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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PZO7

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 **01/04/2022** (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 :
Nicole Osterlosh, Unit Supervisor 01/27/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/27/2022 (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.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

CMS Certification Number (CCN): 245018

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 January 4, 2022 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PZO7

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(L4) **4444 RESERVOIR BOULEVARD NORTHEAST**
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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 **10/07/2021** (L34)

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

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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

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A. In Compliance With Program Requirements Compliance Based On:
___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)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Lisa Prokosch, HFE NE II 11/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/03/2021 (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)

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
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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
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03-Risk of Involuntary Termination
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INVOLUNTARY
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 27, 2021

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

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

Dear Administrator:

On October 7, 2021, a survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 26, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Crest View Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 26, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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 10/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/4/21 through 10/7/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/4/21 through 10/7/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5018164C (MN65187), H5018168C (MN63370), H5018171C (MN61587), H5018174C (MN65799), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5018163C (MN77185), H5018165C (MN65159), H5018166C (MN64467), H5018167C (MN64396), H5018169C (MN62703), H5018170C (MN59412), H5018172C (MN60012), H5018173C (MN67860). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 11/05/2021

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 10/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		11/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	C 10/07/2021

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

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F 578	Continued From page 2 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's resuscitation status order matched the resident's stated request of Full Code for 1 of 28 residents (R8) reviewed for advance directives. Findings include: R8's diagnosis included anxiety disorder, major depressive disorder, adult failure to thrive, unspecified dementia with behavioral disturbance and unspecified psychosis not due to a substance or known physiological condition obtained from the admission Minimum Data Set (MDS) dated 7/8/21. In addition, the quarterly MDS dated 10/1/21, indicated R8 had intact cognition. During review of R8's Provider Orders for Life Sustaining Treatment (POLST) dated and signed by the nurse practitioner 7/20/21, indicated "Attempt Resuscitation" however the physician order dated 7/1/21, on the electronic medical record (EMAR) indicated R8 was "Do Not	F 578	It is the policy of Crest View Lutheran Home that each resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Resident R8□s POLST and EMAR not matching on 10/5/21 at the time of survey was immediately looked into and corrected on 10/5/21. For all other residents this deficient practice could have affected, a whole-house audit was conducted to ensure all POLST and EMARs match. The POLST policy and procedure was reviewed and updated on 10/19/2021 to reflect the new process of the Director of Social Services bringing each POLST to the daily IDT meeting to review for completion and make sure everything in	

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F 578	Continued From page 3 Resuscitate (DNR)." On 10/5/21, at 12:05 p.m. licensed practical nurse (LPN)-A, facility nurse consultant, was asked how she would know what a resident's code status was if there was an emergency. LPN-A stated she would look in the chart first and then the EMAR. When asked if the POLST and EMAR did not match, LPN-A stated she would go by the POLST. LPN-A verified R8's POLST and EMAR did not match, and did not know why. On 10/5/21, at 12:07 p.m. registered nurse (RN)-A stated she would look in the chart at the POLST. On 10/5/21, at 12:25 p.m. RN-B stated he would look in the chart at the POLST. Review of Crest View Lutheran Home POLST policy and procedure revised 1/20 directs: 4. Once POLST is signed by the resident/resident representative the original POLST form will be given to the physician to sign and copies will be placed in the chart until the original is signed. 5. Once a POLST is completed or updated the face sheet must also be updated.	F 578	the EMAR system matches before filing in the resident□s chart. Staff will be re-educated on this policy and procedure by November 18th, 2021. Audits to ensure the POLST match the EMAR will be completed for all new admissions and re-admissions weekly for four weeks and then brought to QAPI to review results with the committee and decide on whether they continue based on the results. The Director of Nursing will be responsible for compliance. Compliance date: 11/18/2021	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		11/18/21

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F 609	Continued From page 4 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report timely to the State Agency (SA) a vulnerable adult who left the facility against medical advice for 1 of 1 residents (R100) reviewed for abuse allegations. Findings include: R100's 9/7/21, significant change Minimum Data Set (MDS) assessment identified his cognition was intact and he was independent with all activities of daily living (ADLs) except bed mobility which was listed as needing supervision. Diagnosis included type 2 diabetes (on insulin), traumatic amputation of his right great toe with	F 609	It is the policy of Crest View Lutheran Home that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries or unknown source, and misappropriation of resident property, are reported immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey	

