DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0VDV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00602

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245414**
2.STATE VENDOR OR MEDICAID NO.
(L2) **892028100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VIEWCREST HEALTH CENTER**
(L4) **3111 CHURCH STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 5** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 07/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 08/18/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/02/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5414

On June 27, 2014 a Post Certification Revisit (PCR) was completed and verfied correction of deficiencies issued pursuant to the May 15, 2014 standard survey, as of June 25, 2014. Refer to the CMS 2567b for the results of this visit.

The facility has request a continuing waiver for life safety code deficiency K55, which has been forwarded to CMS Region V office and recommended for approval.

Effective June 25, 2014, The facility is certifiede for 92 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5414

August 17, 2014

Mr. Robert Dahl, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811

Dear Mr. Dahl:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 25, 2014 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 92 skilled nursing facility beds.

Your request for waiver of has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirement: K55.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 2, 2014

Mr. Robert Dahl, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: Project Number S5414025

Dear Mr. Dahl:

On May 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 15, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 15, 2014, effective June 25, 2014 and therefore remedies outlined in our letter to you dated May 29, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K55 at the time of the May 15, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5414r14.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245414	A. Building B. Wing	6/27/2014

Name of Facility	Street Address, City, State, Zip Code
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/25/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/25/2014**	ID Prefix **F0461** Reg. # **483.70(d)(1)(vi)-(vii), (d)(2)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **06/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PH	07/02/2014	12835	06/27/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/15/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0VDV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00602

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245414**

2.STATE VENDOR OR MEDICAID NO.
(L2) **892028100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VIEWCREST HEALTH CENTER**
(L4) **3111 CHURCH STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/15/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Chris Elmgren, HFE NEII — 06/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath
Enforcement Specialist — 07/02/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
AW K55 PDF in ACO. 07/02/2014
Emailed CMS 07/02/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5414

On May 15, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections were required. The facility has been given an opportunity to correct before remedies would be imposed. Refer to the CMS 2567 along with the facility's plan of correction for both health and life safety code. Post Certification Revisit to follow.

The facility has request a continuing waiver for life safety code deficiency K55, which has been forwarded to CMS Region V office and recommended for approval.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3650

May 29, 2014

Mr. Robert Dahl, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811

RE: Project Number S5414025

Dear Mr. Dahl:

On May 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 24, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 24, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5414s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	POC- VHC This plan and response to the survey findings is written solely to maintain certifications in the Medicare Medical Assistance programs and as required and submitted as Credible Allegations of Compliance.	
F 156 SS=D	Census: 86 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156	F156 VHC will utilize appropriate SNFABN forms to inform residents of potential non-coverage of MC part A services and their right to appeal the denial to Medicare. Facility SS staff received training on ANFABN requirements on 5/15/14. Training included the use of CMS 10123 and 10124 forms (Mc Part A Generic Denial and Expedited appeal process) and CMS 10055 (uniform denial letter). Each Resident discharged from Medicare Part A services since 5/15/14 has received the CMS 10123, CMS 10124 and the CMS 10055 as required by MC guidelines.	

OK 6-19-14 PLN

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 06/09/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and	F 156	DON/designee will audit the MC denial process for residents discharged from MC Part A services, 2XwkX2, then 1xwkX4. Audit results will be brought to the QAPI Committee for further recommendations for follow up. Completion date 6/20/14	

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F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of all Medicare Part A skilled services for 2 of 3 residents (R59, R102) reviewed for liability notice and beneficiary appeal rights review. Findings include: R59 was discharged from Medicare Part A on 12/23/13, and discharged home on 12/24/13. The facility did not provide R59 and/or her legal representative with a SNFABN/ Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform her of potential	F 156		

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 156	Continued From page 3 liability for non-covered services and of her right to appeal the denial to Medicare. R102 was discharged from Medicare Part A on 3/10/14, and discharged home on 3/11/14. The facility did not provide R102 and/or his legal representative with a SNFABN/ CMS-10055 or a uniform denial letter to inform him of potential liability for non-covered services and of his right to appeal the denial to Medicare. 5/14/14, at 6:07 p.m. the director of social services (SS)-A was interviewed and verified she did not provide SNFABN/ Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document, review the facility failed to ensure dignity was maintained during the supper meal for 1 of 2 residents (R52) reviewed for dignity. R52 was removed from the dining room while eating. Findings include: R52's face sheet identified diagnoses that included dementia and loss of weight. The annual Minimum Data Set (MDS) dated 3/11/14, indicated the following . R52 had short and long term memory problems with moderately impaired decision-making skills. The MDS further indicated R52 required extensive assist of 2 staff for bed	F 241	F241 Dignity VHC'endeavors to care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. NA-G was re-educated on facility Dignity Policies regarding explaining intent of care to a resident prior to having care provided and when being removed from an area such as the DR. All NAR staff will be re-educated on facility Dignity Policies. DON/designee to complete random audits of the supper meal in the DR 2xwkx4, then 1xwkx4, and of resident cares, 2xwkx4, then 1xwkx4, to ensure dignity regarding explaining intent of care prior to providing the care/procedure.	

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F 241	Continued From page 4 mobility, transfers, ambulation, and toileting, and extensive assist of 1 staff for dressing, personal hygiene, bathing, and locomotion on unit. The MDS also indicated R52 was able to feed self after the meal was set up. R52's care plan for nutrition dated 3/5/14, indicated R52 needed cues to stay at the table and that she had a history of weight loss. R52's care plan dated 12/4/13, indicated R52 had behaviors and required all care/procedures to be explained in simple terms and in a calm and quiet manner. R52's care plan for memory loss dated 7/2/13, indicated R52 required yes/no questions, to be allowed time for decision-making, and to be offered one choice at a time with time allowed for responses. The nursing assistant care sheet directed staff to set up R52 for meals and to provide cues and reminders. The care sheet also directed staff to calmly and quietly explain to resident the intent of care needing to be done. On 5/14/14, R52 was continuously observed from 3:52 p.m. until 4:07 p.m., when R52 was taken from the dining room before supper, to her room by nursing assistant (NA)-G. At approximately 30 seconds later, NA-G, opened the door and left the room with R52. NA-G said he checked R52's incontinent brief. R52 was taken back to the dining room. On 5/14/14, R52 was continuously observed from 4:08 p.m. to 5:12 p.m. R52 was served her supper in the dining room. She was served chicken tetrazzini, a bowl of rice krispies with milk, green salad, a piece of cake, milk and orange juice. At 4:28 p.m., R52 was eating her cereal when NA-G quickly removed R52 from the dining room and brought her to her room. NA-A entered the room. NA-G stated he was told by the registered nurse (RN) to reposition R52 and	F 241	Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date 6/25/14	

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F 241	Continued From page 5 check her for incontinence. NA-G and NA-A stated it was not a common occurrence to remove residents from the dining room. R52 yelled, "Ow" with every movement, was agitated, and had a scowling expression. R52 resisted the transfer with the sliding board, back to the wheelchair from her bed. R52 sat in the doorway in her wheelchair, stated it was terrible and was scowling. R52 was returned to the dining room at 4:42 p.m.. R52 sat without eating or drinking until 4:49 p.m., when she was cued by a staff member to eat her cake. R52 then ate her cake and took sips of her liquids. She was removed from the dining room, after supper at 5:12 p.m. On 5/14/14, at 5:26 p.m. RN-B verified she had directed the nursing assistants to reposition and check R52's incontinent brief. The facility policy for dining-atmosphere/environment dated 6/12/12, directed staff to treat residents with dignity and respect and to provide service that will help to make dining a special event to be looked forward to and remembered. The facility policy for dignity dated 9/13, indicated residents shall be treated with dignity and respect at all times. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. It also directs staff to explain procedures before they are performed and to inform residents in advance if they are going to be taken out of their usual or familiar surroundings.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	F279 Care Plans VHC develops comprehensive Care Plans that meet a resident's medical, nursing and psychosocial needs as identified in the comprehensive assessment.	

