Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 7, 2026

Administrator
CREST VIEW LUTHERAN HOME
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

RE: CCN: 245018

Cycle Start Date: March 19, 2026

Dear Administrator:

On March 19, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective March

19, 2026. This prohibition is not subject to appeal. 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.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245018**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**
NAME OF PROVIDER OR SUPPLIER **CREST VIEW LUTHERAN HOME**		STREET ADDRESS, CITY, STATE, ZIP CODE **4444 RESERVOIR BOULEVARD NORTHEAST , COLUMBIA HEIGHTS, Minnesota, 55421**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 3/18/26 through 3/19/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H50188801C (2806769 and 2805267) with citation issued at F600 PAST NON-COMPLIANCE The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to protect a resident’s right to be free from physical abuse for 1 of 3 residents (R1) reviewed for abuse. This resulted in actual harm when	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0600 SS = G	Continued from page 1 R2 struck R1 in the face resulting in swelling to the eyebrow, nose fracture, and a laceration to the lip that required hospitalization. The facility had implemented actions on 3/16/26 to prevent recurrence prior to the survey; therefore, the citation was issued at past non-compliance (PNC). Findings include: R1’s order summary report dated 3/6/26, identified R1’s diagnoses included primary hypertension, traumatic subdural hemorrhage with loss of consciousness of unspecified duration and non-Alzheimer’s dementia. R1’s comprehensive admission Minimum Data Set (MDS) dated 3/13/26, indicated R1 had severe cognitive impairment with no behaviors. R1 required substantial/maximal assistance for toileting, and transfers. R1’s activities of daily living (ADLs) care plan dated 3/6/26, indicated R1 was categorically vulnerable adult and required substantial/maximal assistance of one with transfers. Associated interventions directed staff to monitor signs of emotional distress or mood and behavior changes. It also directed staff to provide and maintain safe consistent environment as well as supervision as needed. R1’s progress note dated 3/15/26 at 9:19 p.m., indicated R2 struck R1 in the face while both residents were in the TV room. The strike caused R1 to fall from her chair. Staff were present and witnessed the event. Based on staff accounts, the incident appeared unprovoked. R2 was placed on 1:1 supervision immediately following the incident. R1 sustained swelling to the eyebrow, a laceration to the lip and was transferred to the hospital for evaluation. R1’s emergency department (ED) provider notes dated 3/15/26 identified R1 was transferred to ED for an evaluation of assault and fall. The note further indicated emergency medical services (EMS) reported that R1 had been struck in the head by another resident, causing her to fall forward out of her wheelchair. R1’s head computed tomography (CT) scan identified a large left forehead hematoma (a localized collection of clotted blood trapped under the skin) with associated swelling, a lip laceration, and closed fracture of nasal bone. R2’s order summary report dated 2/11/26, indicated R2’s diagnoses included disorientation, dementia, other symptoms and signs involving appearance and behavior. R2’s admission Minimum Data Set (MDS) dated 1/29/26, indicated R2 had moderate cognitive impairment with no behaviors identified. R2 required no assistance with transfers or ambulation. R2’s activities of daily living (ADLs) care plan dated 2/25/26, R2 was independent with transfers and ambulation. R2’s ADLs care plan dated 2/25/26 directed staff to monitor for signs of emotional distress or	F0600		

