



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Crest View Lutheran Home
4444 Reservoir Boulevard NE
Columbia Heights, MN 55421
Anoka County

Report #: H5018025

Date: June 30, 2005

Date of Visit: 4/30/05
Time of Visit: 7:35 a.m.

By: Jaime Hujanen, R.N.
Special Investigator

Kristine Lohrke, R.N.
Special Investigator

An unannounced visit was made in order to investigate the following allegation of neglect in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statute 626.557.

The allegation is: There have been at least 20 falls in the facility in the last month, and there are numerous falls every weekend. The falls are occurring because the staff is not following the care plans. They are not transferred as they should be, staff take 25 to 30 minutes to respond to call lights, and this includes tabs alarms. Nobody takes any responsibility to see that staff actually do their job. It is a facility wide problem. The nurses don't make the aids do their job, the administrative level does not make the nurses do their job. There is a new administrator and a new DON and they take no responsibility for anything that is happening. There are red bottoms from residents not being washed and turned, but the real problem is the falls. Resident #1 fell two weeks ago on the Garden station (on a weekend) and she lost an eye. Another resident (resident #2) has a broken shoulder from staff lifting her by her arms, when they are suppose to use a hooyer. On Willow, a resident (resident #3) fell and broke his hip. He died within a week, and they did not even call the coroner like they are suppose to. Staff don't assist residents to eat. It is scary to see the total lack of care being provided...nobody cares.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessee Statement.

The investigation included a review of the following:

- Resident #1, #2, and #3's medical records, including the medical records from hospitalizations.
- Incident and accident reports for March and April.
- The facility staffing records for March and April.
- Nursing assistant assignment sheets for April.
- The facility's incident tracking logs for March and April.

- Facility policies and procedures including:
 - Falls
 - Turning and repositioning
 - Resident transfers
 - Transfer Belts- Mandatory Use Of
 - Reportable deaths
 - Call lights
 - NAR Orientation
 - Vulnerable Adult
- Personnel files, including orientation and training.

Observations of three additional residents were made, including a review of their medical records. In addition a tour of the facility was conducted.

Resident #3

Resident #3's medical record was reviewed and revealed the following: Prior to a hospital admission on 2/21/05 he was independent with mobility. He was admitted to the facility's secured dementia unit on 3/1/05 with diagnoses including Parkinson's disease, blindness to the right eye, and Dementia. Upon admission to the facility, he required assistance of one staff member with all transfers and ambulation due to his unsteady gait and poor vision. He had physician's orders for a high/low bed (a bed that can be lowered to the floor), a perimeter (concave) mattress, a sensor alarm, and a TABS alarm (personal alarm device) for safety due to unsafe transfers. In addition, he had orders to receive physical therapy, (PT).

According to the Physical Therapy Plan of Treatment form, resident #3 received physical therapy from 3/2/05 to 3/31/05 due to decreased balance and unsafe transfers. Resident #3's goals included the ability to demonstrate independence with bed mobility, transfers and ambulation. On 3/31/05, physical therapy documented that resident #3 was "strong in gait, transfers, bed mobility and balance." In addition, PT documented that all of resident #3's goals had been met. He was discontinued from PT with recommendations to be independent with bed mobility, transfers and ambulation. Consequently, on 4/1/05 a physician's order was written to discontinue resident #3's high/low bed, concave mattress, TABS alarm and sensor alarm. Although the staff discontinued resident #3's TABS alarm and sensor alarm according to the physician's orders, they did not discontinue resident #3's high/low bed and concave mattress.

The Integrated Progress Notes dated 4/3/05 at 3:10 a.m., documented by employee (E), indicated that resident #3 was restless during the night. Once during the shift he was found kneeling on his bed. The next time he was found attempting to stand on his bed. Another time during the night shift he was found standing on his bed. Employee (E) indicated that she reported this information to the next shift and requested that resident #3's high/low bed, TABS alarm and sensor alarm be reinstated due to "2nd day of unsafe bed behaviors (without) bed sensor and Tabs to alert staff to resident movements." In addition, she documented that she put this information on the 24-hour report and calender. No further progress notes or assessments were found in regard to resident #3's unsafe behavior.

The 24 hour report, dated 4/3/05 on the night shift, documented that resident #3 was "up on knees in bed and standing on bed. (no) alert since DC (discontinue) of Bed sensor Tabs DC'ed. Dangerous beh (behavior) all noc (night). Could we have back tabs sensor (and) bed." No further documentation was found on the 24 hour reports regarding this behavior.

