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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9UWF

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 **09/11/2017** (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:

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

* Code: **A*** (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):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 10/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/04/2017 (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
10/03/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245414 October 4, 2017

Ms. Katie Collins, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

Dear Ms. Collins:

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 September 5, 2017 the above facility is recommended for:

92 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2017

Ms. Katie Collins, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: Project Number S5414028

Dear Ms. Collins:

On August 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 27, 2017. 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 September 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 12, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2017, effective September 5, 2017 and therefore remedies outlined in our letter to you dated August 11, 2017, will not be imposed.

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9UWF

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 **07/27/2017** (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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (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): On 7/24/17, through 7/27/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. In addition, an investigation of complaint number H5414053 was conducted and found to be unsubstantiated.

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR Social Worker Specialist — 08/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 10/02/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 11, 2017

Ms. Katie Collins, Administrator
Viewcrest Health Center
3111 Church Street
Duluth, MN 55811

RE: Project Number S5414028, H5414053

Dear Ms. Collins:

On July 27, 2017, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the July 27, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5414053 that was found to be unsubstantiated.

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:

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

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

Remedies - 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
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 September 5, 2017, 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 September 5, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 October 27, 2017 (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 January 27, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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 _____	07/27/2017

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 On 7/24/17, through 7/27/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. In addition, at the time of the standard survey, an investigation of complaint number H5414053 was conducted and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site 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		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records.	F 164		9/5/17

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

Electronically Signed | 08/17/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	07/27/2017

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 164	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal resident information was communicated in a private manner for 1 of 1 residents (R77) reviewed for dignity.	F 164	F164: DON and/or designee will implement corrective action for Resident R77 affected by this practice by: • NA-F and NA-G were verbally educated on the Dignity Policy and the	

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 _____	07/27/2017

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 164	Continued From page 2 Findings include: R77's Face Sheet printed 7/27/17, indicated R77's diagnoses included major depressive disorder and anxiety disorder. R77's quarterly Minimum Data Set (MDS) dated 7/5/17, indicated R77 had a moderate cognitive impairment. R77's care plan dated 8/14/17, indicated R77 was able to understand most of a conversation and required assistance for toilet use. On 7/25/17, at 2:31 p.m. nursing assistant (NA)-F was giving a verbal report to NA-G at the change of shift, while in the hallway, approximately 1/3 to 1/2 way down the hall from the nurses station. NA-F reported that R77 had had a bowel movement (BM) and described the size of the BM to NA-G, while residents were in nearby rooms with their doors open. NA-F's verbal report was heard clearly at the nurse's station. On 7/25/17, at 2:41 p.m. NA-F verified she had talked about R77's BM in the hallway. NA-F stated personal resident information should not be announced in the hallway, and it would probably be embarrassing for the resident to have personal information announced in public. NA-F stated staff could find a more private place to discuss and report resident information. On 7/25/17, at 3:04 p.m. R77 stated she would not like it if her BM's were talked about in the hallway. R77 stated she would be embarrassed and stated they should not talk about those things in the hallway with other people around.	F 164	need to go to private areas (such as med rooms, shower rooms, etc) or to lower voices when discussing confidential resident information on 8/21/17 by Nurse Manager. • Social Services met with Resident R77 on 8/21/17 to ensure resident did not have any distress related to NA-F and NA-G discussing R77 bowel movements in the hallway. DON and/or designee will assess residents having potential to being affected by this practice including: • All residents have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: • Education will be provided to all Nursing Staff by DON or designee regarding our Dignity Policy and the need to go to private areas (such as med rooms, shower rooms, etc) or to lower voices when discussing confidential resident information by 9/5/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random audits of staff interactions involving resident private information will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Social Services or Facility Representative to ensure done in privacy. • Monitoring will be reported to Quality Assurance Committee quarterly and as	

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F 164	Continued From page 3 On 7/26/17, at 2:28 p.m. registered nurse (RN)-A stated reports should be done quietly and the staff could go into a better location. On 7/26/17, at 10:38 a.m. the director of nursing (DON) verified she would expect staff to discuss resident information in private and not in the hallway. The facility policy and procedure for Dignity dated 9/13, directed staff would maintain an environment in which confidential clinical information is protected, and verbal staff-to-staff communication would be conducted outside the hearing range of residents and the public.	F 164	needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow the care plan for dressing changes to promote healing of current pressure ulcers for 1 of 2 residents (R143) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):	F 282	DON and/or designee will implement corrective action for Resident R143 affected by this practice by: • LPN-C was educated on 7/28/17 on following plan of care for R143 pressure ulcer treatment to right ischium pronominal and right front lateral hip. • R143 Care Plan was reviewed on 7/31/17 to ensure that each pressure	9/5/17

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F 282	Continued From page 4 Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration	F 282	ulcer was correctly identified on the care plan along with the appropriate MD treatment order for each pressure ulcer. DON and/or designee will assess residents having potential to being affected by this practice including: • All residents with pressure ulcers have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: • DON and/or Designee will assess all residents with pressure ulcers care plans to ensure appropriate MD treatments are identified on the care plan by 9/5/17. • Education will be provided to all Licensed Nursing Staff by DON or Designee regarding following residents plan of care when doing treatments for residents pressure ulcers by 9/5/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random audits of residents' dressing changes will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Nurse Manager or Nursing Representative to ensure they are being completed per MD orders/Care Plan. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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F 282	Continued From page 5 Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R143's Face Sheet printed 7/27/17, indicated R143's diagnoses included a malignant neoplasm (tumor) of the head, face, neck and sinus, heart failure, stage four (severe) chronic kidney disease, type two diabetes and severe protein-calorie malnutrition. R143's admission Minimum Data Set (MDS) dated 5/5/17, indicated R143 was cognitively intact. The MDS identified R143 was at risk for pressure ulcers, had two unstageable pressure ulcers, and had pressure reducing devices on the bed and in the chair. R143's care plan dated 5/2/17, indicated R143 had a pressure ulcer to the right ischium and the right lateral hip. The care plan directed staff to provide treatment to the pressure ulcers as directed by the doctor.	F 282		

