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	06/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rights were maintained for 2 of 4 residents (R15 and R43) reviewed for dignity. Findings Include: R15R15's annual Minimum Data Set (MDS) dated [DATE], identified R15 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R15's diagnoses included progressive neurological conditions (a disease that causes the nervous system to gradually deteriorate over time), multiple sclerosis (a chronic, often disabling disease that attacks the central nervous system, specially the brain and spinal cord), renal failure (a condition where the kidneys lose their ability to effectively filter waste and excess fluid from the blood), depression, retention of urine, presence of urogenital implants, and hydronephrosis (a condition where one or both kidneys swell due to a backup of urine, often caused by a blockage or obstruction in the urinary tract). MDS also indicated R15 had an indwelling external catheter. During observation on 6/23/25 at 2:53 p.m., R15's urinary catheter leg drainage bag, which was approximately three-quarters full of yellow colored liquid, was showing out the bottom of R15's pant leg and was resting on top of R15's right foot. Drainage bag was visible to all residents and staff present in the dining room. During observation on 6/25/25 at 11:54 a.m., R15 was coming back from the dining room. R15's urinary catheter leg drainage bag, which was approximately one-half full of yellow colored liquid, was showing out the bottom of R15's pant leg and was resting on top of R15's left foot. Drainage bag was visible to all residents and staff that walked past.During observation on 6/26/25 at 11:23 a.m., R15 was seated in the dining room with the urinary catheter leg drainage bag, which was approximately one-half full of yellow colored liquid, was showing out the bottom of R15's pant leg and was resting on top of R15's left foot. Drainage bag was visible to all residents and staff that walked past.During interview on 6/26/25 at 7:28 a.m., R15 stated she was not happy about people being able to see her catheter drainage bag. R15 stated, there is really nothing I can do about it. During interview on 6/26/25 at 2:21 p.m., nursing assistant (NA)-H stated she noticed R15's catheter drainage bag does tend to slide down her leg onto foot. NA-H stated there was nothing she needed to do regarding the catheter drainage bag other than emptying. During interview on 6/26/25 at 3:46 p.m., registered nurse (RN)-F stated R15 had a urinary catheter and NA's should ensure it was covered when R15 was outside her room. RN-F stated she noticed R15's catheter does tend to slide down her leg if not secured onto R15's calf. During interview on 6/26/25 at 4:16 p.m., licensed practical nurse (LPN)-A stated she would expect the urinary catheter drainage bag to be secured on R15's upper calve under her pants. LPN-A stated it should be covered and not visible as it was a dignity concern.During interview on 6/26/25 at 5:44 p.m., assistant director of nursing (ADON) stated she would expect staff to place urinary catheter drainage bag so it was not visible as it could be a dignity concern for the resident.R43R43's annual MDS dated [DATE], identified R43 had moderate cognitive impairment and required assistance with all ADLs. R43's diagnoses included atrial fibrillation (a common type of irregular heartbeat that originates in the heart's upper chambers (atria)), heart failure (a condition where the heart can't pump enough blood to meet the body's needs), cerebrovascular accident (occurs when blood flow to the brain is interrupted, causing brain cells to die due to lack of oxygen and nutrients) and depression. During observation on 6/24/25 at 4:18 p.m., R43 was seated in the dining room with his JP (Jackson Pratt) drainage bag (type of surgical drain used to remove fluids from a surgical site), which was approximately one-half full of greenish-brown liquid, was placed on top of R43's clothing on his right and was visible to all residents and staff present in the dining room. Staff did not attempt to assist R43 with covering bag nor did they ask.During observation on 6/26/25 at 11:03 a.m., R43 was seated in the dining room with his JP drainage bag, which was approximately three-quarters full of greenish-brown liquid, was placed on top of R43's clothing on his right and was visible to all residents and staff that walked past. Staff did not attempt to assist R43 with covering bag nor did they ask.During interview on 6/26/25 at 11:05 a.m., R43 stated staff did not normally cover the drainage bag. R43 stated he felt, embarrassed, that everyone can see the drainage bag.During interview on 6/26/25 at 2:27 p.m., NA-H stated R43's drainage bag was normally placed on top of R43's right thigh. NA-H stated there was nothing that she needed to do regarding the JP drain. NA-H confirmed bag probably should not be visible to others and should have something placed over it.During interview on 6/26/25 at 3:46 p.m., RN-F stated R43 had a JP drain that NA's should assist with covering when outside his room. RN-F stated she had never seen R43 mess with or move the drainage bag. During interview on 6/26/25 at 4:16 p.m., LPN-A stated she had never seen R43 mess with or move the drainage bag. LPN-A

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure results of complaint investigations were available for review. This had the potential to affect all 78 residents residing in the facility, as well as family, visitors, and staff.Findings include:During observation on 6/23/25 at 11:32 a.m., the facility survey results were in a three ring binder labeled Annual Survey Results. The survey results posted included the recertification survey results from the past three recertification surveys however, lacked the 2567's (reports completed by surveyors regarding findings of investigations and the responses by the facility) regarding complaint investigations.A review of Aspen Central Office (ACO-an online computerized federal document site which contains the surveys completed for facilities, including both recertification surveys, and complaint investigation) indicated complaint investigations were completed without citations on the following date following the recertification survey of 4/4/24: 3/6/24. Additionally, complaint investigations were completed and were noted to have citations issued on the following dates: 5/23/24, 7/29/24, and 10/30/24. During interview on 6/26/25 at 3:06 p.m., the administrator stated she was unaware that the requirements for posting of survey results were not met by placement of the corresponding letter from all investigations. A facility policy was requested for posting of survey results, but was not available.

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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)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 replacement of items as needed, however, was not received

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Window Blinds 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. 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. 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. 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. 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. 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. 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. Shower rooms (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. R47 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). 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. 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. 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. 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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for 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 ensure parameter mattress (a type of mattress cover or encasement designed to create a gentle barrier around the edge of the bed, preventing falls) was not used in a manner to restrain resident while in bed for 1 of 1 resident (R4) reviewed for restraints.Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R4's diagnoses included chronic obstructive pulmonary disease (COPD) (a progressive lung disease that makes it hard to breathe), non-Alzheimer's dementia, hemiplegia (a condition characterized by paralysis on one side of the body), anxiety disorder, depression and insomnia. MDS did not indicate R4 utilized physical restraints. R4's care plan reviewed 6/26/25, identified R4 had a potential alteration in safety and falls related to right hemiplegia, assisted with transfers and psychotropic medication use. Staff were directed to assist R4 with ADLs per his need and per request and had a parameter mattress in place. R4's care plan did not identify the use of pillows to prevent R4 from crawling out of bed. During review of R4's electronic health record (EHR), Physical Device assessment completed on 4/25/25 indicated R4 utilized grab bars that were on bed and a Broda wheelchair. Physical device assessment did not identify the parameter mattress was assessed or utilized by R4. During observation on 6/23/25 at 11:18 a.m., R4 was lying on his back in the middle of his bed with his blankets covering to his chest on a parameter mattress. On R4's right and left side, a pillow was placed that ran along R4's body from his shoulders to his hips. R4's bed was in low position.During observation on 6/24/25 at 3:39 p.m., R4 was lying on his back in the middle of his bed with his blankets covering to his chest on a parameter mattress. On R4's right and left side, a pillow was placed that ran along R4's body from his shoulders to his hips. R4's bed was in low position.During observation on 6/25/25 at 12:06 p.m., R4 was lying on his back in the middle of his bed with his blankets covering to his chest on a parameter mattress. On R4's right and left side, a pillow was placed that ran along R4's body from his shoulders to his hips. R4's bed was in low position.During observation on 6/26/25 at 7:24 a.m., R4 was lying on his back in the middle of his bed with his blankets covering to his chest on a parameter mattress. On R4's right and left side, a pillow was placed that ran along R4's body from his shoulders to his hips. R4's bed was in low position.During interview on 6/25/25 at 12:45 p.m., nursing assistant (NA)-G stated R4 preferred to stay in bed. NA-G confirmed R4 had a parameter mattress, and pillows were placed on both sides of his upper body. NA-G stated R4 was not able to reposition himself and was not able to get out of bed by himself for approximately the past year. During interview on 6/26/25 at 2:26 p.m., NA-H confirmed R4 had a parameter mattress, and pillows were placed on both sides of his upper body. NA-H stated R4 was not able to get out of bed by himself and has never tried to get out of bed by himself for some time. During interview on 6/26/25 at 3:46 p.m., registered nurse (RN)-F stated R4 did not like to get up and that he needed assistance to get out of bed. RN-F stated R4 has not attempted to get out of bed for approximately the past year. RN-F stated R4 was a fall risk. RN-F confirmed R4 had a parameter mattress, and pillows were placed on both sides of his upper body. RN-F stated nursing completes the physical device assessment and stated the parameter mattress/pillows should have been assessed and indicated on the assessment as it could be considered a restraint. RN-F stated she was not sure why R4 still had the parameter mattress in place or why staff were utilizing pillows. During interview on 6/26/25 at 4:14 p.m., licensed practical nurse clinical coordinator (LPN)-A stated parameter mattress needed to be assessed in the physical device assessment that were completed by the nurses on the floor. LPN-A stated the mattress/pillows could be considered a restraint if resident was not able to get out of bed. LPN-A stated R4 was a fall risk and could roll himself out of the bed. During interview on 6/26/25 at 5:40 p.m., assistant director of nursing (ADON) stated parameter mattresses were assessed through the physical device assessment. ADON stated parameter mattresses help resident identify the edge of the bed. The mattress could be considered a restraint when it was used to prevent the resident from getting out of bed or if resident was immobile. ADON confirmed parameter mattress was not assessed or mentioned on the physical device assessment and should have been. The facility Physical Devices policy, dated 3/2023, indicated Crest View Lutheran Homes would assist residents in remaining as independent and safe as possible when transferring or repositioning. 1. The unit nurse or designee will complete the physical device assessment on admission, re-admission, signification change of condition and annually 2. The unit nurse or designee will request physical devices based on the

