

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  06/26/2025
NAME OF PROVIDER OR SUPPLIER  Crest View Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  (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

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, and interview, the facility failed to maintain the appearance and integrity of the walls in the memory care unit, including the medication room, to provide for a surface which could be cleaned and homelike appearance. The facility failed to maintain furniture which was clean, with intact, washable surfaces in the memory care day room. The facility failed to ensure room blinds were kept in a state of good repair to provide visual privacy in 3 of 4 resident rooms (rooms [ROOM NUMBER]) observed to have blinds in disrepair. The facility failed to ensure shower rooms were kept in good repair in 3 of 4 shower rooms toured during survey. These concerns had potential to affect any resident who used the three shower rooms. Further, the facility failed to fully investigate missing personal items for 1 of 1 resident (R47) with reports of personal items that was reported missing for approximately nine months. Findings include: During observation on 6/24/25, at 8:44 a.m., in the memory care dayroom, it was noted a brown vinyl covered chair with a wooden frame in day room, placed next to the dining room entry way had a split in the materiel in the center of the seat in the center which measured approximately 10 inches in length. This split was noted to be fully through the materiel, open to the inner cushion. In addition to the center of the chair, there was another area on the upper right side of the chair which was approximately one and a half inches in length, with areas branching out on each end of the split, approximately one half inch to one inch on each side. Near the entry of the dayroom, there was a metal box which is locked with a padlock, labeled Timer. This box is noted to be pulled away from the wall, with broken cement noted where it would be affixed to the wall. The blinds on the far corner in the dayroom is noted to have three broken slats in the blinds, which remain in place but do not allow the blinds to fully close. There is an exit in the dayroom. In the memory care dayroom, there is an exit at the far side of the room. On the wall on the lower, left side of the door frame, there is an area approximately four inches in diameter that is lacking paint which exposed the the cement. The paint surrounding the area has bubbled and is lifting away from the cement. On 6/24/25, at 3:56 p.m., during observation in the memory care unit, it was noted R283's closet shelf had been removed, leaving an area of two inches in width around the entire perimeter of the closet where the top layer of the sheet rock was gone, and the plaster was visible. The closet doors had been removed and the closet opening was open. In addition, on the wall next to the bed for R283, it was noted the sheet rock had been damaged through to the plaster in an area which was estimated to be approximately nine inches in width and 18 inches in height. Attempts to discuss with R283 were limited due to language barrier. R283 acknowledged the areas and shrugged her shoulders. On 6/26/25, at 1:56 p.m. during observation of memory care medication storage room with registered nurse (RN)-B, it was noted on the lower wall on the left side of the room next to the floor, the protective vinyl liner had pulled away from the wall, and paper was pulled away from the sheet rock. This left the plaster in the sheet rock exposed, with plaster dust noted on the floor. The area was measured off by RN-B with footsteps and was observed to be approximately three feet long, and approximately one foot in height. In addition to this, there was also an area on the wall to the right side of the room, next to the paper towel dispenser, where the top sheet had peeled away, and brown paper remained. This area was noted to be approximately nine inches high and six inches wide. RN-B stated these areas need to be repaired. On 6/26/25, at 2:03 p.m. a tour was completed with the Environmental Service Director (ESD). ESD stated when staff identified areas of concern, they should fill out forms, and place the forms in the boxes designated for them. ESD stated the department depended on staff to notify them of any need for repairs. ESD stated the maintenance staff were mindful of watching for needed repairs, however, it was a joint effort. ESD stated there were specified boxes they should put them so the department is aware. Upon reviewing R283's room, ESD stated the wall needed to be fixed. ESD stated the shelves were removed from the closets last year due to concerns with sprinkler functioning. ESD stated the shelves were removed, however, the walls were not patched, and they needed to do so. ESD stated the closet doors were removed from the closets in memory care as the residents were pulling the doors off and maintenance could not keep up with replacing them. ESD stated the box which was padlocked shut, that had pulled away from the wall would have to be repaired. ESD stated there were no work orders present for repair of this area. ESD stated the brown chair with the split in the vinyl will need to be disposed of as it can not be cleaned properly. A facility policy was requested for maintaining the environment with routine checks and audits, and process for repairs and replacment of items as needed, however, was not received</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Window Blinds</p> <p>On 6/24/25 at 9:07 a.m., room [ROOM NUMBER] was observed on the Evergreen unit. The room had a large window along the far wall which had white colored, plastic blinds which were pulled closed. The lower one quarter of the blind slats were missing which allowed the building and windows next door to be visible while inside the room, despite the blinds being closed.