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F 282	Continued From page 6 R143's Physician's Order Sheet indicated on 5/5/17, the physician ordered treatment to the pressure ulcers Iodosorb (an antimicrobial agent in combination with desloughing and fluid management properties effective at preparing the wound bed to heal) with calcium alginate (a dressing which forms a soft, integral gel when it comes into contact with wound exudate. The exudate is absorbed and provides moist wound healing which results in faster healing of difficult wounds), cover with gauze and an abdominal dressing. The dressing was ordered to be changed daily. On 7/26/17, at 12:02 p.m. R143's dressing change was observed completed by licensed practical nurse (LPN)-C. The right front lateral hip dressing consisted of a 4 x 4 dressing covered with an abdominal dressing, which in turn was covered by a Tegaderm dressing. The right ischium pronominal pressure ulcer had only a Tegaderm dressing. LPN-C stated the Tegaderm dressing was incorrectly applied, as it was the only dressing covering the pressure ulcer. LPN-C stated she thought the right ischium pronominal pressure ulcer area was new. LPN-C applied the Iodosorb gel to the with a cotton swab to the calcium alginate dressing, and applied it to the right front lateral hip pressure ulcer. LPN-C then covered both the right front lateral hip and the right ischium pronominal pressure ulcers with an abdominal dressing and secured all the edges of the dressing with wide paper tape. LPN-C did not clean or apply Iodosorb gel or the calcium alginate to the right ischium pronominal pressure ulcer. LPN-C stated the right ischium pronominal pressure ulcer had been healed on 6/15/17. LPN-C stated she had not seen the dressing covered with Tegaderm until today, and she had	F 282		

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F 282	Continued From page 7 only changed R143's dressing one other time. LPN-C stated the physician's order did not include to cover the dressing with Tegaderm, but the progress note did. LPN-C stated she was not going against what the physician's orders directed. On 7/27/17, at 9:00 a.m. registered nurse (RN)-B stated she would expect would expect staff to do the same treatment to both pressure ulcers. On 7/27/17, at 10:45 a.m. the director of nursing (DON) stated she would expect a pressure ulcer treatment to be done as ordered by the physician. The scenario was explained to the DON, and she further stated she would expect the same treatment to both areas on right hip as ordered.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 314		9/5/17

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F 314	Continued From page 8 by: Based on observation, interview and document review, the facility failed to provide dressing changes per physician orders to promote healing of current pressure ulcers for 1 of 2 residents (R143) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the	F 314	DON and/or designee will implement corrective action for Resident R143 affected by this practice by: • LPN-C was educated on 7/28/17 on following plan of care for R143 pressure ulcer treatment to right ischium pronominal and right front lateral hip. • R143 MD treatment orders will be reviewed once he returns from hospital to ensure that each pressure ulcer treatment was correctly identified on the eTAR per MD order. DON and/or designee will assess residents having potential to being affected by this practice including: • All residents with pressure ulcers have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: • DON and/or Designee will assess all residents with pressure ulcers to ensure that all treatments on the eTAR are accurate per MD orders and specifies the location of the pressure ulcer. • Education will be provided to all Licensed Nursing Staff by DON and/or Designee regarding following residents plan of care when doing treatments for residents pressure ulcers by 9/5/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including:	

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F 314	Continued From page 9 extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R143's Face Sheet printed 7/27/17, indicated R143's diagnoses included a malignant neoplasm (tumor) of the head, face, neck and sinus, heart failure, stage four (severe) chronic kidney disease, type two diabetes and severe protein-calorie malnutrition. R143's admission Minimum Data Set (MDS) dated 5/5/17, indicated R143 was cognitively	F 314	• Random audits of residents' dressing changes will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Nurse Manager or Nursing Representative to ensure they are being completed per MD orders/Care Plan. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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intact, and required extensive assistance bed mobility, transfers, toilet use, dressing, and personal hygiene. The MDS further revealed R143 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS identified R143 was at risk for pressure ulcers, had two unstageable pressure ulcers, and had pressure reducing devices on the bed and in the chair.

R143's Care Area Assessment (CAA) dated 7/25/17, indicated R143 was at risk for pressure ulcers and currently had two pressure ulcers on the right front hip and the right ischium (lower and back part of the hip bone). The CAA also indicated R143's chronic anemia increased the risk of skin breakdown, and R143's malnutrition could impair the healing of the pressure ulcers. The CAA further indicated R143 received a nutritional supplement to assist in wound healing, and indicated the plan would be for wound care to both the right front lateral pressure ulcer and the right ischium pressure ulcer.

R143's care plan dated 5/2/17, indicated R143 had a pressure ulcer to the right ischium and the right lateral hip. The care plan directed staff to provide treatment to the pressure ulcers as directed by the doctor.

R143's Physician's Order Sheet indicated on 5/5/17, the physician ordered treatment to the pressure ulcers Iodosorb (an antimicrobial agent in combination with desloughing and fluid management properties effective at preparing the wound bed to heal) with calcium alginate (a dressing which forms a soft, integral gel when it comes into contact with wound exudate. The exudate is absorbed and provides moist wound

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healing which results in faster healing of difficult wounds), cover with gauze and an abdominal dressing. The dressing was ordered to be changed daily.

R143's Skin Condition/Wound Progression notes indicated the following:

On 4/24/17, R143 was admitted with unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 6 centimeters (cm) by 10 cm. The ulcer base tissue was 50% slough and 50% granulation and no odor was present. The right ischium pressure ulcer measured 4 cm by 7 cm. The pressure ulcer base tissue was 50% slough and 50% granulation and no odor was present. The treatment to both pressure ulcers consisted of Allevyn Life foam dressing (a padded absorbent foam dressing) to be changed every three days and as needed.