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F 609	Continued From page 5 continued use of antibiotics due to infection, chronic kidney disease stage 3, high blood pressure and psychotropic use. R100's active provider signed orders for September 2021 included: Insulin Aspart sliding scale, subcutaneously (SQ) with meals for diabetes, and Insulin Glargine 30 units SQ every (Q) bedtime (HS) diabetes, Metformin 1000 milligrams (mg) by mouth (PO) Q day- diabetes and Fluoxetine (antidepressant) 40 mg by mouth (PO) Q morning. R100's undated care plan identified an admission date of 8/13/21, following a right great toe amputation with a plan for a short-term rehabilitation therapy. R100's identified goal was return to his prior living situation following discharge. Areas identified in the care plan included alteration in safety, falls related to right Great toe amputation, psychotropic, insulin and anticoagulant medication use, in addition to antibiotics prescribed until 9/21/21, for infection in the right foot. R100 was considered to have vulnerability due to compromised health, decline in independence, age, placement and diagnoses. R100's Progress Notes: On 9/4/21, at 10:00 p.m., progress note identified R100 had signed himself out in the LOA book at 4:00 p.m. and would return at 8:00 p.m.. The note identified R100 was aware he was scheduled to receive both insulin and his medications that evening. When R100 was 2 hours past the documented time for return, the charge nurse attempted to contact the emergency contact person and also R100's cell phone without result. The documentation identified a message was left on R100's voice	F 609	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. MAARC report was filed for R100 on 10/7/2021. For all other residents this deficient practice could have affected, a whole house audit was conducted on 11/3/2021 for any other residents who□s LOAs went longer than expected or turned into AMA discharges. Staff will be re-educated on the LOA and AMA policy and procedure by November 18th, 2021. A risk/benefits statement has been added to every resident□s sign out sheet for them to read and acknowledge before they go out on LOA. Audits for ensuring a MAARC report is filed after every AMA discharge will be conducted on every AMA discharge during that time frame every week for four weeks until results are evaluated at QAPI to be decided on to continue or discontinue. The Director of Nursing will be responsible for compliance. Compliance date: 11/18/2021	

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mail requesting an update as to when he planned to return.

On 9/5/21, at 7:09 a.m., progress note identified R100 had neither contacted or returned to the facility following leaving on 9/4/21, at 4:00 p.m.. A progress note at 9:43 a.m., identified R100 had still not contacted or returned to the facility and an additional voice mail was left requesting R100 to contact the facility to inform if he was alright, and when he planned to return. An attempt was also documented to contact the emergency contact without result. The note identified R100 returned to the facility after 12:15 p.m. on 9/5/21. The progress note identified R100 was aware of his scheduled medication and insulin doses, but the record lacked any documentation indicating education had been provided on the importance of taking medications and insulin as ordered. Nor had R100 requested his medication to be sent with him when he was leaving the facility on LOA.

On 9/7/21, at 10:36 p.m., progress note identified R100 had signed out of the facility at 1:00 p.m. with no identified date and time of return. Attempt to contact R100 and emergency contact were not successful, with notation that supervisor notified and continued to wait for R100's return.

On 9/9/21, at 11:21 a.m., progress note identified R100 returned to the facility at 11:00 a.m.. He was gone for 2 days, 1:15 p.m. progress note identified R100 presented to therapy and informed them he was not going to follow 9/3/21, provider order for strict none weight bearing (NWB), on his right lower extremity. Education was provided on safety and healing by following NWB orders, with the resulting risk of further infection with potential further amputations. R100

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was not receptive and was discharged from therapy due to safety concerns.

On 9/13/21, at 4:01 p.m., progress note identified continuation of Augmentin for Osteomyelitis (inflammation of bone or bone marrow, usually due to infection).

On 9/14/21, at 2:29 p.m. R100 informed staff he was going out to smoke and would do his wound dressing upon return, but resident did not return and nursing staff were informed R100 had called and would not be returning on 9/14/21. R100 failed notify staff of his intent to leave the facility and no medications or insulin were provided for use during his absence.

On 9/18/21, at 12:45 p.m. R100 was discharged against medical advice (AMA), when he requested an unidentified family member to pick up his belongings from the facility.

Interview on 10/07/21, at 3:40 p.m., with the interim director of nursing (IDON) identified R100 had signed himself out on LOA on 9/14/21, at 2:30 p.m. and failed to return. Medications and insulin was not provided for resident use while out of the facility as he had stated he would be returning when his medication was due. The IDON identified R100 had telephoned the facility stating he would be returning at a later time but there was no documentation as to when he had telephoned or who he had spoken with. The IDON identified R100 was his own responsible party and had been discharged when his family picked up his belongings. The IDON identified she had not completed an incident report due to R100 had signed himself out of the facility and the facility was not responsible for him. The

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IDON verbalized she thought R100 was scheduled to discharge on 9/23/21, and the licensed social worker (LSW) had already obtained the discharge orders. Instead R100 had a family member retrieve his belongings on 9/18/21, resulting in that becoming the date of discharge.

