| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245018 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crest View Lutheran Home | 4444 Reservoir Boulevard Northeast<br>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) |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to protect a resident's right to be free from physical abuse for 1 of 3 residents (R1) reviewed for abuse. This resulted in actual harm when R2 struck R1 in the face resulting in swelling to the eyebrow, nose fracture, and a laceration to the lip that required hospitalization. The facility had implemented actions on 3/16/26 to prevent recurrence prior to the survey; therefore, the citation was issued at past non-compliance (PNC). Findings include: R1's order summary report dated 3/6/26, identified R1's diagnoses included primary hypertension, traumatic subdural hemorrhage with loss of consciousness of unspecified duration and non-Alzheimer's dementia. R1's comprehensive admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment with no behaviors. R1 required substantial/maximal assistance for toileting, and transfers. R1's activities of daily living (ADLs) care plan dated 3/6/26, indicated R1 was categorically vulnerable adult and required substantial/maximal assistance of one with transfers. Associated interventions directed staff to monitor signs of emotional distress or mood and behavior changes. It also directed staff to provide and maintain safe consistent environment as well as supervision as needed. R1's progress note dated 3/15/26 at 9:19 p.m., indicated R2 struck R1 in the face while both residents were in the TV room. The strike caused R1 to fall from her chair. Staff were present and witnessed the event. Based on staff accounts, the incident appeared unprovoked. R2 was placed on 1:1 supervision immediately following the incident. R1 sustained swelling to the eyebrow, a laceration to the lip and was transferred to the hospital for evaluation. R1's emergency department (ED) provider notes dated 3/15/26 identified R1 was transferred to ED for an evaluation of assault and fall. The note further indicated emergency medical services (EMS) reported that R1 had been struck in the head by another resident, causing her to fall forward out of her wheelchair. R1's head computed tomography (CT) scan identified a large left forehead hematoma (a localized collection of clotted blood trapped under the skin) with associated swelling, a lip laceration, and closed fracture of nasal bone. R2's order summary report dated 2/11/26, indicated R2's diagnoses included disorientation, dementia, other symptoms and signs involving appearance and behavior. R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment with no behaviors identified. R2 required no assistance with transfers or ambulation. R2's activities of daily living (ADLs) care plan dated 2/25/26, R2 was independent with transfers and ambulation. R2's ADLs care plan dated 2/25/26 directed staff to monitor for signs of emotional distress or mood and behavior changes including agitation/aggression. R2's care plan did not identify specific agitative or aggressive behaviors or triggers that may cause agitation or aggression. R2's psychiatric visit note assessment dated [DATE] identified R2 had moderate cognitive impairment. The note further recommended that the care team track and monitor behavioral dysregulation to identify triggers and beneficial interventions. The interdisciplinary team (IDT) was advised to review findings and develop a behavior support plan if agitation persists. Meaningful assessment was limited due to R2's agitation during the evaluation. Given concern involved a highly vulnerable peer, emphasis remained on maintaining appropriate supervision, reinforcing boundaries, (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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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | and ensuring objective monitoring of behaviors. R2's record reviewed between 3/11/26 through 3/15/26 showed no progress notes demonstrating implementation of the psychiatric visit note assessment recommendations. During this period, the record did not reflect monitoring of behavioral dysregulation, identification of triggers, or documentation of interventions attempted. Further no evidence that the interdisciplinary team reviewed, evaluated, or initiated development of a behavior support care plan that would include appropriate supervision, boundaries, and a monitoring system. R2's ED provider note dated 3/15/26 identified R2 was transferred to ED for evaluation related to aggressive behavior. EMS reported R2 had assaulted R1 and a staff member due to frustration with R1. The note further indicated R2 reported R1 had been harassing him and would not leave him alone, so he hit her. Record review of R2's discharge note dated 3/17/26 indicated R2 was discharged to psychiatric hospital because the safety of individuals in the facility was endangered due to R2's clinical or behavioral status. The note further indicated R2 had been involved in two physical altercations with other residents since admission, where R2 was the victim in the first incident and the perpetrator for the second incident involving R1. During an interview on 3/19/26 at 2:46 p.m., a family member (FM)-A stated staff informed her R1 had been sitting in the TV room area with several other residents when R2 sitting behind her suddenly jumped up and punched her in the back. She reported that R1 sustained a broken nose and forehead hematoma. FM-A expressed fear and uncertainty about R1's safety in the facility and added R2 was no longer on the unit. During an interview on 3/18/26 at 3:31 p.m., nursing assistant (NA)-B stated R2 had a history of impulsive aggression. Staff monitored R2 for agitation, would keep a close line of sight of him, and redirect him to his room when needed. NA-B explained she knew when R2 was agitated because he would demonstrate facial expression changes and spoke in Spanish. NA-B reported prior to the incident on 3/15/26, R2 would become agitated and angry when R1 talked loudly to the television or to staff. When this occurred, she would separate R2 from other residents during those episodes. NA-B stated nurses were aware of both R1's and R2's behaviors but she did not know whether this information was documented and was unsure of where staff were supposed to document episodes of behaviors in the medical record. During an interview on 3/19/26 at 12:16 p.m., NA-C stated R2 could be rude and made angry remarks in Spanish to other residents at times but was usually redirectable. R2 often appeared visibly angry and primarily spoke Spanish when agitated, which he believed created a communication barrier when R1 spoke loudly or called out to staff. NA-C reported nurses had been aware of both R1's and R2's behaviors but did not know whether these behaviors were documented in the medical record or reported to the provider. NA-C worked on 3/15/26, earlier in the day shift prior to the altercation