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharge for 1 of 3 residents (R43) reviewed for hospitalizations. Findings include:R43's annual MDS dated [DATE], identified R43 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R43's diagnoses included atrial fibrillation (a common type of irregular heartbeat that originates in the heart's upper chambers (atria)), heart failure (a condition where the heart can't pump enough blood to meet the body's needs), hypertension (high blood pressure), cerebrovascular accident (occurs when blood flow to the brain is interrupted, causing brain cells to die due to lack of oxygen and nutrients), depression, attention-deficit hyperactivity disorder (ADHD) (a neurodevelopmental condition that affects brain function and behavior, primarily in the areas of attention, hyperactivity, and impulsivity) and aortic aneurysm and dissection (An aortic aneurysm is a bulge or ballooning of the aortic wall, while an aortic dissection is a tear in the aorta's inner lining, allowing blood to flow between the layers).R43's medical record identified the following MDS assessments:1) 12/3/24 discharge with return anticipated, with a 12/12/24 entry tracking record2) 1/12/25 discharge with return anticipated, with a 1/22/25 entry tracking recordR43's hospital Discharge summary, dated [DATE], indicated R43 was hospitalized with acute metabolic encephalopathy (a sudden and widespread disturbance in brain function caused by metabolic problems) and acute on chronic hypoxemic hypercapnic respiratory failure (a person with a pre-existing chronic respiratory condition experiences a sudden worsening of their condition, leading to both low blood oxygen (hypoxemia) and high blood carbon dioxide (hypercapnia) levels).R43's hospital Discharge summary, dated [DATE], indicated R43 was hospitalized with acute on chronic hypoxemic hypercapnic respiratory failure.Review of the notices to the ombudsman that the facility provided identified:1) Monthly notice for December 2024 discharges - R43 was not listed2) Monthly notice for January 2025 discharges - R43 was not listed There were no other notices to the ombudsman provided by the end of the survey. During interview on 6/26/25 at 4:29 p.m., social service assistant (SS)-B stated she notified the Ombudsman monthly of all transfers and discharges via fax. SS-B confirmed R43's hospitalizations on 12/3/24 and 1/12/25 were missed and were not reported to the Ombudsman. SS-B stated it was important for the Ombudsman to be made aware of all transfers/discharges so additional support could be offered if applicable. A policy was requested but was not received.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for 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 ensure a comprehensive care plan was developed and implemented to include post-traumatic stress disorder (PTSD) triggers and interventions for 1 of 1 resident (R47) who had a diagnosis of PTSD.Findings include:R47's quarterly Minimum Data Set (MDS) dated [DATE], identified R47 had intact cognition and required assistance with all activities of daily living (ADLs). R47's diagnoses included alcoholic cirrhosis of liver without ascites (severe, irreversible liver disease caused by long-term, excessive alcohol consumption), 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). During review of R47's electronic health record (EHR), initial visit notes from Associated Clinic of Psychology (ACP), dated 3/17/22, indicated R47 had the following diagnoses: Posttraumatic Stress Disorder and Adjustment disorders with mixed disturbance of emotions and conduct. Visit note indicated R47 had a longstanding history of abuse and had experienced complex trauma since childhood; expressed a general mistrust of people in authority and anxiousness about dependency on others for cares; and reported re-experiencing of trauma and mistrust towards those she sees in authority and has anxiousness about dependency on others. Visit note indicated staff could utilize memory care approaches of making eye contact, explain step-by-step cares, move slowly, and ask questions with some coping tools: socializing, exercise, faith, thought reframing, and musicDuring review of R47's EHR, follow up visit note from ACP, dated 4/2/25, indicated R47 had the following diagnoses: Posttraumatic Stress Disorder and Adjustment disorders with mixed disturbance of emotions and conduct. R47's care plan failed to indicate PTSD triggers and interventions. During interview on 6/26/25 at 2:26 p.m., nursing assistant (NA)-H stated she was not aware of R47's history of PTSD and was not aware of triggers. NA-H stated R47 frequently gets upset with staff and was not sure the reason behind it. NA-H stated it would be important to know if a resident had certain triggers so if they exhibit behaviors we know how to respond. NA-H stated if resident had a history of trauma, it would be on resident's care plan.During interview on 6/26/25 at 3:36 p.m., registered nurse (RN)-F stated she was not aware of R47's history of trauma. RN-F stated R47 had a lot of anxiety and did not like being at the facility. RN-F was not aware of any triggers and confirmed there was no plan of care for PTSD for R47. During interview on 6/26/25 at 4:07 p.m., licensed practical nurse clinical coordinator (LPN)-A stated she was not aware of R47's history of trauma. LPN-A stated if a resident had a diagnosis of PTSD, it would be included on the resident's individualized care plan with any interventions that are in place for resident. During interview on 6/26/25 at 4:39 p.m., social worker (SS)-A stated trauma assessments are completed by herself or the social services assistant. Triggers and interventions would be added to the resident's care plan as it was very important for all staff to know as it could lead to worsened mental health or suicidal ideation. SS-A confirmed trauma assessment was not completed or included in R47's care plan. During interview on 6/26/25 at 5:38 p.m., assistant director of nursing (ADON) stated if a resident had a diagnosis of PTSD, it would be included on the care plan. ADON stated social services would complete the trauma assessment and add information related to PTSD on the resident's care plan. ADON stated R47's care plan should have included behavior monitoring, PTSD/trauma triggers, how staff would avoid those triggers and interventions to be used if R47 was triggered. ADON confirmed R47's care plan did not include PTSD diagnosis, triggers or coping strategies and should be included in care plan. ADON stated it would be important for staff to know the resident's back story and triggers so they can provide the resident with the best possible care. The facility Trauma Informed Care policy, undated, indicated Crestview was dedicated to ensuring that all residents receive appropriate person-centered care as it related to their personal circumstances, including those with a history of trauma or Post-Traumatic Stress Disorder (PTSD).1. Residents undergo a Trauma-Informed Care Assessment upon admission and at least annually or as necessary. Care plans are developed as part of the assessment process. Assessments may consider military service, history of violence or abuse, displacement, medical trauma, or other events that may have contributed to PTSD.2. Staff are trained upon hire and at least annually in regard to trauma and person-centered care, including information about managing behaviors and de-escalation techniques.3. Interactions with residents are conducted in a calm, respectful manner to promote trust. Staff are instructed to explain procedures before initiating care, offer choices and

