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	12/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide care consistent with a resident's needs, and care plan to eliminate/reduce the risk of an accident during a bed bath for 1 of 3 residents (R1). This resulted in actual harm to R1 when staff repositioned her without a drawsheet and with too much force caused R1 to slide out of the bed to the floor. As a result, R1 sustained a fracture to the left femur that required surgical intervention. The facility had implemented actions to prevent reoccurrence prior to the survey on 12/8/25, therefore, the citation was issued at past non-compliance. Findings include: R1's admission record dated 3/20/25, indicated R1's diagnoses included low back pain, chronic congestive heart failure, closed bicondylar fracture of the left femur, generalized weakness, and hospice care. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and was on hospice. R1 required substantial/maximal assistance to roll left to right and return to laying on back, as well as the ability to transfer to and from a bed to a chair. R1's mobility care plan dated 6/25/25, instructed to use two staff assist for bed mobility. R1's activities of daily living care plan dated 6/25/25, indicated R1 required assistance from two staff with dressing and undressing, and R1 preferred bed bath. R1's activities of daily living care plan dated 3/20/25, indicated R1 had a self-care deficit. A historic intervention initiated 3/20/25 and cancelled on 6/25/25, informed R1 was substantial/maximal assistance- Helper does more than half the effort. Helper lifts or holds trunk or limbs. R1's skin care plan intervention dated 3/21/25, indicated R1 used an air mattress, directed staff to lift (R1) do not slide to prevent shearing (of skin) and move slowly when truing and repositioning in bed. R1's progress note dated 11/12/25 at 7:42 p.m., indicated R1 had a fall out of bed during incontinence care. R1 was noted on the floor next to the wall in a sitting position with left leg slightly flexed and was complaining about severe pain on her back and left hip. The root cause analysis for the fall identified the bed brakes were not on with the corresponding intervention identified as staff were to ensure the bed breaks were on before starting cares. R1's progress note dated 11/13/25 at 3:00 p.m., indicated staff reported while assisting R1 with cares, she slid off bed when staff attempted to move her closer in order to provide cares. The note further indicated R1 was admitted to the hospital with left femur fracture and the facility initiated staff education regarding fall prevention during bed mobility and care observations. R1's hospital discharge summary note dated 11/18/25 at 7:59 p.m., identified R1, who was bedbound, had an accident at the nursing home where R1 slid out of bed when undergoing a sponge bath. Per emergency medical services (EMS), R1 had rolled out of her bed onto her left side and back. X-rays of R1's left femur was noted to be an acute comminuted and displaced fracture through the distal femoral diaphysis with 14. 6-centimeter butterfly fragment. R1's hospital orthopedic note from the Discharge summary dated [DATE] at 11:04 a.m., indicated given the nature of the injury as well as her and family's desire for pain control, R1 was taken to the operating to undergo retrograde intramedullary nailing with open reduction of her left periprosthetic femur fracture. R1's progress note dated 11/19/25 at 6:00 p.m., indicated R1 was re-admitted to the facility from the hospital as a result of sliding out of bed and she was total assist for activities of daily living (ADLs). During an interview on 12/9/25 at 11:28 a.m., a family member (FM)-A stated staff informed her R1 slid out of bed, injured her hip, and was sent to the hospital. After requesting and reviewing the incident report, FM-A stated she learned that during incontinence care, staff pulled R1 forcefully toward the edge of the bed. The bed was not locked at the time, which contributed to R1 sliding off the bed. During an interview on 12/9/25 at 12:58p.m., nursing assistant (NA)-A indicated she worked on 11/12/25 when R1 fell out of bed. NA-A explained R1 was a two person assist for a bed bath, and she and NA-B had been responsible for providing care to R1 that evening. NA-A stated she locked the bed brakes on her side of the bed and thought NA-B did the same on her side. NA-A had to leave the room to get a draw sheet, leaving NA-B in R1's room alone. Upon returning to the doorway, she heard a loud noise and saw R1 lying on her back on the floor. NA-A denied being at the bedside with NA-B at the moment R1 fell. During a subsequent interview on 12/10/25, at 10:03 a.m. NA-A further explained R1's draw sheet had been soiled with stool, so it was removed off the bed; leaving R1 on a bare mattress with no sheet. NA-A had to leave the room to get a clean draw sheet. NA-A then reiterated she did not see R1 fall but heard the noise then saw R1 on the floor. During an interview on 12/9/25 at 3:28p.m., NA-B stated she had worked on 11/12/25, it was her first time working on the hallway where R1 resided. NA-A asked her for help providing a bed-bath to R1. R1 required two staff and R1 had been incontinent of stool. NA-B indicated the air mattress had been