STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245018	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement effective interventions to minimize the risk of pressure ulcer development for 1 of 2 residents (R2) observed to utilize an ineffective pressure redistribution cushion and not receive assistance for turning/repositioning or offloading. Findings include: R2's undated [DIAGNOSES REDACTED]. R2's admission Minimum Data Set ((MDS) dated [DATE], indicated R2 was cognitively intact and required extensive assistance with bed mobility, supervision with toileting and dressing, and limited assistance with grooming and ambulation. The MDS also indicated R2 had no open skin areas or pressure ulcers present. R2's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 5/13/20, indicated due to weakness, R2's level of assistance needed varied from set up assistance, to supervision, to requiring assistance. R2's Pressure Ulcer CAA dated 5/13/20, indicated R2 was at risk for pressure ulcer development due to the need for assistance with bed mobility and his incontinence of bowel. R2's Care Plan with revision date of 5/6/20, directed staff to assist R2 with dressing, grooming and bathing. The care plan identified an alteration in skin integrity related to decreased mobility on 5/13/20, and directed staff to monitor skin with cares, encourage physical activity as able, and to notify dietary with any open area or skin changes. The care plan lacked interventions to address offloading (relieve pressure with elevation to allow for tissue reperfusion) or turning and repositioning to prevent pressure ulcer development. The care plan also lacked identification of the use of any pressure relieving devices. R2's skin risk evaluation/body audit dated 5/27/20, indicated R2 was a high risk for pressure ulcer development. The audit identified R2 had an air mattress on the bed, a cushion in his wheelchair, R2 was able to reposition himself when in bed, and had no actual open areas or areas of concern on his skin. The audit summary indicated R2 utilized a wheelchair to move around. However, the audit did not address R2's ability to offload pressure when seated in his wheelchair, or the amount of time R2 spent sitting in his wheelchair. On 6/23/20, from 9:15 a.m. until 12:36 p.m. R2 was continuously observed: -At 9:15 a.m. R2 was observed seated in his wheelchair, facing the outside room door with his chin resting on his chest, asleep. R2 was seated on top of a thin, black seat cushion. -At 9:55 a.m. R2's position remained unchanged. No staff were observed to have entered his room. -At 10:19 a.m. R2's position remained unchanged. He appeared to be sleeping in his wheelchair and did not respond to a knock on his door. -At 10:39 a.m. R2's position remained unchanged. -At 10:55 a.m. R2 was awake and he had turned on his radio and was listening to the radio. -At 11:02 a.m. R2 remained seated in the wheelchair. An unidentified nursing assistant (NA) entered R2's room, donned gloves and proceeded to drain R2's urinary leg bag into a graduate, emptied the graduate, removed her gloves, washed her hands and exited the room. At no time did the NA offer nor provide R2 repositioning/offloading assistance. R2 remained seated in the wheelchair. -At 11:38 a.m. Another unidentified NA entered R2's room with his lunch meal, set up the meal on the over-bed table, and exited the room. At no time did the NA offer nor provide repositioning/offloading assistance. R2 remained seated in the wheelchair. -At 12:20 p.m. R2 remained seated in his wheelchair, in front of his bedside table, eating lunch. -At 12:36 p.m. R2 remained seated in his wheelchair, in front of his bed, talking on the phone. On 6/24/20, at 8:06 a.m. NA-H and NA-I were observed assisting R2 to dress. Both of R2's inner thighs were noted to have approximately 3.0 centimeters (cm) by 3.0 cm, deep, red areas on bilateral inner thighs and also a 4.0 cm x 4.0 cm deep, red area to the coccyx with a small amount of peeling skin in the center of the reddened area. At this time, registered nurse (RN)-A stated R2's skin had improved and he no longer had any open areas. RN-A directed the NA to apply skin barrier cream to the reddened areas. On 6/24/20, at 4:14 p.m. NA-G stated R2 was not identified on their care directive sheet as requiring repositioning/offloading assistance. NA-G stated the staff assisted R2 only when he requested and R2 was pretty good about asking for help when he needed something. NA-F stated R2 was not able to independently lift his weight off and up from a sitting