On 5/1/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 9 cm by 4.8 cm. The ulcer base tissue was 95% slough and 5% granulation and a slight foul odor was noted. The right ischium pressure ulcer measured 4 cm by 3.8 cm. The pressure ulcer base tissue was 95% slough and 5% granulation. The treatment to both pressure ulcers remained the same. A request was made to the physician to change the treatment of both pressure ulcers to Iodosorb gel with calcium alginate, cover with gauze and an abdominal dressing every day.

On 5/5/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and

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the right ischium. The right front lateral pressure ulcer measured 10 cm by 4.5 cm. The pressure ulcer base tissue was 95% slough and 5% granulation and no odor was noted. The right ischium pressure ulcer measured 5.5 cm by 3.5 cm. The pressure ulcer base tissue was 95% slough and 5% granulation. The treatment to both pressure ulcers remained the same. The physician was re-faxed with the request to change the treatment of both pressure ulcers to Iodosorb gel with calcium alginate, cover with gauze and an abdominal dressing every day.

On 5/12/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 10 cm by 3 cm. The pressure ulcer base tissue was 100% slough. The pressure ulcer was slightly smaller with less exudate. The right ischium pressure ulcer had healed (bridged) in the middle forming two smaller pressure ulcers. The proximal pressure ulcer measured 2.8 cm by 2.2 cm. The distal pressure ulcer measured 1.3 cm by 0.7 cm. The pressure ulcer base tissue was 100% slough. The treatment to the pressure ulcers was changed to Iodosorb gel with calcium alginate, cover with gauze and an abdominal dressing every day.

On 5/19/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 9.5 cm by 3 cm. The pressure ulcer base tissue was 100% slough. The pressure ulcer was slightly smaller with less exudate. The right ischium pronominal ulcer measured 1.6 cm by 2 cm. The distal pressure ulcer measured 0.9 cm by 0.8 cm. The pressure

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ulcer had improved since starting the new treatment. The pressure ulcer base tissue was 100% slough. The treatment to the pressure ulcers remained the same.

On 5/25/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 9.5 cm by 3.7 cm. The pressure ulcer base tissue was 100% slough and the slough had loosened. The right ischium pronominal pressure ulcer measured 1.6 cm by 2 cm. The distal pressure ulcer measured 0.4 cm by 0.4 cm. The pressure ulcer had improved since starting the new treatment. The pressure ulcer base tissue was 100% slough. The proximal pressure ulcer was unchanged, but the distal pressure ulcer was smaller and almost healed. The treatment to the pressure ulcers consisted of Iodosorb gel with calcium alginate, cover with gauze and a Tegaderm (a transparent adhesive cover dressing) every day. The Tegaderm dressing was new, and this was not ordered by the physician.

On 6/8/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and the right ischium. The right front lateral pressure ulcer measured 9 cm by 3.7 cm. The pressure ulcer base tissue was 100% slough and the slough had loosened. The right ischium pronominal pressure ulcer measured 1.4 cm by 2 cm. The distal pressure ulcer measured 0.2 cm by 0.1 cm. The pressure ulcer base tissue was 100% slough. The treatment to the pressure ulcers remained the same.

On 6/15/17, R143 continued to have unstageable pressure ulcers on the right front lateral hip and

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the right ischium. The right front lateral pressure ulcer measured 8.2 cm by 4 cm. The pressure ulcer base tissue was 100% slough and the slough had loosened. The right ischium pronominal pressure ulcer measured 1.4 cm by 2 cm. The distal pressure ulcer was healed. The pressure ulcer base tissue was 100% slough. The treatment to the pressure ulcers remained the same.

On 6/22/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip, and the pressure ulcer on the right ischium was documented as Stage 3. The right front lateral pressure ulcer measured 8 cm by 3.2 cm. The pressure ulcer base tissue was 100% slough and the slough had loosened. The right ischium pronominal pressure ulcer measured 1.4 cm by 1.6 cm. The pressure ulcer base tissue was 20% slough and 80% granulation. The treatment to the pressure ulcers remained the same.

On 6/26/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip and a Stage 3 pressure ulcer on the right ischium. The right front lateral pressure ulcer measured 8 cm by 3.2 cm by 1.1 cm. The pressure ulcer base tissue was 100% slough and more slough had loosened and there was depth to the ulcer. The right ischium pronominal pressure ulcer measured 1.4 cm by 1.5 cm. The pressure ulcer base tissue was 20% slough and 80% granulation. The treatment to both pressure ulcers remained the same.

On 7/3/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip and a Stage 3 pressure ulcer on the

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right ischium. The right front lateral pressure ulcer measured 7 cm by 3.5 cm by 1 cm. The pressure ulcer base tissue was 90% slough and 10% granulation. The right ischium pronominal pressure ulcer measured 1.8 cm by 1.5 cm. The pressure ulcer base tissue was 20% slough and 80% granulation. The treatment to the pressure ulcers remained the same.

On 7/14/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip and a Stage 3 pressure ulcer on the right ischium. The right front lateral pressure ulcer measured 8 cm by 3.2 cm by 0.9 cm. The pressure ulcer base tissue was 95% slough and 5% granulation. The right ischium pronominal pressure ulcer measured 1.1 cm by 1.4 cm. The pressure ulcer base tissue 100% granulation. The treatment to the pressure ulcers remained the same.

On 7/20/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip and a Stage 3 pressure ulcer on the right ischium. The right front lateral pressure ulcer measured 8.5 cm by 2.9 cm by 0.5 cm. The pressure ulcer base tissue was 95% slough and 5% granulation. The right ischium pronominal pressure ulcer measured 1 cm by 1.4 cm. The pressure ulcer base tissue 100% granulation. The treatment to the pressure ulcers remained the same.