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F0600 SS = G	Continued from page 2 mood and behavior changes including agitation/aggression. R2's care plan did not identify specific agitative or aggressive behaviors or triggers that may cause agitation or aggression. R2's psychiatric visit note assessment dated 3/11/26 identified R2 had moderate cognitive impairment. The note further recommended that the care team track and monitor behavioral dysregulation to identify triggers and beneficial interventions. The interdisciplinary team (IDT) was advised to review findings and develop a behavior support plan if agitation persists. Meaningful assessment was limited due to R2's agitation during the evaluation. Given concern involved a highly vulnerable peer, emphasis remained on maintaining appropriate supervision, reinforcing boundaries, and ensuring objective monitoring of behaviors. R2's record reviewed between 3/11/26 through 3/15/26 showed no progress notes demonstrating implementation of the psychiatric visit note assessment recommendations. During this period, the record did not reflect monitoring of behavioral dysregulation, identification of triggers, or documentation of interventions attempted. Further no evidence that the interdisciplinary team reviewed, evaluated, or initiated development of a behavior support care plan that would include appropriate supervision, boundaries, and a monitoring system. R2's ED provider note dated 3/15/26 identified R2 was transferred to ED for evaluation related to aggressive behavior. EMS reported R2 had assaulted R1 and a staff member due to frustration with R1. The note further indicated R2 reported R1 had been harassing him and would not leave him alone, so he hit her. Record review of R2's discharge note dated 3/17/26 indicated R2 was discharged to psychiatric hospital because the safety of individuals in the facility was endangered due to R2's clinical or behavioral status. The note further indicated R2 had been involved in two physical altercations with other residents since admission, where R2 was the victim in the first incident and the perpetrator for the second incident involving R1. During an interview on 3/19/26 at 2:46 p.m., a family member (FM)-A stated staff informed her R1 had been sitting in the TV room area with several other residents when R2 sitting behind her suddenly "jumped up and punched her in the back." She reported that R1 sustained a broken nose and forehead hematoma. FM-A expressed fear and uncertainty about R1's safety in the facility and added R2 was no longer on the unit. During an interview on 3/18/26 at 3:31 p.m., nursing assistant (NA)-B stated R2 had a history of impulsive aggression. Staff monitored R2 for agitation, would keep a close line of sight of him, and redirect him to his room when needed. NA-B explained she knew when R2	F0600		

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F0600 SS = G	Continued from page 3 was agitated because he would demonstrate facial expression changes and spoke in Spanish. NA-B reported prior to the incident on 3/15/26, R2 would become agitated and angry when R1 talked loudly to the television or to staff. When this occurred, she would separate R2 from other residents during those episodes. NA-B stated nurses were aware of both R1’s and R2’s behaviors but she did not know whether this information was documented and was unsure of where staff were supposed to document episodes of behaviors in the medical record. During an interview on 3/19/26 at 12:16 p.m., NA-C stated R2 could be rude and made angry remarks in Spanish to other residents at times but was usually redirectable. R2 often appeared visibly angry and primarily spoke Spanish when agitated, which he believed created a communication barrier when R1 spoke loudly or called out to staff. NA-C reported nurses had been aware of both R1’s and R2’s behaviors but did not know whether these behaviors were documented in the medical record or reported to the provider. NA-C worked on 3/15/26, earlier in the day shift prior to the altercation R2 had to be redirected to his room after showing escalating agitation. Then later when NA-C was in the TV room, R2 was sitting approximately six feet away sitting in a recliner behind R1. R2 suddenly got up, walked over to R1, and hit her in the face causing R1 to fall from her wheelchair. The incident happened “within a fraction of a second” in front of staff. After the incident, NA-C remained with R1 until the nurses arrived, helped assess her and ensured R2 was safely supervised. During an interview on 3/18/26 at 2:59 p.m., NA-A explained R2 sometimes became agitated when R1 yelled at the television or called out to staff in a loud voice but never been physically aggressive before this incident. On 3/15/26 prior to the incident, R1 spoke loudly, “Can someone turn down the television?” R2 had responded “Chica” (girl in Spanish), at which point NA-A told R2 to calm down that R1’s comment was not directed at him. NA-A explained dayshift staff reported R2 was agitated earlier in the morning, but she was not informed of the specific triggers and did not know whether these behaviors were documented in the care plan. NA-A was in the TV room when she observed R2 walk toward R1 and struck her in the face, causing R1 to fall from her chair. NA-A reported staff immediately intervened, separated the residents, and called the nurse. R2 walked to his room while R1 remained on the floor bleeding until the nurses arrived. NA-A reported being unaware of any behavioral support plan in place for R2. During an interview on 3/19/26 at 1:03 p.m., a licensed practical nurse (LPN)-A, the pm supervisor stated she heard an emergency page and immediately responded to the call in the TV room on	F0600		