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, observation and document review, the facility failed to update the care plan with specific interventions for 1 of 1 resident (R43) reviewed for respiratory care.Findings include:R43's annual MDS (Minimum Data Set) dated 4/14/25, identified R43 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R43's diagnoses included atrial fibrillation (a common type of irregular heartbeat that originates in the heart's upper chambers (atria)), heart failure (a condition where the heart can't pump enough blood to meet the body's needs), hypertension (high blood pressure), cerebrovascular accident (occurs when blood flow to the brain is interrupted, causing brain cells to die due to lack of oxygen and nutrients), depression, attention-deficit hyperactivity disorder (ADHD) (a neurodevelopmental condition that affects brain function and behavior, primarily in the areas of attention, hyperactivity, and impulsivity) and aortic aneurysm and dissection (An aortic aneurysm is a bulge or ballooning of the aortic wall, while an aortic dissection is a tear in the aorta's inner lining, allowing blood to flow between the layers). MDS indicated R43 received oxygen therapy.R43's care plan (CP), reviewed 6/26/25, included R43's use of oxygen but failed to indicate the reason for use, the rate oxygen was to be set at and the route of which the oxygen was supposed to be administered. During interview on 6/26/25, at 4:16 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R43 needed to wear oxygen at all times and care plan should be specific to the resident. LPN-A confirmed R43's oxygen problem area and interventions on the CP were not specific to R43.During interview on 6/26/25, at 5:44 p.m., assistant director of nursing (ADON) stated care plan should have resident specific information, so staff know when, how and what oxygen liter flow should be used. ADON confirmed R43's care plan did not include specific information related to R43's oxygen therapy.The facility Care Planning Policy, revised 6/6/24, indicated the facility would develop a comprehensive care plan that contained problems/strengths, goals and approaches. The care plan will ensure the resident is receiving the appropriate care required to maintain or attain the resident's highest level of practicable function possible, as well as accommodation of preferences. The problem/strength statements will be dated as they occur. The goal statement should be in measurable terms so progress or decline can be determined. Interventions should be written to help meet the goal. The interventions should be individualized to the resident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and document review, the facility failed to provide supervision, cues, and hands on assistance as needed to eat during meals, and with snacks, for 1 of 1 residents (R5) whom required staff direction for eating. Findings include:R5's quarterly Minimum Data Set (MDS) indicated R5 had had impaired cognition and required substantial assistance to complete activities of daily living (ADL's) including eating. R5's medical diagnoses included aphasia (a language disorder which impacts the ability to speak), dementia, and dysphagia (difficulty swallowing).R5's care plan, revised on 5/5/25, identified R5 has potential for alteration in nutrition related to hypertension (high blood pressure), dysphagia, variable intakes and history of refusing meals. The care plan further defined R5 required one-to-one assistance with meals, and cueing/encouragement with foods/snacks/supplements. R5 was identified as having a gradual weight loss and her goal was to maintain current nutritional status as evidenced by stable weight. R5's nutritional care plan directed staff to cue and direct resident to eat and take fluids. R5's diet order was for mechanical soft texture, with thin consistency liquids. R5's care plan directed staff to feed resident at meals, set up tray: arrange food, cut meat, and apply condiments, butter/jelly bread. On 6/24/25 9:24 a.m., R5 was observed to be sleeping in the dining room following breakfast meal. R5 was observed to be sleeping upright in wheelchair at this time. R5 was not being assisted to move out to the day room, or assisted to her room to lay down to rest. On 6/24/25 at 2:30 p.m., snacks were being served in the dayroom. R5 was alert. R5 was offered a cookie and water at this time. R5 did not accept cookie or water at this time.On 6/25/25 at 1:54 p.m. , R5 was observed in the dayroom, and was noted to be alert and interacting with staff. Resident was seated facing the television. R5 was offered pudding, and accepted assistance from staff to eat pudding. On 6/25/25, at 11:18 a.m., R5 was observed to be in the dining room, with meal set up in front of her, without staff assistance present. R5 sat with food in front of her, not initiating any attempts to eat. At 6/25/25 11:19 a. m., nursing assistant (NA)-D was moving around the dining room and was providing residents with assistance to set up meals. R5 was noted to have moved her plate to the center of the table. Staff were observed offering fluids to R5, however, did move plate back in front of R5, or offer to provide assist with meal. On 6/25/25 at 11:25 a.m., NA-D passed by R5's table, and then sat down to assist R5 with dining. This was seven minutes after R5 had initially been served her meal. On 6/26/25 at 8:12 a.m., NA's C, D, and E were observed in the dining room at this time. NA-E stated trays had just arrived in the dining room. NA's-C, D, and E were observed serving and setting up trays. On 6/26/25 at 8:31 a.m., R5 was observed leaning back in her chair in a semi reclined position. R5 was observed sitting with her eyes closed, and her mouth open. R5 had been in this position for approximately five minutes. Surveyor continued with continuous observation until 8:36 a.m., when NA-D arrived to R5's table, aroused R5 and prompted R5 to eat her meal. R5 proceeded to eat her meal independently. Once R5 resumed eating, NA-D continued to move about the dining room, providing prompts and cues to others. At 8:38 a.m., R5 had again stopped eating. NA-D provided cues and encouragement to continue eating and moved R5's plate in a position to be more accessible. At 8:40 a.m., R5 was observed to be sitting with eyes closed, without eating. NA-D sat down across the table from R5 to assist tablemate, however, offered no further prompts or cues to R5. At 8:42 a.m. , R5 was aroused by NA-D, R5 began eating again. At 8:44 a.m., NA-C sat down next to R5 to assist her with her meal, however, another resident called out to go to the bathroom, and NA-C left to provide assistance to the other resident. At 8:46 a.m., R5 resumed eating her breakfast. At 8:51 a.m., NA-E approached R5 to prompt her to drink her beverages. At 8:52 a.m., staff were observed clearing plates. R5 continued to be chewing, however, was sitting with her eyes closed. At 8:55 a.m., R5's plate was removed. R5 ate only her donut. On 6/26/25 at 1:41 p.m., NA-C stated the dining room service went well. NA-C stated the staff went around and provided assistance to the ones [residents] who need help. NA-C stated R5 preferred anything sweet. When R5 fell asleep, staff provided prompts to wake her up. R5 was reported by NA-C to have eaten her donut this morning. NA-C stated they managed with the staff they had, adding sometimes the nurses come to help. NA-C stated when residents needed assist to go to the bathroom, one of the staff in the dining room would leave to provide assistance. NA-C stated they reached out to nurse for assistance if help was needed. During interview on 6/26/25 at 2:00 p.m., registered nurse (RN)-B stated staff began to serve trays upon their arrival. RN-B stated R5 required assistance to eat. RN-B did comment when a resident needed to go to the bathroom, one of the dining room NA's left the resident they were assisting to assist that resident to the bathroom. RN-B stated he was available to help in the dining room when asked

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to consistently meet the identified needs and preferences of 3 of 4 residents (R7, R19, and R76), reviewed for activities.Findings include: R7R7's quarterly Minimum Data Set (MDS) MDS dated [DATE], indicated R7 was alert and oriented. The MDS identified R7's vision was adequate and indicated he was able to see fine detail, including regular print in newspapers/books. The MDS indicated R7 did not require corrective lenses. R7's MDS of 12/1/24, 2/3/24, and 5/4/25 lacked completion of Preferences for Customary Routine and Activities. R7's annual assessment of 11/4/24, identified the following for preferences for Customary Routine and Activities: R7 identified it was very important to listen to music he liked, to complete favorite activities, to go outside to get fresh air when the weather was good, and participate in services or practices; it was somewhat important to keep up the news; it was not very important to do things in groups of people, or to have books, newspapers, and magazines to read. R7's care plan revised on 5/6/25, indicated R7 was independent in making activity choices and how leisure time was spent. R7 preferred Life Enrichment staff did not knock on his door or enter his room to invite him to activities. The care plan identified staff were to offer activities R7 could do independently if he was not interested in a structured activity. R7 enjoyed listening to [NAME] Cash and coloring in his room. Staff were to provide invitations to activities of interest such as sports, music programs, scripture and song, TV/movies, animal visits, and arts and crafts. Staff were directed to monitor R7's progress on an ongoing basis. On 6/24/25 at 8:57 a.m., R7 was observed in his room watching television. R7 stated he previously had a CD player available for use, however, it was no longer available. R7 stated it had been missing for the past three weeks. R7 stated he enjoyed listening to music; however, he was no longer able to do so as he did not have a CD player. On 6/25/25 at 6:45 p.m., R7 was observed in his room watching television. On 6/26/25 at 10:40 a.m., life enrichment assistant (LEA)-A stated all staff of the Life Enrichment department assisted in completing the care plan. The care plan was adapted as indicated by identified preferences. Staff tracked invitations to activities on attendance sheets and indicated if resident participated or refused. LEA-A stated she was unaware R7 no longer had a CD player available for use and would provide him with one. LEA-A stated R7 did not wish to have activities, or coloring supplies provided to him. Upon review of activity calendars for April, May and June, it was noted although invited to activities, R7 had not participated in any activities in either April or May 2025. R7 was noted to have received one to one interaction on June 18, 2025 which was identified as interests for the topic. This visit was not documented in R7's narrative notes to reflect further insight. In addition, even though a one-to-one visit was completed, there were no updates or change in current interventions on R7's care plan to better meet his needs. R19 (continued on next page)

