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	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Lutheran Home	4444 Reservoir Boulevard Northeast Columbia Heights, MN 55421

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on observation, interview, and record review, the facility failed to follow physician orders for one of one resident (R1) reviewed for physician orders. The facility received an order for a cervical collar to be used by two licensed staff; one to stabilize the resident's cervical spine and one for care of the cervical collar and were observed not following the orders. Findings included: During an observation on 7/24/24 at 11:17 a.m., licensed practical nurse (LPN)-A donned personal protective equipment (PPE) and went into R1's room. Family member (FM)-B was sitting in the room besides R1. LPN-A stated to R1 that she was there to assist R1 in putting his cervical collar on. R1 was seated in his recliner. FM-B stood in front of R1 and grabbed his shoulders while assisting him forward. LPN-A put the foam piece around R1's neck and then placed the hard plastic brace on top of the foam piece. LPN-A tightened the brace by pulling the Velcro straps on each side of his neck. After LPN-A tightened the cervical collar, R1 screamed out. LPN-A asked R1 if the cervical collar was too tight and R1 stated that the cervical collar was too tight. LPN-A loosed up the brace via Velcro straps and R1 stated the cervical collar felt good. LPN-A doffed her PPE and washed her hands with soap and water. LPN-A did not support R1's cervical spine while putting on R1's cervical collar. R1's medical records indicated R1 was admitted to the facility on [DATE] with an admitting diagnosis of personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. R1's additional diagnoses included displaced posterior arch fracture of first cervical vertebra, nondisplaced type II dens fracture, heart failure, chronic obstructive pulmonary disease (COPD), neuromuscular dysfunction of bladder, and major depressive disorder. R1's fall incident report dated 5/30/24 indicated R1 was found on the floor in his room. It was reported when R1 was found, R1's recliner was in the raised position. The report indicated R1 was assisted off the floor via mechanical lift, facial skin tear was cleaned and covered with gauze, and was sent to the emergency department for further evaluation. R1's hospital records dated 6/3/24 indicated R1 was admitted to the hospital with a primary diagnosis of odontoid fracture with type II morphology (cervical fracture). While in the hospital, R1 was given a cervical collar to be worn twenty-four hours a day for seven days a week for three months. R1's care plan dated 6/3/24 indicated R1 had a cervical collar to be worn for twenty-four hours a day for seven days a week for three months. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's brief interview for mental status (BIMS) dated 6/6/24 indicated R1 had a score of zero, which indicated R1 had severe cognitive impairment. R1's treatment administration record dated 6/3/24 indicated R1 was to wear his Aspen (cervical) collar twenty-four hours a day for seven days a week for three months. The entry indicated R1 was to wear his cervical collar must be worn, including while bathing. R1's hospital records dated 7/4/24 indicated R1 was seen in the emergency department due to an unrelated fall. The hospital records indicated R1's had an order requiring assistant of two people for any movement including removing the cervical collar. R1's physician order dated 7/10/24 indicated R1 had an order for a cervical collar to be on for twenty-four hours a day for seven days, including while bathing. The order stated the cervical collar must be used by two people: one for stabilizing the spine and the other for care of the cervical collar. An interview was attempted with R1 on 7/24/24 at 9:03 a.m., but R1 was not able to be interviewed due to his cognition. During an interview with FM-A on 7/24/24 at 10:30 a.m., FM-A stated there were times she would have to hold R1's spine while the nurses would fix the cervical collar. FM-A stated she is happy to help with the cervical collar, but she shouldn't have to be able to because there should be two nurses adjusting the cervical collar. During an interview with LPN-A on 7/24/24 at 11:22 a.m., LPN-A stated she assisted R1 in putting on her cervical brace with herself and FM-B. LPN-A admitted she is supposed to have one other nurse or aide assisting in putting the cervical collar on. LPN-A stated she put R1's cervical collar on because FM-B was there. During an interview with the director of nursing (DON) on 7/24/24 at 12:45 p.m., the DON stated licensed staff should assist R1 in putting on his cervical