had a clear picture of 5. SW-A stated she would have dult report if had known FM-A with or providing supervision to day. SW agreed she failed to opropriate discharge occurred. 1 at 11:23, with R10's ILS R10 had an ILS worker who ome twice a week for 2 hours				

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Minneso	ta Department of He	alth				ATTIOVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00005	B. WING		C 11/0) 5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CREST V	IEW LUTHERAN HO	MF	ERVOIR BO A HEIGHTS,	ULEVARD NORTHEAST MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	but that staff only p The ILS supervisor was safe to be hom advanced care suc 24-hour supervision stated the previous refused services to R10 was a "liability" not safe at home. L	a mental health case manager rovided services via phone. stated she did not feel R10 he alone and required h as a nursing home with h. The ILS supervisor further home care agency nurse R10 because the agency felt ' as they determined she was later interview on 11/4/21 at				
	ILS worker (ILS-A) adult report becaus nursing agency file and was awaiting d reports.	supervisor stated neither the or herself filed a vulnerable se the previous home care d 3 prior to her hospitalization eterminations from those				
	therapist assistant recommended have on her cognitive tes 12/30 indicating de Recommendations based on the visits	1 at 1:45 p.m., with physical (PTA)-A identified therapy e 24-hour supervision based sting with a SLUM score of mentia upon discharge. for 24-hour supervision was therapy had with R10 while in questioned her safety to be alone.				
	identified R10 requ garbage, laundry, s companion-type pe nurse or other thera the present time. IL her own at this time	1 at 2:00 p.m., with ILS-A ired additional support with upervision"Maybe a rson". R10 does not have a apies provided in her home at .S-A felt R10 was not safe on a due to significant memory ory of wandering and mobility.				
Minnesota D	health case manag	1 at 4:00 p.m. with mental er (MHCM)-A identified her phone and completed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00005	. ,		COM	E SURVEY PLETED C 05/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	/IEW LUTHERAN HO	ME 4444 RES	SERVOIR BOU	LEVARD NORTHEAST		
SHEST		COLUME	BIA HEIGHTS,	MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21475	Continued From pa	age 11	21475			
	on R10's mental here mental health there stated R10's mental down" with 2 recen been more manic w MHCM-A stated R1 since she was hosy conversations with mid-sentence, was what happening in Interview on 11/4/2 primary care physic saw R10 prior to he Based on R10's me and exit-seeking be opinion, R10 was me	wed medications and check in ealth. There was no current apist caring for R10. MHCM-A al health has been "up and t hospitalizations as R10 had within the past few months. 10 had not seen a psychiatrist pitalized. During her R10 she would stop confused, and "not clear" of the moment. 1 at 8:54 a.m., with R10's cian (MD)-B identified he last er admission to the facility. edical history, hospitalization, ehavior, in his expert medical not safe to be home alone and upervision and care. R10 een discharged to home from				
	Community Access (CADI)-A case mar notified of R10's dis by the facility regar occurring to assist arrangements. CAI the resident was cu CADI-A stated FM- in R10's care and co medication set up of	DI-A stated she does not feel urrently safe to be home alone. A was never actively involved does not want to help with or administration.				
