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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3SLV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245018**

2.STATE VENDOR OR MEDICAID NO.
(L2) **935840400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/11/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **122** (L18)
13.Total Certified Beds **122** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 12/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 12/28/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/03/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245018

December 28, 2018

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 27, 2018 the above facility is certified for:

122 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 122 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 28, 2018

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

RE: Project Number S5018032

Dear Administrator:

On November 5, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 18, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 18, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 27, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 18, 2018, effective November 27, 2018 and therefore remedies outlined in our letter to you dated November 5, 2018, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3SLV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00005

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245018**

2.STATE VENDOR OR MEDICAID NO.
(L2) **935840400**

3. NAME AND ADDRESS OF FACILITY
(L3) **CREST VIEW LUTHERAN HOME**
(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
(L5) **COLUMBIA HEIGHTS, MN** (L6) **55421**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/18/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **122** (L18)
13.Total Certified Beds **122** (L17)

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	122			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Magdalene Jares, HFE NE II 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 11/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 5, 2018

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

RE: Project Number S5018032

Dear Administrator:

On October 18, 2018, a standard survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the October 18, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5018119 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is November 27, 2018.

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.

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire

Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 18, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 18, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/15/18, through 10/18/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted October 15, 2018, through October 18, 2018, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5018119 was completed and was not found to be substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		11/27/18

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

Electronically Signed | 11/15/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R44) was provided privacy during cares. Findings include:	F 550	F550 It is the Policy of Crest View Lutheran Home to ensure quality care is delivered in a dignified way to all people we serve.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 R44's diagnoses included dementia with behavioral disturbance, major depressive disorder, and psychotic disorder with delusions obtained from the quarterly Minimum Data Set (MDS) dated 8/7/18. In addition, the MDS indicated resident required extensive physical assistance of one staff with activities of daily living including getting dressed and personal hygiene. The MDS also indicated R44 had severely impaired cognition. R44's care plan dated 7/31/18, identified R44 had an alteration in self care: dressing, grooming, bathing related to Dementia, and impaired balance and directed staff to provide assistance of one with dressing and undressing. On 10/16/18, at 7:10 a.m. nursing assistant (NA)-C was observed to enter R44's room, approached R44's bed and stated she was going to get her ready for the day. R44 got up from bed and sat on edge of bed. NA-C was then observed to apply a pair of gripper socks to both R44's feet and R44 ambulated to the bathroom with a walker. At 7:11 a.m. R44 was observed seated on the toilet with the bathroom door wide open but the entrance door to the room from the hallway was shut. At 7:12 a.m. NA-C assisted R44 to take off pants and shirt and R44 sat on the toilet naked. -At 7:13 a.m. NA-D was observed to open the door to the room from the hallway and wheeled R44's roommate into the room as R44 sat on the toilet naked with the bathroom door open. R44's roommate looked into the bathroom when going through the room. NA-C was observed at the same time to leave the room and go into the hallway to get a towel on the linen cart leaving	F 550	This includes providing privacy and dignity while assisting with activities of daily living. Resident R44’s plan of care was reviewed by an interdisciplinary team, and includes care that promotes dignity and privacy. The Quality of Life -- Dignity Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Quality of Life -- Dignity Policy details the procedure for providing quality care while promoting resident dignity and privacy. All staff will be re-educated on these policies and procedures by November 27th. Audits for ensuring resident privacy and dignity during cares will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility’s next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

both doors open as R44 sat naked on the toilet. NA-D turned around and shut the room door as NA-B returned into the room.
-At 7:15 a.m. NA-C was observed to wash R44's body as she sat on the toilet with the bathroom door still open. At this same time R44's roommate was observed attempting to open the door to the hallway but was not able and as she turned around to the right she looked into the bathroom as R44 sat on toilet naked.
-At 7:17 a.m. NA-C finished washing R44 then came out of the bathroom, went into the closet to get a shirt, went back into the bathroom and put it on R44.
-At 7:18 a.m. NA-D was observed to cue NA-C to shut the bathroom door as she was going to open the door to the hallway to bring R44's roommate out of the room. NA-C was then observed go into the bathroom and shut the door.

On 10/17/18, at 7:35 a.m. licensed practical nurse (LPN)-A stated "They need to cover as much as possible, they don't have to expose all the body." LPN-A stated the staff were supposed to close the bathroom door during cares.

On 10/17/18, at 7:40 a.m. NA-C stated "The bathroom is too tight and I did not want to hurt her when I shut the door." NA-C verified the bathroom door had been left open during the cares and stated she was supposed to close it to provide privacy but with the tight space it was difficult.

On 10/17/18, at 1:25 p.m. the director of nursing (DON) stated the nursing assistant was supposed to shut the door and provide privacy during cares. In addition, the DON stated staff were supposed to keep residents covered during cares and not to expose resident.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor choices for 1 of 1 resident (R87) reviewed for bathing preferences. Findings include:	F 561	F561 It is the Policy of Crest View Lutheran Home to encourage and provide resident self- determination and preference with cares. This includes their preference in frequency and setting for bathing.	11/27/18

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F 561	Continued From page 5 R87 was admitted to the nursing home on 3/9/17, with diagnoses which included other fracture of right femur and presence of cardiac pacemaker. R87's quarterly Minimium Data Set (MDS) dated 6/14/18, was 14. During an interview on 10/16/18, at 8:13 a.m. R87 stated he felt that he was not able to make his own choices in regards to his bathing routine. R87 stated he would like to take a bath, but they don't ask and "just put in the shower". R87 went on to say they "about froze me to death" in the shower. Review of progress note dated 1/19/18, identified that R87 was offered a change in his bathing/showering schedule. Resident stated that he would prefer a bath instead of a shower. Team card updated to give him a tub in Linden station every Thursday AM. R87's care plan interventions dated 2/2/18, identified R87 was offered a change in his bathing/showering schedule. Resident stated that he would prefer a bath instead of a shower. Undated Nursing Assistant (NA) Team Sheet idenfied R87 prefered tub bath Thus AM (Linden). NA documentation for R87 revealed R87 received: two bed baths and one shower in October, two bed baths and one shower in September, two showers and one bed bath in August, and four showers in July. On 10/18/18, at 7:13 a.m. R87 was observed outside of the shower room on the Evergreen Unit. R87 was in his wheelchair and dressed for the day. R87 was interviewed on 10/18/18, at 7:28 a.m. R87 said he was given a shower and	F 561	Resident R87's plan of care was reviewed by an interdisciplinary team, and includes his stated preference for bathing. This is reflected on his personalized team assignment sheet that his primary care givers use to provide care. For all other residents that this practice may have affected, a whole-house audit for bathing preferences will be completed by November 9th. The Resident Preferences Policy and Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Resident Preferences Policy details the procedure for identifying resident preferences upon admission, and ensuring they are being followed and reviewed routinely. All staff will be re-educated on these policies and procedures by November 27th. Audits for ensuring resident preferences are being followed, will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance.	