On 7/27/17, R143 continued to have an unstageable pressure ulcer on the right front lateral hip and a Stage 3 pressure ulcer on the right ischium. The right front lateral pressure ulcer measured 7.8 cm by 3.2 cm by 0.3 cm. The pressure ulcer base tissue was 50% slough and

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F 314	Continued From page 16 50% granulation. The right ischium pronominal pressure ulcer measured 1 cm by 1.4 cm. The pressure ulcer base tissue 100% granulation. The treatment to the pressure ulcers remained the same. On 7/26/17, at 12:02 p.m. R143's dressing change was observed completed by licensed practical nurse (LPN)-C. LPN-C washed her hands, and set up the dressing supplies. LPN-C donned gloves and removed the soiled dressing. The right front lateral hip dressing consisted of a 4 x 4 dressing covered with an abdominal dressing, which in turn was covered by a Tegaderm dressing. The right ischium pronominal pressure ulcer had only a Tegaderm dressing. LPN-C stated the Tegaderm dressing was incorrectly applied, as it was the only dressing covering the pressure ulcer. LPN-C stated she thought the right ischium pronominal pressure ulcer area was new. The right front lateral hip dressing had a large amount of serosanguineous drainage. LPN-C removed the gloves, washed her hands and donned new gloves. LPN-C washed the right front lateral hip pressure ulcer with normal saline. The pressure ulcer measured 8 cm by 3 cm and had a red beefy wound bed. The right ischium pronominal pressure ulcer measured 2.5 cm by 1 cm, and was covered with a tan colored exudate that appeared to be slough. LPN-C applied the Iodosorb gel to the with a cotton swab to the calcium alginate dressing, and applied it to the right front lateral hip pressure ulcer. LPN-C then covered both the right front lateral hip and the right ischium pronominal pressure ulcers with an abdominal dressing and secured all the edges of the dressing with wide paper tape. LPN-C did not clean or apply Iodosorb gel or the calcium alginate to the right	F 314		

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ischium pronominal pressure ulcer. LPN-C stated the right ischium pronominal pressure ulcer had been healed on 6/15/17. LPN-C stated she had not seen the dressing covered with Tegaderm until today, and she had only changed R143's dressing one other time. LPN-C stated the physician's order did not include to cover the dressing with Tegaderm, but the progress note did. LPN-C stated she was not going against what the physician's orders directed.

On 7/27/17, at 9:00 a.m. registered nurse (RN)-B stated the treatment for the right ischium pressure ulcer was the same as the right front lateral hip pressure ulcer and consisted of Iodosorb gel with calcium alginate, cover with gauze and a Tegaderm. The Tegaderm dressing was added to secure the dressing in place because R143's skin was sensitive to tape. RN-B verified the electronic Treatment Administration Record (eTAR) did not specify to do the treatment to both areas. RN-B further stated there was not a separate order for each area. RN-B would expect staff to do the same treatment to both pressure ulcers.

On 7/27/17, at 9:45 a.m. R143's pressure ulcers were observed with RN-B. The right ischium pressure ulcer wound bed was observed to have a dried tan cover which RN-B was able to peel off. RN-B stated it was the calcium alginate. The right ischium pressure ulcer measured 0.8 cm by 1 cm, had 100% granulation tissue, and remained a Stage 3. RN-B stated the right ischium pressure ulcer was dry because the dry abdominal dressing covered it, and there appeared to be slough the day before because it had covered by the Tegaderm. RN-B was informed LPN-C did not do a treatment to the right ischium pressure ulcer

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F 314	Continued From page 18 on 7/26/17. RN-B verified R143's right ischium pressure ulcer was the pronominal pressure ulcer. RN-B stated she monitored R143's pressure ulcers once a week, had seen them on 7/20/17, and had never observed the dressings to be incorrect. On 7/27/17, at 10:45 a.m. the director of nursing (DON) stated she would expect a pressure ulcer treatment to be done as ordered by the physician. The scenario was explained to the DON, and she further stated she would expect the same treatment to both areas on right hip as ordered. The facility's Skin Ulcer Protocol updated 11/7/16, directed appropriate care and services will be provided to prevent, treat, and monitor progress of all healing pressure ulcers.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider	F 325		9/5/17

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F 325	Continued From page 19 orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dietary supplement was given to prevent further weight loss for 1 of 3 residents (R117) reviewed for nutrition. Findings include: R117's Face Sheet printed 7/27/17, indicated R117 diagnoses included COPD (chronic obstructive pulmonary disease), end stage renal disease, and edema. R117's admission Minimum Data Set (MDS) dated 3/21/17, indicated R117's admission weight was 121 pounds. On 6/24/17, the registered dietician (RD) progress note indicated R117 experienced a significant weight loss of 15.8 pounds or 12.8% of body weight in past 90 days. The note indicated R117's intake at meals was variable. The note also indicated R117 refused foods, and also had ends stage kidney disease which was likely contributing to her nutritional decline. The RD recommended offering R117 a can of Nepro (a dietary supplement) per day R117's care plan dated 4/4/17, directed 120 milliliters (ml) Nepro supplement to be provided with the brunch meal. On 7/26/17, at 8:10 a.m. R117 was observed eating her breakfast meal. No Nepro supplement was provided.	F 325	DON and/or designee will implement corrective action for Resident R117 affected by this practice by: • R117 care info was updated for nursing to administer Nepro supplement and document amount consumed on 8/16/17. DON and/or designee will assess residents having potential to being affected by this practice including: • All residents who receive dietary supplements have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: • All current recommendations for dietary supplements were reviewed on 8/16/17 by Dietary Assistant to ensure that they are assigned to Nursing to give and amount of consumption is being documented. • Dietary Manager will inform Nurse Manager when a dietary supplement is initiated and the Nurse Manager will ensure the order is placed in the eMAR for the Licensed Nurse to give during med passes to promote intake at meals. • A Dietary Supplements Policy was created on 8/21/17. • All Licensed Nurses and Dietary Staff will be educated on the process of Nursing administering dietary	