According to the Integrated Progress Notes, dated 4/12/05 at 3:20 a.m., employee (E) documented that resident #3 was found sitting on the floor next to his bed. He had an abnormal outward rotation to his

left lower extremity. An x-ray was ordered and the results indicated that resident #3 had an "intertrochanteric left hip fracture." He was sent to the emergency room for treatment and returned to the facility on 4/13/05. He had a physician's order for comfort cares only and consequently died on 4/15/05 at 8:10 p.m. The integrated progress notes further indicated that on 4/16/05 the County Coroner was notified regarding resident #3's death.

The facility's Fall Report and Assessment completed after resident #3's fall on 4/12/05 was reviewed and indicated the following: "(R)esident tends to crawl around bed on knees @ noc (night)."

Employee (E), nurse, was interviewed on 5/6/05 at 8:40 a.m. and stated the following:

- She was a full time, night shift nurse responsible for two units, including resident #3's unit.
- Prior to 3/31/05 resident #3 had a high/low bed, TABS alarm and sensor alarm for safety due to unsafe transfers.
- On 3/31/05 resident #3 was discontinued from physical therapy with recommendations that he could be independent with bed mobility, transfers and ambulation.
- After resident #3 was discharged from physical therapy, he received a physician's order on 4/1/05 to discontinue his high/low bed, TABS alarm and sensor alarm.
- During the night shift on 4/2/05, she heard "rustling" in resident #3's room and found him standing on his bed.
- During the night shift on 4/3/05 she found resident #3 crawling on his bed.
- She documented the incident and requested that resident #3's high/low bed and sensor alarm be reinstated.
- She indicated that she was not aware of an assessment or evaluation that was done in regard to resident #3's unsafe behavior.
- On 4/12/05 she was notified by a nursing assistant that resident #3 was found on the floor next to his bed.
- She notified the on-call physician, obtained an order for an x-ray, and notified the next shift of resident #3's fall.

Employee (B), nurse, was interviewed on 4/30/05 at 2:12 p.m. and on 5/13/05 at 9:00 a.m. and stated the following:

- On two to three separate occasions (dates unknown) she responded to resident #3's TABS alarm sounding and found him crawling in bed.
- One time on (unknown date) she received a report from employee (E) regarding resident #3 standing on his bed; she also read this on the 24-hour board.
- She monitored resident #3 during the day shift regarding that incident and he did not have any unsafe behavior.
- She was unsure what behaviors resident #3 had or how those behaviors were monitored on the afternoon and night shifts.
- No assessments or evaluations were completed regarding resident #3's unsafe behavior after he was found crawling/standing in bed.
- If unsafe behavior was seen on the night shift, a TABS alarm should have been used to notify the staff of the unsafe behavior so it could be monitored.

Employee (G), Physical Therapy, was interviewed on 5/12/05 and stated the following:

- Resident #3's physical therapy was discontinued on 3/31/05 with recommendations that he could be independent with bed mobility, transfers and ambulation.

- She was aware of one incident prior to 3/22/05 (unknown date) that resident #3 was found standing on his bed; this information was discussed at his care conference on 3/22/05.
- She was unaware of any other unsafe behavior by resident #3 prior to or after his discharge from physical therapy on 3/31/05.

Employee (C), nursing assistant, was interviewed on 5/4/05 at 3:58 p.m. and stated the following:

- She worked full time, night shift on resident #3's unit.
- Resident #3 did not get up a lot at night and when he did, he was steady on his feet.
- On one occasion (date unknown) she responded to resident #3's TABS alarm sounding and found him on his bed on his hands and knees.

Employee (L), administrative staff, was interviewed on 5/20/05 at 10:48 a.m. and stated that the night nurse documented resident #3's behavior of crawling on his bed at night and the nursing supervisor failed to follow up on that information.

Resident #1

Resident #1's medical record was reviewed and revealed the following: She resided on a long-term care unit. She ambulated independently with the assistance of a walker with a steady gait and did not have a history of falls.

According to the Integrated Progress Notes, dated 4/8/05 at 1:15 a.m., resident #1 was found on the floor next to her bathroom by employee (E), nurse. Resident #1's right eye was swollen and was not reactive to the light. Employee (E) applied ice to the right side of resident #1's face and she was sent to the emergency room. Resident #1 returned to the facility on 4/12/05 with a diagnosis of a ruptured globe to the right eye. Resident #1 did not lose an eye.

During the site visit on 4/30/05, resident #1 was visited. She was unable to be interviewed due to her cognitive limitations.

Employee (K), administrative nurse, was interviewed on 4/30/05 at 10:00 a.m. and stated that resident #1 was independent with a steady gait prior to her fall in the middle of the night on 4/8/05.