position while seated in his wheelchair. -At 4:22 p.m. RN-D stated when he would see R2, he would ask him to lie down (pressure relief) in which R2 a lot of times, would comply. RN-D stated he knew R2 was to be turned and repositioned every two hours every day, because that is what he implemented for all his residents. RN-D verified the nurses aide care sheet did not direct the aides to offload or reposition R2 and should have. On 6/25/20, at 9:58 a.m. R2 was observed seated in the wheelchair and when asked if he was able to offload independently, R2 attempted to lift his buttocks up off the wheelchair, but was unable to do so. -At 10:30 a.m. licensed practical nurse (LPN)-A stated R2 was unable to lift his weight up/offload off the wheelchair seat/cushion independently. At this time, LPN-A attempted to assist R2 to a standing position, however, R2 was unable to stand and balance and required additional weight bearing assistance. LPN-A exited the room to obtain another staff member to assist. Shortly thereafter, RN-A and LPN-A entered the room and with the use of a gait belt and wheeled walker, assisted R2 to a standing position in order to observe the condition of his buttock skin. When RN-A lowered R2's pants and incontinent brief, R2's bilateral inner thighs and coccyx were a notably deep red in color with no open areas. However, the black Roho (inflatable seat cushion used for preventing and treating pressure ulcers) seat cushion, R2 was seated on, was flat and devoid of air. RN-A confirmed the seat cushion was deflated and the cushion's rubber fingers were flattened down with a firm surface felt underneath. RN-A stated she would call therapy to have the Roho cushion replaced as it was not effective with providing pressure relief. R2 was seated back down into the wheelchair without a pressure redistribution cushion on the seat. Upon leaving R2's room, RN-A notified therapy and requested they come and air up R2's Roho cushion. On 6/25/20, at 11:00 a.m. the assistant director of nursing (ADON) stated on June 3rd he was notified by an NA that R2 had an open area on his left buttock and at that time, he had assessed the wound as a pressure ulcer and also assessed R2's chair. The ADON stated during the chair assessment, he had noted R2's Roho pressure redistribution cushion would not hold air, therefore he had ordered a new cushion for R2. The ADON stated he felt replacing the Roho cushion with a new cushion along with R2's ability to micro shift his weight while seated in the wheelchair, would be adequate pressure relief interventions for R2 and no further interventions were needed. He had not updated the NAs care sheet or care plan because R2 could shift (redistribute weight) on his own. The ADON stated he thought R2 needed some assistance to reposition in bed, but was unsure if R2 was on a turning and repositioning schedule. However, the ADON stated he had not assessed R2's ability to lift his weight (offload) up off the wheelchair seat and verified R2 required assistance to stand and transfer from his wheelchair. The ADON stated he had talked to R2 regarding the need to lie down to relieve pressure on his buttocks, however, verified this directive was not noted on R2's care plan or nursing assistant care sheets to inform the NAs that R2 required repositioning assistance and encouragement to do so. On 6/25/20, at 2:00 p.m. the director of nursing (DON) verified R2 had a history of [REDACTED]. DON also indicated she would have expected this information be documented on the care plan. The facility policy Skin and Pressure Ulcer Policy and Procedures with a review date of 6/17, indicated weekly body audits were to be performed by licensed nurse on resident's bath day and findings documented. The policy directed staff to encourage ambulation, activity and mobility as tolerated; establish and record an individualized turning and repositioning schedule if the resident was immobile. The policy indicated frequency of position changes was titrated for the individual resident.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.**

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