</p> <p>On 6/23/25 3:32 p.m., room [ROOM NUMBER] was observed on the Evergreen unit. The room had a large window along the far wall which had white colored, plastic blinds which were pulled closed. There were several blind slats missing which allowed the building and windows next door to be visible while inside the room, despite the blinds being closed.</p> <p>On 6/24/25 at 9:12 a.m., room [ROOM NUMBER] was observed on the Evergreen unit. The room had a large window along the far wall which had white colored, plastic blinds which were pulled closed. There were several slats missing from the blinds which allowed the building and windows next door to be visible while inside the room, despite the blinds being closed.</p> <p>On 6/26/25 at 10:42 a.m., reviewed maintenance/housekeeping work order forms from 8/14/24 through 6/25/25, no work order forms regarding rooms [ROOM NUMBER] window blinds were found.</p> <p>When interviewed on 6/26/25 at 12:31 p.m., nursing assistant (NA)-A stated maintenance request slips needed to be filled out when anything was broken. NA-A stated there was a lot of blinds that were broken, this was a privacy concern.</p> <p>When interviewed on 6/26/25 at 12:38 p.m., registered nurse (RN)-D stated maintenance forms for broken blinds or anything that needed to be repaired or replaced was to be filled out right away. Broken blinds created a privacy concern.</p> <p>When interviewed on 6/26/25 at 12:40 p.m., care coordinator (CC)-A stated there was a lot of broken window blinds in the building which created a privacy concern for the residents especially during cares.</p> <p>Shower rooms</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/23/25 at 12:51 p.m., the shower room on Evergreen unit was observed, there was an electric heater on the wall. The grate covering the heating element had red/brown substance with a red/brown substance along the bottom edge of the casing. There was green and white tiles in the first half of the room where the toilet and sink were located, along the three walls there was a thick black substance where the floor and wall met. In the shower stall the tile where the wall and floor met there was thick black substance around the perimeter of the shower stall with a brown substance extended up the wall tiles about one and half inches. On the half wall, separating the toilet are from the shower stall, there was one tile on the lower portion of the wall missing which exposed the bare wall underneath to water. On the floor between the half wall and the outer wall there was a long brown tile, there was a black and brown substance extending from the brown tile into the shower stall about one and a half inches. On 6/23/25 at 3:05 p.m., Shower room E-2 was observed. The toilet was noted to have a black ring at the level of the water. Where the silver colored flush system connects to the toilet had a slimy black substance around the edge. On the tile surrounding the toilet, was a thick dark brown substance that extended from the toilet about one and half inches across the tile. At the edge of the shower stall there were four tiles missing from the bottom edge, which exposed the bare wall underneath to water. There were four tiles inside the shower stall that were cracked. Around the perimeter of the shower stall there was a black substance where the tiles of the wall met the tiles of the floor. On the floor surface extending from the wall under the shower head into the shower about 4 inches was a slimy orange/yellow substance. The light fixture above the sink contained a reddish/brown substance on all metal surfaces of the fixture.</p> <p>On 6/24/25 at 2:15 p.m., memory care shower room was observed. The toilet was noted to have a black ring at the level of the water. On the wall to the right of shower head the lower eight tiles were cracked. On the wall across from the opening into the shower stall there were five cracked tiles. On the floor from where it meets the wall there was a brownish orange substance extended about six inches across the floor and about four inches up the wall. Across from the shower stall opening, about twelve inches up the wall, was a brown substance smeared across four tiles.</p> <p>On 6/26/25 at 10:22 a.m., the brown substance smeared on the wall in memory care shower room continued to be on the wall.</p> <p>When interviewed on 6/26/25 at 12:25 p.m., trained medication aid (TMA)-A stated housekeeping cleaned the shower rooms daily, they were also sprayed with disinfectant after each use for cleanliness and infection control.