	of nursing (DON) id discussed at the in on 10/21/21, the da but information reg	1 at 1:00 p.m., with the director dentified R10's discharge was terdisciplinary (IDT) meeting ay before she was discharged, arding R10's needed care was FM-A pushed facility staff to do				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED
	or connection		A. BUILDING:	<u> </u>		
		00005	B. WING			C 05/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BEST	/IEW LUTHERAN HO	ME		JLEVARD NORTHEAST		
		COLUME	BIA HEIGHTS,	MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21475	Continued From pa	age 12	21475			
	eluded she would p R10. R10 had been after R10 had elop a car of an unknow "moderate" cognitiv difficulty holding a unaware of recomm R10 to have 24-ho R10 had prior men admission, but uns she required. The I R10's physician to discharge so the M services would pot discharge was app facility was respons place and policies ensure the safety a Interview on 11/5/2 administrator ident provide a safe disc discharge was "qui together" and ensu before discharge. The not have enough d agreed there was lip physician. The adm communication new therapy, nursing, p the administrator. I begin upon admiss discharge plans. The	eds to be improved between hysicians, social services, and Discharge planning should sion. The SW was to coordinate he administrator agreed it therapy and the physician were				
	and Procedures ide	ust 2019, Discharge Policies entified it was the responsibility linate discharge planning and	,			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	COM	E SURVEY PLETED	
		00005	B. WING			C 11/05/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
REST	/IEW LUTHERAN HO	ME	SERVOIR BOU BIA HEIGHTS, I	LEVARD NORTHEAST MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21475	Continued From pa	age 13	21475				
	to coordinate comr residents upon dise	nunity services necessary for a charge.	a				
	11/5/21, at 3:45 p.r through interview a facility reviewed an procedures, review	n on 11/4/21 was removed on n. when it could be verified and document review, the ad revised policies and ved other resident's medical cy, and educated staff to those					
	administrator or de revise policies and medically related s each resident throu discharge and mak- with outside resour need of additional abuse, or financial identify other reside deficient practice, r policies and procee provided by social amount of time. The should be taken to Performance Impro-	THOD OF CORRECTION: The esignee could develop and/or procedures to ensure ocial services are provided to ughout their stay and upon ke referrals to or collaborate rces for a resident who is in mental health, substance services. The facility should ents who are at risk for the review, re-educate staff to dures, and audit services to be services for a measurable he results of those audits the Quality Assurance ovement (QAPI) committee to d for further monitoring or					
21980		R CORRECTION: 21 DAYS	21980			12/8/21	
	Maltreatment of Vu Subd. 3. Timing of reporter who has re						

	ta Department of He	alth (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00005	B. WING		C 11/05/202	
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ODEST W	IEW LUTHERAN HO	4444 RES	SERVOIR BOU	LEVARD NORTHEAST		
CHEST V		COLUME	BIA HEIGHTS, N	/IN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 14	21980			
21980	or who has knowled has sustained a phy reasonably explained information to the c individual is a vulned the individual is a dru reporter is not required maltreatment of the to admission, unles (1) the individual wat another facility and believe the vulnerate previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this se as described above (c) Nothing in this known or suspected knows or has reason been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe the 626.5572, subdivisi (5), occurred must r subdivision. If the r time believes that a agency will determine	dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an trable adult solely because nitted to a facility, a mandated ired to report suspected individual that occurred prior s: as admitted to the facility from the reporter has reason to ole adult was maltreated in the nows or has reason to believe a vulnerable adult as defined t, subdivision 21, clause (4). required to report under the ection may voluntarily report				
	the criteria under se 17, paragraph (c), c facility may provide	ection 626.5572, subdivision clause (5), the reporter or to the common entry point or agency information explaining				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPI	LETED
		00005	B. WING		11/0	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CREST \	/IEW LUTHERAN HOI					
				PROVIDER'S PLAN OF CORR		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
21980	Continued From pa	ige 15	21980			
	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.					