Resident #2

The Office of Health Facility Complaints investigated the allegation that resident #2 had a broken shoulder from staff lifting her by her arms, when they are suppose to use a hooyer lift (a mechanical lift), in March of 2004. The investigation concluded that neglect of health care did occur in connection with the failure to transfer resident #2 with a mechanical lift in accordance with her plan of care.

A review of the facility's incident tracking log for April 2005 was completed and revealed that thirty-three residents had falls during the month of April. A total of forty-eight falls occurred involving the thirty-three residents. Although the facility identified a concern with the increased number of falls that were occurring, the current falls program was not revised to address that area of concern to minimize the risk of falls and the risk of falls with injuries.

Employee (D), administrative staff, was interviewed on 4/30/05 at 1:15 p.m. and on 5/5/05 at 3:39 p.m. and stated the following:

- The Quality Assurance and Assessment committee had identified concerns regarding the high number of falls by residents in the facility.
- The interdisciplinary team had concerns with the current fall program.

- A new fall program or interventions regarding the current program had not been initiated

In addition, during the site visit on 4/30/05 observations were made and call lights and tabs alarms were answered in a timely manner and staff assisted residents to eat in the dining room.

Conclusion: As defined by federal regulatory requirements at 42 CFR 483.13 (c), and the current statutory definition of neglect specified in Minnesota statute 626.557, the preponderance of evidence indicates **neglect of health care did occur** in relation to the facility's failure to reassess resident #3's unsafe behavior during the nights prior to his fall. The facility staff were aware of resident #3's unsafe behavior of crawling/standing on his bed, however, the facility failed to assess, re-evaluate and revise interventions to decrease resident #3's risk for falls and injury. Documentation review and interviews established the following: Resident #3 tended to crawl around his bed on his knees at night. On 4/2/05 resident #3 was found crawling on his bed and standing on his bed. On 4/3/05 at 3:10 a.m., he was found crawling on his bed. The facility did not reassess or evaluate this behavior. On 4/12/05 at 3:20 a.m. resident #3 was found on the floor next to his bed with a left hip fracture. He subsequently died on 4/15/05.

The preponderance of evidence indicates that **neglect of health care did not occur** in connection with the allegation that staff neglected resident #1 and she fell on the Garden station and lost an eye. Staff interviews and the review of resident #1's medical records in relation to her injury established that resident #1 did receive proper care in accordance with her plan of care. Prior to resident #1's fall, she ambulated independently with the assistance of a walker and a steady gait. She did not have a history of falls. Although resident #1 did sustain a ruptured globe to her right eye during an unexpected fall, she did not lose an eye.

Resident #2's injury was investigated by this office on 3/31/05 and it was determined that **neglect did occur**. See report #H5018024.

During the course of the investigation problems were identified in regard to the staffs' failure to follow resident care plans and facility policies and procedures and to re-evaluate interventions. Therefore, the following federal deficiencies are issued: 42 CFR 483.20 (k) (3) (ii)/ tag F282, 483.25/tag F309 and 483.25 (h) (2)/ tag F324.

The "mitigating factors" in Minnesota Statute 626.557, Subdivision 9c (c) were considered and it was determined that the facility is responsible for the neglect. The facility will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

xc: Division of Compliance Monitoring - Licensing & Certification
Board of Nursing
Board of Nursing Home Administrators
Anoka County Medical Examiners
Columbia Heights City Police Department
Anoka County Attorney
Columbia Heights City Attorney



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:

Crestview Lutheran Home
4444 Reservoir Boulevard NE
Columbia Heights, MN 55421
Anoka County

Report #: H5018025

Date: June 22, 2005

Date of Visit: July 12, 2005
Time of Visit: 2:24p.m.

By: Jaime Hujanen, R.N.
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up three federal deficiencies which were issued on May 31, 2005, as the result of an investigation which had been completed on May 20, 2005.