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F 561	Continued From page 6 was not offered a bath. If they offered me a bath, "I would have soaked for one and a half hours". R87 went on to say that he told his son he wanted to go home with his son just so he could take a bath. When asked if R87 was offered a bath the morning of 10/18/18, R87 replied, "they don't offer me a bath, they stick me in the old shower". R87 went on to add, "it would be nice to have been offered.". NA-E was interviewed on 10/18/18, at 11:16 a.m. NA-E said he told R87 it was his shower day and brought him to the shower. NA-E took out his team card sheet and indicated that he did not know that R87 preferred to take a bath and did not offer R87 a bath. Licensed practical nurse (LPN)-C was interviewed on 10/18/18, at 11:20 a.m. and stated the team sheet indicated what the preference was for each resident. When asked about resident's preferences, receiving a bath or a shower, she would hope the resident would get what they preferred.	F 561	Compliance date: 11/27/2018	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		11/27/18

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F 584	Continued From page 7 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a clean and sanitary environment for 15 residents rooms (Rooms 10, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 50, 51, 52, 53) on 3 of 4 units reviewed for environmental concerns. In addition the facility failed to ensure window blinds were in good repair and functional for 1 of 1 room (Room 13).	F 584	F584 It is the Policy of Crest View Lutheran Home to provide a clean living environment for the people we serve. This includes having clean divider curtains and walls, and properly working window blinds. For all other residents that this practice may have affected, brand new divider	

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F 584	Continued From page 8 Findings include: A tour of the facility was completed with the Director of Environmental Services on 10/18/18, at 11:06 a.m. During the tour, the following environmental issues were found in resdients rooms. - Room 32, the privacy curtain between the resident beds had multiple gray spots from bottom of curtain to the mid area. The seam at the bottom of the privacy curtain has large soiled gray and pink water spots. The door to room facing the hall has multiple scratches across the door from wheelchairs. - Room 33 the wall under the window had multiple soiled areas. - Room 34 bed A had multiple brown spots on the walls. - Room 35's privacy curtain between bed A and B had areas of worn thread that had beaded up. The bottom quarter of the privacy curtain had large soiled stains of yellow and brown. The curtain around bed A had multiple large stains of brown and gray. - In room 36 the privacy curtain between beds had numerous brown stains. - Room 37's privacy curtain, between resident beds, had multiple stains, more at the seam level but most of stains were on the bottom third. - Room 38's privacy curtain between resident beds had numerous large brown stains on the lower third of the curtain. - Room 39's privacy curtain, by head of bed A, had multiple dark brown stains. The privacy curtain between beds had multiple gray stains. The wall by window was very soiled with spills - Room 40's privacy curtain, between resident beds, had multiple large stains on the lower third	F 584	curtains for each resident room have been purchased and will be installed upon delivery. A whole-house audit for clean living environments will be completed by November 9th. This whole-house audit specifically monitors clean curtains, walls, and properly working window blinds. The Clean Living Environment Policy and Procedure for Crest View Lutheran Home was created and reviewed by an interdisciplinary team on November 15th. The Clean Living Environment Policy details the procedure for routine auditing of resident rooms to ensure that they are clean. All staff will be re-educated on these policies and procedures by November 27th. Audits for clean living environments will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Environmental Services based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Environmental Services will be responsible for compliance. Compliance date: 11/27/2018	

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of the privacy curtain.
- Room 41's privacy curtain, between resident beds, had stain marks on the lower third of the privacy curtain.

The director of environmental services (DES) was interviewed at the start of the room tour, 10/18/18, at 11:06 a.m. and confirmed the facility had not done environmental audits for at least three months. In addition, the DES stated that environmental services received work orders from the facility staff to complete maintenance requests and once the work order was received it was completed by the end of the work day. He also stated when a resident moved out of the facility, environmental services painted the room and changed out the privacy curtains. He further stated the privacy curtains when washed still maintained the stains and voiced a need for purchasing new privacy curtains because the stains were not removed by laundering.

Willow Unit:
On 10/15/18, at 12:30 to 4:00 p.m. during room observations on the unit, the privacy curtains in shared resident rooms 50, 51, 53 and 52 were observed with visible brown and red stains which were visible when the curtains were pulled shut.

On 10/16/18, 11:00 a.m. and 10/17/18, at 2:30 p.m. during random observation the curtains remained soiled even though a house keeping staff was observed around the unit going from room to room completing daily clean.

On 10/18/18, at 9:49 a.m. the environmental tour was completed on the unit with the director of environmental services. During the tour he verified all the soiled curtains. When asked what

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F 584	Continued From page 10 the procedure was he stated "They are supposed to do a work order when they see them. We try to do monthly audits when we have time." He further stated some of the curtains had permanent stains when they washed them. Privacy curtain and broken blinds: On 10/15/18, at 5:41 p.m., during the initial interview with resident, in room 13 it was observed that the window blinds had five broken slats on large middle blind and three broken slats on the small left blind. On 10/16/18, at 8:36 a.m., in room 10, two smears of brown substance were observed on the privacy curtain between bed A and bed B. On 10/18/18, at 11:06 a.m. during a tour and interview with the Director of Environmental Services, the director was told about the soiled curtain in room 10 and shown the broken blinds in room 13. The director stated the procedure for staff was to notify environmental services of repairs and cleaning and fill out a work order. In addition to the work orders, the director added maintenance did spot checks weekly and work orders were completed as soon as possible. The director was shown the blinds in room 13 and stated they needed to be replaced. He added that no work order had been made out for the blinds.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		11/27/18

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F 623	Continued From page 11	F 623		

the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

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F 623	Continued From page 12 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 13 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the ombudsman of long term care of transfers for 3 of 3 residents (R8, R47, R89) reviewed for hospitalization. Findings include: R8, on 10/15/18, at 1:44 p.m., during interview, stated she went to the hospital in July. During a review of R8's electronic and paper record it was revealed R8 went to the hospital on 7/20/18 and returned to the facility on 7/22/18. R8's diagnosis included heart failure. R8's quarterly Minimum Data Set (MDS) dated 7/10/18, indicated R8 cognition was intact. R47, on 10/15/18, 4:36 p.m., during interview, R47 stated she went to the hospital in July 2018. During review of R47's electronic and paper medical record it was revealed R47 had transfered to the hospital on 7/24/18, and returned to the facility on 8/4/18. R47's quarterly MDS dated 7/19/18, indicated R47 had intact cognition and with diagnoses including chronic	F 623	F623 It is the Policy of Crest View Lutheran Home to notify the Ombudsman for Long Term Care with every resident discharge or transfer. The Resident Discharge and Transfer Policy and Procedure for Crest View Lutheran Home was created and reviewed by an interdisciplinary team on November 15th. The Resident Discharge and Transfer Policy details the procedure notifying the Ombudsman for Long Term Care for every resident discharge or transfer. All staff will be re-educated on these policies and procedures by November 27th. Audits for discharge and transfer notifications will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Social Services based on audit results.	