Interview on 10/07/21, at 3:50 p.m. with the licensed social worker (LSW), identified R100 was supposed to be discharged on 9/23/21, but left the facility on LOA on 9/14/21. When R100 failed to return, by 9/23/21, the LSW questioned how to proceed and if R100 should be considered as discharged AMA. The LSW verbalized he was instructed to wait and see if R100 returned to the facility to retrieve the discharge instructions and his medications. When R100 contacted the LSW at an unidentified date and time, and requested his girlfriend be allowed to pick up his belongings the decision was made by administration to allow release of personal items but R100 was listed as AMA and medications were not to be released until R100 was able to retrieve them.

The LSW identified he was not informed of R100's location, but heard from an unidentified source he had gone to Chicago. R100 was absent from facility for the week of 9/14/21-9/18/21. The LSW identified to his knowledge no medication or arrangements had been made prior to R100 leaving on 9/14/21. The medical record identified R100's discharge plan was to include the arrangement of home care services and management of wound care at the time of discharge and to his knowledge this did not take place. The LSW identified he had been informed R100 was on LOA and was not considered AMA, as a result he had not filed a

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F 609	Continued From page 9 report with the state agency. Interview on 10/07/21, at 4:10 p.m. with the administrator identified an LOA as a planned leave from the facility with orders, medications and safety measures in place. In the instance of a resident leaving un-announced and then later telephoning to state he was not going to return that day was considered AMA and should have been reported to the State Agency. The administrator identified she was not aware if any reporting of R100's leaving the facility with out staff knowledge, or the provision for medications had been completed to the state agency or county case manager following the incidents.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		11/18/21

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F 636	Continued From page 10 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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F 636	Continued From page 11 Based on observation, record review and interview, the facility failed to accurately assess 1 of 1 resident (R67) who received oxygen. Findings include: On 10/4/21, at 4:33 p.m. R67 was observed resting in bed with oxygen being administered via nasal cannula. The oxygen was running at 3 liters, and the oxygen tubing was dated 10/3/21. R67's significant change Minimum Data Set (MDS) dated 8/21/21, identified R67 was cognitively impaired. R67's diagnoses included encephalopathy, unspecified cirrhosis of liver, chronic ischemic heart disease, and unspecified dementia without behaviors. The MDS did not identify R67 to receive oxygen. R67's physicians orders printed 10/7/21, did not include orders for oxygen. R67's care plan revised 10/5/21, did not identify R67 received oxygen. During interview on 10/7/21, at 10:39 a.m. registered nurse (RN)- C stated she completed R67's MDS assessment. RN-C indicated information for the MDS was received from physician order, nurse practitioner notes, and staff progress notes. RN -C verified R67 had a significant change MDS completed in August, and the MDS does not indicate R67 received oxygen. RN-C indicated it was missed on the MDS, and therefore was not added to the care plan.	F 636	It is the policy of Crest View Lutheran Home that the facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment or each resident□s functional capacity. Order received for Resident R67 to have oxygen on 10/7/21 and care plan and MDS updated to reflect R67□s oxygen updated on 10/7/2021. For all other residents this deficient practice could have affected, everyone on oxygen will be audited for proper orders, care planning and MDS□s. New admission and re-admissions charts will be brought to the daily IDT meeting for review of oxygen and orders each day for three days from the time of admission or re-admission. Staff will be re-educated on oxygen orders and documentation surrounding oxygen by November 18th, 2021. Audit ensuring proper oxygen orders and documentation will occur on all residents on oxygen once a week 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 QAPI meeting next month for review. The Director of Nursing will be responsible for compliance.	

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F 636	Continued From page 12	F 636	Compliance date: 11/18/2021	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents participated and were engaged in the care planning process and also failed to provide quarterly care planning	F 657	It is the policy of Crest View Lutheran Home must ensure residents participate and are engaged in the care planning process as well as provide care planning	11/18/21