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F 325	Continued From page 20 On 7/26/17, at 11:44 a.m. R117 was observed eating her brunch meal. No Nepro supplement was provided, On 7/27/17, at 8:50 a.m. R117's meal slip for that day's brunch meal was reviewed. The meal slip listed choices of French toast, mandarin oranges, assorted juice, and sauerkraut. R117's meal slip did not list Nepro or any other dietary supplement. On 7/27/17, at 8:21 a.m. the dietary manager (DM) stated R117's intake of dietary supplements had not been documented. On 7/27/17, at 8:52 a.m. dietary aide (DA)-B stated she would not be giving a dietary supplement to R117 at brunch later today. DA-B checked the Resident Drinks sheet, and confirmed R117 was not listed on the sheet to receive any special drinks or supplements. The facility was unable to provide a policy on dietary supplements.	F 325	supplements between meals during med passes by 9/5/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random audits of current recommendations for dietary supplements and amount consumed will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Dietary Manager or Facility Representative. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		9/5/17

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F 329	Continued From page 21 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a labs were completed as ordered by a physician for 2 of 5 residents (R13 and R65) reviewed for unnecessary medications. In addition, the facility failed to ensure gradual dose reduction and risk versus benefit was addressed for 1 of 5 residents (R65) reviewed for unnecessary medications. Findings include: R65's face sheet printed 7/27/17, indicated R65's	F 329	DON and/or designee will implement corrective action for Resident R13 and R65 affected by this practice by: • R65 has an appointment with Dr. Bork (Psych MD) the week of 8/21/17. Paperwork will be sent with to appointment regarding residents current psychoactive medications and need for MD to address either a gradual dose reduction of psychoactive medications or to provide a thorough risk vs. benefit	

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F 329	Continued From page 22 diagnoses included paranoid schizophrenia, major depressive disorder, anxiety disorder, type 2 diabetes mellitus, hypercholesterolemia (high cholesterol levels in the blood) and hyperlipidemia (high levels of fats in the blood). R65's quarterly Minimum Data Set (MDS) dated 6/28/17, indicated R65 was cognitively intact. R65's Care Area Assessments (CAA) dated 6/19/17, indicated R65 last had dose adjustments of the Abilify in 2011 with an increase, Clonazepam in 2012 for a trial discontinuation and was re-initiated again in 2013, and the Effexor was increased in 2013. R65's CAA indicated R65 was seen by psychiatry 4/16, and then refused further visits, but was to see other psychiatric services in the future. R65's Physician Orders Sheet printed 7/27/17, included orders for Abilify (antipsychotic medication) 15 milligrams (mg) daily, Clonazepam (for anxiety) 0.25 mg daily and twice daily as needed, Effexor XR (for depression) 300 mg daily, Metformin HCl (for diabetes) 500 mg twice daily, Pravastatin Sodium (for high cholesterol) 40 mg daily. The orders also included labs for lipid panel (to check cholesterol levels), and microalbumin test (to check for kidney damage) every February 27th R65's consultant pharmacist review dated 4/13/17, indicated a recommendation had been made to the physician to address benefits of current psychoactive medication regimen versus the risks associated with the potential reduction in dosing. On 4/24/17, the physician responded to the faxed recommendation with "OK."	F 329	statement. • R65 MD stated he will address need for missed microalbumin and liver profile lab work to be completed when he rounds next on week of 8/21/17. • R13 lab was completed per MD order on 7/27/17. DON and/or designee will assess residents having potential to being affected by this practice including: • All residents who have lab orders or meds that require labs have potential to be impacted by this practice. • All residents on psychoactive medications have potential to be impacted by this practice. DON and/or designee will implement measures to ensure this practice does not reoccur including: • Process for transcribing lab orders was revised. When lab work is ordered and transcribed by Nursing staff, it will be placed on unit desk calendar as well as into electronic medical record to come up on EMAR/ETAR to alert staff nurse to check to ensure lab was completed on that date. Nursing staff will be trained by DON and/or Designee on need to ensure order is transcribed on to the calendar as well as into the electronic medical record. Nursing Staff and TMAs will also be trained by DON and/or Designee on the need to follow-up to ensure lab work was completed when it shows up on the EMAR/ETAR by 9/5/17. • When pharmacist recommendations are received monthly, DON will give these	

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F 329	Continued From page 23 R65's physician visit notes dated 4/28/17, lacked documentation of risks versus benefits of psychoactive medications, or gradual dose reductions. R65's physician visit notes dated 6/23/17, lacked documentation of risks versus benefits of psychoactive medications, or gradual dose reductions. On 7/25/17, R65's pharmacy review indicated a repeated request for the physician to address the risks versus benefits for psychoactive mediations was made. R65's medical record lacked liver profile or microalbumin labs for R65, indicating they were not done as ordered. On 7/27/16, at 9:03 a.m. registered nurse (RN)-A stated they fax consultant pharmacist recommendations to the physician. and the pharmacist will repeat the request if the physician does not address it within a couple of visits. The recommendations are put in the resident's chart for the physician to review. On 7/27/17, at 9:56 a.m. the consultant pharmacist verified he had made a recommendation on 4/13/17, for the physician to document risks versus benefits for psychoactive medications, and repeated the recommendation on 7/25/17, as the physician did not respond to the first recommendation. The consultant pharmacist stated he waits for another physician visit for a response and then re-issues the recommendation. On 7/27/17, at 10:30 a.m. director of nursing	F 329	to the Unit Managers for appropriate follow-up with MD. Recommendations will be brought to weekly Nurse Manager Communication Meetings until they are resolved appropriately such as MD to address benefits of current psychoactive medication regimen versus the risks associated with the potential reduction in dosing. If items are not resolved as of next pharmacist review date, DON will contact MD office for further intervention. If items are still unable be resolved, DON will notify Medical Director for further instruction. Nurse Managers will be trained on this process by DON on 8/24/17 and will start the process 8/25/17. • Nurse Managers will review all residents with meds that require labs to ensure that their orders were completed correctly. Nurse managers will also review all residents taking psychotropic meds to ensure a risk vs benefits was completed by MD. All review will be done by 9/5/17. DON and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random audits will be completed to ensure that lab work is transcribed correctly on calendar and EMAR/ETAR and that nursing staff are checking to ensure lab work is being completed when it is noted on the EMAR/ETAR that day 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Nurse Manager or Nursing Representative • Random audits will be completed of pharmacy recommendations regarding psychoactive medication review to ensure	