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

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition and required assistance with all activities of daily living (ADLs). R19's diagnoses included chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), non-Alzheimer's dementia, anxiety disorder, depression, schizophrenia (a chronic mental disorder that disrupts a person's thinking, behavior, and emotions) and nicotine dependence. R19's MDS of 11/2/24, 1/31/25, and 5/1/25 lacked completion of Preferences for Customary Routine and Activities. R19's annual assessment, dated 8/5/24, identified the following for preferences for Customary Routine and Activities: R19 identified it was very important to listen to music she liked; to be around animals such as pets; keep up with the news and to go outside to get fresh air when the weather was good; it was somewhat important to have books, newspapers, and magazines to read, to do things in groups of people and to participate in religious services or practices; it was not very important to do favorite activities. R19's care plan reviewed on 6/26/25, indicated R19 had an activity intolerance related to her cognitive impairment, disease process, physical limitations, anxiety and her limited attention span. Staff were to encourage resident to participate in activities of her interest such as music performances, bingo, arts and crafts, happy hour, parties, word games, trivia and to assist R19 to and from activities as needed. Staff were to offer independent activity items that were of interest as needed, to provide one on one (1:1) attention and cueing when needed during activities to maximize participation, to provide monthly activity calendar and to provide 1:1 visits as needed. Upon review of the calendars from April 2025 to June 2025, it was noted R19 had participated in twelve out of 98 scheduled activities and was invited and refused 16 times in April 2025; attended twelve out of 103 scheduled activities and was invited and refused 18 times in May 2025; and attended six out of 87 scheduled activities and was invited and refused 16 times in June 2025. R19's monthly activity calendars indicated R19 had eight 1:1 activities completed in April, four 1:1 activities completed in May and one 1:1 activity completed in June. R19's narrative notes lacked documentation of 1:1 visits. In addition, even though a 1:1 visit was completed, there were no updates or change in current interventions on R19's care plan which would better meet her needs. During observation on 6/23/25 at 4:42 p.m., R19 was sitting in her wheelchair in the doorway leading to her room. R19 had previously been walking up and down hallway. There was no scheduled activity at the time of observation. During observation on 6/25/25 at 1:05 p.m., multiple unidentified staff asked R19 if she would like to go to bingo with R19 declining. During observation on 6/26/25 at 2:56 p.m., R19 was wandering up and down hallway talking to herself. During interview on 6/25/25 at 12:47 a.m., nursing assistant (NA)-G stated we occasionally offer R19 activities, but she refused frequently and preferred to roam hallway. During interview on 6/26/25 at 3:37 p.m., registered nurse (RN)-F stated R19 liked activities and would attend activities if asked. RN-F stated R19 frequently wandered up and down hallway. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/25 at 5:22 p.m., assistant director of nursing (ADON) stated she would expect staff to offer and encourage all activities to R19. ADON stated R19 was more introverted, but staff should attempt to find things R19 liked to do. ADON stated activities were important to keep the resident happy and to decrease the chance of worsened depression cause by boredom. R76 R76's quarterly MDS dated [DATE], identified R76 had severe cognitive impairment and required assistance with all ADLs. R76's diagnoses included non-traumatic brain dysfunction (brain damage that occurs due to internal factors, rather than external trauma), Alzheimer's disease with late onset, diabetes mellitus (a group of metabolic diseases characterized by high blood sugar levels), anxiety disorder and depression. MDS indicated R76's hearing was moderate difficulty needed hearing aids. R76' s significant change assessment, dated 8/5/24, identified the following for preferences for Customary Routine and Activities: R76 identified it was very important to be around animals such as pets, to do things in groups of people, to do favorite activities and to go outside to get fresh air when the weather was good; it was somewhat important to listen to music she liked, to keep up with the news and to participate in religious services or practices; it was not very important to have books, newspapers and magazines to read. R76' s care plan reviewed on 6/26/25, indicated R76 had an activity intolerance related to her cognitive impairment, disease process, physical limitations, tendency to wander and her limited attention span. R76 was dependent on staff to meet her activity needs and was extremely hard of hearing and needed assistance in order to actively participate in every activity. Staff were to encourage resident to participate in activities as needed to alleviate extra energy and for staff to provide invite and assistance to and from activities such as word games, parties, music performances, bingo, card games, puzzles and arts/crafts. Staff were to offer independent activity items that were of interest as needed, to provide 1:1 attention and cueing when needed during activities to maximize participation, to provide monthly activity calendar and to provide 1:1 visits as needed. Upon review of the calendars from April 2025 to June 2025, it was noted R76 had attended four out of 98 scheduled activities in April 2025, attended five out of 103 scheduled activities in May 2025 and attended four out of 87 scheduled activities in June 2025. R76's monthly activity calendars indicated R76 had one 1:1 activity completed in April, two 1:1 activities completed in May and one 1:1 activity completed in June. R76's narrative notes lacked documentation of 1:1 visits to reflect further insight. In addition, even though a 1:1 visit was completed, there were no updates or change in current interventions on R76's care plan which would better meet her needs. During observation on 6/23/25 at 3:32 p.m., R76 was sitting in the hallway by the nurses' station with a few other residents looking around. There was no scheduled activity at time of this observation. During interview on 6/26/25 at 2:25 p.m., NA-H stated R76 participated in activities occasionally. If R76 was assisted to an activity, R76 would leave the activity shortly after arrival. During interview on 6/26/25 at 3:46 p.m., RN-F stated R76 would participate in activities on and off. RN-F stated R76 usually sits in the hallway by the nurse's station. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/25 at 4:09 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R76 occasionally attended activities. LPN-A expected staff to attempt to assist R76 to all activities. LPN-A stated R76 was very hard of hearing, and it was possible that could deter R76 participating in activities. During interview on 6/26/25 at 5:37 p.m., ADON stated she would expect staff to offer and encourage all activities to R76. ADON stated R76 was very hard of hearing, but staff should attempt to find things R76 liked to do. ADON stated activities were important to keep the resident happy and to decrease the chance of worsened depression cause by boredom. The facility policy Crest View Senior Communities Life Enrichment Programming Requirements identified an ongoing program of activities shall be provided based on comprehensive assessments and care plans, designed to meet the interests, and physical, mental, emotional, social, spiritual, cultural, and leisure needs of each resident. The policy identified programs, equipment and materials will be adapted as necessary. The policy goes on to state a one-to-one program shall be scheduled and provided by a staff member or volunteer for any resident who is unable or unwilling to participate in group programs. The policy further identified each one-to one program/visit will be documented, with the focus of the visit identified. The policy lacked specification as to the frequency of the one-to-one visits for those unable or unwilling to participate in group activities.