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F 657	Continued From page 13 conference meetings for 3 of 3 residents (R22, R47, R90) reviewed for participation in care planning. Findings Include: R22's Face Sheet printed 10/7/21, indicated R22 was admitted to the facility on 3/26/21, and diagnoses included anxiety disorder and essential primary hypertension. R22's admission Minimum Data Set dated 6/30/21, indicated R22 was cognitively intact, had clear speech, and was usually understood. During interview on, 10/5/21, at 12:47 p.m. R22 stated she had not been invited to care conference meetings and had not attended care conferences since admission 3/26/21, into the facility and did not know when she would be discharging. During interview on 10/7/21, at 1:28 p.m. director of social service (DSS)-A stated he only began working at the facility in July (7/21). DSS-A stated he did not believe care conferences had been occurring per schedules due to staffing issues in the department. DSS-A also stated R22 was scheduled for a care conference "today" 10/7/21, but had discharged that morning, however was unable to show documentation care conferences had been scheduled for R22. DSS-A reviewed social service progress notes and was unable to find documentation that R22 or representatives had been invited to care conference meetings since admission in 3/26/21. R47's admission minimal data set (MDS) dated 2/15/21, indicated R47 was cognitively intact with diagnoses of end stage renal disease (ESRD),	F 657	conference meetings upon admission, quarterly and annually. Resident R22 & Resident R90 are no longer resides at the facility. Therefore, care planning conference for these residents cannot be done. Resident R47 is currently a resident and has a care planning conference set up for 11/11/2021 at 11 am with resident and resident representative planning to attend. For all other residents this deficient practice could have affected, a whole-house audit was conducted to ensure all residents have had an admission, quarterly and annual care planning meeting with resident and responsible parties invited to participate. The Care Planning Conference Policy and Procedure for Crest View Lutheran Home was reviewed and updated by the interdisciplinary team on November 4th, 2021. The Care Planning Conference Policy details the procedure and frequency for conducting care planning conferences and who is involved. Audits ensuring care planning meetings are completed with the appropriate parties involved will be conducted once a week for four weeks, and then scheduled periodically thereafter by the Administrator based on audit results. Outcomes and results from these audits will be brought to the facility's QAPI meeting next month for review.	

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F 657	Continued From page 14 diabetes and left sided hemiplegia/hemiparesis (weakness/paralysis affecting one side of the body). R67's care plan was initiated on 2/9/21 and included revisions in March, April, May, August and October. R67's progress notes included one care conference summary on 3/12/21, at 11:00 a.m. which indicated, "social worker)SW) met with resident and resident brother via phone, met to discuss resident's progress and discharge planning. resident is working with therapy, resident reports concerns with leg pain. Family is working on resident's MA application. based on how much progress resident makes from therapy, family/resident will discuss discharge options. SW will continue to follow." During interview on 10/4/21, at 5:41 p.m. R67 stated not being involved in determining his plan of care and could only recall one care conference since his admission in February. During interview on 10/7/21, at 1:30 p.m. director of social services (DSS) stated all care conferences were documented in the electronic health record (EHR) under progress notes in the care conference summary category. DSS further stated if a care conference note was not documented, it did not happen. DSS stated the facility was currently revamping the care conference process and they recently performed an audit and discovered many care conferences had been missed and had made up most of the previously missed care conferences in September. DSS stated any that had not been done in September were scheduled to be	F 657	The Administrator will be responsible for compliance. Compliance date: 11/18/2021	

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F 657	Continued From page 15	F 657		

completed in October. DSS confirmed R67 had not had a care conference since 3/12/21, and was not on the schedule to have one in October. DSS further stated the expectation was to have a care conference upon admission, quarterly and with any significant changes in condition and would include resident and/or resident representative participation and input when appropriate.

During interview on 10/7/21, at 2:21 p.m. director of nursing (DON) stated the expectation was care conferences should be conducted on admission, quarterly and impromptu (as needed).
R90's quarterly MDS dated 9/11/21, indicated R90's cognition was severely impaired with diagnoses of Alzheimer's disease, and dementia.

R90's care plan initiated on 7/1/20, indicated resident had altered communication related to dementia, delusions, and disorientation.

During an interview on 10/07/21, at 1:42 p.m. director of social services (DSS) stated he was behind on care conferences and planned to restart care conferences in October. DSS stated R90's last care conference was on 10/2/20, conducted via phone call with R90's family.

The facility Care Conferences Policy and Procedures revised 3/19/21, indicated the resident care conference was a meeting held quarterly or as needed to ensure coordinating and continuity of resident care, which involved the resident, significant family members, and members of the interdisciplinary health team. Prior to each care conference, social service contacted the residents and family member, and invited them to the care conference and conduct

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F 657	Continued From page 16 the meetings as well as document using the care conference summary in the EHR.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents respiratory care equipment were maintained for 2 of 3 residents (R4, R250). The facility also failed to ensure physician order was obtained for oxygen therapy use for 1 of 3 residents (R67), reviewed for respiratory care. Findings include: R4's Face Sheet printed 10/7/21, indicated R4 diagnoses included Alzheimer's disease and personal history of covid. R4's significant change Minimum Data Set (MDS) dated 1/2/21, indicated R4 had severe cognitive impairment, required extensive assist with personal hygiene, bed mobility and transfers. R4's care plan dated 2/2/18, lacked indication of oxygen usage or interventions.	F 695	It is the policy of Crest View Lutheran Home that the facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consist with professional standards of practice, the comprehensive person-centered care plan, the resident goals and preferences. Resident R4 and R250's respiratory equipment were audited and corrected on 10/7/2021. For all other residents this deficient practice could have affected, everyone on oxygen will be audited for proper orders, care plan, equipment in the room and replacement and labeling of equipment. Staff will be re-educated on oxygen orders, documentation surrounding	11/18/21