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F 623	Continued From page 14 obstructive pulmonary disease, heart failure, diabetes mellitus and bipolar disorder. On 10/17/18, at 2:03 p.m. the social service director (SSD) stated that no notification of the ombudsman regarding hospital transfers for R8 or R47 could be found. - At 2:14 p.m. the Administrator stated a transfer form is filled out when someone goes to the hospital and that transfer form was faxed to the ombudsman. - At 2:40 p.m. SSD provided a copy of the acute care transfer documentation checklist. The checklist did not include notification to ombudsman. The SSD stated she was unable to find any documentation indicating a notification was sent to ombudsman about the hospitalization for R8 and R47. R89 was admitted to the facility on 7/31/18. The discharge with return anticipated MDS dated 8/2/18, indicated R89 was transferred to the hospital on 8/2/18. A review of the medical record lacked documetation of the ombudsman being notified R89's transferred to the hospital. During an interview in 10/18/18, at 12:41 p.m. social worker (SW)-B stated she would fax weekly notifications to the ombudsman of those residents who were transferred to the hospital. The SW-B further stated she was not working at the facility during the time R89 went to the hospital. On 10/18/18, at 4:00 p.m. no further information was provided of the ombudsman being notified of the transfer.	F 623	Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Social Services will be responsible for compliance. Compliance date: 11/27/2018	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		11/27/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 15 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide a bed hold notification for 3 of 3 residents (R8, R47, R89) reviewed for hospitalization. Findings include: R8, on 10/15/18, at 1:44 p.m. R8 stated she went to the hospital in July 2018.	F 625	F625 It is the Policy of Crest View Lutheran Home to notify residents and their representatives of the bed hold procedures at the time of discharge to the hospital. The Bed Hold Notification Policy and	

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F 625	Continued From page 16 On 10/16/18, at 3:26 p.m. R8's records were reviewed. The electronic record indicated R8 went to the hospital on 7/20/18, and returned to the facility on 7/22/18. A review of progress notes in the electronic record and miscellaneous documents hard copy record was made and lacked documentation of a bedhold notification being provided to R8 or R8's representative. R47, on 10/15/18, at 4:36 p.m. R47 stated she went to hospital in July 2018. On 10/17/18, at 7:34 a.m. review of both electronic and paper records was done. R47's census record indicated a tranfer to the hospital on 7/24/18, with a return to facility on 8/4/18. A progress note dated 7/24/18, indicated R47 had labored breathing with shortness of breath and requested to go to the hospital. The progress note did not indicate if there was a bed hold notification provided to the resident or the resident's representative. On 10/17/18, at 2:03 p.m. the social service director (SSD) stated that no bed hold could be found for this resident. The SSD added all residents receive a the bed hold policy on admission, but no bed hold was issued upon transfer to the hospital. SSD also stated no documentation of family being notified could be found. - At 2:40 p.m. SSD provided a copy of the acute care transfer documentation checklist and a copy of bed hold policy, but no record of that being provided to R8 or R47 could be provided.	F 625	Procedure for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Bed Hold Notification Policy details the procedure for notifying residents and their representatives of the bed hold procedure at the time of discharge. This policy includes who is responsible for the notification and written acknowledgements of the procedure are obtained. All staff will be re-educated on these policies and procedures by November 27th. Audits for bed hold notifications will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Social Services based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Social Services will be responsible for compliance. Compliance date: 11/27/2018	

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F 625	Continued From page 17 R89 was admitted to the facility on 7/31/18, with diagnoses that included end stage renal disease, chronic atrial fibrillation and essential hypertension. During a review of the medical record it was revealed R89 was transferred to the hospital on 10/5/18. The record lacked information of a bed hold notice being provided to R89 or his family representative. During an interview on 10/18/18, at 12:41 p.m., the director of social services stated upon admission a resident, or family representative, would be given the bed hold policy to sign. If a resident was transferred to the hospital, the bed hold notice would be within the packet of information that was sent with the resident to the hospital. During an interview on 10/18/18, at 3:33 with the health unit coordinator (HUC)-F, it was identified the process during a transfer to the hospital was to send a copy of the bed hold with the resident to be signed. The nursing staff would then put information in the progress note about the bed hold. No further information was provided during the survey that a bed hold notice was provided to R89 when he was transferred to the hospital on 10/5/18.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		11/27/18

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F 677	Continued From page 18 Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R75) who was dependent on staff for trimming and cleaning fingernails had nail care completed. Findings Include: R75's diagnoses included Alzheimer's disease and anxiety disorder obtained from the quarterly Minimum Data Set (MDS) dated 9/7/18. In addition, the MDS indicated R75 had severely impaired cognition, did not reject cares and required extensive assistance of one staff with ADL's including personal hygiene. R75's care plan dated 8/29/18, identified R75 had an alteration in self care, dressing, grooming, bathing related to weakness, impaired balance and dementia. The care plan iidentified R75 had history of refusing cares however directed staff to leave R75 safe, if resistive with cares, and return later to attempt cares again. In addition, the care plan directed the nursing assistants (NA's) to provide nail care. On 10/15/18, at 12:25 p.m. R75 was observed seated in wheelchair in the day room asleep. When approached, R75's fingernails on both hands were observed to be long, jagged on the edges with brown matter underneath them. On 10/16/18, at 9:43 a.m. R75's nails remained long, jagged edged and with brown matter underneath them. On 10/16/18, at 4:01 p.m. R75 was observed seated on wheelchair in the dayroom and nursing assistant (NA)-F was sitting right next to R75 and did not offer to trim and clean the nails for R75.	F 677	F677 It is the Policy of Crest View Lutheran Home to provide quality nail care and grooming for the people that we serve. Resident R75 had her nail care completed on October 18th, and has received nail care weekly since that point. For all other residents that this practice may have affected, a whole-house audit for nail care will be completed by November 9th. The Nail Care and Grooming Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Nail Care and Grooming Policy details the procedure for providing proper nail care, as well as making sure each resident is adequately groomed daily. The procedure also lists the steps needed in the event that a resident denies cares. All staff will be re-educated on these policies and procedures by November 27th. Audits for nail care and grooming will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review.	