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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** Based on observation, interview and document review the facility failed to promote and provide positioning assistance to 1 of 3 (R72), residents reviewed for positioning. Further, the facility failed to implement interventions 1 of 3 residents (R19) reviewed for vision. Findings include: R72's quarterly Minimum Data Set (MDS) dated [DATE], identified R72 had impaired cognition and was dependent of staff for assistance with activities of daily living (ADLs) including mobility and transfer, and was wheelchair bound. R72 had an impairment on one side and was identified as being dependent on staff for assistance with eating. R72's medical diagnoses include dementia, anxiety, psychotic disorder, secondary parkinsonism, and a joint disorder. R72's care plan revised 1/23/25, identified R72 had alteration in mobility related to dementia. The care plan directed staff to turn and reposition, transfer, and boost up in bed with the assist of two staff. R72 used a wheelchair and received assistance of one staff to propel wheelchair. R72's care plan identified R72 has a foam/gel cushion in the wheelchair. R72's care plan lacks direction as to how to position R72 in wheelchair. On 6/23/25 at 4:54 p.m., R72 was observed sitting in the wheelchair in the dayroom. R72's wheelchair was noted to have no footrests in place on the wheelchair. R72's tips of her slippers were touching the ground however, her heels of her slippers were approximately two inches off of the ground. R72 had a foam/gel cushion in wheelchair and her hips were positioned against the back of the wheelchair however, there was a slight angle downward of lower body without foot pedals in place. R72 had an extended headrest on the top of the wheelchair back however, R72 was holding her head forward, and her head did not rest against the headrest. On 6/24/25 at 8:32 a.m., R72 was observed in the dining room. R72 was noted to have the tips of slippers touching the floor, however, her heels of her slippers continued to rest approximately 2 inches off the floor. There were no footrests in place. On 6/24/25 at 3:47 p.m., R72 was observed being propelled down the hall by staff and it was noted wheelchair continued to lack footrests. R72 was observed to have the tips of her slippers touching the ground, however, her heels of her slippers were elevated approximately two inches off the ground. On 6/25/25 at 7:06 p.m., nursing assistant (NA)-B stated most of the time R72 slouches to the right side of the wheelchair, and staff use pillows and blankets to position her upright. R72's feet were not supported as she was sitting. NA-B stated R72 used to have foot rests on her wheelchair, however, NA-B stated she had not found them in R72's room when they assisted her in getting up today. On 6/25/25 at 7:15 p.m., registered nurse (RN)-E stated R72's feet were not supported when sitting in the wheelchair, and legs were observed to be suspended from the wheelchair, with only the toes of her slippers touching the ground. RN-E stated footrests placed on both sides of the wheelchair might help to R72 to support her feet. On 6/26/25 at 1:18 p.m., R72 was observed resting in her room, on her bed. R72's wheelchair with the extended headrest was in her room. There was a second wheelchair in her room which was not in use. Upon looking around room, there were no footrests found. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 1:21 p.m., RN-B stated staff provided assistance to R72 to reposition to maintain her in an upright position. R72's feet were supported with footrests. Upon being informed R72 had no footrests currently in place, RN-B proceeded to the room to find the footrests. RN-B stated R72 had changed wheelchairs approximately two to four weeks ago to provide better positioning. RN-B stated he was unaware footrests were not currently being used, however, should have been in place to provide support to R72's feet. On 6/26/25 at 3:59 p.m., clinical coordinator (CC)-A stated when there were concerns observed with R72's positioning of her feet not touching the floor, staff should have sought out the opinion of therapy to offer positioning suggestions. CC-A stated therapy would be able to determine if additional positioning devices were indicated or determine if foot pedals were needed to promote good positioning, and support of R72's feet. The facility policy, Activities of Daily Living (ADL's), revised 11/23 indicated residents unable to carry out ADL's independently will receive the services necessary to maintain good nutrition .and mobility. The policy further identified services would be provided for residents with ADL's, which included mobility (transfer and ambulation, and walking). The policy identified the resident response to interventions will be documented, monitored, evaluated, and revised as appropriate. The policy lacked direction to staff regarding provision of assistance with wheelchair positioning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition and required assistance with all activities of daily living (ADLs). R19's diagnoses included chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), non-Alzheimer's dementia, anxiety disorder, depression, schizophrenia (a chronic mental disorder that disrupts a person's thinking, behavior, and emotions) and nicotine dependence. MDS identified R19's vision was adequate and R19 wore eyeglasses. R19's care plan reviewed 6/26/25, identified R19 had an alteration in skin integrity with an intervention to apply a band-aid around metal nose piece on glasses for extra padding. During observation on 6/23/25 at 4:46 p.m., R19's eyeglasses were positioned on the very tip of her nose causing indent with skin under metal nose piece being purple in color. Glasses lacked padding (band-aid) over metal piece that went over the bridge of R19's nose. During observation on 6/24/25 at 3:58 p. m., R19 was seated in the dining room and eyeglasses were positioned on the very tip of her nose causing an indent with skin under metal nose piece being purple in color. Glasses lacked padding (band-aid) over metal piece that went over the bridge of R19's nose. During observation on 6/26/25 at 7:22 a.m., R19 was seated in the dining room and eyeglasses were positioned on the very tip of her nose causing an indent with skin under metal nose piece being purple in color. Glasses lacked padding (band-aid) over metal piece that went over the bridge of R19's nose. During interview on 12:47 p.m., nursing assistant (NA)-H stated R19 glasses were often on the tip of her nose and confirmed there was an indent and skin was purple. NA-H stated there were no interventions in place to protect skin.During interview on 6/26/25 at 3:37 p.m., registered nurse (RN)-F stated R19 often had an indent and purplish colored skin on her nose where her glasses settled. RN-F stated she was not aware of the intervention to wrap a band-Aid around the metal frame to protect the skin on R19's nose.During interview on 6/26/25 at 4:03 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R19 recently got new glasses and may need her glasses readjusted. LPN-A stated she expected staff to update her on the indent and skin discoloration and to use the band-aid intervention that was in place to assist with protecting the skin. During interview on 6/26/25 at 5:22 p.m., assistant director of nursing (ADON) stated she would expect the nurse to monitor the skin on R19's nose for any abnormality and to ensure a band-aid was in place. ADON confirmed R19's care plan indicated band-aid to be used on glasses. ADON stated it was important to follow interventions to protect R19's skin integrity and to prevent pressure sores. A policy regarding eyeglasses was requested but was not received.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids/devices were available to maintain hearing/communication needs for 1 of 1 resident (R76) reviewed for hearing. Findings Include: R76's quarterly MDS dated [DATE], identified R76 had severe cognitive impairment and required assistance with all ADL's. R76's diagnoses included non-traumatic brain dysfunction (brain damage that occurs due to internal factors, rather than external trauma), Alzheimer's disease with late onset, diabetes mellitus (a group of metabolic diseases characterized by high blood sugar levels), anxiety disorder and depression. MDS indicated R76's hearing was moderate difficulty needed hearing aids.R76's care plan, reviewed 6/26/25, identified R76 had an alteration in communication related to hard of hearing and had two hearing aids. The care plan directed staff to ensure glasses and bilateral hearing aides were worn daily, to anticipate needs as needed, allow R76 time to respond, observe for changes in communication and speak clearly and validate the message was sent was understood by R76. During observation on 6/23/25 at 2:48 p.m., R76 was sitting in the hallway by the nurses' station and was having difficulty hearing staff. R76 was not wearing any hearing assistive devices.During observation on 6/24/25 at 4:03 p.m., R76 was sitting at the dining room table and was attempting to have a conversation with a co-resident but was having difficulty hearing her. R76 was not wearing any hearing assistive devices. During observation on 6/25/25 at 11:53 a.m., R76 was sitting in the hallway by the nurses' station and was having difficulty hearing staff. Unidentified nurse leaned down and talked loudly directly into R76's ear for R76 to be able to hear nurse.During observation on 6/25/25 at 12:07 p.m., unidentified staff went to R76's room and got a pocket talker and assisted R76 with putting them on her ears and turning it on.During observation on 6/25/25 at 12:22 p.m., unidentified nurse was attempting to communicate with R76 with R76 still having difficulty hearing her.During observation on 6/26/25 at 2:20 p.m., R76 was sitting in the hallway by the nurses' station and was having difficulty hearing staff. R76 was not wearing any hearing assistive devices. During interview on 6/25/25 at 12:51 p.m., nursing assistant (NA)-G stated R76 was very hard of hearing and had a pocket talker R76 should wear at all times when awake.During interview on 6/26/25 at 2:25 p.m., NA-H stated R76 was extremely hard of hearing and has a pocket talker R76 could use when she asks for it. During interview on 6/26/25 at 3:46 p.m., registered nurse (RN)-F stated R76 had significant hearing impairment and has a pocket talker R76 could use when she asks for it. During interview on 6/26/25 at 4:09 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R76 had significant hearing impairment, and the left ear was better than the right ear but still had increased difficulty hearing. LPN-A stated she was not sure what had happened to R76's hearing aids. LPN-A stated R76 had a pocket talker she could wear if she desired but did not like it too much and not sure if it made any difference in her ability to hear. During interview on 6/26/25 at 5:37 p.m., assistant director of nursing (ADON) stated R76 should wear the pocket talker at all times as it was important for R76 to be able to hear and communicate with other residents and staff for socialization and her mental health. A policy was requested but was not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a thorough smoking assessment was completed for residents who wished to smoke for 1 of 1 resident (R19) reviewed for smoking. Findings include: R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition and required assistance with all activities of daily living (ADLs). R19's diagnoses included chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), non-Alzheimer's dementia, anxiety disorder, depression, schizophrenia (a chronic mental disorder that disrupts a person's thinking, behavior, and emotions) and nicotine dependence. The MDS lacked documentation R19 was a current tobacco user.R19's care plan reviewed 6/26/25, indicated R19 had elected to be an active smoker and was an independent smoker, had a goal of remaining free from injury associated with smoking and follow the facility smoking policy. The care plan went on to indicate smoking assessment would be completed per facility policy and R19 was to wear a smoking apron when she went out to smoke. R19's last and most recent smoking assessment, dated 8/2/24, lacked evidence the smoking apron was being used and/or assessed. During observation on 4:35 p.m., unidentified staff assisted R19 outside to smoke. Unidentified RN provided reminder to staff assisting R19 reminder she needs to wear an apron, staff replied, oh yeah.During interview on 6/23/25 at 4:31 p.m., R19 stated she was an active smokier and stated she did not have difficulty with lighting cigarettes and does not wear any certain smoking equipment. During interview on 6/25/25 at 12:47 p.m., nursing assistant (NA)-G stated R19, per care plan, was able to smoke independently and wore a smoking apron that was hanging over by the door where R19 went out to smoke. During interview on 6/26/25 at 2:22 p.m., NA-H stated R19, per care plan, could smoked independently and used a smoking apron when going out to smoke. During interview on 6/26/25 at 3:37 p.m., registered nurse (RN)-F stated R19, smoked independently and did not wear a smoking apron when going out to smoke. RN-F stated floor nursing was responsible for completing the smoking assessments and they should be completed every six months. During interview on 6/26/25 at 4:03 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R19, per care plan, was able to smoke independently and should wear a smoking apron when going out to smoke. LPN-A stated smoking should be reassessed quarterly. During interview on 6/26/25 at 5:22 p.m., assistant director of nursing (ADON) stated smoking assessments should be completed every six months as it was important to see if anything had changed and to ensure resident was still safe to smoke. ADON confirmed last smoking assessment was completed on 8/2/24 and stated R19 should have had another smoking assessment completed since 8/2/24. ADON confirmed smoking apron was not assessed or identified on the smoking assessment. The facility Smoking Policy, dated 2/25, indicated staff are responsible for ensuring that residents are kept safe from accidents related to smoking.-Residents who have been identified as smokers will be assessed upon admission, reviewed quarterly, annually, and as needed for significant changes or incidents that occur.-The Individualized Smoking Evaluation will determine whether a resident has been deemed safe to smoke without supervision. All findings from the Individualized Smoking Evaluation will be documented in the resident care plan.-If an individualized Smoking Evaluation determines that a resident will need supervision in order to safely smoke, a scheduled smoking plan will be developed for the resident and update in the Care Plan. Smoking materials for these residents will be held by the Nursing Staff and given to residents according to resident smoking plan. -It is required that all resides who are evaluated as needing a smoking apron, based on their Individualized Smoking Evaluation, will always wear one while smoking. Smoking aprons are located next to the door to the smoking patio.