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F 695	Continued From page 17 R4's Treatment Administration Record dated for 10/21, noted staff signature for 10/3/21, for change oxygen (02) tubing, initial and date, every night shift, every Sunday. R4's Order Summary Report indicated the following orders: - 9/11/21, change 02 tubing, initial and date every night shifts, every Sunday. - 9/11/21, start oxygen 2 liters (L)/minute (min), keep oxygen saturations greater than 90 percent, every shift for hypoxia. - 9/20/21, admit to hospice. R250 R250's Face Sheet dated 10/7/21, indicated R250 diagnoses included chronic obstructive pulmonary disease and congestive and diastolic heart failure. R250's care plan revised on 9/13/21, indicated received oxygen therapy related to pneumonia and interventions included change tubing per protocol. R250's Physician Orders Summary indicated order dated 9/30/21, to check portable oxygen tank to make sure they are not empty every shift. Order 9/19/21, oxygen at 2L per nasal cannula with activity. During observation on 10/5/21, at 12:28 p.m. R4 was in bed with oxygen tubing in place and attached to liquid oxygen tank. Oxygen tubing was undated and humidifier canister was undated. R4's Oxygen tubing and humidifier canister were	F 695	oxygen and labeling of respiratory equipment by November 18th, 2021. Audit ensuring proper oxygen orders, documentation of residents on oxygen, and respiratory equipment and labeling will be done once a week 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 QAPI meeting next month for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/18/2021	

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F 695	Continued From page 18 observed undated on: - 10/6/21, at 12:47 p.m. -10/7/21, at 2:25 p.m. During observation on 10/5/21, at 12:34 p.m. R250 oxygen tubing and humidifier canister were undated. During interview on 10/7/21, at 12:17 p.m. interim director of nursing (DON) stated oxygen tubing are changed weekly along with the humidifier canisters. DON further stated since tubing and humidifier canister were changed weekly, staff were not expected to label or date the tubing or the canister. During interview on 10/7/21, at 2:35 p.m. licensed practical nurse (LPN)-B stated anyone could change the oxygen tubing and stated the tubing and humidifier got changed perhaps every two weeks but was unsure. The facility Oxygen Tubing and Oxygen Humidifier Maintenance Policy and Procedure revised 8/20, indicated to maintain the health and safety for residents using oxygen, nursing staff were to check all oxygen tubing and water in the oxygen humidifier (bubbler) will be checked once daily during rounds. Oxygen tubing and humidifier will be changed once per week by the nursing staff on the night shift. The tubing was to be dated and initialed with a permanent marker when changed. On 10/4/21, at 4:33 p.m. R67 was observed resting in bed with oxygen being administered via nasal cannula. The oxygen tank was running at 3 liters, and the oxygen tubing was dated 10/3/21	F 695		

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F 695	Continued From page 19 R67's significant change Minimum Data Set (MDS) dated 8/21/1, identified R67 was cognitively impaired. R67's diagnoses included encephalopathy, unspecified cirrhosis of live, chronic ischemic heart disease, and unspecified dementia without behaviors. The MDS did not identify R67 to receive oxygen. R67's physicians orders printed 10/7/21 did not include orders for oxygen. R67's care plan revised 10/5/21 did not identify R67 received oxygen. During interview on 10/5/21 at 9:00 a.m., licensed practical nurse (LPN)-D stated "if a resident is on oxygen, it is on the MAR (medication administration record) and TAR (treatment administration record). It is signed off every shift, and the night shift is responsible for changing the tubing weekly and marking it." During interview on 10/7/21 at 10:15 a.m. LPN -A verified R67's record lacked physician orders for oxygen, and R67's care plan did not include oxygen use.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		11/18/21