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F0600 SS = G	Continued from page 4 3/15/26. LPN-A reported when she arrived, NA-A and NA-B were present, along with several other residents. LPN-A stated NA-A reported that R2 came up behind R1 and struck her on the right side of the face, below the ear, causing R1 to fall forward from her wheelchair. LPN-A explained she instructed staff to keep the residents separated, initiated 1:1 supervision for R2 and directed staff to call the law enforcement while she was contacting the provider. LPN-A asked NA-A and NA-B whether there had been any behavior earlier in the day that might have led to the incident. She reported they told her R2 had been grumbling in Spanish toward R1 on previous shift but there had been no reports of physical aggression. LPN-A stated she was unaware about any behavior reports and had not previously heard of R2 being aggressive. LPN-A reported she was unaware of whether the care team tracked and monitored R2's behavioral dysregulation to identify triggers and beneficial interventions, and she did not know of any behavioral support plan in place for R2. LPN-A explained she did not identify anything that could have prevented the incident and did not observe any warning signs leading up to it. During an interview on 3/19/26 at 2:00 p.m., a registered nurse (RN)-A, the assistant of the director of nursing (ADON) stated she was informed on 3/15/26 that R2 struck R1, causing R1 to fall from her wheelchair to the floor. RN-A explained LPN-A told her R2 had been sitting by the wall in the TV room and R1 was sitting in front of him, approximately six to eight feet away watching television. RN-A explained she instructed staff to call 911, keep the residents separated, and initiated 1:1 supervision for R2. Her immediate focus after the incident was to ensure residents' safety and confirming 1:1 supervision for R2. RN-A expressed concern R2 might not be appropriate for the locked unit due to his pacing, ambulatory, and unpredictability. RN-A reported R2 had a diagnosis of dementia and had been involved in a previous resident to resident altercation, though the facility had concluded he was the victim. RN-A stated R2 sometimes became agitated he spoke in Spanish but was generally redirectable. RN-A reported she was unaware of the ACP recommendation for the care team to track and monitor R2's behavioral dysregulation to identify triggers and beneficial interventions. She also did not know whether the interdisciplinary team (IDT) had been advised to review findings and develop a behavior support plan for R2. RN-A added she expected nurses to ask appropriate questions when behaviors were reported and to document behaviors according to the resident care plan. RN-A did not recall any recent behavior reports brought to the interdisciplinary team (IDT) meeting. RN-A stated staff receive annual abuse-prevention training and were	F0600		

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F0600 SS = G	Continued from page 5 required to report any suspected abuse immediately to a supervisor or nurses. R2’s medical record from 3/11/26 through 3/15/26 showed no evidence the facility implemented the ACP recommendations to track and monitor R2’s behavioral dysregulation. There was no behavioral support plan developed despite repeated staff observations of agitations. Although staff were aware of R2’s known triggers including loud environments and R1’s frequent vocalizations; these observations were not documented. During an interview on 3/19/26 at 10:47 a.m., a nurse practitioner (NP)-A stated R2 should not have been placed in the memory care unit because he was ambulatory and wandered into other residents’ rooms, which she believed created a safety risk. NP-A reported she referred R2 for an evaluation by Associated Clinic of Psychology (ACP) but had not received the assessment results. NP-A was unaware of any agitation or aggressive behaviors from R2 prior to the incident and expected nurses to notify the provider of any changes in a resident’s mood/behavior. NP-A explained when she attempted to talk to R2, he appeared visibly angry, “charged up”, became loud while speaking in Spanish, and then walked away to his room. Abuse Prohibition/Vulnerable Adult Policy dated 11/25 directed the facility to protect residents against abuse by anyone, including, but not limited to, facility staff, and other residents or self-abuse. The policy required the interdisciplinary care plan team to review residents requiring behavioral interventions during target behavior meetings to develop individual behavior plans. Record reviewed indicated by 3/16/26, staff were interviewed to gather details regarding the circumstances surrounding the incident. No further incidents were reported to the staff. -On 3/15/26 R2 was placed on 1:1 supervision and later discharged to the psychiatric hospital on 3/17/26. -On 3/16/26 the facility had developed and started education for all staff on the abuse policy and procedures as well as strategies for managing aggressive behaviors. -On 3/16/26 the facility began reviewing all residents with behavioral histories to ensure care plan were current to include triggers with appropriate individualized interventions. -On 3/18/26 through 3/19/26 staff were interviewed and were able to articulate appropriate abuse policy and procedures. This deficient practice is being cited at past Non-compliance	F0600		

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April 7, 2026

Administrator
CREST VIEW LUTHERAN HOME
4444 RESERVOIR BOULEVARD NORTHEAST
COLUMBIA HEIGHTS, MN 55421

Re: Event ID: 1F52A6H1

Dear Administrator:

The above facility survey was completed on 1F52A6-H1 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

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20000	Initial Comments	20000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:

On 3/18/26 through 3/19/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H50188801C (2806769 and 2805267) with no licensing orders issued.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		