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Based on observation, interview and document review, the facility failed to implement appropriate infection control practices related to COVID-19 by failing to conduct required health screenings for all who entered the facility. This practice had the potential to affect all 95 residents who resided in the facility. The facility also failed to ensure appropriate hand hygiene was performed during the provision of personal cares for 1 of 3 residents (R4) observed to receive cares. Findings include: During observation on 6/23/20, at 6:55 a.m. the front entrance doors of the facility were observed to be unlocked. There were no signs to identify visitor restrictions were in place or to direct visitors to seek screening prior to entrance into the facility due to COVID-19 precautions. The entrance also lacked signage indicating mask use was required. Upon entry into the facility, alcohol based hand gel was available to use. A male resident was observed seated in a wheelchair, in the middle of the main lobby area, with no facial mask on. A staff member was noted to be seated at a table, charting and did not acknowledge the state agency (SA) staff's presence. Both surveyors entered the facility unnoticed and proceeded to walk through the main lobby area, and through the swinging doors that lead to the Evergreen unit. Upon entrance to the unit, the SA staff proceeded to walk down the hallway, past several occupied resident rooms, with their doors wide open to the hall. Three staff members were noted to be wearing masks. The SA staff greeted licensed practical nurse (LPN)-F who stated he would find the director of nursing (DON). LPN-F and trained medication aide (TMA)-A did not question the SA's presence nor inquire about having been screened upon entrance to the facility. LPN-F led the SA staff back through the Evergreen unit and back into the facility entrance area. On 6/25/20 at 7:05 a.m. the DON escorted the SA staff to a conference room. When asked about the unlocked/manned front door, the DON stated the door was unlocked by the night charge nurse at around 6:00 a.m. so that the day shift staff could enter the facility. The DON stated the staff would enter through the main entrance and walk to the time clock area to be screened by the night charge nurse. The time clock area was located approximately 25 feet from the entrance and near staff offices. The DON confirmed the facility did not have any positive or suspected positive COVID-19 cases in the facility and yesterday, they had moved two residents off the COVID unit because they had been symptom free for greater than three days. -At 7:10 a.m. the facility's front entrance doors remained unlocked with no staff member monitoring. There was no signage in the interior or exterior of the entrance or lobby area to alert visitors of any COVID-19 restrictions or screening. -At 7:15 a.m. RN-C was observed trying to enter the facility. RN-C rang the bell to request assistance. On entering the facility, RN-C stated that door is never locked. That's why I was so surprised to find it locked now. -At 8:15 a.m. The DON and administrator entered the conference room and proceeded to screen the SA staff. The DON stated the night nurse should have screened the surveyors when they first entered the facility. -At 9:00 a.m. a brief tour of the facility was conducted with the administrator. Double doors connecting the adjoining assisted living facility to the Evergreen unit were observed to be unlocked. The administrator verified the doors were unlocked. -At 1:30 p.m. the receptionist stated she did all the screenings for employees and visitors during her 8:00 a.m. to 4:00 p.m. shift. The receptionist stated she believed there were signs on the assisted living doors to direct visitors to her in order to be screened. Two separate residents were observed to go up to the reception area to speak with the receptionist. One resident, with a mask positioned down by her neck, checked on mail delivery and immediately left the area. Another female resident, with a mask worn but not covering her nose, spoke with the receptionist about a money concern and then remained seated in the reception area for several minutes. Staff did not remind or encourage the two residents on proper use of the masks. During this time, two separate, unmasked, Fed-Ex delivery persons were observed to drop off packages in the reception area. Both delivery persons passed within two to three feet of the resident seated in the reception area, in order to place packages on a bench, directly in front of the receptionist window. Another resident who had been seated outside in his wheelchair, entered the facility and wheeled past the lobby and into the hallway area to return to his room. When asked for the resident's name, the receptionist stated she had not seen the resident who had just entered. The receptionist confirmed she did not have a clear view of all angles of the facility entrance, therefore