				It is the policy of Crest View L Home that all alleged violation		
				abuse, neglect, exploitation or mistreatment, including injurie unknown source, and misappi	s or	
	Findings include:	Findings include:		resident property, are reported	ż	
	Agency (SA) at 12: at 3:30 p.m., R2 wa R1's waist and tum ear as she sat in ch taken R1's walker a intervened and redi Action taken to prot	7/21, report to the State 27 a.m., identified on 10/26/21 as observed by nurse touching my while whispering into R1's hair in the lounge area. R2 had away from R1. The nurse irected R2 away from R1. tect the resident was to ate the 2 residents and initiate		immediately but no later than a the allegation is made, if the e cause the allegation involve al result in serious bodily injury, than 24 hours if the events tha allegation do not involve abus result in serious bodily injury, administrator of the facility and officials (including to the State Agency and adult protective so where state law provides for ju long-term care facilities) in acc	vents that buse or or not later at cause the e and do not to the d to other Survey ervices urisdiction in	
	R2 had the followin behavioral disturba	cord printed 11/2/21, indicated g diagnosis: dementia with nce, major depressive sorder, and seizures.		with State law through establish procedures. Nursing staff and other depart were re-educated on the VA P Reporting Requirements by N	shed mental staff olicy and	
	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.			16th, 2021. For all other residents this def practice could have affected th report will be reviewed daily by DON/designee for indications that were not already reported electronic alert statement has to routinely used computer ap	icient ne 24-hour / of abuse . An been added	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	LETED	
		00005	B. WING			11/05/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CREST	VIEW LUTHERAN HOI		ERVOIR BO	ULEVARD NORTHEAST , MN 55421			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) IDEFICIENC				(X5) COMPLET DATE	
21980	R2's care plan 10/2 behavior problem re advances towards of behaviors/self trans belong to him espe- adaptive equipment resident rooms. The safety and the safer interrupted related to administer medicati to ambulate as nee may be placed on 1 needed. Review of R2's prog 10/26/21 at 2:54 p.r be leaning on a cha sitting, started to to talking in residents walker away. R2 als walker away and wh he became impulsive that the incident has administration. Add identified R2 had be during the shift. R2 settle in one place. fall risk. 10/27/21 at 10:13 a witnessed touching inappropriately in the was visibly distress were separated and supervisor aware. A identified that nursin had taken another in walker, staff returner	7/21, identified R2 had elated to unwanted sexual other residents, impulsive afers, taking things that do not cially walkers, refusing t, and wandering into other e identified goal was resident ty of others will not be to behaviors. Staff to ions as ordered. Staff to assist ded when restless. Resident :1 or 15 minute checks as gress notes identified: m., identified R2 was noted to air where another resident was uch resident inappropriately, left ear, and then took her so took another residents hen staff tried to redirect him ve. There was no indication d been reported to itional note at 6:17 p.m., een restless and agitated was stubborn and difficult to R2 had needed 1:1 related to m., identified R2 had been	21980	(Paycom and Point Click Ca staff of this requirement. Audits of progress notes to supervisor notification will b daily by DON/ADON at or b rounds and brought to IDT a results shared at QAPI. The Director of Nursing will for compliance.	ensure e conducted efore clinical as needed, and		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00005	B. WING		C 11/05/2021	
	PROVIDER OR SUPPLIER			TATE, ZIP CODE		05/2021
		4444 BES		JLEVARD NORTHEAST		
CREST	IEW LUTHERAN HO	COLUMB	IA HEIGHTS,	MN 55421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 17	21980			
		ecord printed 11/2/21, indicated of dementia, diabetes, and disorder.				
	10/11/21, indicated dysfunction, demen required physical a transfers and requi Care Area Assessr indicated R1 had tr loss/dementia, falls	um Data Set (MDS) dated I R1 had diagnoses of brain ntia, and depression. R1 issistance of one-person for ired the use of a walker. R1's nent (CAA) dated 10/11/21, riggered for cognitive s, and psychotropic drug use planned with a referral for s.				
	vulnerable adult re decline in independ R1's care plan dire Vulnerable Adult po observe for change care plan further in one staff with all gr	ed 11/2/21, indicated R1 was a lated to compromised health, dence, and her diagnoses. cted staff to follow the olicy and procedure, and es in mood or behavior. R1's idicated R1 required assist of rooming needs, showering, and wheelchair mobility.				