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F 279	Continued From page 6 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a medication care plan for 2 of 5 residents in the sample (R29 and R63) whose medications were reviewed. Findings include: R29, admitted to the facility in March, 2014, had an undated temporary care plan which did not address the use of Coumadin (a medication used to prevent and treat blood clots) or for monitoring/treating diabetes. R29's most recent physician orders dated 4/2/14, directed staff to administer Coumadin 2.5 mg every Monday and Friday for seven days and 2.0 mg the other five days. Her diabetic orders included blood glucose monitoring three	F 279	R29 and R63's Care Plans were updated to ensure Problem, Goals, and Interventions include potential SEs and symptoms of Coumadin and/or Insulin use. All residents who receive Coumadin and/or Insulin medication will be reviewed and revised as needed, to ensure the Care Plan Problem, Goal and Interventions address monitoring for s/s related to the use of medications by 6/13/14. DON/designee will audit all new residents admitted to the facility on Coumadin and/or Insulin to ensure temporary Care Plans address monitoring of s/s related to use of the medication. DON/designee will audit the comprehensive Care Plans for all new residents to ensure the Problem, Goal and Interventions related to the use of Coumadin and/or Insulin are completed by day 21. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date 6/25/14	

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F 279	Continued From page 7 times a day and insulin - in three different doses - three times daily. The temporary care plan lacked identification of potential side effects and symptoms related to the use of Coumadin and did not address signs and symptoms of hyper or hypoglycemia. RN-C stated, on 5/15/14 at approximately 2:00 p.m., R29's care plan should include monitoring for Coumadin side effects such as bleeding and bruising. She said a diabetes care plan should include monitoring for signs and symptoms of hyper and hypoglycemia. The director of nursing (DON) stated, on 5/15/14 at 2:05 p.m., the Coumadin and diabetes are not on R29's care plan but should be. She added the care plans were to be completed within 20 days of admission and acknowledged R29's care plan was not comprehensive or completed within the required time frame. R63's Face Sheet dated 5/15/14, indicated diagnoses to include atrial fibrillation. The quarterly Minimum Data Set (MDS) dated 4/25/14, indicated R63 was cognitively intact. R63's current Physician's Orders dated 5/15/14, directed Coumadin be administered daily, 4 mg by mouth every Monday, Wednesday, and Friday, and 5 mg by mouth every Sunday, Tuesday, Thursday, and Saturday. An EMAR [electronic medication administration record] Monthly Report for May, 2014, indicated R63 was receiving Coumadin 4 mg by mouth 1 time per day at bedtime every Monday,	F 279		

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F 279	Continued From page 8 Wednesday, and Friday and Coumadin 5 mg by mouth 1 time per day at bedtime every Sunday, Tuesday, Thursday, and Saturday. R63's Care Planning Report dated effective 5/15/14, lacked a focus, outcome or interventions to address the use of Coumadin. On 5/15/14, at 10:48 a.m. registered nurse (RN)-D stated R63's care plan lacked direction for monitoring bruising or bleeding related to the use of Coumadin. RN-D confirmed R63's care plan or EMAR should contain some direction for monitoring potential side adverse effects related to the use of Coumadin.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation as directed by the care plan for 1 of 1 residents (R68) reviewed for activities of daily living (ADL's); and failed to provide pressure relief interventions for 1 of 3 residents (R52) reviewed for pressure ulcers. Findings include: R68's face sheet indicated diagnoses including a history of brain cancer, hemiplegia (paralysis on	F 282	F282 VHC goal is to ensure services provided by the facility are provided by qualified persons in accordance with each resident's written Plan of Care. ALL NAR staff were re-educated on following the POC regarding restorative Ambulation and how to notify the nurse if the resident is refusing or services were not provided. DON/designee will audit Restorative programs 2xwkx2, then 1xwkx4 to ensure the programs are being provided according to the POC or documentation is present for the reason why not and RN Rstv Coordinator is aware of it. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up Completion date 6/25/14	

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 8 Wednesday, and Friday and Coumadin 5 mg by mouth 1 time per day at bedtime every Sunday, Tuesday, Thursday, and Saturday. R63's Care Planning Report dated effective 5/15/14, lacked a focus, outcome or interventions to address the use of Coumadin. On 5/15/14, at 10:48 a.m. registered nurse (RN)-D stated R63's care plan lacked direction for monitoring bruising or bleeding related to the use of Coumadin. RN-D confirmed R63's care plan or EMAR should contain some direction for monitoring potential side adverse effects related to the use of Coumadin.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation as directed by the care plan for 1 of 1 residents (R68) reviewed for activities of daily living (ADL's); and failed to provide pressure relief interventions for 1 of 3 residents (R52) reviewed for pressure ulcers. Findings include: R68's face sheet indicated diagnoses including a history of brain cancer, hemiplegia (paralysis on	F 282	F282 VHC goal is to ensure services provided by the facility are provided by qualified persons in accordance with each resident's written Plan of Care. ALL NAR staff were re-educated on following the POC regarding restorative Ambulation and how to notify the nurse if the resident is refusing or services were not provided. DON/designee will audit Restorative programs 2xwkx2, then 1xwkx4 to ensure the programs are being provided according to the POC or documentation is present for the reason why not and RN Rstv Coordinator is aware of it. All staff were re-educated on the importance of following residents' plan of care including ADL assistance and importance of placing pressure relieving devices.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 9 one side of the body), osteoarthritis and urinary tract infections (UTI's). The quarterly Minimum Data Set (MDS) dated 1/30/14, indicated R68 had no significant cognitive impairment; had no behaviors; and required the extensive assistance of staff with all ADL's. The restorative care plan revised 5/13/14, (during the survey), indicated R68 was capable of ambulating with two staff assist and a wheeled walker followed by the wheelchair (w/c). The care plan directed staff to ambulate R68 BID with a gait belt and walker as far as tolerated 7 days a week followed by the w/c. The nursing assistant Care Card (not dated), directed the NA's to walk R68 BID with a wheeled walker and two staff assist. The Walking Therapy Detail Report from 4/9/14, to 5/12/14, indicated R68 was assisted with ambulation 39 of 68 opportunities from 5-20 feet. No ambulation was documented on eight days (4/15, 4/16, 4/18, 4/19, 4/20, 4/23, 5/4, and 5/7). A fax to the physician dated 4/30/14, indicated R68 had a decline in ambulation distance. A physical therapy (PT) evaluation was ordered by the physician. On 5/15/14, at 12:26 p.m. R68 was observed to ambulate with nursing assistants (NA)-D and NA-E. NA-D applied a transfer belt and both staff assisted R68 up from the w/c and ambulated approximately 120 feet using a wheeled walker. R68's knees were slightly bent. NA-D pulled the w/c behind. R68 sat twice in the w/c to rest between walking and had a shuffling gait. NA-D stated R68 used to ambulate twice the distance,	F 282	DON/Designee will audit staff during ADL assist 2x/week x 2 then 1x/week x 4 to ensure that cares are being completed per residents' individual plan of care. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date 6/25/14	

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F 282	Continued From page 9	F 282		

one side of the body), osteoarthritis and urinary tract infections (UTI's).
The quarterly Minimum Data Set (MDS) dated 1/30/14, indicated R68 had no significant cognitive impairment; had no behaviors; and required the extensive assistance of staff with all ADL's.

The restorative care plan revised 5/13/14, (during the survey), indicated R68 was capable of ambulating with two staff assist and a wheeled walker followed by the wheelchair (w/c). The care plan directed staff to ambulate R68 BID with a gait belt and walker as far as tolerated 7 days a week followed by the w/c. The nursing assistant Care Card (not dated), directed the NA's to walk R68 BID with a wheeled walker and two staff assist.

The Walking Therapy Detail Report from 4/9/14, to 5/12/14, indicated R68 was assisted with ambulation 39 of 68 opportunities from 5-20 feet. No ambulation was documented on eight days (4/15, 4/16, 4/18, 4/19, 4/20, 4/23, 5/4, and 5/7).

A fax to the physician dated 4/30/14, indicated R68 had a decline in ambulation distance. A physical therapy (PT) evaluation was ordered by the physician.