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F 677	Continued From page 19 On 10/17/18, at 9:20 a.m. to 9:32 a.m. NA-B was observed to provide R75 with pericares, got R75 dressed, and transferred her to the wheelchair. During the observation NA-B was heard to inform R75 that activities was going to do her nails, however, staff did not offer to clean or trim them for her. On 10/17/18, at 10:29 a.m. NA-B stated she had completed providing R75 morning cares. -At 10:34 a.m. when the activities staff was asked what she did for residents during nail care, she stated she was a certified NA and would cut the nails for residents who were not diabetic and file the nails. R75 was observed seated at the table next to the table where the nails were being done, eating toast. On 10/17/18, at 1:04 p.m. licensed practical nurse (LPN)-A verified R75's nails were long, jagged edged and had matter underneath them. LPN-A stated the NA's were supposed to do the nail care for residents who were not diabetic and if a resident refused nail care they were supposed to let the nurse know. LPN-A reviewed the medical record and verified there was no refusal of nail care or cares documented. In addition LPN-A verified R75 had received a scheduled shower on 10/15/18, and no refusals had been documented. -At 1:05 p.m. LPN-A approached R75 who allowed him to trim the nails. On 10/17/18, at 1:22 p.m. the director of nursing (DON) stated staff are supposed to complete nail care.	F 677	The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/27/18

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F 684	Continued From page 20 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate the cause of bruising for 2 of 3 residents (R211, R38) reviewed for non-pressure related skin concerns. In addition, the facility failed to follow physician orders for 1 of 1 resident (R78) reviewed for frequent loose stools. Findings include: R211's diagnoses included Alzheimer's disease and psychotic disorder obtained from the admission Minimum Data Set (MDS) dated 10/10/18. In addition the MDS indicated resident required extensive assistance of one to two staff with activities of daily living (ADL's) and had severely impaired cognition. R211's care plan dated 10/4/18, indicated R211 had a potential for alteration in skin integrity related to incontinence and daily Aspirin use. Care plan directed staff to monitor skin with cares. On 10/15/18, at 2:17 p.m. R211 was observed with dark purple bruises on bilateral hands and wrist areas. When asked how she got the bruises	F 684	F684 It is the Policy of Crest View Lutheran Home to notify the appropriate parties when a bruise or skin change in condition is first observed. It is also the Policy of Crest View Lutheran Home to follow all physician orders in a timely manner. Residents R211 and R38 had their changes in skin condition assessed and had incident reports created. Resident R78 a stool culture was collected for c-dif and was determined to be negative. The Skin Change Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Skin Change Policy details the procedure for making appropriate notifications for a change in skin condition, and how to monitor it to ensure proper documentation and communication occurs. The Physician Orders Policy and Procedure was reviewed and updated by an Interdisciplinary team on November 15th.	

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F 684	Continued From page 21 R211 looked at surveyor and mumbled repeatedly, unable to answer the question. On 10/16/18, at 9:52 a.m. R211 was observed seated on wheelchair which was parked in the dayroom listening to music. The dark bruises on both hands and wrist areas were visible when standing ten feet away. During the observation multiple staff including nursing assistant (NA)-D approached R211 who was weepy asking her what was wrong however no staff acknowledged the bruises. On 10/17/18, at 10:37 a.m. licensed practical nurse (LPN)-B approached R211 who was seated on wheelchair in the dining room and verified the bruises on her hands. Review of R211's Progress Notes dated 10/3/18, through 10/16/18, lacked documentation that the bruises had been assessed. A nursing Progress Note dated 10/17/18 (after concern had been brought to the attention of facility staff by the surveyor), indicated R211 had four bruises. The note indicated the measurements, color and shape of the bruises were as follows: -The right dorsal hand first knuckle bruise was purple to magenta in color measuring 1.0 centimeter (cm) x 0.6 cm; -The right wrist bruise measured 2.5 cm x 1.2 cm, dark purple to blue in color and was oblong in shape. -The left second knuckle bruise measured 2.2 cm x 2.4 cm, was purple/magenta in color with irregular shape; -Left first knuckle bruise measured 1.0 cm x 1.0 cm and was magenta-purple in color On 10/17/18, at 10:39 a.m. LPN-A stated the	F 684	The Physician Orders Policy details the procedure for following physician orders, including those related to specimen collection. All staff will be re-educated on these policies and procedures by November 27th. Audits for skin change procedure as well as audits for physician orders will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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NA's had not reported any bruising on R211. The LPN-A stated if the bruises were old they would think it was already noted but when it was new they were supposed to notify the nurse to assess and start monitoring them.
-At 10:40 a.m. LPN-B reviewed the medical record and verified all the bruises had not been identified, assessed or documented. In addition, LPN-B stated the aides were supposed to file the pink slips if they identified any concerns and a risk management should be completed, "We will assess them and do a risk management on them now."

On 10/17/18, at 1:23 p.m. the director of nursing stated "When they find the bruises they are supposed to report to the nurse to do a risk management, report to doctor and monitor them. We talk about the bruises in IDT [interdisciplinary team] and discuss if there is anything we can do and we try to find the cause and ways to prevent them."

R38, on 10/16/18, at 10:26 a.m. during an interview when asked if she had any skin concerns, R38 stated she had open areas on her lower legs and right hip. R38 further explained she had a dressing on the right hip.

On 10/17/18 at 1:55 p.m. R38 was observed seated on her wheelchair in the room and open ulcerations were observed on the right shin and around the front and back of left calf, an ulcer was covered with a ABD bandage which was hanging off the leg. The bandage on the left calf was observed with a nickel size light clear bloody drainage on it.

R38's diagnoses included type 2 diabetes mellitus

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and methicillin resistant staphylococcus aureus infection (MRSA) obtained from the October 2018 medication administration record. R38's quarterly Minimum Data Set (MDS) dated 8/1/18, identified R38 had intact cognition and did not reject cares.

R38's care plan dated 8/17/17, identified R38 had a potential for alteration in skin integrity related to decreased mobility, incontinence, diabetes and use of Aspirin. The care plan directed staff to monitor skin with cares and to notify dietary and the wound nurse with any open area or skin changes.

R38's pressure ulcer Care Area Assessment (CAA) dated 11/2/17, directed staff to monitor skin with cares and to notify dietary with any open areas or skin changes.