</p> <p>When interviewed on 6/26/25 at 12:31 p.m., nursing assistant (NA)-A stated housekeeping cleaned the shower rooms, nursing assistants did not clean the shower rooms.</p> <p>When interviewed on 6/26/25 at 12:38 p.m., registered nurse (RN)-D stated shower rooms were cleaned daily by housekeeping, The showers should be sprayed with disinfectant after every use by the nursing assistants.</p> <p>When interviewed on 6/26/25 at 12:40 p.m., care coordinator (CC)-A stated she was not sure how often the shower rooms had been cleaned, she had wondered about the black stuff in the shower and was not sure if that was stains or mold.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/26/25 at 2:03 p.m., a tour was completed with the Environmental Service Director (ESD). Upon reviewing shower rooms ESD stated shower rooms were cleaned daily. ESD verified there were tiles that needed to be replaced, ESD had tried several chemicals on the mold. ESD verified there were many rooms with broken blinds which needed to be replaced, room audits were completed monthly.</p> <p>Facility policy Clean Living Environment dated 1/2024 indicated broken blinds would be repaired or replaced by maintenance and would be audited on a rotating basis. In addition the policy indicated overbed tables, door knobs, night stand, dresser and bed rail surfaces would be cleaned by housekeeping; floors, under beds and bathrooms would be wet-mopped; mirrors, sinks, toilets and walls would be cleaned and disinfected to avoid the spread of disease. However, the policy did not address shower rooms.</p> <p>R47</p> <p>R47's quarterly Minimum Data Set (MDS) dated [DATE], identified R47 had intact cognition and required assistance with all activities of daily living (ADL)'s. R47's diagnoses included alcoholic cirrhosis of liver without ascites (severe, irreversible liver disease caused by long-term, excessive alcohol consumption), hypertension (high blood pressure), renal failure (occurs when the kidneys lose their ability to adequately filter waste and excess fluids from the blood), hepatic encephalopathy (brain dysfunction that can occur in people with severe liver disease) and fibromyalgia (chronic disorder characterized by wide-spread musculoskeletal pain, fatigue, sleep disturbances, and cognitive difficulties).</p> <p>During review on 6/26/25, Missing Items Log indicated 8/29/24 - resident is missing Cologne with large cosmetic spray, six [6] pairs of leggings, 12 pairs of small socks, new jar of coconut oil, four [4] bras, two [2] pairs of diamond earrings and a double garbage bag of other personal items - unknown if items were found.</p> <p>During interview on 6/24/25 at 3:43 p.m., R47 stated she had multiple different items that had gone missing such as a wallet, jewelry, socks, bras, leggings, perfume and a bag with a lot of miscellaneous items in it that were sitting on her bed. R47 stated she informed multiple staff of missing items and had not heard anything regarding the missing items. R47 stated the items had been missing for approximately nine months and had not been found yet.</p> <p>During interview on 6/25/25 at 12:46 p.m., registered nurse (RN)-F stated R47 reported missing items to several staff throughout the last several months. RN-F stated when an item is reported missing, she would go and look for the missing item, would tell the supervisor and complete a missing items form.</p> <p>During interview on 6/26/25 at 4:07 p.m., licensed practical nurse care coordinator (LPN)-A stated when a missing item was reported, room and laundry are searched. If item was unable to be located a missing items report was completed and given to the receptionist who would make copies for each department. LPN-A stated she was not aware if R47's items were located or not.</p> <p>During interview on 6/26/25 at 4:22 p.m., social worker (SW)-A stated if an item was reported as missing a missing item form should be completed. The missing items would be discussed at our morning meeting; a room search would be completed and most recently SW-A started to email the laundry person to see if they have found the missing item.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 6/26/25 at 4:29 p.m., social services assistant (SS)-B stated she had been responsible for the missing items reports for approximately the past year and was not aware that she had to track the missing items, follow-up and resolutions. SS-B stated she was not aware if R47's items were located.</p> <p>The facility Missing Items policy, undated, identified it was the policy of Crest View Lutheran Home to assist the resident in retaining and using personal possessions that space and safety permit. If an item(s) becomes missing, a thorough investigation will be conducted in attempt to recover the missing item(s). We will make every attempt to assure that possessions are not lost, misplaced or stolen. 1. Residents and families/resident representative are strongly encouraged to keep cash in the Resident Trust Account, in their personal bank account, or at home with the resident until needed. Personal items that are of value (i.e. family heirlooms, jewelry, etc.) are not recommended.2. When a resident/resident representative report a missing item, representative and/or the staff person who identifies missing item will complete a Priority Report for the missing items. 