On 5/15/14, at 12:26 p.m. R68 was observed to ambulate with nursing assistants (NA)-D and NA-E. NA-D applied a transfer belt and both staff assisted R68 up from the w/c and ambulated approximately 120 feet using a wheeled walker. R68's knees were slightly bent. NA-D pulled the w/c behind. R68 sat twice in the w/c to rest between walking and had a shuffling gait. NA-D stated R68 used to ambulate twice the distance,

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F 282	Continued From page 10 but her foot had been bothering her. On 5/15/14, at 1:45 p.m. the registered nurse manager (RN)-E confirmed R68's ambulation records were incomplete and did not indicate R68 was assisted with ambulation as directed. RN-E stated that staff should report to her if a resident was not ambulating according to their program, and verified there had been no report of R68 not walking as recommended. RN-E stated R68 should be ambulated as directed by the care plan. R52's face sheet indicated diagnoses that included dementia with behavioral disturbances, open wound lower limb, and osteoporosis. The annual MDS dated 3/11/14, indicated R52 had short and long term memory problems with moderately impaired decision-making skills for daily living. The MDS also indicated R52 required extensive assist of two staff for bed mobility, transfers, toileting, and extensive assist of one staff for dressing, bathing, personal hygiene, and locomotion around unit in wheelchair. The MDS further identified R52 as being at risk for development of pressure ulcers, and had one Stage II pressure ulcer that developed 2/26/14. R52's skin risk assessment dated 12/12/13, indicated she was at moderate risk for skin breakdown. The care plan dated 3/12/14, identified the pressure ulcers as deep tissue injuries and directed staff to put pillow between knees and put protective boots on at all times when in bed. The nursing assistant care sheet directed staff to reposition R52 every two hours and assure a pressure pad was on the wheelchair. On 5/15/14, at 9:00 a.m., registered nurse (RN)-A	F 282		

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F 282	Continued From page 11 was observed during a dressing change of R52's pressure ulcers. Nursing assistant (NA)-F assisted RN-A during the dressing change by holding R52's leg up. Following the dressing change, RN-A and NA-F positioned R52 in bed. When asked about what she should have in bed for positioning, NA-F replied, R52 has the body pillow beside her. RN-A and NA-F verified the body pillow is used to prevent her from falling out of bed. When questioned if R52 needed anything else in bed, RN-A and NA-F replied that she did not. R52's blue heel protectors were sitting on the couch. NA-F moved them to the tray table, where they remained when the room was exited. Also, R52 did not have a pillow between her knees, as directed in the plan of care. On 5/15/14, at 9:52 a.m., during an interview regarding the pressure ulcers, RN-B verified R52 was to have the blue boots on and the pillow between her knees every time she is in bed. The facility was unable to provide a policy on procedure on following the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assessment to	F 309	F309 VHC endeavors to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R52 was reassessed for pain with repositioning and dressing changes on 6/10/14. Currently receives Tylenol 650 mg TID. There has been monitoring put into place for 2 weeks during dressing changes to specifically look for pain.	

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F 309	Continued From page 12 determine appropriate pain management prior to repositioning and dressing change for 1 of 1 residents (R52) reviewed for pain. Findings included: R52's diagnoses from face sheet included dementia with behavioral disturbances, open wound lower limb, and osteoporosis. The annual Minimum Data Set (MDS) of 3/11/14, indicated R52 had short and long term memory problems with moderately impaired decision-making skills for daily living. The MDS also indicated required extensive assist of two staff for bed mobility, transfers and toileting The MDS also indicated R52 had range of motion impairment in both arms and legs. The care plan dated 12/4/13, indicated R52 denied pain, could be resistive to cares at times, would holler out and swing at staff during cares. The care plan directed staff to monitor for pain every shift. The nursing assistant care card directed staff to check for signs and symptoms of pain and notify nurse if present. It further directed staff to notify nurse if R52 was resistive to cares, hollered out, or if physical behaviors continued despite interventions, and what interventions were used. R52's physician orders dated 1/23/14, directed Tylenol 650 milligrams (mg) three times daily, in response to a fax which noted, R52 had pain when staff touch left lower extremity and during repositioning. R52 was described as lashing out and trying to bite staff due to complaints of pain. On 2/20/14, the physician ordered Tylenol with Codeine every four hours as needed (PRN) for pain. The medication administration records	F 309	Any resident that exhibit resistance to cares will be reviewed again for the potential cause of pain by 6/13/14. DON/designee will conduct an audit of R52's dressing changes 1xwkx2 and random audits of dressing changes 2xwkx2, then 1xwkx4 to ensure adequate pain management is provided prior to dressing changes. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date 6/25/14	

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F 309	Continued From page 13	F 309		

(MAR) indicated R52 received the Tylenol with Codeine twice in March, three times in April, and twice in May. Follow-up documentation indicated the medication was effective.

The pain assessment dated 3/11/14, indicated R52 was given Tylenol with Codeine prior to dressing change twice to see if it minimized her behaviors during the treatment. The pain assessment also indicated the medication was effective one of the two times to eliminate her behaviors. There was no further assessment related to pain management during treatments.

On 5/14/14, at 4:28 p.m. nursing assistant (NA)-A and NA-G, were observed to transport R52 from the dining room to her room. NA-A and NA-G transferred R52 into bed for repositioning and changed the incontinent brief. R52 yelled, "Ow!" while being transferred and with every movement throughout the procedure. Staff attempted to assure R52 it was alright, but R52 continued to yell, "Ow!" until she was seated in the wheelchair. R52 was scowling, visibly upset and verbalized that it was terrible. R52 was returned to her dinner where she sat quietly.

On 5/15/14, at 9:00 a.m. R52 was observed during a dressing change. R52 repeatedly yelled, "Ow! Ow!" and pulled legs away. The registered nurse (RN)-A, requested assistance from NA-F to hold R52's legs. R52 continued to yell and pull legs away throughout the treatment. When the treatment was complete R52 stopped yelling and pulling away when the legs were in a resting position and not being touched. RN-A stated R52 yells even when the legs were lifted and verified R52 was not given pain medication prior to the dressing change.

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F 309	Continued From page 14 RN-B, interviewed on 5/15/14, at 9:52 a.m., verified the physician order dated 2/19/14, for Tylenol with Codeine every four hours as needed for pain. RN-B stated that R52 is able to express pain and identify the location when she was asked. RN-B verified R52's care card directed observation for nonverbal expressions of pain and notify the nurse if present. The facility policy and procedure on pain dated 4/07, directed staff to identify individuals who have pain or are at risk for pain and to assess pain each quarterly review, whenever there is a significant change in condition and at any time pain is suspected. The policy provides guidance and directives for evaluation, treatment, monitoring and reassessment of pain.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assistance with ambulation was provided twice a day (BID) as recommended by physical therapy (PT) for 1 of 1 residents (R68) reviewed for activities of daily living (ADL's). Findings include: The Face Sheet indicated R68's diagnoses	F 311	F311 VHC strives to give the appropriate treatment and services to residents to improve or maintain his or her abilities. R63's Restorative Nursing Program was reviewed by the Restorative Team on 6/10/14. All NAR staff were re-educated on following the plan of care related to Restorative Ambulation and the system for notifying the charge nurse if resident does not ambulate according to their program.	

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F 311	Continued From page 15 included history of brain cancer, hemiplegia (paralysis on one side of the body) and osteoarthritis. The quarterly Minimum Data Set (MDS) dated 1/30/14, indicated R68 had no significant cognitive impairment; no behaviors; and required the extensive assistance of staff with all ADL's. The physical therapy (PT) Restorative Nursing Program dated 4/7/14, indicated R68's restorative nursing plan should include, but was not limited to, ambulation 70 feet BID with a wheeled walker and contact guard assist (CGA) due to a decline in range of motion (ROM) and ambulation. The goal indicated R68's right knee would be straight during ambulation in order to increase functional gait pattern and distance to 200 feet. A fax to the physician dated 4/30/14, indicated R68 had a decline in ambulation status related to a decrease in ambulation distance. A PT evaluation was ordered by the physician. The restorative care plan revised 5/13/14, (during the survey), indicated R68 was capable of ambulating with two staff assist and a wheeled walker followed by the wheelchair (w/c). The care plan directed staff to ambulate R68 BID with a gait belt and walker as far as tolerated 7 days a week followed by the w/c. The nursing assistant Care Card (not dated), directed the NA's to walk R68 BID with a wheeled walker and two staff assist. The Walking Therapy Detail Report from 4/9/14, to 5/12/14, indicated R68 was provided ambulation assistance on 39 of 68 opportunities from 5-20 feet. No ambulation was documented on eight days (4/15, 4/16, 4/18, 4/19, 4/20, 4/23,	F 311	DON/designee will audit Restorative Ambulation programs provided by the NARs 3xwkx2, 2xwkx2, and then 1xwkx4 to ensure programs are being provided according to the plan of care and that documentation is present for the reason why not. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date 6/25/14	

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F 311	Continued From page 16 5/4, and 5/7). On 5/15/14, at 12:26 p.m. R68 was observed to ambulate with nursing assistants (NA)-D and NA-E. NA-D applied a transfer belt and both staff assisted R68 up from the w/c and ambulated approximately 120 feet using a wheeled walker. R68's knees were slightly bent. NA-D pulled the w/c behind. R68 sat in the w/c to rest twice between walking with a shuffling gait. NA-D stated R68 used to ambulate twice the distance, but her foot had been bothering her. On 5/15/14, at 1:45 p.m. the registered nurse manager (RN)-E confirmed R68's ambulation records did not indicate R68 was ambulated as directed by the care plan. RN-E confirmed refusals were not addressed on the care plan. RN-E stated the ambulation programs were reviewed weekly and documentation of the ambulation was reviewed quarterly. RN-E stated the staff should report to her if a resident was not ambulating according to their program, and verified staff had not reported R68 was not walking as recommended. On 5/15/14, at 2:06 p.m. NA-D and NA-E stated they routinely care for R68. NA-D stated R68 had never refused to ambulate for her. NA-E stated R68 refused to ambulate for her once or twice, but it was rare. The Restorative Nursing Program policy dated 3/2011, indicated the registered nurse would supervise the activities of the restorative nursing program. The policy further indicated the restorative nursing program would be reviewed periodically. During the review, progress, goals, and duration/frequency, will be reassessed and	F 311		