During review of the medical record multiple progress notes revealed the following:
-On 10/16/18, a late entry note indicated the writer had sent an e-clinical note to the medical director on Friday 10/12/18, to request for orders to refer to dermatology for multiple cysts to both lower extremities as the facility had not been able get response from R38's primary physician after multiple attempts.
-On 10/11/18, progress note indicated R38's skin was intact but R38 had a dry cyst on right lower leg and right thigh and the facility medical director, R38's primary physician and the director of nursing (DON) had been notified.
-On 10/9/18, progress note indicated the writer had called the primary physician to follow up regarding a call out to physician on 10/8/18, regarding multiple cysts noted to both lower extremities. The writer indicated she was not able to reach physician and was not able to leave a

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message.
-On 10/8/18, progress note indicated R38 had a small abrasion to the right hip and a bruise to left shin with a bumpy feel that looked like a boil. The note indicated the abrasion measured about 1.0 centimeter (cm) by 0.2 cm and the bruise measured 3.0 cm by 3.0 cm, was bumpy to the touch and R38 complained of pain with touch. The medical record lacked documentation of the cysts on both lower legs being assessed and the area on the left calf which had a dressing.

On 10/18/18, at 8:49 a.m. the resource LPN-B stated she had not followed R38 for wound care rounds since 9/4/18. She stated she did not know about the wound on the back of her calf. The resource LPN-B stated she had recently on 10/8/18, been made aware of the right hip abrasion and at the time she had assessed the area and left it for nursing to monitor. The resource LPN-B stated she would expect nurses to assess and describe the multiple cyst area identified on the progress notes dated 10/9/18, 10/11/18, and 10/16/18.
She also stated if it was something of significance the nurses were supposed to notify her, such as if an area was open and she would have to notify the physician to get treatment orders for her to follow the wound "the nurses should document what skin concerns the residents have. I will look for documentation on the legs." She verified the medical record lack documentation of the multiple cysts and the left calf area covered with a bandage.

On 10/18/18, at 10:51 a.m. NA-A stated when there was any skin concerns they were supposed to report to the nurse. NA-A stated on 10/17/18, she had seen the bandage on R38's left leg and

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thought the nurses knew about the area underneath it. When asked if she had seen the area she stated she knew R38 had a cyst/boil for a while.

On 10/18/18, at 11:39 a.m. the resource LPN-B stated she was not able to find any further assessments of the cyst on both legs and the area covered with the bandage. She stated "someone had assessed it and I should have been notified so I would assess the area and put new gauze and measure it and obtain orders for treatment."

On 10/18/18, at 11:46 a.m. LPN-C stated she was not aware R38 had any skin concerns until 10/17/18, evening shift when R38 had stood up when leaving facility when she observed an ABD dressing fall off the left leg.

On 10/18/18, at 1:50 p.m. the DON stated on Tuesday 10/16/17, R38 did not have a dressing on the left leg when she had observed her. The DON stated LPN-C had obtained an order to have R38 be seen by a dermatologist to have the legs looked at. The DON further stated the wounds were supposed to be assessed and monitored and the wound resource nurse should have been notified as she is good at watching resident wounds.

R78 was admitted to the facility on 8/2/18, for short term / rehabilitation stay with diagnoses including right calf hematoma, right lower calf cellulitis and congestive heart failure (CHF).

During interview with R78 on 10/15/18, at 2:55 p.m. R78 voiced a concern that she was having loose stools and had a blood test that showed no

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infections. R78 talked about the loose stools she was having at night and on days. R78 further stated she did have loose stools shortly after she ate.

On 10/17/18, at 7:57 a.m. R78 was asked about the bowel movements (BM) during night and she stated she had a small soft stool before she went to bed and no stools during the night. Once again, R78 stated she had a blood test and it came back okay, no infection.

During review of the Nursing Progress Notes (PN) and physician orders the following was revealed:
-PN dated 8/21/18, at 10:12 a.m. indicated staff were to check stool for Clostridium (C) difficile (Clostridium difficile is a bacterium that causes inflammation of the colon, known as colitis). A stool sample was collected and sent to the lab with results of negative for C-difficile.

-A physician's order dated 10/4/18, instructed staff to send a stool sample to be sent for culture.

-PN dated 10/14/18, at 9:21 p.m. indicated R78 received Loperamide HCL Tablet 2 milligram (mg) for loose stools and the medication was effective. The physician's order indicated R78 could receive Loperamide HCL 2 mg as needed (PRN) for diarrhea, four times daily (QID), okay to start if stool sample was negative.

-PN dated 10/16/18, at 7:25 p.m. indicate R78 received Loperamide HCL 2 mg for loose stools. The physician's order indicated R78 could receive Loperamide HCL 2 mg QID prn for diarrhea, okay to start if stool sample was negative.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

-PN dated 10/17/18, at 6:05 a.m. indicated R78 had been given Loperamide HCL 2 mg. The physician's order indicated R78 could receive Loperamide HCL 2 mg as needed for diarrhea, four times a day (QID) as needed (prn) ok to start if stool sample was negative. The progress note indicated the Loperamide had been effective, no BM during the shift.

Reviewing R78's PN's, there were 43 nursing progress notes during September 2018, that indicated the resident was having loose stools and 27 episodes of loose stools from 10/1/18, through 10/18/18. Each time R78 voiced she had loose stools, she received Loperamide HCL 2 mg.

The August 2018, Medication Administration Record (MAR) indicated R78 did not receive Loperamide HCL. The September 2018, MAR indicated R78 received Loperamide HCL 23 times and the October 2018, MAR from 10/1/18, through 10/17/18, indicated R78 received Loperamide 13 times.

On 10/18/18, at 10:15 a.m. the registered nurse (RN)-A confirmed there was no results in R78's medical record for a stool culture. RN-A was queried if a stool had been sent to the lab for a culture.

On 10/18/18, at 11:43 a.m., licensed practical nurse (LPN)-H coordinator confirmed a stool had not been collected for R78 as ordered by the physician on 10/4/18. LPN-H further indicated the physician order had not been passed on to the next shift, for a stool to be collected and sent for a culture. LPN-H indicated R78's physician had been called, just before our conversation, and

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F 684	Continued From page 28 they were awaiting further instruction from R78's physician. On 10/18/18, 2:33 p.m. the director of nursing, (DON), stated she had a conversation with LPN-H about R78's frequent loose stools and use of Loperamide. The DON further stated LPN-H had called the physician office and awaiting for further instructions. After reviewing the frequent stools and use of Loperamide, the DON agreed a stool culture should have been done per R78's physician order.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R47) had a hearing device in good working order. Findings include: On 10/15/18, at 4:30 p.m. R47 stated she had a	F 685	F685 It is the Policy of Crest View Lutheran Home to repair or assist in replacing any damaged or lost hearing devices. Resident R47 did not have a broken hearing aid that needed to be fixed. On	11/27/18