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F 329	Continued From page 24 (DON) stated it is the RNs responsibility to follow up on the consultant pharmacists recommendations, and to put them in the chart for the physician to see. If the response is pending, the RN will call or fax the recommendations. DON stated yearly labs are put on the calendars and transferred to the new calendar when the year changes. DON verified she would expect labs to be done as the physician orders. On 7/27/17, at 10:40 p.m. RN-A verified she was unable to locate a liver profile or microalbumin labs for R65, indicating they were not done as ordered. The facility policy and procedure for Drug Regimen Review reviewed and revised 1/9/17, directed that any irregularities noted by the pharmacist would be sent to the attending physician, medical director and DON, and the physician must document in the resident's medical record that the identified irregularity was reviewed and what action was taken to address it, if any. The policy further directed if the physician did not provide a pertinent response, or the consultant pharmacist identifies that no action was taken, the DON and medical director would be notified. The facility policy and procedure for Diagnostic Services reviewed 1/9/17, directed the facility would provide or obtain laboratory services when ordered by a physician.	F 329	appropriate MD follow-up will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by DON or Facility Representative. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	
F 368 SS=D	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals	F 368		9/5/17

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F 368	Continued From page 25 (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a nourishing snack when a greater than 14 hour lapse occurred between supper and breakfast meal times for 1 of 4 residents (R8) reviewed for nutrition. Findings include: R8's Face Sheet, printed 7/27/17, indicated diagnoses that included anxiety, depression, diabetes, post-traumatic stress disorder, respiratory failure and anemia. R8's annual Minimum Data Set (MDS) dated 5/11/17, indicated R8 had moderately impaired cognition, required set-up assistance with eating	F 368	Dietary Manager and/or designee will implement corrective action for Resident R8 affected by this practice by: • R8 is no longer a resident at facility and was discharged on 8/5/17. Dietary Manager and/or designee will assess residents having potential to being affected by this practice including: • All residents have the potential to be affected by this practice. Dietary Manager and/or designee will implement measures to ensure this practice does not reoccur including: • Dining Services Policy was reviewed and revised to include HS snack pass	

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	245414	A. BUILDING _____ B. WING _____	07/27/2017

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F 368	Continued From page 26 and weighed 223 pounds. R8's care plan dated 6/10/16, indicated R8 was to be provided a regular diet and would have meals in the Central Park dining area. R8's undated Care Card indicated R8 was independent with eating after set-up, was to receive a regular texture, potassium restricted diet. On 7/2/7/17, at 10:30 a.m. R8 was interviewed. R8 stated she ate the 4:30 p.m. dinner meal, and then doesn't eat until the 11:00 a.m. brunch the next day, because she liked to sleep in. R8 stated sometimes the evening staff would offer her a bedtime snack, but not always. R8 stated she was sometimes hungry in the evenings, wouldn't ask for a snack, but would wait to be offered a snack. R8's Meals and Weights report, for 4/1/17, to 7/26/17, indicated there were 116 days in the report window and revealed: -No documentation for any a.m. snacks -No documentation for any p.m. snacks -No documentation of percentage of intake for evening snack -27 entries of "Asleep" for evening snack documentation; the other dates were blank -46 days when only 1 meal intake was documented -8 days when no meal intakes were documented -Only 1 day with 3 meals documents. The Meals and Weights report further indicated R8's weight was 225 pounds on 4/3/17, and 203 pounds on 7/26/17.	F 368	process on 8/21/17. • Nursing/CNA Staff will be responsible for passing out nourishing HS snacks to all residents. Resident HS snack lists were developed for Nursing/CNA staff to use to record the offering of snacks at HS on 8/22/17. Kitchen staff will stock unit fridges/units with a variety of nourishing snack items daily for use during HS snack pass. All Nursing/CNA staff and dietary staff will be educated on process of HS snack pass including assisting residents who require assistance with eating and the revised Dining Service Policy by the Dietary Manager or designee by 9/5/17. Dietary Manager and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random audits of HS snack pass/documentation will be done 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Dietary Manager and/or designee. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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F 368	Continued From page 27 On 7/26/17, at 8:41 a.m. housekeeper (H)-A stated intakes were not recorded at the continental breakfast; staff just check who comes to the dining room. H-A stated they are the staff that are responsible for serving and recording attendance at the continental breakfast. On 7/26/17, at 2:15 p.m. dietary aide (DA)-A was observed going from room to room offering an afternoon snack. DA-A stated the dietary department takes a snack cart around in the afternoon, but the nursing staff is responsible for providing an evening, or bedtime snack, with food out of the unit refrigerators. On 7/26/17, at 2:18 p.m. nursing assistant (NA)-B stated the NAs will sometimes ask residents if they want the evening snack, but usually they rely on residents asking them for an evening snack. NA-A confirmed staff rely on residents asking for a snack, and stated she doesn't remember ever recording the evening snack, and they don't have a system or recording sheet for if it was provided or consumed. On 7/27/17, at 8:30 a.m. NA-C stated the evening snack was usually associated with the evening activity, and was usually a cookie or dessert. Otherwise, NA-C stated, the NAs would bring a peanut butter and jelly snack, jello or pudding. NA-C, who worked both day and evening shifts, stated there was not a checklist available to determine what residents would like for a snack, or if they received a snack, but the NAs know what the residents enjoy, and some residents routinely get a snack with their medications. NA-C stated snacks were available whenever a resident requested one, but it would be difficult to provide a snack if a resident were non-verbal.	F 368		