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F 311	Continued From page 17 documented in the resident's record.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to appropriately identify, assess and provide treatment for 2 of 3 residents (R52, R74) reviewed for pressure ulcers. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear. Pressure ulcer definitions: Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate " at risk " persons. Stage II: partial thickness loss of dermis	F 314	F314 VHC ensures that residents that enter the facility without a pressure sore do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. R52's had a comprehensive Assessment/Root Cause Analysis of both foot wounds completed on 6/10/14. The RCA identified multiple blisters found the residents heels and from friction from rubbing on the prior mattress. All other blisters resolved except on the R inner heel which opened up and evolved into a venous stasis ulcer R/T underlying conditions – abrupt onset of LE edema, HTN, Heart Disease, and Atherosclerosis. The L heel was found also on 1/23/14 with purple area that was determined to be d/t DTI caused by bumping her heel on the floor when self-propelling the wheelchair.	

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F 314	Continued From page 18 presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Bruising indicates deep tissue injury. Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. Stage IV: full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. Exposed bone/muscle is visible or directly palpable. Suspected deep tissue injury: a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. These lesions may herald the subsequent development of a Stage III-IV pressure ulcer even with optimal treatment. R52's face sheet dated 4/13/12, indicated	F 314	A P/O was received on 6/10/14, identifying the type of ulcer along with treatment for R72. The Care Plan was reviewed and revised for R52 on 6/4/14. The MDS dated 3/11/14 was modified on 5/15/14 as the RCA identified the skin area was not identified to be pressure related and MDS Coordinator mistakenly coded under DTI/Pressure Ulcer area in Section M of the MDS. R72 had a Root Cause Analysis completed for the open area above the resident's coccyx on 6/10/14. This assessment identified the area to have started as excoriation/rash d/t frequent bowel incontinence from c-diff and colitis, that then evolved into a moisture lesion d/t continuing incontinence (5-10 loose stools daily). A P/O was received on 6/10/14, identifying the type of ulcer along with treatment for R72. Nursing staff were re-educated regarding Skin Protocol.	

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F 314	Continued From page 19 diagnoses that included dementia with behavioral disturbances, open wound lower limb and osteoporosis. The annual Minimum Data Set (MDS) dated 3/11/14, indicated R52 had short and long term memory problems with moderately impaired decision-making skills for daily living. The MDS also indicated R52 required extensive assist of two staff for bed mobility, transfers and toileting. The MDS further identified R52 at risk for development of pressure ulcers with one Stage II pressure ulcer that developed on 2/26/14. The care plan dated 3/12/14, described R52's pressure ulcer as a deep tissue injury and directed a pillow between knees, protective boots when in bed and wound care per physician orders. The nursing assistant care sheet for R52 directed repositioning every two hours, assure a pressure pad was on the wheelchair, Posey boots in bed and a pillow between the knees in bed. R52's physician rounding dictation dated 3/13/14, indicated a Stage III pressure ulcer on the right medial heel extending into the malleolus (ankle). R52's Occupational Therapy (OT) plan of care documentation dated 3/13/14, indicated pressure wounds on the right heel. The wound round progress notes from 1/23/14, through 5/14/14, described the heel ulcers as deep tissue injuries. On 1/23/14, the right heel was identified as an intact blister measuring 3.5 centimeters (cm) by (x) 2.1 cm. The left heel was identified as a deep tissue injury measuring 2 cm x 2.6 cm. On 2/10/14, the wound progress note indicated the right heel blister had opened with area measuring 3.7 cm x 3.5 cm, and dark purple in color. The wound round progress note dated 3/26/14, indicated the right inner heel ruptured blister measured 3.0 cm x 3.5 cm with a wound base of white/yellow slough with scattered pink	F 314	Comprehensive Skin training was provided for Nurse Managers on Comprehensive Skin Assessments, including Root Cause Analysis, updated facility Skin Protocol, and Braden and TT assessments on 6/5/14. The facility Skin Protocol was reviewed and revised to include definition of DTI on 6/4/14. All residents with current skin ulcers will be reviewed to ensure a comprehensive Skin assessment/RCA is completed with corresponding documentation, by 6/25/14. DON/designee will conduct random audits of residents with skin ulcers 2xwkx2, then 1xwkx4 to identify all the appropriate assessment, identification, treatment and care planning pieces are in place. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date: 6/25/14	

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F 314	Continued From page 20 granulation tissue throughout, and an area of firm yellow/brown slough. The wound documentation of 4/5/14, identified the right heel area as a deep tissue injury measuring 2.5 cm x 4 cm, with tan drainage and a wound base with pink tissue, yellow slough and black eschar. The wound documentation dated 4/8/14, identified the left heel wound as a deep tissue injury, measuring 1.3 cm x 1.3 cm with a base of pink granulation and black eschar. A second left heel ulcer measure 1.9 cm x 1.2 cm with a completely yellow wound base. The location of the second ulcer was not documented. The wound documentation dated 5/13/14, identified the right heel wound as a deep tissue injury, measuring 2 cm x 2.3 cm with pink granulation and yellow slough. Margins are regular. The wound documentation dated 5/14/14, identified the left heel wound as a deep tissue injury, measuring 1.1 cm x 1.1 cm with 100% black brown base. On 5/15/14, at 9:00 a.m., registered nurse (RN)-A was observed during a dressing change of R52's pressure ulcers. RN-A measured the left inner heel ulcer as 2 x 1.8 cm. The ulcer was observed to be dark, dry eschar. RN-A identified this ulcer as a Stage I with no drainage. RN-A removed the dressing from the right foot and measured the ulcer as 1.4 cm x 2.0 cm. The wound had pink granulation and yellow slough. RN-A cleansed the right ulcer with normal saline, applied skin prep around the edges and applied bacitracin with a q-tip, put on calcium alginate, and wrapped it with kerlix. Following the dressing change, RN-A and NA-F positioned R52 in bed. When asked about bed positioning, NA-F stated R52 had the body pillow beside her to keep her from falling out of bed. RN-A and NA-F stated R52 did not require any	F 314		

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other interventions for positioning. R52's blue heel protectors were sitting on the couch. NA-F moved them to the tray table, where they remained when the staff left the room. R52 was not provided blue heel protectors or the pillow between her knees as directed in the plan of care.
On 5/15/14, at 9:52 a.m., RN-B verified R52 was to have the posey boots on and the pillow between her knees every time she is in bed.
The corporate consultant RN, interviewed on 5/15/14, at approximately 11:15 a.m., stated she educates the nurses to differentiate between pressure ulcers and deep tissue damage. She stated that, if a wound is deep tissue damage and opens up, it does not get staged because it is not considered to be pressure related. The consultant RN stated R52's was due to friction and not pressure. The consultant RN verified R52 puts her feet together and that was part of the friction, but they determined the wounds were from her shoes and banging her feet on the floor.
The facility policy and procedure for skin ulcers dated 12/1/13, indicated pressure ulcers are contributed to by shearing, friction, and/or moisture. The policy did not address or define deep tissue injury.

R72 had a stage II pressure ulcer above the coccyx that was identified as an excoriated rash. There was no assessment to determine appropriate interventions for treatment or repositioning.

R72's face sheet dated 5/13/14, indicated diagnoses that included pernicious anemia, dementia, adult failure to thrive and ulcerative colitis. The admission MDS dated 3/4/14,

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indicated R72 had intact skin but was at risk for developing pressure. R72 had severe cognitive impairment, frequent incontinence of bowel and bladder, and required extensive assistance of one staff for bed mobility, transfers and toileting.

On 5/15/14, at 12:25 p.m. R72 was taken into his room for toileting. At approximately 12:45 p.m. R72 stood for transfer to a commode with assistance of two staff. There was an open ulcer above the coccyx visible when the brief was removed. The ulcer was a crater with rolled edges, a pink wound base and no odor or drainage. There was no excoriation observed around the ulcer. At 12:50 p.m. RN-C measured the ulcer to be 1 cm by 1.1 cm and applied a duoderm dressing over the ulcer.

The Skin Condition Report dated 4/4/14, indicated R72 had a new excoriation/rash on the coccyx, not present on admission,.The report noted R72 had excoriation to buttocks with blanchable redness surrounding with faint red raised rash surrounding the excoriation. The description did not include the size of the excoriation. The assessment noted pressure reducing or relieving device are in place in bed and chair.