collar per physician's orders. The DON stated she would expect two licensed staff to assist R1 in putting on his cervical collar. The DON stated when a resident returns to the facility from an outside healthcare facility, the nurses would review the resident's medical records, after visit summaries, and physician orders and put orders into the resident's electronic medical record (EMR). The DON stated the nurses would also update the care plan if necessary and then the nursing supervisor would sign off on the care plan. The DON stated there isn't a dedicated supervisor; the acting supervisor changes every day. The DON stated the supervisor for that day (7/24/24) was RN-D. During an interview with RN-D on 7/24/24 at 1:37 p.m., RN-D stated her expectation is that two aides or licensed nurses would assist a resident in putting on and taking off a resident's cervical collar. RN-D stated a family member would not count as part of the two people because the facility had educated the aides and licensed nursing staff about the cervical collar, and it is not the responsibility of the family members. RN-D stated when a resident returns to the facility from an outside healthcare facility, the nursing supervisor or the health unit coordinator (HUC) would look through the medical records from the outside healthcare facility and enter the orders into the resident's EMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the assistant director of nursing (ADON) on 7/24/24 at 1:47 p.m., the ADON stated her expectation would be that two aides or licensed nursing staff would assist a resident with their cervical collar. ADON stated if they did not have two aides or licensed nursing staff assisting with the cervical collar, that the resident could result in further injury to their cervical spine. The ADON stated she trained staff on one staff holding the cervical spine and the other staff moves the cervical collar. The ADON stated she had done education to the aides and licensed nursing staff on cervical collars by demonstrations, and by having the staff teach the ADON back. The ADON stated a family member would not count as one of the two people assisting with the cervical collar. The ADON stated she would be concerned if staff wasn't stabilizing a resident's cervical spine. The ADON stated when a resident enters from the facility from an outside healthcare facility, the supervisors would admit the resident back to the facility, would obtain the outside medical records, and enter the orders into the resident's EMR. During an interview with RN-A on 7/24/24 at 2:30 p.m., RN-A stated he will occasionally work as the acting supervisor at the facility. RN-A stated he works as the acting supervisor the evening of 7/4/24 when R1 was admitted back to the facility. RN-A stated the supervisors would obtain the discharge medical records when a resident is admitted back to the facility from an outside healthcare facility. RN-A stated he did not think he was given the discharge medical records after R1 returned to the facility from the outside healthcare facility on 7/4/24. RN-A stated that his expectations is that the supervisors receive the discharge paperwork when a resident returns to the facility from the outside healthcare facility, the supervisors would enter orders into a resident's EMR, and then fax orders to the pharmacy if necessary. An interview was attempted with RN-B on 7/24/24 at 2:40 p.m. and 7/24/24 at 3:00 p.m. but was unsuccessful. An interview was attempted with RN-C on 7/24/24 at 3:24 p.m. and 7/4/24 at 3:52 p.m. but was unsuccessful. During an interview with the administrator on 7/24/24 at 3:31 p.m., the administrator stated when a resident comes back from the hospital, the supervisor, nurse, or HUC will transcribe the orders from the discharge paperwork, and then a second nurse, supervisor, or HUC will sign off on the orders as well. The administrator stated her expectation is staff would follow the physician orders the way it was written. The facility's Neck Collar policy and procedure indicated the purpose of the cervical collar was to support the neck and spinal cord. The procedure indicated staff must ensure two staff members would assist with applying and removing the cervical collar. The facility provided education dated 7/17/24 that was provided to licensed staff and stated the licensed staff had received an instructional video on how to correctly apply and maintain a cervical collar and to demonstrate the procedure with the supervisor. Visual picture instructions were provided. Instructions provided stated the resident would need to have a second person assist to maintain the proper head, neck, and airway alignment. The education sign-in sheet was signed by eight nurses, including LPN-A.