3. All Missing Items form will be turned into the Reception Desk in order for copies to be made, and for appropriate parties to receive the report.4. If there has been identified deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent immediately report to the nursing supervisor. The Nursing Supervisor will notify the Administrator, or designee. 5. Cash and/or items of a higher value (exceeding \$20) will be reported to the business office and residents will be encouraged to make a police report to the local police department. The Administrator or designee will be immediately notified of missing items and if theft or misappropriation is determined or alleged, a report to the Office of Health Facility Complaints (OHFC) will be made.6. A copy of the report should be routed to the respective staff listed on the form.7. The Director of Social Services or the designee will work with the resident, and others, to investigate the missing item. The form will be updated with notes from the investigation.8. The Director of Social Services or designee will follow-up with the resident and the resident representative by day 14 of initial Priority Report was made. If the item is found, the word FOUND will be written on the form with date and routed back to those who received the initial report. Some items may be replaced, or refunds may be given if staff error led to the items becoming missing.9. A log of missing items will be kept on the Share Drive, along with investigative notes and updates. 10. Missing items will be discussed between an interdisciplinary team at standing morning meetings on Monday-Friday to discuss updates and investigative findings.Crest View Lutheran Home is not liable for replacement or replacement cost of all lost items.</p>		

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<p>F 0607</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and document review the facility failed to develop a policy, without conflicting information, consistent with federal requirement for reporting allegations of abuse to the state agency immediately but no later than two (2) hours. This deficient practice had the potential to affect all residents in the facility. Finding includes: Review of the facility's Resident Protection Plan policy with a revised date of 2/2023, indicated it is the policy of the facility that reports of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property are promptly and thoroughly investigated. Allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately. If the events that cause the allegation involve abuse or result in serious bodily injury the report must be made immediately, and no later than 2 hours after the allegation is made. If the events that cause the allegation do not involve abuse or do not result in serious bodily injury the report must be made immediately, and no later than 24 hours after the allegation is made. Resident Protection Plan policy also indicated it is the policy of the facility that the resident(s) will be protected from the alleged offender(s). If the injury is unexplainable (i.e., fracture), and if the findings of abuse are substantiated (physical, verbal, sexual, financial exploitation), and if there is caregiver neglect (i.e., care plan not followed resulting in resident injury), or if a therapeutic error resulted in injury a report must be made to the Office of Health Facility Complaints immediately, not to exceed 24 hours of the initial findings. During interview on 6/26/25 at 5:53 p.m., administrator stated she would expect staff to report allegations of abuse immediately to her. Administrator stated reports of sexual abuse are to be reported within two hours and everything else are to be reported within 24 hours. Administrator confirmed policy was the most current policy with a date of 2/2023. During interview on 6/26/25 at 6:09 p.m., administrator stated verbal abuse would need to be reported within 24 hours of being made aware of incident. State Operations Manual Appendix PP - (Rev. 229, 4/25/25) included S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or 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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review, the facility failed to consistently perform hand hygiene with change of gloves while performing blood glucose monitoring. Additionally, the facility failed to clean the community glucose monitor after use. This had the potential to affect any of the 14 residents on the memory care unit who may require blood glucose checks, either routine or emergent. Further, the facility failed to ensure soiled personal laundry and linens were bagged (i.e., contained) at the point-of-use and transported in a manner to reduce the risk of cross-contamination and potential infectious spread in 1 of 1 main washrooms (Evergreen and Willow) and 1 of 1 units (Aspen and [NAME]) reviewed. In addition, the facility failed to properly handle and store clean laundry and linens. This had potential to affect all 78 residents within the care