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F 758	Continued From page 20 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to evaluate the continued use of an as needed psychotropic medication every 14 days for 1 of 5 residents (R4) reviewed for unnecessary medication. Findings include: R4's diagnoses included dementia, Alzheimer's disease, psychotic disorder with delusions, and depression obtained from the Admission Record dated 10/7/21. R4's order summary report printed 10/7/21, included lorazepam (anti-anxiety medication) concentrate 2 milligrams (mg) per milliliter (mL), give 0.5 mg sublingually every four hours as needed for restlessness. R4's lorazepam order had a start date of 9/12/21. During an interview on 10/7/21, at 2:53 p.m. licensed practical nurse (LPN)-C verified R4 had an order for lorazepam with a start date of 9/12/21. LPN-C further indicated the medication must be re-assessed every 14 days. During an interview on 10/7/21, at 3:03 p.m. interim director of nursing (DON) indicated as needed psychotropic medication needed to have a reason for continued use after 14 days and be re-assessed by a physician or nurse practitioner. During the interview, interim DON indicated she would search for a rational for use of an as needed psychotropic medication beyond the 14 day period, however the rational was not provided.	F 758	It is the policy of Crest View Lutheran Home that residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. Resident R4 was reviewed by consultant pharmacist to make sure all medications are correctly prescribed with the correct orders. For all other residents this deficient practice could have affected, Consultant Pharmacist completed a whole-house audit for those resident who are on psychotropic medications and that the orders are current. Director of Nursing and Consultant Pharmacist will meet monthly to ensure compliance. Re-education will be completed with nursing staff on the 14-day requirement for PRN psychotropic orders by November 18th, 2021. Psychotropic medications have also been added to the agenda of the daily clinical meeting to review and track. Outcomes and results from these audits will be brought to the facility□s QAPI meeting next month for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/18/2021	

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F 758	Continued From page 22 The facility policy titled Psychotropic Medication Use dated 11/28/16, directed as needed orders for psychotropic drugs should be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the as needed order.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide meals at a palatable temperature and taste. This had the potential to impact all 24 residents who ate in their rooms on Lindon Hall who were reviewed for dining experience Findings include: During an observation on 10/06/21, at 11:28 a.m. chef supervisor (CS)-A started to prepare meals for Lindon Hall. Meals were prepared and placed in Styrofoam containers. At 11:40 a.m. CS-A was asked to make an extra	F 804	It is the policy of Crest View Lutheran Home that each resident received and the facility provides food prepared by the methods that conserve nutritive value, flavor and appearance. New covers and containers were ordered to ensure food stays at the right temperature for longer. For all other residents this deficient practice could have affected, new process for serving one unit at a time was enacted on 10/7/2021 to keep the food delivered to rooms at a hotter temperature.	11/18/21

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F 804	Continued From page 23 meal and that meal temperature would be checked by CA-A once all the Lindon Hall meals had been served. During an observation on 10/06/21, at 11:41 a.m. an unidentified dietary aid placed the uncovered food cart in front of the Lindon Hall nursing station and left. During an observation on 10/06/21, at 11:42 a.m. food remained on the uncovered cart while an unidentified nursing assistant went to the kitchen to collect silverware for the meals. During an observation on 10/06/21, at 11:43 a.m. unidentified nursing assistant returned with the plastic silverware. During an observation on 10/06/21, at 11:44 a.m. the first meal was served. During an observation on 10/06/21, at 12:04 a.m. the last tray was served on Lindon Hall. During an observation on 10/06/21, at 12:05 p.m. the extra meal tray was delivered back to the kitchen for CS-A for a temperature check. During an observation and interview on 10/06/21, at 12:06 p.m. CS-A stated the temperature of the hamburger patty was 97 degrees. CS-A stated the temperature should be at least 155 degrees. CS-A stated the food that was delivered to Lindon Hall did not hold the temperature inside the Styrofoam containers on an open cart. CS-A stated he did not have a closed heated cart to hold and transfer the food. A facility policy for proper food temperature and	F 804	Re-education will be done with Culinary Staff on food temperature by November 18th, 2021. Food temp logs and audits were initiated to be done once a day for 7 days on alternating meals, once a week for four weeks and then evaluated at QAPI after to ensure compliance. Outcomes and results from these audits will be brought to the facility□s QAPI meeting next month for review. The Administrator will be responsible for compliance. Compliance date: 11/18/2021	

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F 804	Continued From page 24 meal preparation and was requested and was not provided.	F 804		
F 880 SS=D	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;	F 880		11/18/21

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F 880	Continued From page 25 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (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 observation, interview and document review, the facility failed to insure appropriate handling and sanitation of reusable medical equipment used for 1 of 1 resident (R151) under contact precautions due to methicillin-resistant staphylococcus aureus (MRSA). Also the facility failed to follow infection control procedures to	F 880	It is the policy of Crest View Lutheran Home that the facility 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	

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	245018	A. BUILDING _____ B. WING _____	C 10/07/2021