R2 had to be redirected to his room after showing escalating agitation. Then later when NA-C was in the TV room, R2 was sitting approximately six feet away sitting in a recliner behind R1. R2 suddenly got up, walked over to R1, and hit her in the face causing R1 to fall from her wheelchair. The incident happened within a fraction of a second in front of staff. After the incident, NA-C remained with R1 until the nurses arrived, helped assess her and ensured R2 was safely supervised. During an interview on 3/18/26 at 2:59 p.m., NA-A explained R2 sometimes became agitated when R1 yelled at the television or called out to staff in a loud voice but never been physically aggressive before this incident. On 3/15/26 prior to the incident, R1 spoke loudly, Can someone turn down the television? R2 had responded Chica (girl in Spanish), at which point NA-A told R2 to calm down that R1's comment was not directed at him. NA-A explained dayshift staff reported R2 was agitated earlier in the morning, but she was not informed of the specific triggers and did not know whether these behaviors were documented in the care plan. NA-A was in the TV room when she observed R2 walk toward R1 and struck her in the face, causing R1 to fall from her chair. NA-A reported staff immediately intervened, separated the residents, and called the nurse. R2 walked to his room while R1 remained on the floor bleeding until the nurses arrived. NA-A reported being unaware of any behavioral support plan in place for R2. During an interview on 3/19/26 at 1:03 p.m., a licensed practical nurse (LPN)-A, the pm supervisor stated she heard an emergency page and immediately<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | responded to the call in the TV room on 3/15/26. LPN-A reported when she arrived, NA-A and NA-B were present, along with several other residents. LPN-A stated NA-A reported that R2 came up behind R1 and struck her on the right side of the face, below the ear, causing R1 to fall forward from her wheelchair. LPN-A explained she instructed staff to keep the residents separated, initiated 1:1 supervision for R2 and directed staff to call the law enforcement while she was contacting the provider. LPN-A asked NA-A and NA-B whether there had been any behavior earlier in the day that might have led to the incident. She reported they told her R2 had been grumbling in Spanish toward R1 on previous shift but there had been no reports of physical aggression. LPN-A stated she was unaware about any behavior reports and had not previously heard of R2 being aggressive. LPN-A reported she was unaware of whether the care team tracked and monitored R2's behavioral dysregulation to identify triggers and beneficial interventions, and she did not know of any behavioral support plan in place for R2. LPN-A explained she did not identify anything that could have prevented the incident and did not observe any warning signs leading up to it. During an interview on 3/19/26 at 2:00 p.m., a registered nurse (RN)-A, the assistant of the director of nursing (ADON) stated she was informed on 3/15/26 that R2 struck R1, causing R1 to fall from her wheelchair to the floor. RN-A explained LPN-A told her R2 had been sitting by the wall in the TV room and R1 was sitting in front of him, approximately six to eight feet away watching television. RN-A explained she instructed staff to call 911, keep the residents separated, and initiated 1:1 supervision for R2. Her immediate focus after the incident was to ensure residents' safety and confirming 1:1 supervision for R2. RN-A expressed concern R2 might not be appropriate for the locked unit due to his pacing, ambulatory, and unpredictability. RN-A reported R2 had a diagnosis of dementia and had been involved in a previous resident to resident altercation, though the facility had concluded he was the victim. RN-A stated R2 sometimes became agitated he spoke in Spanish but was generally redirectable. RN-A reported she was unaware of the ACP recommendation for the care team to track and monitor R2's behavioral dysregulation to identify triggers and beneficial interventions. She also did not know whether the interdisciplinary team (IDT) had been advised to review findings and develop a behavior support plan for R2. RN-A added she expected nurses to ask appropriate questions when behaviors were reported and to document behaviors according to the resident care plan. RN-A did not recall any recent behavior reports brought to the interdisciplinary team (IDT) meeting. RN-A stated staff receive annual abuse-prevention training and were required to report any suspected abuse immediately to a supervisor or nurses. R2's medical record from 3/11/26 through 3/15/26 showed no evidence the facility implemented the ACP recommendations to track and monitor R2's behavioral dysregulation. There was no behavioral support plan developed despite repeated staff observations of agitations. Although staff were aware of R2's known triggers including loud environments and R1's frequent vocalizations; these observations were not documented. During an interview on 3/19/26 at 10:47 a.m., a nurse practitioner (NP)-A stated R2 should not have been placed in the memory care unit because he was ambulatory and wandered into other residents' rooms, which she believed created a safety risk. NP-A reported she referred R2 for an evaluation by Associated Clinic of Psychology (ACP) but had not received the assessment results. NP-A was unaware of any agitation or aggressive behaviors from R2 prior to the incident and expected nurses to notify the provider of any changes in a resident's mood/behavior. NP-A explained when she attempted to talk to R2, he appeared visibly angry, charged up, became loud while speaking in Spanish, and then walked away to his room. Abuse Prohibition/Vulnerable Adult Policy dated 11/25 directed the facility to protect residents against abuse by anyone, including, but not limited to, facility staff, and other residents or self-abuse. The policy required the interdisciplinary care plan team to review residents requiring behavioral interventions during target behavior meetings to develop individual behavior plans. Record reviewed indicated by 3/16/26, staff were interviewed to gather details regarding the circumstances surrounding the incident. No further incidents were reported to the staff. ˆ-On 3/15/26 R2 was placed on 1:1 supervision and later discharged to the psychiatric hospital on 3/17/26. -On 3/16/26 the<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | facility had developed and started education for all staff on the abuse policy and procedures as well as strategies for managing aggressive behaviors. -On 3/16/26 the facility began reviewing all residents with behavioral histories to ensure care plan were current to include triggers with appropriate individualized interventions. -On 3/18/26 through 3/19/26 staff were interviewed and were able to articulate appropriate abuse policy and procedures. This deficient practice is being cited at past Non-compliance |