center. Findings include:</p> <p>On 6/24/25 at 3:54 p.m., an observation was completed of medication pass on the memory care unit. During this observation, registered nurse (RN)-E was observed as she performed a blood glucose scan (a test to see how residents current blood sugar was). RN-D applied gloves prior to getting the glucometer (machine which tests and reads blood sugars) out of the medication cart. RN-E then removed a test strip from the bottle and placed it into the machine and proceeded to R283's room to check blood sugar. RN-E cleaned R283's finger with alcohol before sticking R283's finger for a blood drop and blood sugar reading was obtained. RN-E returned to the medication cart with gloves on and placed glucometer on the top of the medication cart, placing nothing between the machine and the medication cart. RN-E proceeded to removed and disposed of test strip from the machine. RN-E then returned the blood glucose monitor to the medication cart, and placed it on top of case it had been stored in without cleaning or disinfecting the machine. RN-E removed soiled gloves without performing hand hygiene with alcohol or washing hands with soap and water.</p> <p>On 6/24/25, at 3:56 p.m., RN-E stated R283 required insulin based on glucose reading. RN-E opened cart to retrieve insulin pen, grabbed a clean pair of gloves without performing hand hygiene, and proceeded to go to the computer behind the desk to verify order. RN-E proceeded to R283's room, put on clean gloves, verified with resident need for insulin and administered insulin. Following insulin administration, RN-E returned to medication cart, removed gloves, and again, failed to perform hand hygiene. RN-E then proceeded to document administration of insulin in the computer. RN-E stated she should have performed hand hygiene before applying gloves to obtain blood sugar, when she removed gloves after placing glucometer in the cart, and before she proceeded to obtain insulin or accessed the computer. RN-E stated she should have performed hand hygiene before applying clean gloves and again after insulin was administered and gloves were removed. RN-E stated hand washing was an acceptable alternative to hand hygiene. RN-E stated she had not disinfected the glucometer prior to placing the glucometer into the medication cart as she normally cleaned the glucometer at the end of the shift. RN-E stated R283 is the only diabetic who receives blood sugar checks on the memory care unit. RN-E then went on to say she tried to clean it immediately after having checked blood sugars, however, as the evening meal was here, she needed to get the insulin to R283, as well as proceed to the dining room to assist with service. RN-E stated the glucometer is wiped with disinfectant wipes to clean. RN-E stated if she needed to leave early, she would assure the oncoming staff were aware to clean the glucometer. RN-E stated it was important to clean the glucometer to sanitize it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/26/25, at 1:22 p.m. an interview was completed with the infection control (IC) nurse, who was also the assistant director of nursing (ADON). The IC/ADON stated it was her expectation that each unit had two glucometers on each medication cart and cleaned them before each use. IC/ADON stated they could alternate glucometers for use with two glucometers. IC/ADON stated staff were to use disinfectant wipes, and go by contact time per recommendations of wipes. IC/ADON stated it was important to sanitize the glucometers to kill any bloodborne pathogens or germs on the glucometer.</p> <p>A facility policy, Blood Glucose Monitoring Infection Control, identified as being revised 2023, indicated it was the facility policy that glucometer units were disinfected after use. The policy further states blood glucose meters are to be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. The facility policy, Hand Washing, revised 3/23 identified to prevent the spread of infections, handwashing must be practiced by all individuals in contact with patients and patient's environments. The policy identified that hand washing/hand sanitizing must be done before performing invasive procedures, after removing gloves, after touching anything which might have been contaminated with blood or bodily fluids, and also before and after providing personal cares for a resident.</p> <p>Laundry</p> <p>On 6/26/25 at 10:34 a.m., the campus' main laundry washroom (downstairs) was toured with housekeeper (HSK)-A present. HSK-A explained they were the primary person who completed laundry for the care center. HSK-A stated downstairs laundry room was used to process laundry from the Evergreen and [NAME] units. The soiled linen receiving area was located on one end of the room with the washers and dryers on the opposite end of room however, in the walking path between these areas were a series of mobile, clothing racks with clean clothes hanging. Two clothing racks that contained clean clothing, were up against the wall with one rack being covered and the other one not covered. On the other side of the walking path was a mobile cart that contained clean clothing on hangers draped over the top of the cart uncovered. HSK-A