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F 685	Continued From page 29 hearing aid, but it was broken. R47 added the facility knew about the broken hearing aide, but had not done anything about getting it fixed. R47 stated the hearing aide was still in her room. R47's Admission Record dated 10/18/18, indicated an admission to the facility on 6/29/17. R47's care plan dated 1/15/18, did not address the hearing aides. The nursing assistant undated Team 1 Care Sheet indicated R47 had a right and left hearing aide. On 10/17/18, at 9:15 a.m. licensed practical nurse (LPN)-F stated the health unit coordinator (HUC) had been notified about the broken hearing aide more that a month ago. LPN-F stated the battery door was broken off the hearing aide. - At 9:38 LPN-F asked HUC-G about the hearing aide repair and asked the health unit coordinator to get it in for repair. Review of facility policy Resident Ancillary Services Policy and Procedure indicated the facility had ancillary services for hearing aides.	F 685	10/19/18, On-Site Hearing came to Crest View Lutheran Home to fix R47's hearing aid; however, the hearing aid was assessed to be working properly. For all other residents that this practice may affect, a whole-house review of all hearing devices was conducted on November 13th. All devices were in proper working order. The Hearing Device Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Hearing Device Policy details the procedure for identifying broken or missing hearing devices and the steps necessary to notify appropriate parties and either fix or assist in replacing missing devices. All staff will be re-educated on these policies and procedures by November 27th. Audits for staff knowledge of the procedure for hearing devices will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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F 693	Continued From page 30	F 693		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to check for placement of a feeding tube before giving medications to 1 of 1 resident (R22) observed for medication administration through the feeding tube. Findings include: On 10/16/18, at 8:36 a.m., licensed practical nurse (LPN)-F entered R22's room to give medications. LPN-F added 10 cubic centimeters (cc) of water to each medication cup with a	F 693	F693 It is the Policy of Crest View Lutheran Home to provide tube proper medication administration for residents receiving medications through a feeding tube. This includes checking placement of the feeding tube. Resident R22's plan of care was reviewed by an interdisciplinary team on November 12th for feeding tube placement and	11/27/18

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F 693	Continued From page 31 crushed medication tablet in it. LPN-F drew up water into a 60 cc syringe and put the stethoscope into her ears. LPN-F put the tip of the syringe into the port of the resident's feeding tube and was going to push the water through the feeding tube when surveyor asked LPN-F if pushing water was how placement of a feeding tube was supposed to be checked? LPN-F replied, "No." LPN-F added, she knew how to check placement, it should be checked with air, not water. LPN-F removed the syringe tip from the feeding tube port, checked the placement with air and attempted to put the first medication through the feeding tube by gravity. LPN-F did not attempt to flush the feeding tube with water after she checked for placement. LPN-F was not able to instill the medications. LPN-F removed the syringe barrel from the feeding tube and decided to contact the primary care provider (PCP) about the medications. LPN-F did not attempt to flush with water prior to stopping the process. - At 10/16/18, at 9:07 a.m. LPN-F disposed of the medication. R22's Admission Record dated 10/18/18, indicated R22 had diagnosis of dysphagia (difficulty swallowing). R22's Order Summary Report dated 9/27/18, indicated R22's feeding tube was to be flushed with 240 cc's of water five times and medications were to be given through the feeding tube. On 10/16/18, at 3:48 p.m. LPN-G was asked if the feeding tube was checked again and she stated she was unaware of whether that had been done and explained the PCP gave an order for medications to be given orally. On 10/18/18, at 8:59 a.m. the director of nursing	F 693	medication administration. For all other residents that this practice may affect, a whole-house review of all residents receiving medications through a tube feeding was completed on November 15th. The Tube Feeding Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Tube Feeding Policy details the procedure for tube checking placement prior to administering medications. All staff will be re-educated on these policies and procedures by November 27th. Audits for medication administration via feeding tube will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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F 693	Continued From page 32 (DON) was asked about the procedure for checking placement of a feeding tube. The DON stated the nurse needed to instill air through a syringe or draw back on the syringe for residual stomach contents. The DON added placement should not be checked by pushing water through a syringe, and the nurse needed to follow the facility policy for the procedure. Review of the facility policy Med Administration - Tube Feeding dated 10/23/17, indicated to check for placement via auscultation and or aspiration before any fluids or medication was administered.	F 693		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		11/27/18

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F 755	Continued From page 33 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify when medications were opened and/or identify when the medications would expire, which resulted in administration of expired medications, for 2 of 2 residents (R50, R26) who received medications out of the same medication cart. Findings include: R50's Medication Administration Record (MAR) for September and October 2018, identified R50 received Latanoprost solution 0.005% (a medication that reduces the pressure in a patients eye) one drop to each eye daily at bedtime. On 10/16/18, at 11:07 a.m., during observations of medication storage, a vial of Latanoprost 0.005% solution was observed for R50 without an open date, but with a dispense date of 8/9/18. Licensed practical nurse (LPN)-F stated she was unsure how long it was good for. LPN-F stated there was a sticker on the bag, that indicated the eye drops were to be discard 42 days after being opened. LPN-F stated if there was no date when something was opened staff were to use the dispense date. LPN-F verified R50's Latanoprost	F 755	F755 It is the Policy of Crest View Lutheran Home to label and store medications in a safe manner in order to ensure resident safety. This includes dating medications when opened and/or identifying when medications will expire. Resident R50 and R26 plans of care were reviewed by an interdisciplinary team on November 15th for medication administration. For all other residents that this practice may affect, a whole-house review of medication carts will be completed by November 27th by the Director of Nursing and her designees. The Medication Storage Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Medication Storage Policy details the procedure for labeling when medications are opened and/or identifying when medications will expire.	

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F 755	Continued From page 34 was expired and there was not another bottle of Lanatoprost in the medication cart. R50's MAR's indicated R50 received 26 doses of expired Latanoprost. R26's MAR from June 2018, through October 2018, was reviewed and identified R26 received morphine 2.5 milligram solutab (a fast acting opioid pain medication) every four hours as needed for pain or shortness of breath. On 10/16/18, at 11:07 a.m., during observations of medication storage, a card of morphine 2.5 milligram (mg) tablets, with seven tablets on the card, was found in the narcotic drawer of the medication cart. The word "Expired" was written on the card in black permanent marker. The expiration date on the back of the card was 6/3/18. LPN-F verified R57's card of morphine had an expiration date of 6/3/18. LPN-F stated the hospice nurse had told the staff to continue using them. LPN-F reviewed page 40 of the narcotic book labeled with R26's name and Morphine 2.5 mg and verified R26 received 18 expired doses between 6/21/18 and 10/8/18. During interview on 10/17/18, at 8:49 a.m. the director of nurses (DON) stated staff should check all medications for expiration dates. The DON stated staff were not to give the residents expired medications. Rising Pharmaceuticals, Inc. Latanoprost Ophthalmic Solution drug insert dated 11/17, indicated "Once a bottle is opened for use, it may be stored at room temperature up to 25 [degrees] C (77 [degrees] F) for 6 weeks."	F 755	All staff will be re-educated on these policies and procedures by November 27th. Audits for medication storage will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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F 880	Continued From page 35	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		11/27/18