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 05/31/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/20/2005
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BLVD NE 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 CORRECT ON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted in order to investigate complaint # H5018025. The following deficiencies are issued.	F 000	This plan and the individual responses to each F-tag are written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement.	
F 282 SS=D	483.20(k)(3)(ii) RESIDENT ASSESSMENT The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the care plan for 2 of 4 residents (#5 and #6) observed. Findings include: Resident #6's medical record was reviewed and indicated that she had diagnoses including Degenerative Joint Disease and Osteoporosis. Her care plan indicated that she was at high risk for falls. In addition, the care plan indicated that she had 7 falls between January 2004 and September 2004. On 12/8/04 hip protectors (an orthopedic device for residents with Osteoporosis and/or a history of falls to reduce the risk of a hip fracture related to a fall) were ordered to be utilized due to her high risk of falls. Her most recent physician's orders, dated April 1, 2005, indicated that her hip protectors were to be worn at all times. Her fall risk assessment indicated that she was at a high risk for falls. Her "Physical Device Assessment" form, dated 3/31/05, indicated that she continued to require hip protectors at all times due to her fall risk. The	F 282	We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed and in any legal or administrative proceeding. F 282 Resident Assessment It is the policy of Crest View Lutheran Home that services are provided or arranged in accordance with each resident's written plan of care. Resident #6's Care Plan has been reviewed for appropriate indication and use of hip protectors. Employee (H) NAR has been counseled on the use of hip protectors in general in the facility as well as specifically for resident #6. The facility has inventoried the number of hip protectors in the facility to ensure that there is a sufficient supply of hip protectors available for residents who may require them.	6/22/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kevin J. Sullivan Administrator 6-9-05

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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F 282	<p>Continued From page 1</p> <p>current Nursing Assistant, NAR, assignment sheet indicated that hip protectors were to be on resident #6 at all times.</p> <p>On 4/30/05 at 9:30 a.m. employee (H), NAR, was observed while providing care to resident #6. Resident #6 did not have hip protectors on. Employee (H) stated that the staff used to use hip protectors, but they do not use them anymore. Employee (J), nurse, was interviewed at 1:40 p.m. and stated that according to resident #6's care plan and NAR sheets, she should have on hip protectors. Employees (H) and (J) were unable to locate resident #6's hip protectors.</p> <p>Resident #5's medical record was reviewed and indicated that she was at risk for skin breakdown due to her fragile skin. A nursing order, dated 4/1/05, indicated that resident #5 required geri sleeves bilaterally to her arms and legs at all times. Resident #5's care plan, dated 11/3/04, indicated that her potential for skin breakdown and fragile skin required her to wear geri sleeves to her arms and legs. In addition, the current NAR assignment sheet indicated that resident #5 required geri sleeves to her arms and legs.</p> <p>On 4/30/05 at 9:05 a.m. employee (G), NAR, was observed providing care to resident #5. Resident #5 did not have geri sleeves on her arms or legs. When employee (G) was queried regarding resident #5's geri sleeves, she was unaware that resident #5 was required to wear them. Employee (J) was interviewed at 1:40 p.m. and indicated that resident #5 was required to wear geri sleeves due to skin tears and that she should have had them on.</p>	F 282	<p>Resident #5's Care Plan has been reviewed for the appropriateness of the use of geri sleeves to her arms and legs.</p> <p>Employee (G) NAR has been counseled on the use of geri sleeves for Resident #5 and the utilization of the NAR assignment sheet to ensure that appropriate care is provided to the resident's in their assignment</p> <p>NAR staff was inserviced on June 6th and 7th on the use of NAR assignment sheets to ensure that residents receive the appropriate care as outlined in their individual plans of care.</p> <p>The DON or designee will randomly audit a minimum of 5 NAR's on a weekly basis to ensure that resident's are receiving appropriate care as outlined in the Plan of Care/NAR assignment sheets. Results will be shared and monitored at the quarterly Quality Assurance Committee.</p> <p>The Nursing Supervisors have been reminded at inservices on May 5th, 2005, of their responsibilities for (1) following each resident care plan review ensure that the NAR assignment sheet matches the current Plan of Care and (2) monitor on an ongoing basis during their shifts that NARs follow care plans and to intervene, as needed.</p> <p>Completion date for certification purposes only: June 22, 2005</p>		

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F 309 F 309 SS=D	Continued From page 2 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide the necessary care and services to one of one resident (#3) whose medical record was reviewed. The staff failed to re-evaluate and revise interventions for resident #3 when the resident exhibited unsafe behavior. Findings include: Resident #3's medical record was reviewed and indicated that he was admitted to the facility's secured dementia unit on 3/1/05 with diagnoses including Parkinson's disease, blindness to the right eye, and Dementia. Upon admission to the facility, he required assistance of one staff member with all transfers and ambulation due to his unsteady gait and poor vision. He had physician's orders for a high/low bed (a bed that can be lowered to the floor), a perimeter (concave) mattress, a sensor alarm, and a TABS alarm (a personal alarm device) for safety due to unsafe transfers. In addition, he had orders to receive physical therapy.	F 309 F 309	F 309 Quality of Care It is the policy of Crest View Lutheran Home that each resident receive and be provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Staff involved in Resident #3 incident were counseled on timely evaluation after resident incident and intervention. Staff are scheduled to attend inservices described below, as well. The facility Policies and Procedures for Safety Assessments and Application of Safety Devices has been reviewed and continues to be current and consistent with applicable law and standards? Licensed staff has been inserviced on both Policies and Procedures for Safety Assessments and Application of Safety Devices, as well as appropriate reporting of unsafe behaviors at anytime in a 24-hour period. Inservices will be completed on June 9 th , 14 th , and 15 th . Unsafe behaviors will be reviewed by the interdisciplinary team at morning meeting for appropriateness of the immediate action taken with the unsafe behavior and will determine any additional interventions necessary	6/22/05	