R72's physician order dated 4/17/14, indicated wound care treatment to the coccyx as needed.

R72's Tissue Tolerance-Repositioning Observation form dated 5/14, indicated no concerns with current skin integrity. On 5/15/14, at approximately 1:30 p.m. RN-B was interviewed and was unable to state why R72's Tissue Tolerance-Repositioning Observation form did not address the open lesion and indicated every three

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F 314	Continued From page 23 hour repositioning. The care plan dated 5/15/14, indicated excoriation to buttocks with a duoderm patch since 5/13/14. RN-C, interviewed on 5/15/14, at 1:20 p.m., stated the, "Open lesion" had rolled edges and was located over a bony prominence. St 3:24 p.m. RN-C stated that the lesion did have some depth.	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to date and label open food packages. This had the potential to affect 84 of 84 residents who received food prepared from the kitchen. Findings include: During the initial tour of kitchen on 5/12/14, at 7:50 a.m., the food service director (FSD) verified left over and repackaged perishable food items were not dated. There was an undated, unlabeled bag of chopped ham in the refrigerator. The FSD	F 371	F371 Food Storage All dietary staff will be re-educated on policy and procedure on the safe storage of food including proper storage of opened containers, labeling, and dating. Food Service Director/Designee will audit food storage areas daily x 2 weeks, then 3x/week x 2 weeks, then once a week to ensure the proper storage of food. Audit results will be brought to the QAPI Committee for further recommendations and/or follow-up. Completion Date: 6/25/14	

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F 371	Continued From page 24 stated that the ham was taken from a larger bag of frozen chopped ham on approximately 4/29/14. An unsealed, 16 once package of ham lunch meat with three slices inside was not dated. Four unlabeled and undated sandwiches were inside a zip lock bag in the refrigerator. Fruit slices were repackaged in an unlabeled quart plastic container dated 4/2. The FSD stated the fruit was taken from a larger can and she thought they could keep canned fruit that long. An open, undated gallon container of pudding was half empty in the refrigerator. FSD stated foods removed from larger packages or thawed in the refrigerator were not routinely labeled or dated. The policy on the safe storage of food dated 2007, indicated leftover food was to be kept no longer than 3 days in refrigerator or 180 days in the freezer. When food containers were opened, the food should be placed into proper storage containers, labeled, dated, and placed into proper storage area. Leftovers were to be placed in dated and labeled storage containers and stored appropriately.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 Nursing staff were re-educated on the need to document the temperatures in the medication refrigerator on a daily basis, to adjust the temperature if goes below 36 degrees and to report if the temperature goes down to 32 degrees (freezing temperature).	

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F 431	Continued From page 25 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication refrigerator temperatures were maintained within manufacturers' recommended levels in 1 of 3 medication refrigerators in which 4 residents unopened insulin vials were located (R5, R26, R39, R60). Findings include: On 5/14/14, at 12:51 p.m. during an initial inspection of the facility's medication storage	F 431	Med Room Refrigerator on Green Valley Nursing Unit was replaced due to increased variations with fridge temps from day to day. DON/designee will conduct audits of the medication refrigerator Temperature logs on a daily basis. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date: 6/25/14	

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F 431	Continued From page 26 room and refrigerator on the Green Valley unit, the medication storage refrigerator was observed with licensed practical nurse (LPN)-A. The thermometer located on the inside of the refrigerator was observed to be at 34 degrees Fahrenheit (F). The Refrigerator Temperature Log for 2014, was taped to the front of the refrigerator and was noted to lack multiple days' monitoring temperatures as well as temperatures within the recommended levels as follows: * January, 2014 - 8 out of 31 days with no temperatures recorded * February, 2014 - 8 out of 28 days with no temperatures recorded, and 3 days with temperatures less than 36 degrees F, specifically 32 degrees F on 3/18/14, 31 degrees on 2/24/14, and 32 degrees F on 2/28/14 * March, 2014 - 7 out of 31 days with no temperatures recorded, and 14 days with temperatures less than 36 degrees F, specifically 32 degrees F on 3/1/14, 31 degrees F on 3/2/14, 33 degrees F on 3/4/14, and 3/5/14, 32 degrees on 3/6/14, 34 degrees F on 3/11/14, 33 degrees F on 3/14/14, 31 degrees F on 3/18/14, 34 degrees F on 3/19/14, 33 degrees on 3/21/14, 34 degrees on 3/22/14, 31 degrees F on 3/23/14, and on 3/27/14, and 33 degrees F on 3/28/14. *April, 2014 - 10 out of 30 days with no temperatures recorded, and 1 day with a temperature at 34 degrees F on 4/1/14. *May, 2014 - 4 out of 14 days with no temperatures recorded, and 2 days with temperatures below 36 degrees F, specifically 30 degrees F on 5/5/14, and 33 degrees F on 5/13/14. On the bottom of the Refrigerator Temperature Log, instructions were noted to be written which	F 431		

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F 431	Continued From page 27 included temperature is to be between 36 - 46 degrees F. If temp [temperature] below 36 degrees, check to ensure insulin is not frozen (if frozen, discard and reorder), turn dial to lower number (to get temp back up within range). In the bottom drawer of the Green Valley medication refrigerator were noted to be unopened vials of insulin belonging to 4 residents: R5 - one vial of Novolog insulin dispensed 4/27/14, R26 - one vial of Humulin insulin dispensed 5/2/14, R39 - 2 vials of Novolog insulin with dispensed dates of 4/19/14, and 5/14/14, and R60 - one vial of Lantus insulin dispensed 5/8/14. On 5/14/14, at 12:51 p.m. LPN-A stated the refrigerator temperatures were to be checked and recorded daily but she was not sure on which shift that happened, possibly on night shift. LPN-A confirmed the temperature of 34 degrees F was below the recommended level and verified the low temperatures and the missing readings on the Medication Refrigerator Log since January, 2014. On 5/15/14, at 11:16 a.m. registered nurse (RN)-E stated night shift was assigned to monitor refrigerator temperatures each night, record the temperature on the log, and then adjust the temperature based on the directions on the bottom of temperature monitoring log. RN-F confirmed the temperature recorded on 5/14/14, at 33 degrees F was below the acceptable levels. RN-F verified the recorded temperature readings since February, 2014, and stated the staff should have re-checked the temperatures if an adjustment was made inside the refrigerator to bring the temperature back within acceptable	F 431		

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F 431	Continued From page 28 levels. RN-F further confirmed the medication refrigerator log had multiple missing temperatures where the temperatures were not recorded nightly, and were not recorded at all following temperatures below the acceptable levels. On 5/15/14, at approximately 2:00 p.m. the director of nursing (DON) stated medication storage refrigerators should be monitored daily for acceptable temperatures levels. A Medication Storage Policy dated 7/2012, directed Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station, stored separately from food, and temperatures were to be kept between 36 and 46 degrees Fahrenheit.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 Nursing and NAR staffs are being re-educated on the facility IC Policies regarding the need to ensure resident personal equipment and personal hygiene products are stored properly to prevent potential contamination and spread of infection and the need to wash their hands between appropriate glove changes during cares. Nursing staff were also in serviced regarding the facility policy for changing gloves during dressing changes.	

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F 441	Continued From page 29 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident personal equipment (urinals) and personal hygiene care products (lotions, powders, ointments, disposable wipes) were stored appropriately in 6 of 37 rooms (R60, R5, R68, R125, R38, R99, R7) to prevent potential contamination and decrease the risk of possible spread of infection. In addition, the facility failed to ensure proper hand hygiene and glove changes were completed during a dressing change for 1 of 2 residents (R52) who were observed during a dressing change. During observations of resident rooms the following concerns were noted: On 5/12/14, at 10:45 a.m. R60's bathroom	F 441	DON/designee will audit cares 3xwkx2, then 1xwkx4 to ensure appropriate washing of hands when changing gloves. DON/designee will complete random audits of resident rooms 3xwkx4, then 1xwk thereafter to ensure personal equipment and personal hygiene products are being stored appropriately. DON/designee will audit dressing changes 2xwkx2, then 1xwkx4 to ensure gloves are being utilized appropriately. Audit results will be brought to the QAPI Committee for further recommendations and/or follow up. Completion date: 6/25/14	

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(shared with R5) had an empty urinal and an empty plastic graduate stored on the floor directly beside the toilet on the right side (the facility toilet seats had no covers). R68's bathroom (shared with R125) had a 1/2 bottle of lotion, an open container of powder, and a tube of protective skin ointment stored on the back base of the toilet directly behind the toilet seat.