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F 880	Continued From page 36 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain an infection control program that included tracking and trending of all infections in the facility including potential infections that did not require the use of an antibiotic. In addition the facility failed to follow infection prevention practices in cleaning and sanitization of equipment used. In addition, failed to ensure appropriate hand hygiene for 1 of 4	F 880	F880 It is the Policy of Crest View Lutheran Home to maintain an infection control program that includes tracking and trending of all infections in the facility, including potential infections that did not require the use of an antibiotic. In addition, it is also the Policy of Crest View	

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F 880	Continued From page 37 residents (R75) reviewed for activities of daily living and failed to clean and sanitize multi-use equipment after used in 1 of 1 resident's (R22) room. Findings include: A review of facility documents titled Resident Infection Control and Antibiotic Stewardship Narrative Report dated August 2018 through October 17th, 2018 identified the following: Resident's initials and the physician's order for the antibiotic including the date the antibiotic was prescribed. The Narrative Report did not, identify the resident's room number, the onset of symptoms, tracking of symptoms or a resolution date. The log lacked evidence of infections that were treated without an antibiotic. A review of the facility documents titled Monthly Infection Control Log (Line List) dated April 2018 to July 2018 identified the following: Resident name, admit date, room number, unit number, type of infection, body site of infection, date of onset, date culture was taken, culture organism, if it was antibiotic resistant along with the type and start date of the antibiotic and the dated the LOEBS (assessment to identify the minimal criteria to initial antibiotics) assessment was completed. The log further identified if the resident acquired the infection from the community or the nursing home and the date resolved. During an interview on 10/18/18, at 7:41 a.m. the staff development coordinator said every morning she would pull a 24 hour report of antibiotic use	F 880	Lutheran Home to follow infection prevention practices for cleaning of medical equipment, as well as ensure proper hand hygiene and glove changes occurs. Residents R75 and R22 plans of care were reviewed by an interdisciplinary team on November 15th. For all other residents that this practice may affect, a review of the infection prevention program at Crest View was reviewed and discussed with the Medical Director on November 12th during the monthly QAPI committee meeting. The updated program will include additional monitoring and trending of all confirmed and potential infections in the facility. The Infection Prevention Program for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Infection Prevention Program details the procedure for monitoring and tracking all confirmed and potential infections in the facility. This includes the communication between clinical personnel of all possible infections that are not being treated by an antibiotic, for tracking and monitoring purposes. The Glucometer Cleaning Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Glucometer Cleaning Policy details the procedure for cleaning and storing glucometers and glucometer supplies in order to ensure resident safety.	

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

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F 880	Continued From page 38 and put that information into the Resident Infection Control and Antibiotic Stewardship Narrative Report. The nursing staff would notify her if there was a LOEBS assessment completed and whether or not antibiotic therapy was initiated. The staff development coordinator indicated tracking infections was a "work in progress" and was coming up with a system to keep track of everything. When questioned about tracking infections that were not antibiotic related, for example upper respiratory infections, the staff development coordinator identified the licensed practical nurse (LPN) coordinators on each unit tracked that information. The staff coordinator thought the LPN coordinators would track that information and "manage it". During an interview on 10/18/18, at 8:15 a.m. LPN-E indicated if a resident displayed symptoms of an infection, she completed a LOEBS assessment to determine if they met the criteria to start on antibiotic. LPN-E stated would update the director of nursing and the staff development coordinator if someone started on an antibiotic. LPN-E stated she would update the staff development coordinator if a resident exhibited cold or flu symptoms and the staff development coordinator would "track it from there". During an interview on 10/18/18, at 9:07 a.m. LPN-C said on the days she worked, she would go through the 24-hour report and talk with the nurses and if any resident was not feeling well she would do a LOEBS assessment at the beginning of the illness, a week after antibiotics were started (if antibiotics were started) and would redo the LOEBS assessment if the resident still exhibited symptoms. LPN-C stated she would notify the staff development coordinator if a	F 880	The Glove Technique Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Glove Technique Policy details the procedure for changing gloves and ensuring proper hand hygiene. All staff will be re-educated on these policies and procedures by November 27th. Audits for infection prevention, glucometer cleaning, and glove changing will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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	245018	A. BUILDING _____ B. WING _____	C 10/18/2018

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F 880	Continued From page 39	F 880		

resident started on antibiotics and during IDT morning meetings the staff development coordinator was made aware of residents that started on antibiotics or exhibited symptoms of a cold or flu. LPN-C stated if there were residents on the unit that exhibited signs and/or symptoms of cold or flu, the staff development coordinator would track it.

An undated policy titled Infection Surveillance indicated nursing staff would identify residents with symptoms or identified infections and complete the LOEB's assessment for the respective type of infection/suspected infection: urinary tract infection, respiratory tract infection, skin, soft tissue and mucosal infection and fever of unknown source. The policy went on to identify the infection preventionist or designee would be alerted to identify any necessary intervention and add to the Monthly Infection Control Log for follow up and data collection. The Infection Preventionist was to utilize this information to document infection site, type of infection, pathogen if known, signs and symptoms, resident location, etc., in order to identify trends or clusters for action.

Glove use:
On 10/17/18, from 9:20 a.m. to 9:32 a.m. nursing assistant (NA)-B was observed providing R75 with pericares. During the observation, NA-B approached R75, and stated she was going to get her ready. NA-B then completed front pericare with a wet towel. NA-B turned R75 to the right side and was observed to use multiple wet wipes to wipe stool off R75's bottom. After NA-B finished, she tucked the soiled linen under R75's body then applied the clean incontinent pad under R75 and fastened it on both sides, still with the

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F 880	Continued From page 40	F 880		

same gloves used to provide pericare.
-At 9:32 a.m., NA-B was observed to touch R75's body, linen and other clean clothing. Surveyor suggested NA-B change gloves, wash hands before proceeding with cares and assisting R75 with getting dressed.

During interview, on 10/17/18, at 10:29 a.m. NA-B stated she was supposed to change the gloves and wash hands after pericare.

On 10/17/18, at 1:22 p.m. the DON stated staff are supposed to remove the gloves and wash hands before they continued with cares after doing pericare when going from dirty to clean.