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F 368	Continued From page 28 On 7/27/17, at 10:32 a.m. registered nurse (RN)-A stated the kitchen staff bring down snacks for the evening, and the NAs are responsible for passing evening snacks. RN-A stated staff will offer the snack when they are doing bedtime cares, or at about 7:00 p.m. when they are in resident's rooms. RN-A stated staff should offer non-verbal resident snacks, and help them with eating the snack. RN-A stated the evening snack was not considered a meal so consumption was not recorded, and confirmed there was no system for ensuring all residents are offererd a snack. On 7/27/17, at 10:55 a.m. the director of nursing (DON) stated if the evening snack was absolutely something they wanted a resident to have, it would be included on the electronic Medicaiton Administration Record (eMAR) or electronic Treatment Administration Record (eTAR). The DON stated the kitchen brings food out to the units, and the staff go by what the resident requests. The DON confirmed there was not a system by nursing that ensures evening snacks are provided to all residents. The DON confirmed there was no documentation of evening snacks being offered or consumed. The facility Meal Time/Locations undated, indicated dinner was provided in the facility from 4:30 - 5:30 p.m. in the main dining room and brunch was scheduled for 11:00 a.m. (17.5 hours between the meals). The facility policy on Dining Services dated 5/11/17, directed coffee and juice are delivered throughout the building at 2:00 p.m each day, and evening snack carts are delivered throughout the building at 7:30 p.m. each day. The policy further	F 368		

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F 368	Continued From page 29 directed nursing and dietary service will work together to provide consistency, continuity and uniformity of meal service and snacks are available to residents on request.	F 368		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the food mixer, measuring cups and utensils were cleaned to prevent cross contamination and food-borne illness. This had the potential to affect all 84	F 371	Dietary Manager and/or designee will implement corrective action affected by this practice by: • The Mixer, measuring cups, and	9/5/17

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F 371	Continued From page 30 residents who resided in the facility and ate food prepared from the kitchen. Findings include: On 7/24/17, at 11:55 a.m. during a tour of the kitchen with the dietary manager (DM), the food mixer had dried, white, crusty food debris on the hub where the attachments are inserted and on the splash guard. DM verified the mixer had been cleaned and was ready for use. DM further verified the mixer should be free of food debris. In addition, a 1/4 cup measuring cup was found in the utensil drawer coated with light brown, dry, grainy food debris. DM verified the measuring cup was dirty and should not be in the clean utensil drawer. On 7/26/17, at 10:31 a.m. during a tour of the kitchen with DM, the food mixer hub and splash guard were clean, though there was dry, white, crusty food debris on the area above the hub, underside of the mixer. DM verified the findings and mixer had been cleaned and were ready for use. DM stated the mixer did not disassemble and was difficult to clean. In addition, all the measuring cups in the utensil drawer had brown and white grainy food debris in them. DM also identified unclean measuring spoons. DM stated it looked like cream of wheat, but was not sure. DM verified the unclean food preparation equipment could cross contaminate foods. The facility's Daily Cleaning Tasks check list did not include the cleaning of the mixer. The facility policy and procedure for Using Sanitary Practices to Prepare, Serve, and Store Food revised 2/16, directed equipment and	F 371	utensils were cleaned per facility policy. Dietary Manager and/or designee will assess residents having potential to being affected by this practice including: • All residents have the potential to be affected by this practice. Dietary Manager and/or designee will implement measures to ensure this practice does not reoccur including: • The Kitchen Daily Cleaning Tasks checklist was updated on 8/18/17 to reflect cleaning of the mixer. • The Dietary Aides and Cooks will be responsible for completing the Kitchen Daily Cleaning Task list. • Training will be completed with all Dietary Staff by the Dietary Manager on who is responsible for completing the Kitchen Daily Cleaning Task Checklist and on the proper procedure of cleaning the mixer, measuring cups, and utensils by 9/5/17. Dietary Manager and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random kitchen audits will be completed 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter by Dietary Manager and/or designee to ensure kitchen items (utensils, measuring cups, mixer, etc.) are clean. This will include opening of drawers, cupboards, etc. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance	

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F 371	Continued From page 31 utensils would be clean prior to use. The undated facility policy and procedure for Cleaning Mixer, directed cook to clean the mixer after each use, using a sanitizing solution to wipe down the entire mixer, including the guard and attachment mounting.	F 371	Committee will make recommendations for ongoing monitoring.	
F 465 SS=F	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the drip pan under the stove top was free of food debris and grease drippings. This had the potential to affect all 84 residents who resided in the facility and ate food prepared in the kitchen. Findings include: On 7/24/17, at 11:55 a.m. during a tour of the kitchen with the dietary manager (DM), it was revealed the grease drip pan under the stove top had been lined with aluminum foil and had a large amount of yellow food dripping and grease on the	F 465	Dietary Manager and/or designee will implement corrective action affected by this practice by: • The Drip pan under stove was cleaned per facility policy. Dietary Manager and/or designee will assess residents having potential to being affected by this practice including: • All residents have the potential to be affected by this practice. Dietary Manager and/or designee will implement measures to ensure this	9/5/17