On 5/12/14, at 1:39 p.m. R60 stated he occasionally used the shared bathroom with staff assistance, and verified R5 also used the bathroom. The quarterly Minimum Data Set (MDS) dated 4/18/14, identified R60 was cognitively intact.

On 5/12/14, at 2:59 p.m. R99's bathroom (shared with R7) had an open container of TENA disposable wipes stored on the back base of the toilet directly behind the toilet seat.

On 5/13/14, at 8:32 a.m. R68's bathroom was now shared with R38 as R125 had changed rooms.

On all days of the survey (5/12/14, 5/13/14, 5/14/14, and 5/15/14), the urinal and plastic graduate remained stored on the floor in R60's (R5) shared bathroom; the lotion, powder and ointment remained stored on the back base of the toilet in R68's (R125, R38) shared bathroom; and the disposable wipes remained stored on the back base of the toilet in R99's (R7) shared bathroom.

On 5/15/14, at 8:59 a.m. nursing assistant (NA)-E stated she had routinely taken care of R60 and R5, and confirmed both residents occasionally used the shared bathroom. NA-E stated R38 was

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F 441	Continued From page 31 only in the room for a few days while her room was being equipped with air conditioning, and did not use the bathroom as she used the commode. On 5/15/14, at 9:05 a.m. R38 stated she did not use the shared bathroom and pointed to a commode in her room. The admission MDS dated 4/25/14, identified R38 did not have significant cognitive impairment. On 5/15/14, at 2:00 p.m. the registered nurse manager (RN)-E observed the urinal and graduate stored on the floor in R60's shared bathroom; the lotion, powder and ointment stored on the back base of the toilet in R68's shared bathroom; and the disposable wipes stored on the back base of the toilet in R99's shared bathroom with the surveyor. RN-E confirmed items should not be stored on the floor or on the toilet base, and would have the potential for contamination and spread of infection. RN-E stated R60, R125, R38, and R99 did not use the bathrooms. The Administration of Bedpan/Urinal and Bedpan Sanitation policies/procedures (not dated), directed "Do not place urinal on floor or bedside stand", and to store residents' urinals in the bedside units. Policies/procedures regarding the appropriate storage of resident personal hygiene products related to infection control were requested. No further policies/procedures were provided. R52's face sheet indicated diagnoses that included dementia with behavioral disturbances, open wound lower limb, and osteoporosis. On 5/15/14 at 9:00 a.m. registered nurse (RN)-A was observed during a dressing change of R52's	F 441		

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F 441	Continued From page 32 bilateral heel ulcers. RN-A washed her hands after entering the room, set up supplies, washed her hands and put on two pairs of gloves. RN-A measured the left heel ulcer, removed the dressing from the right foot with the same gloves and measured the right heel ulcer. RN-A turned on the call light with the same gloves, to call for assistance in lifting R52's leg up during the dressing change. RN-A cleansed the right heel ulcer with normal saline, applied skin prep around the edges, applied bacitracin with a q-tip, then calcium alginate, and wrapped the right foot with kerlix, still wearing both pairs of gloves. During an interview at the end of the dressing change, RN-A verified she had performed the dressing change as she usually does and that she did not change her gloves between the two ulcers. RN-A stated she wears two pairs of gloves so she can take one pair off. RN-A affirmed she touched the call light with her dirty gloves. Two pairs of gloves were observed on RN-A's hands at the end of the interview. On 5/15/14, at 9:48 a.m., RN-A verified she did not remove the top layer of gloves and did not wash hands during the dressing change. On 5/15/14, at 9:52 a.m. during an interview, RN-B verified wearing two pairs of gloves during a dressing change was not acceptable. RN-B stated that handwashing and changing gloves should be done between wounds and after removing the dirty dressings. The undated facility policy for dressing change, directs nurses to put on disposable gloves, remove soiled dressing and place in plastic bag, dispose of gloves in plastic bag and wash hands. It further directs the nurse to put on a new pair of disposable gloves, cleanse wound, apply treatment as prescribed, apply dressings, then remove gloves.	F 441		

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F 461 SS=E	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide each resident bedroom with at least one window to the outside. Findings Include: During the facility tour on 5/15/14, at 10:00 a.m., it	F 461	F 461 BEDROOMS – WINDOW/ FLOOR, BED/FURNITURE/ CLOSET Bedrooms must have at least one window to the outside, and have a floor at or above grade level Resident rooms wavier for windows to the outside have been requested – Please see attached. Requested date: 06/12/2014	

Name of Facility: Viewcrest Health Center

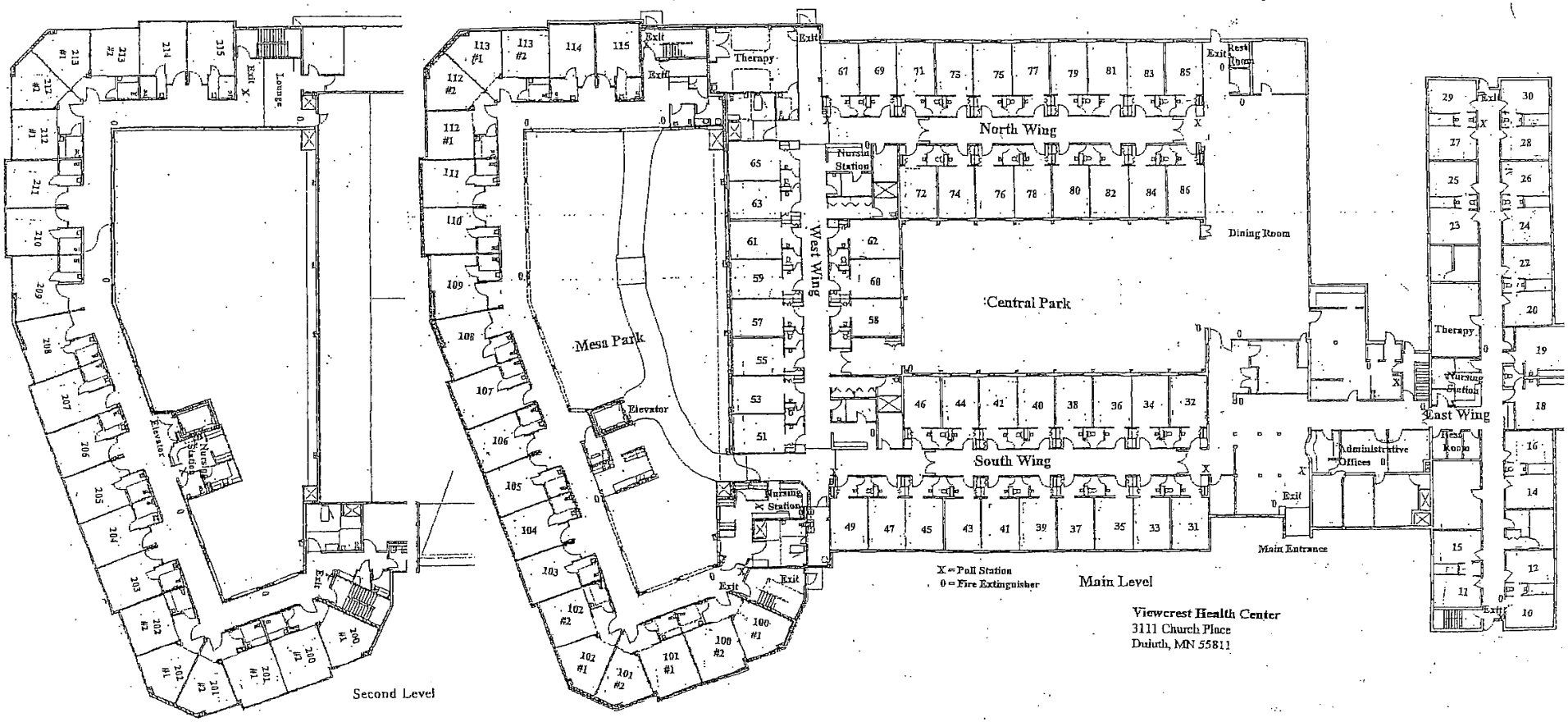
2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K55 F461	An annual waiver is requested for K55 for the following reasons: A. There is not adverse effect of the health and safety of the facility's residents and staff since the completion of the building project. 1. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the fire alarm system. 2. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 3. Resident sleeping rooms are equipped with hard-wired single station smoke detectors. 4. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 5. Annual service and maintenance contracts exist to service all the facility's fire protection systems. 6. The building fire alarm system is monitored to provide automatic fire department notification. 7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted quarterly on each shift. B. A renewal waiver for one year is being requested for the resident rooms that have windows facing an interior courtyard. Room 32, 34, 36, 38, 40, 42, 44, 46, 51, 53, 55, 57, 58, 59, 60, 61, 62, 63, 65, 72, 74, 76, 78, 80, 82, 84 & 86 1. The affected rooms are located in a fire-resistive, fully sprinkled portion of the building. 2. This condition was approved, by MDH, prior to construction of the atrium spaces. 3. The fire and safety of the residents is not negatively affected by this condition.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date