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F 309	<p>Continued From page 3</p> <p>According to the Physical Therapy Plan of Treatment form, resident #3 received physical therapy from 3/2/05 to 3/31/05 due to decreased balance and unsafe transfers. Resident #3's goals included the ability to demonstrate independence with bed mobility, transfers and ambulation. On 3/31/05, physical therapy noted that resident #3 was "strong in gait, transfers, bed mobility and balance." In addition, PT noted that all of resident #3's goals had been met. He was discontinued from PT with recommendations to be independent with bed mobility, transfers and ambulation. Consequently, on 4/1/05 a physician's order was written to discontinue resident #3's high/low bed, concave mattress, TABS alarm and sensor alarm.</p> <p>The Integrated Progress Notes dated 4/3/05 at 3:10 a.m., documented by employee (E), nurse, indicated that resident #3 was restless during the night. Once during the shift he was found kneeling on his bed. The next time he was found attempting to stand on his bed. Another time during the night shift he was found standing on his bed. Employee (E) indicated that she reported this information to the next shift and requested that resident #3's high/low bed, TABS alarm and sensor alarm be reinstated due to "2nd day of unsafe bed behaviors (without) bed sensor and Tabs to alert staff to resident movements." In addition, she noted that she put this information on the 24-hour report and calender. No further progress notes or assessments were found in regard to resident #3's unsafe behavior.</p> <p>The 24 hour report, dated 4/3/05 on the night shift, documented that resident #3 was "up on</p>	F 309	<p>Nursing supervisors were inserted on June 9th, 14th and 16th about their responsibility for appropriate reporting and follow through on resident safety assessment and interventions.</p> <p>Falls will continue to be monitored, tracked and reviewed by the Interdisciplinary Team at morning meeting for analysis of the fall and any revisions to the resident's plan of care.</p> <p>The DON will monitor and track resident falls after each Interdisciplinary team meeting on the incident tracking form and report to the quarterly Quality Assurance Committee for analysis of trends and any resulting quality improvement opportunities</p> <p>Completion date for certification purposes only: June 22, 2005</p>	

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F 309	<p>Continued From page 4</p> <p>knees in bed and standing on bed. (no) alert since DC (discontinue) of Bed sensor Tabs DC'ed. Dangerous beh (behavior) all noc. Could we have back tabs sensor (and) bed." No further documentation was found on the 24 hour reports regarding this behavior.</p> <p>According to the Integrated Progress Notes, dated 4/12/05 at 3:20 a.m., employee (E) indicated that resident #3 was found sitting on the floor next to his bed. He had an abnormal outward rotation to his left lower extremity. An x-ray was ordered and the results indicated that resident #3 had an "intertrochanteric left hip fracture." He was sent to the emergency room for treatment and returned to the facility on 4/13/05. He had a physician's order for comfort cares only and subsequently died on 4/15/05 at 8:10 p.m.</p> <p>The facility's Fall Report and Assessment, documented by employee (E), completed after resident #3's fall on 4/12/05 was reviewed and indicated the following: "resident tends to crawl around bed on knees @ noc (night)."</p> <p>Employee (E) was interviewed on 5/6/05 at 8:40 a.m. She indicated that her responsibilities included supervision of two separate floors. She stated that on 3/31/05 resident #3 was discharged from physical therapy with recommendations that he could be independent with bed mobility, transfers and ambulation; after resident #3 was discharged from physical therapy, he received a physician's order to discontinue his high/low bed, TABS alarm and sensor alarm. Although employee (E)'s documentation from 4/3/05 at 3:10 a.m. in the</p>	F 309			