Hand Washing Policy and Procedures dated 10/13, instructed staff, "Hand washing/ Hand Sanitizing must be done:
a. Before performing invasive procedures.
b. Before contact with particularly susceptible residents
c. Before touching food or medications to be given to residents.
d. Before and after touching wounds of any kind.
e. Before and after providing personal cares for a resident.
f. After removing gloves
g. After touching anything that may have been contaminated with blood or bodily fluids.
h. After caring for a resident with an active infection.
i. After going to the bathroom, nose blowing, covering a sneeze and coughing.
j. Before eating and before going home at the end of the shift."

Glove Technique policy revised 2/08, instructed staff ""Wear clean non-sterile gloves when

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F 880	Continued From page 41 touching blood, body fluids, secretions, excretions and contaminated items; put on clean gloves just before touching mucus membranes and non-intact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces..." Cleaning and sanitization of multi-use equipment: On 10/16/18, at 8:36 a.m LPN-F was observed carrying a cover for a plastic container used to store glucometer supplies with 10 medication cups with crushed and liquid medications into R22's room. LPN-F set the cover on R22's bedside table in bed B. R22 was on contact precautions (precautions to prevent spreading of infectious disease) due to Clostridium (C) difficile (Clostridium difficile is a bacterium that causes inflammation of the colon, known as colitis). LPN-F attempted to give R22 medications through the feeding tube without success. LPN-F picked up the container cover, with the medication cups, and carried it across the room placing it on the liquid oxygen tank near bed A. LPN-F then removed gown and gloves and washed her hands. LPN-F again picked up the cover from the oxygen tank and walked to the nursing station. LPN-F set the cover down on the desk near the computer without cleaning it after leaving R22's room. - At 9:05 a.m. LPN-F made two phone calls and picked up the tray and placed it on the medication cart while she poured the contents of each medication cup into a drinking cup. - At 9:08 a.m. LPN-F then placed the cover on the treatment cart next to the container it was taken	F 880		

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F 880	Continued From page 42 from. At no time did LPN-F clean or sanitize the cover. - At 9:09 a.m. LPN-F was asked about sanitizing the cover being used as a tray. LPN-F stated she should have sanitized the cover before setting on the counter in the nurses station and before putting it on the cart after leaving R22's room. R22's Admission Record dated 10/18/18, indicated R22 had diagnoses of cerebral infarction and hemiplegia secondary to the cerebral infarction. R22's Laboratory Results dated 10/5/18, indicated R22 tested positive for C-difficile in her colon. On 10/18/18, at 8:59 a.m. the DON stated the nurse should have sanitized the tray before setting it down on anything after leaving a resident room. Review of facility Infection Control Policy undated, indicated in section 1i (b) cleaning and disinfection needed to happen for resident care equipment including shared equipment.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883		11/27/18

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F 883	Continued From page 43 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 883		

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F 883	Continued From page 44 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Prevnar 13 vaccine (a pneumonia vaccine PCV13) was offered and provided for 1 of 5 residents (R61) reviewed for immunizations. Findings include: R61's Record of Admission, identified an admission date of 9/11/13. The medication administration record (MAR) for August 2016 indicated PCV13 was scheduled on 8/1/16, however the MAR lacked evidence the PCV13 was given. During an interview on 10/18/18, at 3:33 p.m. health unit coordinator (HUC)-F identified the order was put on the MAR but there was no documentation indicating the PCV13 vaccination had been administered. The Pneumococcal Vaccination policy with revision date of 8/16, identified staff were to ensure all residents were provided the opportunity and encouraged to receive the pneumococcal vaccination. Each resident would be offered the immunization, the resident or resident's legal representative had the opportunity to refuse immunization, a consent would be signed, an order obtained and the vaccine given.	F 883	F883 It is the Policy of Crest View Lutheran Home to ensure all residents either receive or are offered pneumococcal vaccinations upon admission, and as indicated per standing orders provided by the Medical Director. For all other residents that this practice may affect, a whole house audit was completed on November 12th in order to determine which residents may not have received their requited immunizations. The Pneumococcal Vaccination Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Pneumococcal Vaccination Policy details the procedure for offering, administering, and monitoring pneumococcal vaccinations for the residents of Crest View Lutheran Home. All staff will be re-educated on this policy and procedure by November 27th. Audits for pneumococcal vaccinations will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next	

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F 883	Continued From page 45	F 883	monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 5 residents (R51) who required assistance with eating was safe to be fed by non-nursing personnel reviewed during dining observation Findings Include: R51's diagnoses included dementia obtained from the admission Minimum Data Set (MDS) dated 8/16/18. In addition, the MDS indicated R51 had severely impaired cognition and required extensive assistance of one staff with eating. On 10/15/18, from 4:29 p.m. to 4:57 p.m., during dinner the director of life enrichment was observed seated next to R51, and physical assisted her to eat. During the observation R51 took several bites of the food, dessert and fluids from the director of life enrichment but never	F 948	F948 It is the Policy of Crest View Lutheran Home to ensure that residents who require assistance with eating, receive assistance from trained personnel. This includes clinical and occupational therapy staff. Resident R51's plan of care for eating was reviewed by an interdisciplinary team on November 15. The Feeding Assistance Policy for Crest View Lutheran Home was reviewed and updated by an interdisciplinary team on November 15th. The Feeding Assistance Policy details the procedure for residents who require assistance, receiving it from qualified clinical or occupational therapy	11/27/18

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F 948	Continued From page 46 coughed. At 4:58 p.m. R51 had eaten approximately 25% of the meal, 240 milliters of orange juice. In addition during the entire observation multiple nursing staff were observed in the dining room including licensed practical nurse (LPN)-D however none intervened. -At 4:58 p.m. when the director of life enrichment was asked if she was a nursing assistant or if she had received paid feeding assistant training from a State approved program she stated "no." She stated she had received training to feed residents in another facility she had worked at. On 10/16/18, at 11:22 a.m. the director of human resource reported the administrator had checked with the director of life enrichment and identified she did not receive paid feeding assistance training. On 10/18/18, at 2:31 p.m. the administrator stated the staff member was not supposed to assist residents to eat as the facility did not have any paid feeding assistants.	F 948	personnel. All staff will be re-educated on this policy and procedure by November 27th. Audits for meal-time assistance will be completed weekly for four weeks, and then scheduled periodically thereafter by the Director of Nursing based on audit results. Outcomes and results from these audits will be brought to the facility's next monthly QAPI meeting for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/27/2018	

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	245018	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 17, 2018. At the time of this survey, Crest View Lutheran Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Crest View Lutheran Home is a 2-story building with a partial basement. The building was constructed in 1964 with additions in 1968 and 2007 and was determined to be built of Type II (111) construction. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 122 beds and had a census of 105 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.