Second Level
Main Level
North Wing
South Wing
West Wing
East Wing
Central Park
Mesa Park
Dining Room
Therapy
Nursing Station
Elevator
Lounge
Rest Room
Administrative Offices
Main Entrance
X = Pull Station
0 = Fire Extinguisher
Viewcrest Health Center
3111 Church Place
Duluth, MN 55811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 34 was observed that 27 of 92 resident rooms did not have a window to the exterior. The exterior courtyard was enclosed in 2002, which is now an enclosed year-round usable indoor courtyard. The lack of windows to the outside was confirmed by the facility Maintenance Supervisor and the Administrator on 5/15/14, at 4:00 p.m.	F 461		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based of observation, interview and document review, the facility failed to ensure walls, doors, and/or ceilings were maintained and repaired in 13 of 35 resident rooms (R18, R52, R43, R100, R60, R76, R84, R44, R26, R95, R16, R63, R67, R91) to maintain a clean/homelike environment; In addition, the facility failed to ensure a worn floor mat was replaced for 1 of 1 residents (R52) to maintain a safe/cleanable surface. Findings include: On 5/15/14, at 10:04 a.m. an environmental tour was completed with the maintenance engineer (ME). The following concerns were observed: R18's room had an area (approximately 12 inches x 6 inches) by the door leading into the room where the paint was scraped off exposing sheetrock. The door leading into the bath room	F 465	F465: SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVION ESD and/or designee will implement corrective action by: • The ESD is making repairs to the Items noted for R18, R52, R43, R100, R60, R76, R84, R44, R26, R95, R16, R63, R67 & 91. • Resident R52's worn floor mat will be replaced to maintain a safe/ cleanable surface. • A policy was written in regard to the regular repair and maintenance of the resident's walls, door and/or ceiling. ESD and/or designee will assess residents having the potential to be affected by this practice including: • All residents are potentially affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 35 had multiple scrapes where varnish was removed exposing bare wood. ME verified the areas needed repair. R52's room had two gouges (one approximately 1 inch x 3/4 inch, and one approximately 3 inches x .5 inches) on the wall to the left of the couch with bare sheetrock exposed. In addition, a floor mat in the room was worn with all four corners tattered, and there was a rip (approximately 3 inches) in the vinyl at one end of the mat with several small worn areas exposing the inner foam. ME verified the areas on the wall needed repair, and stated the facility staff should have replaced the worn floor mat. R43 and R100's room had a large gouge on the wall to the left of the easy chair with the paint missing exposing sheetrock. ME verified the wall needed repair. R60's room had several large gouges on the wall behind the recliner chair with the paint missing exposing sheetrock. ME verified the wall needed repair. R76, R84, R44, and 26's room entrance doorway corners had multiple chipped/gouged areas where paint was missing. ME verified the areas needed repair. R95 and R16's rooms had a few water stains on the ceiling tiles, and R63's room had multiple water stains on the ceiling tiles. ME verified the stained ceiling tiles and stated the facility had a problem in the past related to insulation of the ceiling pipes, and that issue had been fixed. ME was unaware of the new stained ceiling tiles.	F 465	ESD and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff were re-educated on the importance of following the repair requisition policy and procedure beginning the week of 06/09/14. The ESD did a complete inspection of the resident rooms and common areas, and has developed a plan for the repair of others areas/items noted in his inspection. ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • ESD will complete weekly building inspections to look for other items that may need repair. This will continue until compliance is maintained, then monthly thereafter. Maintenance staff were educated also. Completion Date: 06-25-2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 36 R67's room had a large baseball sized gouge in the wall to the right of the headboard of the bed. There were multiple dark scuffs on the floor; several gouges in the wall by the sink in the bathroom; and there was a small circular water stain on a ceiling tile. ME verified. R91's room had a few water stains on the ceiling tiles, and there were multiple large dark scrapes where paint was missing on the heater underneath the window. ME verified. On 5/15/14, at 10:30 a.m., ME verified the above findings and stated he has a "Painting list" but does not have a set schedule or system for maintenance and repair in resident rooms. ME stated he does the work when he can, and just hadn't had time. ME was unaware of the water stained ceiling tiles. ME added, "It's an ongoing thing that needs attention." ME stated the staff should report issues to maintenance on a repair sheet, and confirmed the issues had not been reported. ME confirmed the worn floor mat should have been reported by staff and replaced. Policies and procedures were requested regarding what system the facility used for maintenance, preventative maintenance, and repair in resident rooms. The facility provided Job Description/Performance Standards for the building maintenance helper and housekeeping (not dated) which indicated maintenance, preventative maintenance and repair would be completed as required and as needed. The records did not identify a system was in place for maintenance, preventative maintenance and repair. No policies and procedures were provided.	F 465		
F 514	483.75(l)(1) RES	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514 SS=E	Continued From page 37 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medical record entry revisions were validated by appropriate signature/date for 1 of 1 resident (R52) whose Occupational Therapy (OT) notes were reviewed. Findings include: On 5/15/14, at approximately 9:00 a.m., the OT staff provided a copy of R52's wheelchair positioning assessment dated 3/31/14. The wheelchair assessment indicated R52 was being seen for, "Positioning deficits for functional mobility as a result of nursing needing to remove shoes due to pressure wounds on the R (right) heel." Approximately 15 minutes later physical therapist (PT)-D provided an altered copy of the same OT note and requested the original copy to be returned to the facility at the request of the corporate consultant registered nurse and the	F 514	F514 On 5/15/14 the Occupational Therapist realized that they had documented the wound as a pressure wound in error on their positioning assessment dated 3/31/14. As the MD had not signed the Assessment yet, it was felt that it could be modified. After the MD approved/signed the Assessment, it would then be placed into the medical record. Policy and procedure was updated/revised regarding charting errors and omissions on 6/09/14. DON/designee will audit Therapy notes on a weekly basis to ensure accurate documentation of skin statuses. Audit results will be brought to the QA committee for further recommendations and follow-up. Completion date: 6/25/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 38 administrator. Comparison of the two documents indicated the word, "Pressure" was removed from the original documentation. The altered record was not validated by the author. On 5/15/14, at approximately 10:00 a.m., the consultant nurse and the administrator were interviewed. The consultant nurse stated the OT entry was an error in writing a pressure wounds to the right heel because the wounds were not from pressure. The consultant RN called the OT and asked her to change the notes. The consultant RN stated that even though the notes were two months old, the facility had the right to change them if they felt there was an error. The administrator was in agreement. The facility was unable to provide a policy and procedure on altering or validating entries in the medical record.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #1 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey, Viewcrest Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Statd Fire Marshal Division Health Care Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NHA	Administrator	06/09/14

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 ,and By email to: marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building #1 Viewcrest Health Center, Building #1, is a 1-story building with a partial basement. The original building was constructed in 1960 with additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(11) 2-story. Therefore, the 1960, 1968, and 2002 building was inspected as one building to Type II(000) construction. The 2008 building was inspected as a separate building. The building is fully protected by automatic fire sprinklers. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	**3111 CHURCH STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 92 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 055 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation, an exterior courtyard was enclosed in 2002, and an addition was constructed to the West side of the building in 2008. The enclosing of the courtyard and the addition ,created a condition such that some resident rooms no longer have an outside window. This deficient practice could affect all occupants including residents, staff and visitors, in the area without exterior windows. Findings Include: On facility tour between on 5-14-14 at 2:30PM, it was observed that 27 of 92 resident rooms do not have a window to the exterior. This is because an exterior courtyard was enclosed in 2002, and the 2008 addition to the West. The courtyard(s) are now an enclosed year-round usable indoor courtyards. This deficient practice was confirmed by the facility Maintenance Supervisor (DL) and the	K 055	K055 RESIDENT ROOMS Waiver for windows to the outside-please see attached.	