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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 26 prevent cross contamination for 1 of 1 (unidentified) resident who was set up at an unclean dining room table which contained the previous unidentified resident's dirty dishes. R151's 9/14/21, Discharge Return not anticipated, Minimum Data Set (MDS) assessment identified cognition was intact, and she required supervision for activities of daily living (ADLS) of bed mobility, transfers, walk in room, locomotion on unit. Limited assist with toileting and personal hygiene and Extensive assistance with dressing. Diagnosis included an open wound on the right lower leg, and MRSA in an unspecified site. R151's undated care plan identified MRSA in the right calf wound-dated 8/5/21, Signed provider orders dated 9/28/21(admission orders)-Resident may be placed in isolation precautions (standard, contact, droplet, airborne) per facility infection control policy. Observation on 10/05/21, at 3:51 p.m. of R151's room entrance included signage posted above the personal protective equipment (PPE) cart which identified R151 was on contact precaution and listed necessary PPE as gown, gloves, mask and eye protection was required for any personal contact with R151 or the environment. Observation and interview on 10/06/21, at 9:59 a.m. with physical therapy assistant (PTA)-A wearing PPE of gown, gloves, mask and eye protection while she completed therapy exercises with R151. When PTA completed working with R151 she picked up a pulse oximeter lying on the bed side stand, with no barrier between the surface or R151's personal items. PTA-A used her gloved hand to pull her PPE gown to the side	F 880	communicable diseases and infections. Resident R151□s reusable medical equipment was audited for proper sanitization and replaced if necessary on 10/7/2021. For all other residents this deficient practice could have affected, whole-house audit of the isolation carts was completed. Assistant Director of Nursing will conduct proper cleaning and disinfection of resident use equipment/environmental cleaning on all shifts every day for a week, then will decrease frequency as determined by compliance. Facility held an ADHOC QAPI and discusses the root cause analysis of the deficient practice. Re-education was completed with nursing staff and culinary staff on the process for sanitization in the dining room. Staff will be re-education on the isolation carts and proper usage of the isolation cart equipment with proper sanitization by November 18th, 2021. Outcomes and results from these audits will be brought to the facility□s QAPI meeting next month for review. The Director of Nursing will be responsible for compliance. Compliance date: 11/18/2021	

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F 880	Continued From page 27	F 880		

exposing her scrub top and placed the pulse oximeter into her scrub pocket. The PTA removed her PPE prior to leaving R151's room and washed her hands. PTA-A was interviewed about the pulse oximeter, and reached into her scrub pocket and retrieved the pulse oximeter, and stated she was going to return to the therapy room and use a santi cloth wipe to sanitize it before use for another resident. PTA-A verbalized she had not thought about placing the contaminated oximeter in her uniform pocket and identified doing so had resulted in potential contamination of her pocket.

Interview on 10/06/21, at 1:21 p.m. with the infection control practioner (IP) identified reusable medical equipment should be cleaned with santi-cloths between resident use. The IP identified resident's on precautions were provided with individual equipment when possible, but pulse oximeter's were utilized for multiple residents and she would expect staff to disinfect the device immediately upon leaving the room with supplies available in the PPE cart located outside rooms on precautions. The IP identified placing a pulse oximeter that had been utilized for a resident on contact precautions would be considered contaminated and should not be placed in contact with personal clothing due to infection control concerns.

Review of the April 28,21 policy Disinfecting Contaminated Equipment identified the expectation for reusable equipment to be disinfected appropriately between resident use. Follow manufactures' directions to allow time for disinfectant to remain on surface of equipment.
Meal Service

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F 880	Continued From page 28	F 880		

During an observation and interview on 10/04/21, at 4:38 p.m. nursing assistant (NA)-A assisted an unidentified resident into the dining room. NA-A looked around the room before she positioned the resident at a table space previously used by another resident. The previous resident's dirty dishes remained at the table space selected by NA-A. NA-A pushed the dirty dishes towards another resident who was still eating at the table. NA-A then grabbed a clean clothing protector and silverware setting from another table. Without cleaning the table space, NA-A placed the clean table setting in front of the resident. NA-A stated the dirty plate and glass had not been cleared, so she pushed the stuff out of the way. Asked NA-A if the table should have been cleaned. Without answering NA-A walked away. NA-A picked up the clean clothing protector and silverware setting. NA-A wiped down the table space. NA-A returned the same clothing protector and silverware setting in front of the resident. NA-A then walked out of the dining room.