	10/26/21 at 3:17 p. the lounge this after came and took her her inappropriately The male resident away from R1. The incident had been 10/27/21 at 11:53 a R1 being inappropriate area by another resident	a.m., identified writer witnessed riately touched in the lounge sident. The other resident				
	abdomen, and was note identified R1 v	ker and touched her thighs, s whispering in her ear. The was dressed and there were no R1 was resistant and was				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00005			СОМ	E SURVEY PLETED C 05/2021
					00/2021
IAME OF PROVIDER OR SUPPLIER		DRESS, CITY, ST	ILEVARD NORTHEAST		
REST VIEW LUTHERAN HO	ME	BIA HEIGHTS, I			
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
aggressor had take immediately separa assigned a 1:1 staf 10/27/21 at 4:47 p.1 identified she had b 10/26/21, via phone inappropriately touc thigh, and abdomen her walker taken aw reported to the SA. During interview on the administrator id staff was that all co immediately to the timely reporting to t Interview on 11/1/2 director of nursing of about the incident b reviewing the reside around 9:00 p.m. T had completed a re 12:27 a.m. The DC have been submitte hours of the incider revealed the staff H immediately to her The facility's letter t Requirements date regarding not filing	R1 was unable to move as the en R1's walker. Staff ated the residents and f to the aggressor. m., the director of nurses been updated by the nurse on e that R1 had been ched by a resident on waist, n in the common area and had way and incident had been 11/1/21, at 11:15 a.m. with lentified her expectation for incerns of abuse be reported supervisor or DON to ensure		DEFICIENC	Y)	

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00005		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	(X3) DATE SURVEY COMPLETED C 11/05/2021		
						11/05/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻	JLEVARD NORTHEAST			
CREST \	/IEW LUTHERAN HO		BIA HEIGHTS,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From page 19		21980				
	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.						
	10/5/21, indicated I MDS indicated R12 with dressing and li and transfers with o Area Assessment (inimum Data Set (MDS) dated R12 had intact cognition. The 2 required extensive assistance imited assistance with toileting one staff member. R12's Care (CAA) dated 10/11/21, ered for activities of daily living	e				
	required one staff a daily living (ADL) fo bathing. The care p vulnerable adult. In	ted 10/1/21, indicated R12 assistance with activities of or dressing, grooming, and blan indicated R12 was a terventions included following t policy and procedure.					
	identified R12's dat had reported to her on 10/30/21, during use the bathroom b assistant (NA)-C to change R12 while i NA-C was "rough"	e dated 11/2/21 at 9:42 p.m., ughter had reported that R12 during care conference that g cares R12 had requested to before getting dressed. Nursing Id R12 he was going to just in bed. R12 had reported the and she felt like he was ag doll and she felt scared.	כ				
	registered nurse (F family member, sta conference on 11/2 nursing assistant (I	v on 11/4/21, at 2:11 p.m. with RN)-A who was also R12's ated during R12's care 2/21, R12 stated a male, pool NA) was rude and rushed R12 es the previous weekend.					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOWIDEN.	A. BUILDING:				
		00005	B. WING			C 11/05/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
REST V	IEW LUTHERAN HO	ME	ERVOIR BOU	JLEVARD NORTHEAST MN 55421			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF C		CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21980	Continued From pa	age 20	21980				
	R12 stated during in weekend, a male N rag doll". R12 furth and rude and R12 cares for her again	v on 11/4/21, at 2:53 p.m. with morning cares the previous NA "tossed me around like a ter stated the NA was rough did not want NA providing n. R12's identified she had ent to the day time nurse when e her vitals.					
	social services dire R12's care confere a male, pool NA wa the previous weeke occupational thera unknown family me care conference wi SSD revealed the a have been immed	v on 11/4/21, at 3:26 p.m. ector (SSD) identified during ence on 11/2/21, R12 reported as rough with her during cares end. SSD stated an unknown pist (OT), RN-A and another ember, were present at R12's hich ended around 4:30 p.m. allegation of abuse should iately reported to the director of administrator who then would thin two hours.					
	DON identified if a to staff, the staff sh nurse or superviso report the incident DON stated on 11// registered nurse (F form that R12 filled family member of t The DON stated sh immediately upon to DON further stated R12's care confere	v on 11/5/21, at 2:03 p.m. the resident reported rough cares hould report the incident to a r immediately, and they should immediately to the DON. The 2/21, around 7:30 p.m. RN)-B gave her a grievance d out with the assistance of her the allegation of rough cares. he had reported to the SA receiving the grievance. The d staff who were present at ence should have reported out rough cares immediately.					
		nt Protection Plan, revised incident or suspected incident					

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Minnes	ota Department of He	ealth				
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 11/05/2021	
	00005					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE			
CREST	VIEW LUTHERAN HO		ERVOIR BO	ULEVARD NORTHEAST 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN SHOULD BE COMPLETE	
21980	Continued From page 21		21980			
	COLUMBI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					