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Crest View Lutheran Home	4444 Reservoir Boulevard Northeast Columbia Heights, MN 55421

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to properly assess and obtain orders for 1 of 1 resident (R43) reviewed for use of oxygen therapy.Findings include:R43's annual Minimum Data Set (MDS) dated [DATE], identified R43 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R43's diagnoses included atrial fibrillation (a common type of irregular heartbeat that originates in the heart's upper chambers (atria)), heart failure (a condition where the heart can't pump enough blood to meet the body's needs), hypertension (high blood pressure), cerebrovascular accident (occurs when blood flow to the brain is interrupted, causing brain cells to die due to lack of oxygen and nutrients), depression, attention-deficit hyperactivity disorder (ADHD) (a neurodevelopmental condition that affects brain function and behavior, primarily in the areas of attention, hyperactivity, and impulsivity) and aortic aneurysm and dissection (An aortic aneurysm is a bulge or ballooning of the aortic wall, while an aortic dissection is a tear in the aorta's inner lining, allowing blood to flow between the layers). MDS indicated R43 received oxygen therapy.R43's care plan (CP) reviewed 6/26/25, included R43's use of oxygen but failed to indicate the reason for use, the rate oxygen was to be set at and the route of which the oxygen was supposed to be administered. R43's hospital records dated 5/28/25, included R43 wore three liters of oxygen via nasal cannula, which was his baseline. R43's physician orders, reviewed 6/26/25, lacked an order for oxygen use. R43's electronic health record (EHR) included a nursing note dated 5/29/25 at 10:22 p.m., included resident was on two liters of oxygen via nasal cannula. R43's medication administration record (MAR) and treatment administration record (TAR) lacked evidence of an order for oxygen.During observation and interview on 6/24/25 at 9:42 a.m., R43 was lying in bed and did not have oxygen on. R43 stated he needed to wear oxygen at all times and had a portable oxygen tank hanging on back of his wheelchair. R43 also had an oxygen concentrator in the corner of his room. During observation on 6/24/25 at 3:40 p.m., R43 was sitting in wheelchair in his room and did not have oxygen on. Portable oxygen tank was hanging off the back of R43's chair. At 3:50 p.m., unidentified staff assisted R43 out of his room for dinner and assisted R43 with applying oxygen.During observation on 6/25/25 at 12:04 p.m., R43 was sitting in the dining room looking out the window into the courtyard. R43 had oxygen cannula in nares and was connected to the portable oxygen tank that was hanging on the back of his wheelchair with flow rate set to two and one-half liters. During observation on 6/26/25 at 7:23 a.m., R43 was lying in bed and did not have oxygen on.During observation on 6/26/25 at 11:03 a.m., R43 was sitting at a dining room table. R43 had oxygen cannula in nares and was connected to the portable oxygen tank that was hanging on the back of his wheelchair with flow rate set to two liters. During observation on 6/26/25 at 2:30 p.m., R43 was wheeling down hallway in his wheelchair and did not have oxygen on. R43's portable oxygen was hanging on the back of his wheelchair. During interview on 6/25/25 at 12:49 p.m., nursing assistant (NA)-G stated R43 had to wear oxygen at all times and was not sure of what the flow rate was supposed to be as she was not able to adjust the flow rate. During interview on 6/26/25 at 2:27 p.m., NA-H stated R43 wears oxygen all the time. NA-H stated R43 would occasionally remove oxygen, and staff would assist him with reapplying if noticed. NA-H stated R43 was on two liters per minute.During interview on 6/26/25 at 3:46 p.m., registered nurse (RN)-F stated R43 needed to wear oxygen all the times and the flow rate was to be set at three liters. RN-F looked in R43's EHR and stated she could not locate an order for oxygen. RN-F then looked in R43's hard chart and found an order, dated 4/21/25, for oxygen three liters per minute. During interview on 6/26/25 at 4:16 p.m., licensed practical nurse clinical coordinator (LPN)-A stated R43 wore oxygen at all times but was not always compliant. LPN-A confirmed there were no orders for oxygen therapy in R43's EHR.During interview on 6/26/25 at 5:44 p.m., assistant director of nursing (ADON) stated R43 should wear oxygen at all times. ADON confirmed oxygen was a medication and an order would need to be obtained to administer it. ADON stated she did not see an order for oxygen in R43's EMR. It was her expectation that staff followed up with either the hospital or the primary provider to obtain an order. The DON stated it was important because there are residents who should not be on oxygen, and it should be evaluated by the provider.Contact with nurse practitioner was attempted with no success. The facility Oxygen Documentation and Monitoring policy, dated 11/23, indicated all residents using oxygen will have the proper oxygen orders in pace and appropriate monitoring and documentation will be completed. All residents who are in need of oxygen will have the appropriate orders in place including, but not limited to: liter flow, delivery mode - mask/nasal cannula/etc