it was possible for visitors to enter the facility unnoticed and without screening. . -At 1:45 p.m. The administrator stated there was a sign posted at the front entrance, but it had been taken down yesterday to reword it to include directions for outside visitations the facility was starting to implement and it had not been replaced. -At 2:00 p.m. The reception supervisor verified the front entrance door was unlocked at 6:00 a.m. to allow day shift employees to enter, however, confirmed the front desk remained unmanned until 8:00 a.m. when the receptionist came on duty. On 6/25/20, at 2:40 p.m. The DON stated she would have expected signage regarding visitor restrictions and screening requirements remain in place. The DON also stated she would have expected the SA staff be screened prior to entering the facility. The facility undated policy titled COVID-19 Prevention and Control, indicated the facility followed the Centers for Disease Control (CDC) guidelines and recommendations for the prevention and control of COVID-19. The policy indicated a sign would be posted at every entrance with information regarding restriction of visitors into the facility. The policy indicated only one entrance would be utilized for visitors to use. The policy directed visitors to fill out the screening questionnaire, have their temperature checked, wash hands or use alcohol based hand rub and refrain from physical contact when in the facility. The policy indicated visitors would be given a name tag and a sticker after screening. On 6/23/20, at 12:00 p.m. R4 was observed in bed while NA-B and NA-C provided perineal cares. Both NA's had donned gloves. NA-B and NA-C turned R4 onto left side. NA-C removed a urine soaked brief, threw the brief into the garbage, wiped R4's buttocks with cleansing wipe, and removed the fabric soaker pad from under resident. With the same dirty gloved hands, NA-C placed a clean fabric soaker pad and clean brief under R4. NA-B and NA-C repositioned R4 on her back and NA-B wiped R4's perineal area with cleansing wipe. NA-B and NA-C adjusted and fastened the clean brief, pulled R4's pants up and over the brief and adjusted the clean fabric soaker pad under R4. NA-B proceeded to weave R4's arms into the sleeves of a shirt and positioned the shirt onto R4's upper body. NA-B and NA-C lifted and slid R4 up in bed with the clean fabric soaker pad, and covered R4 with bed linen. NA-B and NA-C independently entered the bathroom, removed their gloves, discarded them in the garbage, and washed their hands. NA-B and NA-C had not removed dirty gloves, performed hand hygiene or donned clean gloves after providing incontinent care and before adjusting clean fabric soaker pad and prior to dressing R4 with a clean brief, clean clothes and covering with bed linens. -at 12:43 p.m. NA-C verified staff were to remove dirty gloves and perform hand hygiene after providing perineal care for a resident. NA-C confirmed she had not removed her dirty gloves or completed hand hygiene after cleansing R4's buttocks and before continuing to care for R4 and stated she should have. -at 12:46 p.m. NA-B stated after completing perineal cares on a resident staff were directed to remove gloves prior to touching anything else and perform hand hygiene prior to continuing to care for resident. NA-B confirmed she had not removed her gloves or performed hand hygiene after completing perineal care on R4 and stated she should have done so. On 6/25/20 at 11:05 a.m. registered nurse (RN)-B stated staff should perform hand hygiene anytime they go from dirty to clean. RN-B stated staff were provided hand sanitizer to carry in their pocket and had been instructed to wash hands and/or use hand sanitizer after doffing dirty gloves, prior to donning clean gloves and any other time hand hygiene was required. -at 2:39 p.m. the DON stated staff were expected to complete hand hygiene whenever they removed gloves and whenever they go from dirty to clean. DON stated it was an infection control breech for staff to perform perineal care and not change gloves or complete hand hygiene. DON stated staff should not pull up residents pants, touch residents shirt or touch bed linen with dirty gloved hands. The Hand Washing policy revised on 1/2020, directed staff to wash their hands to prevent cross contamination and infection both for residents and caregivers. The policy also indicated staff were to wash their hands/use hand sanitizer after assisting residents with personal cares and after touching anything that may have been contaminated with blood or bodily fluids.