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

PRINTED: 05/31/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/20/2005
NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BLVD NE 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 309	<p>Continued From page 5</p> <p>Integrated Progress Notes indicated that she found resident #3 on three separate occasions either kneeling, attempting to stand or standing on his bed, when interviewed she indicated that on 4/2/05 during the night shift she heard rustling in resident #3's room and found him standing on his bed one time and then on 4/3/05 during the night shift she found resident #3 crawling on his bed. She indicated that she documented the incident and requested that resident #3's high/low bed and sensor alarm be reinstated. However, she indicated that resident #3's high/low bed, TABS alarm and sensor alarm were not reinstated and she was not aware of an assessment or evaluation that was done on resident #3's unsafe behavior. On 4/12/05 she was notified by a nursing assistant that resident #3 was found on the floor next to his bed. She updated the on-call physician, obtained an order for an x-ray, and notified the next shift of resident #3's fall.</p> <p>Employee (B), nurse, was interviewed on 4/30/05 at 2:12 p.m. and again on 5/13/05 at 9:00 a.m. She indicated that when resident #3 had his TABS alarm, prior to being discontinued from PT, she found him crawling in bed two to three times; she was alerted to this behavior by his TABS alarm. She stated that she received an update from employee (E) regarding resident #3's unsafe behavior of standing on the bed one time (unknown date). She indicated that she did monitor resident #3 during the day and he did not have any unsafe behavior, although, she was unsure what behaviors resident #3 had or how those behaviors were monitored on the afternoon and night shifts. She verified that there were no assessments or evaluations completed regarding</p>	F 309			

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F 309	Continued From page 6 resident #3's unsafe behavior. In addition, she stated that if unsafe behavior was seen on the night shift, a TABS alarm should have been used to notify them so the unsafe behavior could have been monitored. Employee (G), Physical Therapy, was interviewed on 5/12/05 and stated that resident #3's physical therapy was discontinued on 3/31/05 with recommendations that he could be independent with bed mobility, transfers and ambulation. Although she indicated that at a care conference on 3/22/05 one incident regarding resident #3 standing on his bed (unknown date) was discussed, she was unaware of any other unsafe behavior by resident #3 prior to or after his discharge from physical therapy. Physical therapy was unaware that resident #3 exhibited unsafe behavior during the night shift and therefore did not assess the behavior. Employee (L), administrative staff, was interviewed on 5/20/05 at 10:48 a.m. and stated that the night nurse documented resident #3's behavior of crawling on his bed at night and the nursing supervisor failed to address it.	F 309			
F 324 SS=D	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility staff failed to utilize transfer belts for 2 of 4 residents (#4 and #5) observed,	F 324	F 324 Quality of Care It is the policy of Crest View Lutheran Home that the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Resident #4's care plan has been reviewed for appropriateness of assistance with Activities of Daily Living and the NAR assignment sheet has been updated to reflect the current care requirements.	6/22/05	

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F 324	<p>Continued From page 7</p> <p>who required assistance with transfers. Findings include:</p> <p>The facility's policy and procedure titled "TRANSFER BELTS - MANDATORY USE OF", dated 11/04, directs staff to use transfer belts when assisting residents to transfer, stand or walk to minimize and prevent injury.</p> <p>On 4/30/05 at 3:30 p.m. employee (I), staff development, was interviewed and stated that per facility protocol a transfer belt is to be used on all residents requiring assistance with a transfer.</p> <p>On 4/30/05 at 1:15 p.m. employee (D), administrative staff, was interviewed and stated that a transfer belt must be used with all transfers.</p> <p>Resident #4's medical record was reviewed and indicated that she had diagnoses including Parkinson's disease, Arthritis and Dementia. Her care plan, dated 3/31/05, indicated that she had poor balance and pain. In addition, the care plan indicated that resident #4 required assistance of one to two staff members with all bed mobility, transfers, ambulation and wheelchair propelling. Her fall risk, dated 3/22/05, put her at a high risk for falls. She was working with physical therapy (PT) to improve her balance and strength.</p> <p>On 4/30/05 beginning at 8:10 a.m. employee (F), NAR, was observed assisting resident #4 with cares. He assisted resident #4 to transfer to a standing position without the use of a transfer belt. As resident #4 was standing and holding onto the front of her wheelchair without a transfer</p>	F 324	<p>Employee (F) NAR has been disciplined for not following facility policy on the use of Transfer Belts.</p> <p>Resident #5's Plan of Care has been reviewed for appropriateness of level of assist with Activities of Daily Living</p> <p>Employee (G) has been disciplined for not following the facilities Policy and Procedure on the use of Transfer Belts.</p> <p>NAR staff as per facility protocol will be inserviced in general orientation as well as annually on the Policy and Procedure on the use of Transfer Belts.</p> <p>Nursing supervisors were inserviced on June 9th, 14th and 16th about their responsibility for ongoing monitoring during their shifts of NAR compliance with resident care plans and facility policy on Transfer Belts.</p> <p>DON or designee will randomly audit nursing assistant staff weekly for the proper use of transfer belts during resident cares. A minimum of 5 NAR staff per week will be audited.</p> <p>Results of the audits will be reported quarterly to the Quality Assurance Committee.</p> <p>Completion date for certification purposes only: June 22, 2005</p>	