stated soiled clothing are put in the laundry bin by the entrance of the laundry area by staff. HSK-A stated she would apply a gown and gloves and would sort the clothing in the bin area and would then carry the soiled clothing across the room to the washer, soiled laundry would be unbagged. HSK-A stated when clothes were finished in the dryer, she would place them in clean garbage bags until she could sort and hang them. Three clear garbage bags, each full of clean resident clothing, were sitting on the floor. Two boxes of clean, each full of clean folded bedding, were sitting on the floor along the wall. HSK-A verified the items were not bagged when transporting from the dirty area to the washer and expressed they probably should have been prior to transport as she was walking past clean clothing. HSK-A also verified the garbage bags of clean clothing and bedding in boxes were placed on the floor and stated they probably should not be on the floor due to infection control.</p> <p>(continued on next page)</p>		

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  06/26/2025
NAME OF PROVIDER OR SUPPLIER  Crest View Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/26/25 at 10:44 a.m., a tour of the upstairs laundry unit, that processed laundry from the Aspen and [NAME] units, was completed. The soiled utility room was opened with HSK-A present. Inside was a clothing rack on one side which had clean clothing hanging covered with a sheet and on the other side of room consisted of two sets of stackable washers and dryers and a small cupboard that had a sink and counter space. Area between each side was approximately four feet. HSK-A stated she would bring in soiled laundry, in bags, and place bags on the floor in front of washer to sort and would then place the soiled clothing in the washers. HSK-A stated when clothes were finished in the dryer, she would place the clean clothing on the counter next to the sink to sort and hang on the clothing rack. HSK-A stated all mechanical lifts slings were laundered onsite and were stored in a small white laundry basket, that contained holes on both sides of basket, on the floor under the counter and also stored in a box that was placed on the floor in the corner of room.</p> <p>During interview on 6/26/25 at 1:23 p.m., assistant director of nursing (ADON) verified she was the campus' infection preventionist (IP). ADON explained they have educated staff through staff meetings about the need to bag soiled items when collected and verified soiled laundry and linens should be bagged prior to transport. This was important to do as staff could spread infections from one place to another. ADON stated she would expect HSK-A to transport soiled clothing in bags from the soiled area to the washer and went on to state clean clothing, bedding or slings should not be placed or stored on the floors as that was an infection control concern. ADON stated clean clothing should not be placed on the countertop in the upstairs laundry room as that area, especially the sink, was a highly contaminated area, and was also an infection control concern.</p> <p>A facility Infection Control Program policy, undated, identified the facility would establish a facility-wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors that is based upon facility assessment best practices and regulatory compliance for the goal of quality systems for care. Written standards, policies, and procedures for the Infection Prevention and Control program, include a system for linen handling to prevent the spread of infection to include handling, storing, processing, and transporting linens.</p> <p>A facility policy on soiled laundry handling and transportation was requested but was not received.</p>		

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  06/26/2025
NAME OF PROVIDER OR SUPPLIER  Crest View Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  4444 Reservoir Boulevard Northeast Columbia Heights, MN 55421	

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> During observation and interview, the facility failed to ensure hand rails were securely attached to the wall. This had the potential to affect all residents, staff, and visitors who had access to the handrails. Findings include: During observation on 6/25/25 at 5:53 p.m., handrail between rooms [ROOM NUMBERS] was loose, the handrail was not attached to the second bracket from room [ROOM NUMBER]. The handrail between rooms [ROOM NUMBERS] was loose. The handrail outside of the dining room by the men's restroom was observed to be loose. On 6/26/25 at 2:03 p.m., a tour was completed with the Environmental Service Director (ESD). ESD stated when staff identified areas of concern, there were forms to be filled out and placed into designated boxes. ESD stated the department depended on staff to notify them of needed repairs. ESD stated the maintenance staff were mindful of watching for needed repairs, however, this was a joint effort. On 6/26/25 at 10:42 a.m., reviewed maintenance/housekeeping work order forms from 8/14/24 through 6/25/25, no work order forms regarding handrails was found. A facility policy and/or procedure on handrails was requested, however, none was provided.</p>