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for 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 comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 (R47) resident reviewed who had a history of past traumatic experiences. Findings include:R47's quarterly Minimum Data Set (MDS) dated [DATE], identified R47 had intact cognition and required assistance with all activities of daily living (ADLs). 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).R47's care plan print date of 6/26/25, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization.R47's electronic health record (EHR) lacked evidence the facility assessed R47 for trauma. During interview on 6/25/25 at 6:33 p.m., R47 stated she had post-traumatic stress disorder (PTSD). R47 stated she had a long history of trauma going back to her childhood which consisted of verbal, physical and sexual abuse by multiple family members. R47 stated she would see demon-like shadows in her room at the facility. R47 stated these issues still affect her daily life as she thinks about it often. R47 stated due to her past trauma, she liked to feel in control. R47 stated she would get triggered when staff were demanding and would not listen to what R47 was attempting to communicate to them causing old memories to resurface. R47 stated she got upset during these interactions with staff. R47 stated no one at the facility had ever asked/talked to her about her past trauma. During interview on 6/26/25 at 2:26 p.m., nursing assistant (NA)-H stated she was not aware of R47's history of PTSD and was not aware of triggers. NA-H stated R47 frequently gets upset with staff and was not sure the reason behind it. NA-H stated it would be important to know if a resident had certain triggers so if they exhibit behaviors we know how to respond. During interview on 6/26/25 at 3:36 p.m., registered nurse (RN)-F stated she was not aware of R47's history of trauma. RN-F stated R47 had a lot of anxiety and did not like being at the facility. RN-F was not aware of any triggers and confirmed there was no trauma assessment completed to address R47's PTSD. During interview on 6/26/25 at 4:07 p.m., licensed practical nurse clinical coordinator (LPN)-A stated she was not aware of R47's history of trauma. LPN-A stated if a resident had a diagnosis of PTSD the social worker would complete a trauma assessment and reflect the information received into the residents' plan of care. During interview on 6/26/25 at 4:39 p.m., social worker (SS)-A stated she and her assistant were responsible for completing assessments for trauma. SS-A stated information received from the trauma assessment such as triggers and interventions would be added to the resident's plan of care as it was very important for all staff to know what they consisted of as it could lead to worsened mental health or suicidal ideation. SS-A stated she was not aware R47's diagnosis included PTSD. SS-A confirmed trauma assessment was not completed for R47. During interview on 6/26/25 at 5:38 p.m., assistant director of nursing (ADON) stated if a resident had a diagnosis of PTSD, it would be included on R47's diagnosis list and in the plan of care. ADON stated social services would complete the trauma assessment and would add the information related to PTSD on the resident's care plan based on assessment. ADON confirmed trauma assessment was not completed for R47's and PTSD diagnosis was not added to R47's EHR. ADON stated it would be important for staff to know the resident's back story and triggers so they can provide the resident with the best possible care. The facility Trauma Informed Care policy, undated, indicated Crestview was dedicated to ensuring that all residents receive appropriate person-centered care as it related to their personal circumstances, including those with a history of trauma or Post-Traumatic Stress Disorder (PTSD).1. Residents undergo a Trauma-Informed Care Assessment upon admission and at least annually or as necessary. Care plans are developed as part of the assessment process. Assessments may consider military service, history of violence or abuse, displacement, medical trauma, or other events that may have contributed to PTSD.2. Staff are trained upon hire and at least annually in regard to trauma and person-centered care, including information about managing behaviors and de-escalation techniques.3. Interactions with residents are conducted in a calm, respectful manner to promote trust. Staff are instructed to explain procedures before initiating care, offer choices and autonomy whenever possible, and avoid sudden movements or yelling

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and document review, the facility failed to assure medications were properly labeled with the correct dose for 1 of 1 resident, (R20), who received a liquid medication during observation of medication administration. The facility also failed to assure over the counter (OTC) medications were dated when opened in 2 of 3 medication carts reviewed. The facility also failed to consistently date, and/or remove inhalers which were beyond the dates of recommended use, in 1 of 3 medication carts. In addition, the facility failed to remove vaccines which had either an illegible label, or lacked a label, in 2 of 2 medication rooms reviewed. Findings include: Labeling Error: During observation of medication pass on 6/25/25 at 12:17 p.m., trained medication aide, (TMA)-A, was observed as he set up medications for R20. TMA drew Haldol medication up to the 1 (one) mg (milligram) marker on the medication dropper twice. TMA-A stated R20 received 2 (two) mg twice daily, as directed on the medication administration record (MAR), with a dose of 3 (three) mg at bedtime. Upon review of the label on the medication bottle, it identified the dosage of Haldol was 2 mg per ml (milliliters). The medication label on the bottle directed staff to give 1.5 ml (3 mg) by mouth twice daily, and 1 ml (2 mg) by mouth at bedtime. Upon noting the discrepancy between label and amount prepared, TMA was stopped to seek clarification. On 6/25/25, at 12:26 p.m. clinical coordinator (CC)-A was consulted and stated she would follow up on this and seek clarification of orders. It was also noted there was a new bottle of Haldol in the drawer, dispensed by the pharmacy on 6/9/25, which reflected the same instructions as were reflected on the current bottle. TMA-A stated typically, when there was a change of orders, there was a sticker applied to the label which identified Direction change. See MAR [medication administration record]. TMA-A stated subsequent medications dispensed would then have the correct label from the pharmacy. The current medication had no sticker applied to the label to indicate a change in orders. TMA-A stated he was unsure if anyone had called the pharmacy to clarify. On 6/25/25 at 12:37 p.m., CC-A stated upon review of orders for Haldol, it was noted the orders listed on the MAR were correct. CC-A stated R20's medical record identified the dose of Haldol was decreased to 2 mg in the morning and was increased to 3 mg at bedtime on April 25, 2024. CC-A stated when a new order was received, it was faxed to the pharmacy. If there were remaining medication left, a direction change sticker would be applied to the medication for continued use. Subsequent refills would bear the correct instructions. CC-A stated when a discrepancy was noted during med pass, upon clarification of the order, a sticker should be applied to the medication. CC-A stated either the new order for R20's Haldol was not faxed, or the pharmacy had not followed through. CC-A stated follow through was important to assure the correct dosage of medication was given. CC-A stated this discrepancy should have been noted previously, as this had occurred greater than one year ago. TMA-A stated when he noted a discrepancy, he asked the nurse to check into this. If the label was not correct, he or the nurse would put a direction change sticker on it. The nurse would notify the pharmacy. TMA-A stated I should have caught this. It shouldn't have been that long. TMA-A stated when there were discrepancies, the resident could have been given the wrong dose. Medication Room Observation/Storage/Unlabeled Vaccines: On 6/26/25 at 1:56 p.m., an observation was completed with registered nurse (RN)-B in the memory care unit. The refrigerator was inspected and was noted to contain an plastic bag with an illegible name noted on the label, the date dispensed was illegible, with vials of Arexvy (a vaccine for the RSV-respiratory syncytial virus) in it. RN-B stated he was unsure of who this person was, and stated the vaccine would not be used and should have been removed. On 6/26/25 at 2:39 p.m., the clinical coordinator (CC)-A stated this was an RSV dose for R500, who had been discharged in 4/7/25. R500 was scheduled to receive the RSV vaccine on 4/11/25. CC-A stated R500 was no longer a resident and this vaccine should have been removed from the refrigerator. On 6/26/25 at 3:10 p.m., upon review of the medication refrigerator on the transitional care unit (TCU), it was noted there was one unlabeled vaccine package of RSV vaccine. RN-D stated she was unsure as to who this belonged to and stated it should not have been in the refrigerator. On 6/26/25 at 3:46 p.m., CC-A stated the unlabeled dose of RSV should have been removed from the medication refrigerator and destroyed. Dating of medications: On 6/26/25 at 3:16 p.m. , the medication cart on TCU was reviewed in the presence of registered nurse (RN)-A. During this review, the following over the counter (OTC) medications were opened but not dated:- Daily Vitamins, one bottle which contained 100 tablets, had at least 50 tablets left as estimated by registered nurse (RN)-A.- Banophen (diphenhydramine) 25 mg (milligram-a unit of measurement) one bottle which contained 100 tablets as estimated by RN-A as having approximately 75 or greater remaining - Ibuprofen 200 mg one bottle, which