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F 324	<p>Continued From page 8</p> <p>belt, employee (F) walked to the back of her wheelchair to gather supplies from her closet. When queried regarding the assistance resident #4 required, employee (F) verified that the NAR worksheets directed staff to provide assistance of two staff with transfers. However, he indicated that resident #4 had been working with physical therapy and had improved to only requiring assistance of one staff member with transfers and ambulation. He stated that although resident #4 required the assistance of a transfer belt while walking in the hall, she did not require the transfer belt during transfers.</p> <p>Employee (B), nurse, was interviewed on 4/30/05 at 2:12 p.m. and stated that the NAR work sheets, which noted that resident #4 required assistance of two staff members, needed to be updated; however, she verified that resident #4 required assistance of one staff member with all transfers and ambulation. She further indicated that a transfer belt should be utilized with all transfers.</p> <p>Resident #5's medical record was reviewed and indicated that she had diagnoses including Dementia, Osteoarthritis and CHF. Her care plan, dated 2/22/05, indicated that she required assistance of two for transfers. In addition, the care plan indicated that she had impaired mobility related to her medical conditions. Her NAR sheets indicated that she required assistance of one staff member. Her fall risk, dated 2/23/05, put her at a high risk for falls.</p> <p>On 4/30/05 at 8:05 a.m. employee (G), NAR, was observed transferring resident #5 from a lying position in her bed to her wheelchair alone. She</p>	F 324		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER CREST VIEW LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4444 RESERVOIR BLVD NE COLUMBIA HEIGHTS, MN 55421
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F 324	Continued From page 9 did not use a transfer belt. When interviewed, employee (G) stated that she did not have her transfer belt with her. Employee (G) indicated that she was aware that all assisted transfers required the use of a transfer belt.	F 324		
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Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA /
Identification Number
245018

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
7/12/2005

Name of Facility

Street Address, City, State, Zip Code

CREST VIEW LUTHERAN HOME

4444 RESERVOIR BLVD NE
COLUMBIA HEIGHTS, MN 55421

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/22/2005	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/22/2005	ID Prefix F0324 Reg. # 483.25(h)(2) LSC	Correction Completed 06/22/2005
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
Reviewed By

Date:
Date:

Signature of Surveyor:
Signature of Surveyor:

Date:
Date:

Followup to Survey Completed on:
5/20/2005

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9986 1179

May 31, 2005

Mr. Kevin Genereux, Administrator
Crest View Lutheran Home
4444 Reservoir Blvd NE
Columbia Heights, MN 55421

RE: Project Number H5018025

Dear Mr. Genereux:

On May 20, 2005, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Crest View Lutheran Home

May 31, 2005

Page 2

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Sue Jackson, Assistant Director
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970

Telephone: (651) 215-8816 Fax: (651) 215-8712

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 30, 2005, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC must meet the criteria listed in the plan of correction section above.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Crest View Lutheran Home

May 31, 2005

Page 4

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 20, 2005 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 November 20, 2005 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Crest View Lutheran Home

May 31, 2005

Page 5

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

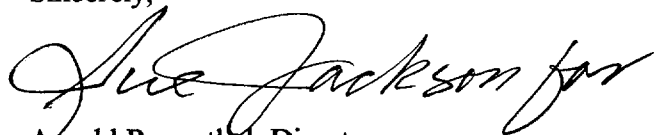
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Arnold Rosenthal, Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 E. 7th Place, Suite #300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8708 Fax: (651) 215-8712

cc: Licensing and Certification File

Certified Mail

Certified Mail #: 7003 2260 0000 9986 1179

Facility: Crest View Lutheran Home

Project #: H5018025

Date sent 6-1-05

- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

- CMS
- Complainant
- Facility
- Other



SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>Maureen Joyce</i></p>	
	B. Received by (Printed Name) <i>Maureen Joyce</i>	C. Date of Delivery <i>6-2-05</i>
1. Article Addressed to:	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
Mr. Kevin Genereux, Administrator Crest View Lutheran Home 4444 Reservoir Blvd NE Columbia Heights, MN 55421	3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.	
	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	

***** 3101 JR

Certified Mail

Certified Mail #:

Facility:

Project #: _____

Date sent _____

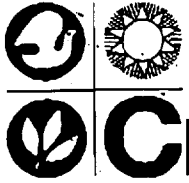
- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

- CMS
- Complainant
- Facility
- Other

2. Article Number (Transfer from service label) **7003 2260 0000 9986 1179**

PS Form 3811, August 2001 Domestic Return Receipt 102595-02-M-1540



Crest View

4444 RESERVOIR BLVD NE
COLUMBIA HEIGHTS, MN 55421
763.782.1611 FAX 782.0857
WWW.CRESTVIEWCARES.ORG

June 9, 2005

Mrs. Sue Jackson
Assistant Director
Office Of Health Facility Complaints
85 East Seventh Place, Suite 300
St. Paul MN 55164-0970

RE: Project Number H5018025

DELIVERED VIA FAX (651) 215-8712

Dear Mrs. Jackson

Enclosed is the correction order for Crest View Lutheran Home for the standard abbreviated survey completed on May 20, 2004. This correction order will serve as the facility's allegation of compliance with the requirement of Minnesota Stat. Section 144.653 or Minnesota Stat. Section 144A.10. Completion date 6/22/05.

If you have any questions, please do not hesitate to contact me at 763-782-1620. Thank you.

Sincerely,

Kevin Genereux
Administrator

Enclosure



Protecting, Maintaining and Improving the Health of Minnesotans

June 30, 2005

Mr. Kevin Genereux, Administrator
Crest View Lutheran Home
4444 Reservoir Blvd Ne
Columbia Heights, MN 55421

RE: Project Number H5018025

Dear Mr. Genereux:

On May 20, 2005, a survey was completed at your facility. You have alleged that the deficiencies cited on that abbreviated standard survey by the Minnesota Department of Health have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

We will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Jackson", is written over the word "Sincerely,".

Sue Jackson, Assistant Director
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970

Telephone: (651) 215-8816 Fax: (651) 215-8712

General Information: (651) 215-5800 • TDD/TTY: (651) 215-8980 • Minnesota Relay Service: (800) 627-3529 •
www.health.state.mn.us

For directions to any of the MDH locations, call (651) 215-5800 • An Equal Opportunity Employer



Protecting, Maintaining and Improving the Health of Minnesotans

June 30, 2005

Kevin Genereux, Administrator
Crest View Lutheran Home
4444 Reservoir Blvd Ne
Columbia Heights, Mn 55421

Re: H5018025

Dear Mr. Genereux:

Enclosed is a copy of an investigative report related to a complaint investigation recently completed by this office. If you have questions relative to this case, please contact the investigator identified in the report.

In accordance with Minnesota Statute 626.557, Subd. 9d., the following information relates to your right to contest the final determination made by the Office of Health Facility Complaints.

How to challenge a finding of maltreatment

- You may request the Department of Health to reconsider the finding of maltreatment by submitting a request for reconsideration to this office **within 15 days** after receiving this notice. Your request for reconsideration should identify why you believe the Department's finding is wrong and provide information to support this claim.
 - If you request reconsideration, the Department will review its previous determination and either uphold or reverse the finding of maltreatment.
 - If the Department upholds the finding of maltreatment, or fails to respond to your request within fifteen (15) days after receiving your request for reconsideration, you will be entitled to a fair hearing before a Department of Human Services referee.
 - If, as a result of the reconsideration, it is determined that maltreatment did not occur, the Department's investigative report will be modified as necessary.
 - You may request a fair hearing before a Department of Human Services referee by notifying this office in writing **within 30 days** of receiving this notice.
 - Please mail or fax your request to me at the address below.
- If you have any questions you may contact me at (651) 215-8708.

Sincerely,

A handwritten signature in cursive script, appearing to read "A Rosenthal".

Arnold Rosenthal, Director

Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8708 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC142



Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2005

Mr. Kevin Genereux, Administrator
Crest View Lutheran Home
4444 Reservoir Blvd NE
Columbia Heights, MN 55421

RE: Project Number H5018025

Dear Mr. Genereux:

On May 31, 2005, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard abbreviated survey, completed on May 20, 2005. This survey found the most serious deficiencies to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required.

On July 12, 2005, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard abbreviated survey, completed on May 20, 2005. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 22, 2005. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard abbreviated survey, completed on May 20, 2005, effective June 22, 2005 and therefore remedies outlined in our letter to you dated May 31, 2005, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Sue Jackson". The signature is written in a cursive style with a large, looping "S" and "J".

Sue Jackson, Assistant Director
Office of Health Facility Complaints
35 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970

Telephone: (651) 215-8816 Fax: (651) 215-8712