During an interview on 10/06/21, at 8:47 a.m. dietary aide (DA)-A stated tables are cleaned before each meal, and in between residents. DA-A stated this must be done according to the health regulations,

During an interview on 10/06/21, at 10:26 a.m. DA-B stated tables need to be cleaned in between residents, after activities, and snacks. DA-B stated once the resident left the table, staff are instructed to clean the table right away. DA-B stated she tried to use the clean table spaces first to prevent cross contamination between residents. DA-B stated she primarily worked in the dining area during meal service to direct residents to the appropriate spot. She stated all

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F 880	Continued From page 29 kitchen staff know to sanitize each table in between use. DA-B stated she kept a close eye in the dining room to make sure nursing staff position residents to the correct table. During an interview on 10/06/21, at 11:16 a.m. director of dining services (DDS)-D stated placing a resident at a table with dirty dishes was "ridiculous and unacceptable." The facility policy Disinfecting Contaminated Equipment reviewed on 4/28/21, identified staff to sanitize all equipment prior to reuse by another resident. Proper chemical use and dry time are recommended per manufacture instructions.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN; CMS-10055) and Notice of Medicare Non-Coverage (NOMNC; CMS-10123) were provided upon termination of Medicare A benefits to 1 of 3 residents (R67) reviewed for beneficiary notices. Findings include: R67's admission Minimal Data Set (MDS) dated 6/23/21, indicated R67 was severely cognitively impaired with diagnoses of encephalopathy and disorder of psychological development. R67's Census List printed on 10/7/21, indicated R67's payer source changed on 8/10/21, and remained in the facility.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1 The SNF Beneficiary Protection Notification Review (CMS-20052) completed by the director of social services (DSS) on 10/6/21, indicated R67's Medicare Part A skilled services started on 7/16/21, and last covered day of Part A services was 8/10/21. The CMS-20052 further indicated the facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. The CMS-20052 identified the required notices were not provided to the resident as they should have. During interview on 10/6/21, at 1:38 p.m. DSS stated the facility failed to provide R67 and/or R67's representitives a notice of non-coverage and that it was "flat out missed" and not provided. During interview on 10/6/21, at 2:42 p.m. administrator confirmed appropriate notices should have been provided to R67 and/or R67's representative but were not provided. The facility policy Form Instructions SNFABN Form CMS-10055 dated 2018, indicated Medicare required skilled nursing facilities to issue the SNFABN to the beneficiary prior to providing care that Medicare usually covers, but may not pay for in certain instances. The undated facility policy Form Instructions for the NOMNC CMS-10123 indicated the NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

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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. At the time of this survey, Crest View Lutheran Home was found not 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/04/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 122 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observations, and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, 5.3.2 and 14.2.1.	K 353	It is the policy of Crest View Lutheran Home that maintenance and testing automatic sprinkler and standpipe systems ae inspected, tested, and maintained in accordance with NFPA 25, Standard for Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system	11/17/21

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K 353	Continued From page 3 These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1) On 10/05/2021, between 9:00 AM to 12:00 PM, documentation review revealed there was no record of a five-year internal pipe inspection or a five-year sprinkler gauge calibration. 2) On 10/05/2021, between 9:00 AM to 12:00 PM, it was revealed in rooms 8, 38, 46, and 48, items were stored within 18" of a sprinkler head. These deficient conditions were verified by the Environmental Director.	K 353	design, maintenance, inspection and testing are maintained in a secure location and readily available. Summit will be at Crest View Lutheran Home on 11/17/21 to complete the 5-Year Inspection. An Audit has been made, filled out and placed into the Fire Book so it is apparent when inspections are due in the future. Maintenance will take out all shelves in the resident□s closest to keep personal thing away from sprinkler heads in rooms 1-61. This will be completed by the end of the year (2021). Shelves have been cleared and notes have been places to not store anything on shelves until they are removed. The Director of Maintenance will be responsible for compliance. Compliance date: 11/17/2021	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		11/17/21

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K 761	Continued From page 4 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to conduct inspections of all fire-rated doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4, and NFPA 80 (2010 edition), section 5.2.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/05/2021, between 9:00 AM to 12:00 PM, it was revealed that the facility's door inspection could not be located at the time of the survey. This deficient condition was verified by the Environmental Director.	K 761	It is the policy of Crest View Lutheran Home that Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non- rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Yearly audit has been made and placed in Fire Book. Minnesota State form for Inspecting Doors has been received and will be utilized going forward for inspecting the doors. The Director of Maintenance will be responsible for compliance. Compliance date: 11/17/2021	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.	K 901		11/17/21

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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
K 901	Continued From page 5 Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and ensure the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition), Health Care Facilities Code, Chapter 4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/05/2021, between 09:00 AM to 12:00 PM, it was revealed the required annual risk assessment was not completed per NFPA 99. This deficient condition was verified by the Environmental Director.	K 901	It is the policy of Crest View Lutheran Home that building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. NFPA 99 Risk Assessment completed on 10/15/2021, emailed to Fire Marshall for feedback, Fire Marshall said “Looks good to me”, and it was placed in the Fire Book. Audit placed in Fire Book to review the Risk Assessment every year. The Director of Maintenance will be responsible for compliance. Compliance date: 11/17/2021	