Name of Facility: Viewcrest Health Center

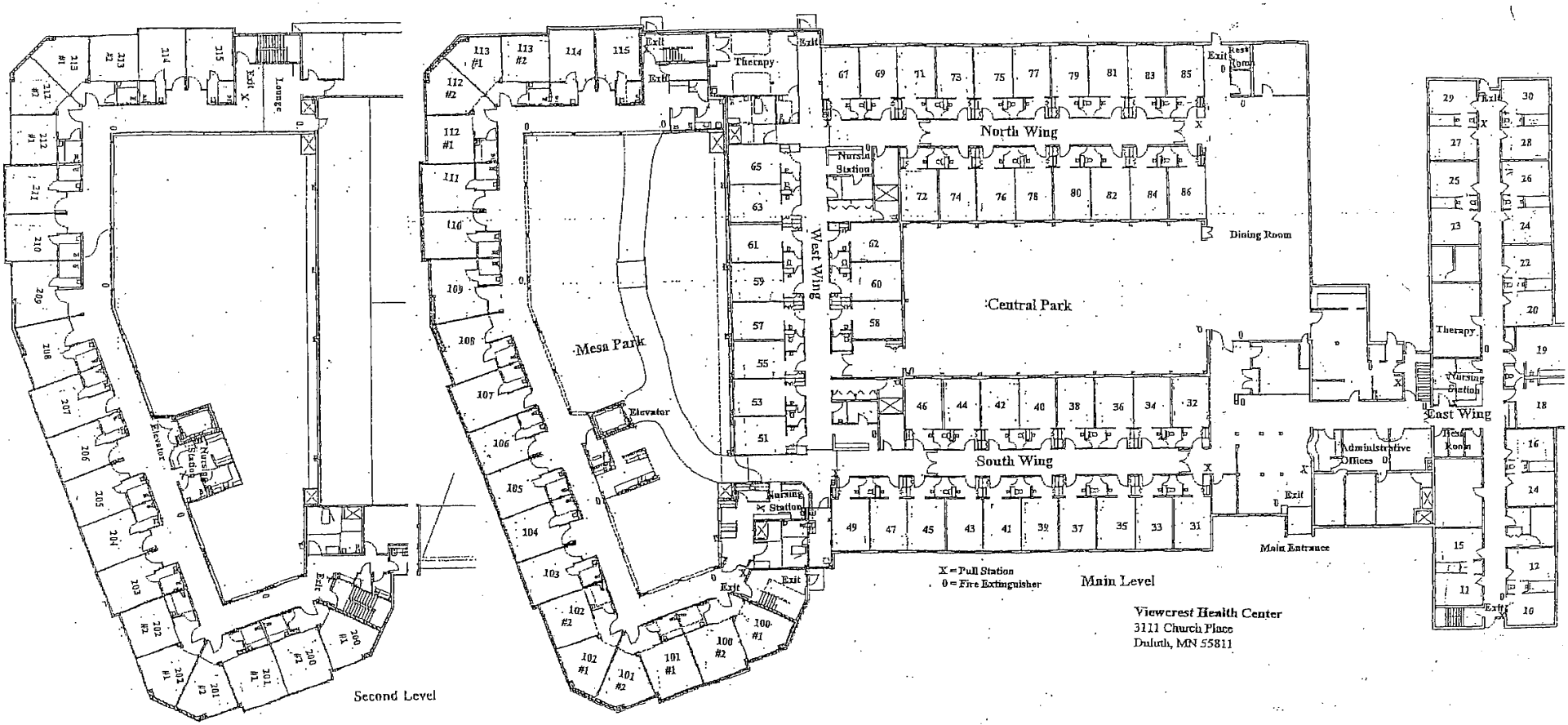
2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K55 F461	An annual waiver is requested for K55 for the following reasons: A. There is not adverse effect of the health and safety of the facility's residents and staff since the completion of the building project. 1. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the fire alarm system. 2. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 3. Resident sleeping rooms are equipped with hard-wired single station smoke detectors. 4. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 5. Annual service and maintenance contracts exist to service all the facility's fire protection systems. 6. The building fire alarm system is monitored to provide automatic fire department notification. 7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted quarterly on each shift. B. A renewal waiver for one year is being requested for the resident rooms that have windows facing an interior courtyard. Room 32, 34, 36, 38, 40, 42, 44, 46, 51, 53, 55, 57, 58, 59, 60, 61, 62, 63, 65, 72, 74, 76, 78, 80, 82, 84 & 86 1. The affected rooms are located in a fire-resistive, fully sprinkled portion of the building. 2. This condition was approved, by MDH, prior to construction of the atrium spaces. 3. The fire and safety of the residents is not negatively affected by this condition.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date


Second Level
Main Level
X = Pull Station
0 = Fire Extinguisher
Viewcrest Health Center
3111 Church Place
Duluth, MN 55811
North Wing
South Wing
West Wing
East Wing
Central Park
Mesa Park
Dining Room
Therapy
Nursing Station
Elevator
Exit
Lounge
Rest Room
Activity Room
Administrative Offices
Main Entrance

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 055	Continued From page 3 Administrator (RD) at the time of discovery.	K 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 02 - VIEWCREST HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #2 THIS INSPECTION ONLY COVERS THE 2008 ADDITION TO VIEWCREST HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey Viewcrest Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. The 2008 addition, building #2, to the Viewcrest Health Center is a two (2) story building with no basement. The construction type is determined to be Type II(111) The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire door. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 92 beds, and the addition has a capacity of 88 beds that were all in use at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 02 - VIEWCREST HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #2 THIS INSPECTION ONLY COVERS THE 2008 ADDITION TO VIEWCREST HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey Viewcrest Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. The 2008 addition, building #2, to the Viewcrest Health Center is a two (2) story building with no basement. The construction type is determined to be Type II(111) The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire door. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 92 beds, and the addition has a capacity of 88 beds that were all in use at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000	FS 6-16-14	

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

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5414022

PRINTED: 05/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Building #1 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division . At the time of this survey, Viewcrest Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Statd Fire Marshal Division Health Care Inspections	K 000	Pock w/ AW for K55 6-16-14 PS	

Dc: 6-24-14

Exit: 5-15-14

RECEIVED
JUN 13 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MHA	Administrator	06/09/14

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 ,and By email to: marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building #1 Viewcrest Health Center, Building #1, is a 1-story building with a partial basement. The original building was constructed in 1960 with additions constructed in 1968, 2002 and 2008. The 1960 and the 1968 building is type II(111) construction. The 2002 building is two (2) story Type II(000), and the 2008 building is Type II(11) 2-story. Therefore, the 1960, 1968, and 2002 building was inspected as one building to Type II(000) construction. The 2008 building was inspected as a separate building. The building is fully protected by automatic fire sprinklers. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 92 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 055 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation, an exterior courtyard was enclosed in 2002, and an addition was constructed to the West side of the building in 2008. The enclosing of the courtyard and the addition ,created a condition such that some resident rooms no longer have an outside window. This deficient practice could affect all occupants including residents, staff and visitors, in the area without exterior windows. Findings Include: On facility tour between on 5-14-14 at 2:30PM, it was observed that 27 of 92 resident rooms do not have a window to the exterior. This is because an exterior courtyard was enclosed in 2002, and the 2008 addition to the West. The courtyard(s) are now an enclosed year-round usable indoor courtyards. This deficient practice was confirmed by the facility Maintenance Supervisor (DL) and the	K 055	K055 RESIDENT ROOMS Waiver for windows to the outside-please see attached.	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	**3111 CHURCH STREET DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 055	Continued From page 3 Administrator (RD) at the time of discovery.	K 055		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, June 16, 2014 10:07 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: jeffrey.juntunen@state.mn.us; 'rdahl@sfhs.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Viewcrest Health Center (245414) 2014 K55 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Viewcrest HC is again requesting an annual waiver for K55, sleeping rooms without outside windows. The exit date was 5-15-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility: Viewcrest Health Center

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K55 F461	An annual waiver is requested for K55 for the following reasons: A. There is not adverse effect of the health and safety of the facility's residents and staff since the completion of the building project. 1. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the fire alarm system. 2. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 3. Resident sleeping rooms are equipped with hard-wired single station smoke detectors. 4. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 5. Annual service and maintenance contracts exist to service all the facility's fire protection systems. 6. The building fire alarm system is monitored to provide automatic fire department notification. 7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted quarterly on each shift. B. A renewal waiver for one year is being requested for the resident rooms that have windows facing an interior courtyard. Room 32, 34, 36, 38, 40, 42, 44, 46, 51, 53, 55, 57, 58, 59, 60, 61, 62, 63, 65, 72, 74, 76, 78, 80, 82, 84 & 86 1. The affected rooms are located in a fire-resistive, fully sprinkled portion of the building. 2. This condition was approved, by MDH, prior to construction of the atrium spaces. 3. The fire and safety of the residents is not negatively affected by this condition.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 6-16-14

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3650

May 29, 2014

Mr. Robert Dahl, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, Minnesota 55811

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5414025

Dear Mr. Dahl:

The above facility was surveyed on May 12, 2014 through May 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at the above number.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5414s14lic.rtf