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F 465	Continued From page 32 foil. DM stated it was supposed to have been cleaned on Sunday and had not been done. The DM stated the ovens were to be cleaned weekly and the stove tops were to be cleaned twice weekly. On 7/26/17, at 10:45 a.m. during a tour of the kitchen with DM, the drip pan under the stove top had the same food debris and grease on the aluminum foil. The DM verified it had not yet been cleaned. The facility's undated Daily Cleaning Tasks checklist lacked the cleaning of the oven, stove, and drip pan. The undated facility policy and procedure for Cleaning Ranges, directed ranges would be cleaned after each use and drip pans were to be washed as needed and/or according to the cleaning schedule.	F 465	practice does not reoccur including: • The Kitchen Daily Cleaning Tasks checklist was updated on 8/18/17 to reflect cleaning of the drip pans, stove and ovens. • The Dietary Aides and Cooks will be responsible for completing the Kitchen Daily Cleaning Task list. • Training will be completed with all Dietary Staff by the Dietary Manager on who is responsible for completing the Kitchen Daily Cleaning Task Checklist and on the proper procedure of cleaning the drip pans, stove, and ovens by 9/5/17. Dietary Manager and/or designee will monitor corrective actions to ensure effectiveness of these actions including: • Random Kitchen Environmental Audits will be completed by the Dietary Manager and/or designee 3x/week x 2 weeks beginning the week of 8/21/17, then weekly thereafter to ensure cleanliness of the kitchen environment, including the drip pans, stove, and ovens. • Monitoring will be reported to Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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K 000	INITIAL COMMENTS Anderson, James A. 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Viewcrest Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/17/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@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 Inspected as one building: Viewcrest Health Center, is a 2-story building with a partial basement. The original building was constructed in 1960 with 3 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(111) 2-story. Since the construction types of the original building and the 3 additions meet the minimum requirements for existing healthcare facilities it was inspected as one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 92 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 271 SS=D	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 7.1.6.2. This deficient practice could affect 20 of 85 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 4:30 p.m. on 07/25/2017, observations revealed the exit discharge located at the exit by the MDS Office had a 1.5 inch drop in elevation at the threshold of the exit door.	K 271	In order to comply with NFPA 101 section 7.1.7 and 7.1.6.2, the exit door located at the MDS office will be sloped using a concrete patch adhesive or asphalt overlay, eliminating the 1.5 sharp elevation drop to the sidewalk. All other exit doors were inspected by the Environmental Services Director and there are no elevation changes that would prohibit the use of the exit. The Environmental Services Director is responsible for the monitoring of the exits for elevation changes and obstructions.	9/5/17

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K 271	Continued From page 3 This deficient condition was verified by the Maintenance Supervisor.	K 271		
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect 20 of 85 residents, as well as an undetermined number of staff, and visitors	K 341	In order to comply with NFPA 101 sections 19.3.4.1 and NFPA 72 section 29.8.3.4 the smoke detector was moved to an adjacent ceiling panel that is more than 36 inches from the diffuser. The Environmental Services Director will tour the building and look for any smoke detectors less than 36 inches from a diffuser. If any are found, they will be relocated to an adjacent ceiling panel that is more than 36 from a diffuser. The Environmental Services Director is responsible for monitoring any construction or renovation that may	9/5/17

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 _____	**07/25/2017**

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 341	Continued From page 4 Findings include: On facility tour between 11:30 a.m. to 4:30 p.m. on 07/25/2017, observation revealed, that the smoke detector located in the corridor outside of resident room 214 was found to be installed within 36 inches of a HVAC vent diffuser. This deficient condition was verified by the Maintenance Supervisor.	K 341	impact the location of the smoke detectors and insure compliance with distance from a diffuser.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 4 smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 85 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke	K 372	In order to comply with NFPA 101 sections 19-3.7.3 and section 8.3 the 1 inch by 4 inch penetration was fire-stopped using fire rated caulking. The Environmental Services Director will complete a facility tour to look for other smoke barrier penetrations and if found, will be fire-stopped.	9/5/17

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2017**

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VIEWCREST HEALTH CENTER	**3111 CHURCH STREET** **DULUTH, MN 55811**

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K 372	Continued From page 5 compartment to another. Findings include: On facility tour between 11:30 a.m. to 4:30 p.m. on 07/25/2017, observations revealed that the smoke barrier wall passing through resident room 47 has a 1 in by 4 inch opening around cable television wires that are passing through the that portion of the smoke barrier wall. This deficient condition was verified by a Maintenance Supervisor.	K 372	The Environmental Services Director is responsible for monitoring any construction or renovation that may require new penetrations be made through a smoke barrier wall and ensure they are properly fire-stopped.	
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had a deficient condition affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect the residents, as well as an undetermined number of staff, and visitors.	K 511	In order to comply with NFPA 101 section 9.1.2 and NFPA 70 2011 edition, the electrical outlet located in the conference room was pulled out, refastened flush with the wall and a new outlet cover was placed on the outlet. The Environmental Services Director conducted an outlet continuity and tension test inspection in all sleeping	9/5/17

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	245414	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2017**

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K 511	Continued From page 6 Findings include: On facility tour between 11:30 a.m. to 4:30 p.m. on 07/25/2017, observations revealed that there is an electrical outlet that is located in the conference room by the MDS office that is missing a cover plate and has been partially dislodged and pushed into the wall. This deficient condition was verified by the Maintenance Supervisor.	K 511	compartments and during that inspection, visually inspected all outlets for any damage, missing covers or broken covers and replaced as necessary. An electrical outlet inspection of all non-sleeping compartment rooms will be conducted to visually inspect for properly attached outlet covers. Any outlets found to be not properly mounted and/or without a cover will be replaced or repaired. Staff will be reminded to report any damage or problems found with any electrical outlet using the established work order process. The Environmental Services Director is responsible for ensuring that all electrical outlets have the proper cover and are functioning properly.	