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a homelike environment for dining, assuring food was offered to residents and assistance was received as needed in a timely manner. This had the potential to affect all 18 residents served in the memory care dining room. Findings include: R5's quarterly Minimum Data Set (MDS) of 5/8/25, indicated R5 had impaired cognition and was dependent on staff for eating. R9's quarterly MDS of 5/19/25, indicated R9 had impaired cognition, and although R9 required set up for meals, R9 was identified as able to complete eating once set up. R21's annual MDS of 4/30/25, indicated R21 had impaired cognition and required set up for meals. Resident was noted to complete the activity. R25's quarterly MDS of 5/13/25, indicated R25 had impaired cognition and required moderate assist with eating. R36's quarterly MDS of 3/28/25, indicated R36 had impaired cognition and required maximal assistance with eating. R41's annual MDS of 3/21/25, indicated R41 had impaired cognition, and required set up for meals. Resident was noted to complete the activity. R42's annual MDS of 3/31/25, indicated R42 had impaired cognition and required supervision or touching assistance with eating, however, when provided with verbal cues, or touching/steadying assistance, as R42 was able to participate in eating. R48's quarterly MDS assessment of 6/2/25, indicated R48 had impaired cognition and required supervision or touching assistance with eating. R48 required set up for meals, however, with supervision or hands on assist, R48 was able to participate in eating. R72's quarterly MDS dated [DATE] identified R72 had impaired cognition and was dependent of staff for assistance with activities of daily living (ADL's), including eating.R74's significant change assessment MDS of 3/4/25, indicated R74 had impaired cognition and required set up for meals. Resident was noted to complete the activity. R283's admission MDS of 6/3/25, indicated R283 had impaired cognition and required set up for meals. Resident was noted to complete the activity. R284's admission MDS of 6/10/25, indicated R284 had impaired cognition and required supervision or touching assistance with eating. This identified R42 required verbal cues, or touching/steadying assistance while eating. On 6/23/25 at 11:20 a.m., it was noted the dining room in memory care was currently serving noon meal. Nursing assistant (NA)-C was the only staff member in the dining room. Covered plates were placed in front of R5, R48, and R72 without assistance provided to remove the domes from the plates, set up for eating, or being given assistance to eat. The remainder of the residents in the dining room had received assistance to remove the domes from the plates, and the plates were set up in front of them. It was noted at that time, the following domed plates were placed for residents who were not in the dining room, which included R41, R74, R283, and R284. On 6/23/25 at 11:26 a.m., R5 and R25 were observed to have their plates uncovered, and in front of them, however, had been offered no assistance or prompts. On 6/23/25 at 11:29 a.m., R283 arrived in dining room and plate was uncovered. R283 was offered a beverage and was set up for her meal. R283 proceeded to eat independently. All other domed/covered plates remain in place for R41, R74, and R284.On 6/23/25 at 11:31 a.m., registered nurse (RN)-G arrived in the dining room. At that time, the cover was removed from the plate placed in front of R48 (18 minutes from the time first observed) however, RN-G did not provide assistance immediately. At 11:33 a.m. NA-C directed RN-G to provide assistance to R48 to eat. RN-G noted there was no silverware in place and left to get silverware. RN-G returned at 11:37 a.m. (four minutes after going to get silverware, six minutes after plate was prepped, and 26 minutes after plate was observed to be served in front of resident). RN-G was observed seated next to R48, who was sitting with her eyes closed, not eating. On 6/23/25 at 11:34 a.m., NA-C was observed as she aided R72. At 11:35 a.m., NA-C provided verbal prompts across the room to have R25 start eating. This was eight minutes after plate had been observed to have been set up. NA-C did not go to R25, or provide any additional prompts. At 11:40 a.m., without further prompts, R25 started to take some bites on her own. On 6/23/25 11:38 a.m., NA-J entered to speak with RN-G, and then stayed to assist R48 when RN-G left the dining room. On 6/23/25 at 11:40 a.m., NA-C provided verbal prompts, from the table where she was seated, to R42 to eat her lunch. On 6/23/25 at 11:41 a.m., stated to R72 that she had completed her meal. On 6/23/25 at 11:42 a.m., NA-C sat down next to R36, who was seated across from R21. NA-C provided hands on assist to R36 to eat her meal. This was 21 minutes after plate was initially set up. R21 was provided with verbal cues to eat her meal. On 6/23/25 at 11:47 a.m., R9 called out Am I supposed to starve? R9's plate was noted in front of her, however, she received no assistance or prompts. On 6/23/25 at 11:47 a.m., NA-K entered the dining room, however, did not offer assistance to any residents

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review the facility failed to appropriately store nutritional supplements in two of two medication rooms reviewed during medication room storage observation. This had the potential to impact all residents who routinely received, or may received nutritional supplements on those units. In addition, the facility failed to ensure the ice machine was in good repair. This had the potential to affect residents, staff and visitors who obtained ice from the kitchen. Findings include: On 6/26/25 at 1:56 p. m., an observation was completed with registered nurse (RN)-B in the memory care unit medication room. The following boxes of nutritional supplements were being stored on the floor: An open box of Breeze (a nutritional supplement) with 5 boxes of supplement remaining. One case of 24 boxes of Boost nutritional supplements which were unopened. There were two boxes of Ensure Plus which contained 24 boxes of nutritional supplement when unopened. There was one unopened box, and an additional box of 20 containers. RN-B stated the supplements were placed there when they were delivered to the unit. RN-B identified an open space in the cupboard below the sink where the supplements could be stored. RN-B stated he was unaware items could not be kept on the floor for storage. On 6/26/25 at 2:39 p.m., the clinical coordinator (CC)-A stated nutritional supplements were currently being kept on the floor of the transitional care unit (TCU) medication room. CC-A was unaware nutritional supplements were also on the floor of the medication room in the memory care unit. CC-A stated nutritional supplements had also been stored in the dining room of the TCU, however, the supplements needed to be kept in a locked cupboard as some residents would take them from the refrigerator. CC-A stated the cupboard lock was broken, so now all supplements were stored in the medication room on the floor. CC-A stated she was unaware items could not be stored on the floor. On 6/26/25 at 3:10 p.m., upon review of the TCU medication unit, it was noted there were nutritional supplements currently being stored on the floor. RN-D stated the count of the boxes of nutritional supplements were as follows: Ensure Plus, 24 count per case, seven full cases. Boost Nutritional Supplement, 24 count per case, two full cases. Breeze Nutritional Supplement, one case of 24 count per case.RN-D stated this was where the supplements were normally kept. RN-D noted there was space on the metal storage shelves in the medication room if some items were moved to make room for the supplements. RN-D stated she was unaware nutritional supplements could not be stored on the floor. A facility policy was requested for storage of nutritional supplements, however, none was received. Ice MachineOn 6/23/25 at 11:18 a.m., during initial kitchen tour observed ice machine, there were two areas measuring one inch by one inch missing black plastic of the surface of the door. In these areas there was firm, yellow insulation with about a quarter of an inch area that was worn down. The left side area had a brown, yellow substance on the firm yellow insulation along the broken edge of the plastic. On 6/25/25 at 11:47 a.m., dietary director (DD) stated she had never noticed there was worn area on the ice machine door. DD stated the worn areas on the door was not able to be appropriately cleaned or disinfected. this was a concern for infection control and particles could get into the ice. Environmental service director (ESD) entered the kitchen, DD showed ESD ice machine door who directed DD to call the repair person as anything he had would not be appropriate to repair the door. 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 the ice machine door was found. Facility policy for ice machine maintenance was requested and was not received.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and document review, the facility failed to ensure the kitchen was kept clean, sanitary and in good repair which had the potential to affect all residents, staff and visitors who received meals from the kitchen.Findings include:During observation of the kitchen and interview on 6/25/25 at 12:18 p.m., dietary director (DD) noted the floor next to the dishwasher had six tiles with corners missing, the grout between four additional tiles was also missing. On the surface where there had been tile and grout there was a green substance on the subfloor. DD stated, yep, there's missing chunks, missing grout and green stuff. DD then stated, watch this, grabbed dish sprayer, soaked down the floor filled the areas where there as missing tile chunks and grout with water stating, see it doesn't look like that anymore, we mop twice a day so it won't look like that later. DD stated this was a cleaning concern and was potential for bacteria to grow. During observation on 6/26/25 at 7:23 a.m., the floor in dishwashing area continued to have missing tile chunks, missing grout and green substance it area where tile and grout had once been. 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 kitchen floor tiles was found. A facility policy and/or procedure on kitchen cleaning and maintenance was requested, however, none was provided.

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	06/26/2025

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.